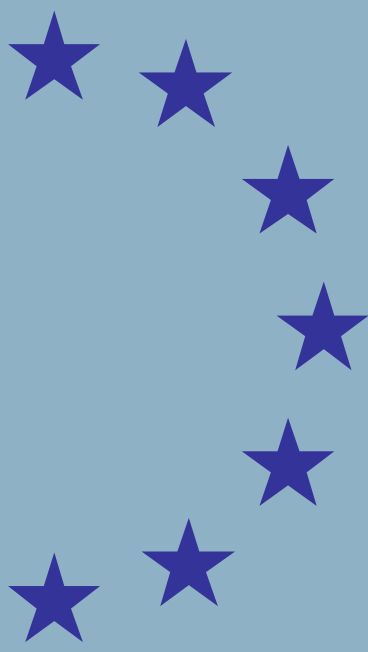




# The Czech Republic

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## Health Care & Long-Term Care Systems



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## **The Czech Republic**

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Health care systems

## 1.6. CZECH REPUBLIC

### General context: Expenditure, fiscal sustainability and demographic trends

*General country statistics: GDP, GDP per capita; population;*

GDP per capita (21,600 PPS in 2013) is lower than the EU average (27,900 PPS). The Czech Republic recorded high real GDP growth before 2009, above the EU average, throughout the decade. As a result of the global economic crisis, real GDP growth was -5.1% in 2009 followed by positive growth rates in 2010 and 2011 and negative growth rates in 2012 and 2013. Current population stands at 10.5 million people and has been fairly stable throughout the decade. The population is projected to increase to 11.1 million by 2060.

### *Total and public expenditure on health*

Total expenditure on health as a percentage of GDP (7.2% in 2013) is below the EU average (10.1%). It has increased from 6.7% in 2006 but it is lower than that registered in 2009. Public expenditure on health as a percentage of GDP is below the EU average (CZ: 6.0% vs. EU: 7.8%). In 2013, total (1,535 PPS) and public (1,279 PPS) per capita expenditure were lower than the EU average in (2,988 PPS and 2,208 PPS).

### *Expenditure projections and fiscal sustainability*

Public expenditure on health care is projected to increase by 1.0 pp of GDP ("AWG reference scenario"), above the average increase of 0.9 pps for the EU. When taking into account the impact of non-demographic drivers on future spending growth ("AWG risk scenario"), health care expenditure is expected to increase by 1.7 pps of GDP from now till 2060 compared to the EU average of 1.6 pps<sup>(80)</sup>. Overall, projected health care expenditure poses a risk to the medium and long-term sustainability of public finances. Over the long run, medium sustainability risks appear for the Czech Republic. These risks derive primarily from the projected impact of age-related public spending (notably health care and

pensions), compounded by the slightly unfavourable initial budgetary position.<sup>(81)</sup>

### *Health status*

Despite showing an improvement, the health status of the Czech population lags slightly behind the EU average. While showing a consistent increase, life expectancy (81.3 years for women and 75.2 years for men in 2013) is still below the EU average (83.1 and 77.6 years of life expectancy in 2013). However, healthy life years are above the respective EU averages (64.2 years for women and 63 years for men in 2013 vs. EU average of 61.8 and 61.6 respectively). Amenable mortality rates show a consistent decrease over the decade but are still fairly high (187 deaths per 100 000 inhabitants in CZ vs. 128 in the EU). Infant mortality is below the EU average (2.6‰ vs. 3.9‰).

### System characteristics

#### *System financing*

The Czech health care system is a compulsory social health insurance (SHI) system with universal coverage. Entitlement to coverage is based on permanent residence rather than SHI contributions, and each person must be covered either through a SHI, a foreign social insurance system or a private health insurance.

The SHI system plus contribution from the state budget comprise 83% of total health expenditure. Stage budget contribution is devoted to capital investments in facilities directly managed by the Ministry of Health (teaching hospitals, specialised health care, research and postgraduate education facilities) or by regional authorities (regional and municipal hospitals), as well as to public health services (training costs of medical personnel, variety of health promotion and disease prevention, medical research, postgraduate education, etc.).

In 2013, mandatory SHI contributions account for 76% of revenues of the SHI system. The remaining 24% comes from the State contributions for certain groups of economically inactive people (children,

<sup>(80)</sup> The 2015 Ageing Report: [http://europa.eu/epc/pdf/ageing\\_report\\_2015\\_en.pdf](http://europa.eu/epc/pdf/ageing_report_2015_en.pdf).

<sup>(81)</sup> Fiscal Sustainability Report 2015: [http://ec.europa.eu/economy\\_finance/publications/eeip/pdf/ip018\\_en.pdf](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf).

students, women or men on parental leave, pensioners, unemployed, imprisoned and asylum seekers). SHI contributions take the form of a payroll tax split between employers and employees; self-employed must contribute a fixed percentage of their profits. Contributions of employed people amount to 13.5% of gross monthly wages, with employees paying 4.5% and employers 9%. The state-financed contributions represented 870 CZK in 2016 for every economically inactive person monthly. These revenues for the Czech health system are therefore set by law; they consist in a fixed amount of money, occasionally adjusted – "valorised".

Next, SHI contributions are redistributed among the funds according to a risk-adjustment scheme based on age and gender. The VZP is the largest fund, covering approximately 59% of the population in 2013. It was the first one created in 1992, covering at that time 100% of the market. However, it is supposed to have the worst risk-structure of the members, as funds established later have been taking over mainly younger and healthier part of the population.

Private spending includes mainly three categories of expenditures: out-of-pocket payments for over-the-counter pharmaceuticals and some dental procedures; co-payments on medical aids and prescription pharmaceuticals, whose price exceeds the reimbursement amounts; and user fees for prescription pharmaceuticals and medical services. Private expenditure accounted for 17% of total health expenditure in 2013. This amount is still among the lowest in the EU, well below the average of 23%. Although available, voluntary health insurance plays a minor role in health care financing (less than 1% of health expenditure in 2012), which is mainly due to the broad range of benefits available under the SHI schemes.

#### *Administrative organisation*

SHI is assured by health insurance funds (in 2013 there were 7 of them, down from 27 in the mid-1990s), which are quasi-public, self-governing bodies that act as payers and purchasers of care. Patients can change their choice of a fund once every 12 months. Funds are obliged to accept all applicants and not allowed to make risk selection.

Even if the state has been decentralised (end of 1992) – and therefore competencies given to regional authorities beside the state level – the level of expenditure in administering such a system does not seem high, though its share in the total health expenditure has slightly increased in recent years. Public and total expenditure on health administration and health insurance as a percentage of GDP, both 0.2% in 2013, are both below the EU average (0.3%).

#### *Coverage of services, types of providers, referral systems and patient choice*

The range of coverage includes "any medical treatment delivered with the aim of maintaining or improving an individual's health status". In practice the benefits are rationed at the point of use by the provider, based on four factors: the negative lists of procedures and services excluded from reimbursement; the positive lists of approved pharmaceuticals, medical aids and dental aids that may be reimbursed (together with the depth of coverage); the annual negotiation process between health insurance funds and health care providers resulting in establishment of specific conditions of reimbursement attached as amendments to the existing long-term contracts between them; the List of Health Services, being a fee schedule of the rationed benefits updated annually by the Ministry of Health.

Primary care is provided by physicians working in private practices or in health centres and polyclinics. Currently 95% of services are provided in private – mainly individual – practices. Polyclinics and health centres are usually private legal entities, which additionally offer ambulatory specialist care. Sometimes health centres are owned by the municipalities, and primary care physicians pay a rent for the use of the facilities.

Patients register with a primary care physician of their choice and can switch to a different doctor once every three months. The gatekeeper role of general practitioners (GPs) is limited. The physicians can refer patients to specialists, but the direct access to the latter is neither institutionally restricted nor economically discouraged. The patients frequently use this option in practice, circumventing the physicians and addressing directly the specialists. The referral is, however, obligatory for admissions to secondary inpatient

care (except for emergency cases). Moreover, visits to the dentists and gynaecologists are always direct and without referral.

Secondary care services are provided by private practice specialists, hospitals and specialised inpatient facilities. Following a series of reforms in the 1990s, formerly state-owned hospitals are currently owned and managed by a wide range of entities: ministries, regions and municipalities, private entities and churches.

Empirical evidence suggests a deficit of GPs and an overutilisation of secondary and tertiary care in comparison with primary care. The number of practising physicians (369 per 100 000 inhabitants) and nurses (799 per 100 000 inhabitants) slightly exceeded or was at the EU averages in 2013 (344 and 837 respectively). However, the number of GPs is lower than the EU average (63 vs. 78 per 100 000 in 2013).

On the other hand, these figures suggest relatively easy access and possibly excessive use of inpatient care. All indicators, although falling over the last years, still exceed significantly respective figures for the entire EU on average: number of acute care beds (437 vs. 356 per 100 000 of population in 2013), number of inpatient hospital discharges (19.5 vs. 16.5 per 100 inhabitants in 2013) and average length of stay in acute care hospitals (6.6 vs. 6.3 days in 2013). Those figures, together with the data on the share of hospital day case in total discharges (3.2% in the Czech Republic vs. 30.4% in the EU in 2013), may suggest an inadequate allocation of resources between acute health care on the one hand and outpatient care on the other hand, only partially explained by the reimbursement system (see below).

#### *Purchasing and contracting of health care services and remuneration mechanisms;*

Health insurance funds conclude long-term contracts with the providers, for five or eight years. Only the framework of such contracts is defined by law. They include necessary conditions for providing health care, general payment mechanisms, conditions for ending the contract, other rights and obligations of both sides, but do not include specific conditions of reimbursement, which are subject to annual negotiations.

GPs are paid according to a system of risk-adjusted capitation fees, accounting for age, but not gender of the patients. The number of patients per physician is subject to a limit above which the payment is reduced. However, some services (such as preventive examinations and visits to patients' homes, accounting in 2011 for approximately 30% of physicians' income) are still paid on the fee-for-service basis.

Ambulatory care specialists are reimbursed using a digressive fee-for-service system, based on the List of Health Services. This List defines the number of points for each service and the threshold of the amount of services up to which providers are fully reimbursed. In case the limit is exceeded, the value of points is reduced. The financial value of the point is bargained annually between insurance funds and provider organisations.

Payments to hospitals are very diverse. Mainly, the system of prospective global budgets is used. The budget's level is based on the amount of services provided during the relevant period of the previous year and the sum of points from the "List of Health Services". A growing number of cases are paid on the basis of diagnosis-related groups (DRGs) system: each year an updated version of the list of relative weights is published and the base rate is set. This system is supplemented with flat fees per insured person which are applied according to the thresholds based on the amount of services provided during the previous year.

#### *The market for pharmaceutical products, the use of Health Technology Assessment and cost-benefit analysis*

Public and private pharmaceutical expenditure accounts for 20% of total current health expenditure, which is slightly more than the EU average (14.9% in 2013). The pharmaceutical reimbursement system is based on reference pricing, whereby the basic reimbursement level for each reference group of substitutes is set at the price of the least expensive of those in the entire EU. Also maximum ex-factory prices for pharmaceuticals are based on international benchmarking, and the group of reference countries includes eight EU Member States (Estonia, France, Italy, Lithuania, Hungary, Portugal, Greece and Spain). The combined maximum amount of mark-ups by pharmacies and

wholesalers is set by the Ministry of Health. The system is regressive, with maximum surcharges being reduced in line with growing ex-factory prices.

In order to constrain pharmaceutical expenditure, health insurance funds are allowed to introduce pharmaceutical budgets for each provider and impose penalties in case of overspending.

#### *eHealth (e-prescription, e-medical records) and information and reporting mechanisms;*

The information and communication technologies are still not sufficiently spread in the Czech health system. Health technology assessment of treatments and procedures is practically not available due to the lack of technical infrastructure. For the same reason, the information on patients owned by the health insurance funds is not efficiently used in practice.

The use of electronic medical records is being currently developed with a number of projects allowing physicians to share patient information between physicians and with the concerned patient. Information systems are broadly used for reimbursement and accounting purposes, and the use of web pages is being increasingly spread among health insurance funds, health care facilities and physicians. A system of mandatory e-prescriptions was approved to be effective from January 2015, but now it is in the process of improvement.

Although the country lacks a unified system for assessing the quality of health services, the providers in some sectors of care (mainly those under direct responsibility of the Ministry of Health) are more and more frequently assessed via surveys, patient satisfaction questionnaires and accreditations.

The government aims to ensure secure sharing of important health and economic information, thereby achieving improved quality, comfort, security and transparency of the health care system. Computerisation allows professionals and patients to make the right decisions based on correct information. Full use of modern communication technologies will contribute to a better and more cost-effective care. In this context, the aim is to create a working government strategy

to ensure standards necessary for the development and sustainability of eHealth and to oversee their implementation.

#### *Health promotion and disease prevention policies*

The need to improve health status further through promotion and prevention activities is a policy priority. The government intends to support the implementation of health promotion projects aimed at promoting and optimisation of physical activity among the general public and specific target groups. It will also support health promotion projects aimed at achieving changes in eating habits and increasing health literacy, especially among children and the youth. It will also focus on reducing the health risks of the living and working environment and reducing health risk behaviour, in particular regarding protection against addictive substances. The government will also promote the prevention of infectious diseases, particularly through measures aimed at antimicrobial resistance and vaccination programs. Currently, total and public expenditure on prevention and public health services as a % of GDP (0.2% and 0.1%, latest data) are below the EU average (0.2%).

#### *Recently legislated and/or planned policy reforms*

A number of measures aimed at improving the cost-effectiveness and governance of the health care sector, based on the priorities in the Government's manifesto and the National Strategy for Health 2020, are in various stages of implementation. In order to provide for a better hospital financing system, the 'diagnosis-related group' project formally commenced in January 2015. However, its outcomes will only be used for financing in 2018 at the earliest. Conversely, fees in the outpatient sector were eliminated in 2015, leading to an increase in the consumption of services.

The introduction of centralised public procurement for selected pharmaceuticals was launched in 2015 and the Commission for Accessing the Placement of Medical Devices also became operational. A complete and compulsory disclosure of contracts between health insurers and providers entered into force in 2016, which should increase the transparency of the Czech health care system and

boost competition among health care providers. In addition, the government implemented the cancellation of cost-sharing fees for hospital care in 2014, as well as the abolishment of fees for outpatient services and prescriptions in 2015. Short-term measures include the reduction of the health insurance companies' reserve fund by a half, i.e. from the current 1.5% to 0.75%. Through this measure, health care has received an additional budget allocation in 2014. In 2014, the government also submitted a proposal to reduce the overhead costs of health insurance companies.

As far as future policy changes are concerned, the Government intends to strengthen the activities leading to a more equitable distribution of funds among health insurance companies. Redistribution of health insurance funds should be influenced by other parameters (e.g. PCG, Pharmacy Cost-Based Groups) to enable more equitable distribution of funds among health insurance companies and thus improve the quality of care for chronically ill patients. In this context, as of 2016 at the moment the Government handed over to parliament a proposal for changing the respective law (592/1992). Additionally, selected public hospitals will be transformed into non-profit entities, with the aim of enhancing management of key hospitals in the country. There are also plans to replace the non-transparent process of determining the reimbursement of medical devices with a new system.

The government aims also at strengthening, through legal measures, the state supervision of health insurance flows and over the functioning of the health insurance companies. The government will introduce a transparent system of quality indicators for comparing and publishing of quality of health care in individual health care facilities, so that these are accessible to both patients and specialists.<sup>(82)</sup> Competencies between the Ministry of Health and the National Reference Centre shall also be specified.

The government's commitment to effectively define the process of entry of new technologies into the health system still continues. A

<sup>(82)</sup> The authorisation will have to be embedded in the amendment to the Act No. 372/2011 Coll. on Health Services.

methodology has been established within the project of implementation of health technology assessment (HTA), which should ensure that new technologies, which are to be covered by the public health insurance system, bring adequate and documented counter value. It is necessary to decide on the form of the institutional arrangements for HTA and the manner of its inclusion in the process of determining the extent of medical care covered by public health insurance. In 2017 the usability of the methodology will be tested further as well as its eventual deployment via a law.

## Challenges

The analysis above has shown that many reforms are ongoing, aiming mainly at an improved efficiency of the health system via cost-containment and more market-oriented solutions, and its results are yet to be evaluated. The main challenges for the Czech health system are as follows:

- To continue increasing the efficiency of health care spending in order to adequately respond to the increasing health care expenditure over the coming decades, which is a risk to the long-term sustainability of public finances.
- To clearly define a basic package of the health care services which are covered from the general insurance (i.e. to have a more explicit definition of SHI benefits).
- To develop a comprehensive human resources strategy that tackles spatial/regional disparities in health care accessibility (physicians' density, waiting times).
- To enhance primary care provision and tackle the excessive use of specialist and hospital care, in particular with a referral system to specialist care either through financial incentives or by making it compulsory; to promote use of GPs' services, by strengthening organisational and financial incentives for both doctors and patients; to foster the coordination of care between primary, secondary and hospital care in order to reduce redundant and duplicated medical examinations and laboratory tests, doctor visits and unnecessary

drug prescriptions; to monitor the impact of the abolishment of patient cost-sharing at different levels of care, especially with regard to avoidable use of services.

- To improve the cost-efficiency within hospitals, ensuring that care is provided in the most clinically appropriate and cost-effective way, by implementing the new DRG based financing system, by increasing the proportion of elective care provided on a day-case basis and day-of-surgery admissions; to consider reducing the high number of acute care bed capacity.
- To further develop the equitable financing system of insurance system in order to minimise patient selection, improve fairness in financing, and reduce fiscal risks.
- To implement the e-prescription tool for pharmaceuticals, improving the rational prescription and use of medicines and enhancing access to cost-effective medicines, while generating savings to payers.
- To introduce a system of quality indicators for comparing and publishing of quality of health care in individual health care facilities, that should be accessible to patients and clinicians.
- To foster the use of centralised procurement procedures for pharmaceuticals, but also for other medical and non-medical goods, generating savings to payers, while ensuring access to high-quality products in the health system.
- To ensure a greater and more systematic use of health technology assessment to achieve decisions, for example about the SHI coverage or reimbursement rates.
- To foster health promotion and disease prevention activities, promoting healthy life styles and disease screening given the pattern of risk factors (smoking, alcohol, obesity, circulatory system diseases).



Table 1.6.1: Statistical Annex – Czech Republic

General context												EU- latest national data		
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
<b>GDP</b>														
GDP, in billion Euro, current prices	88	96	109	124	138	161	148	156	164	161	157	9289	9800	9934
GDP per capita PPS (thousands)	18.5	19.0	20.0	21.2	22.3	21.3	19.9	20.6	21.6	21.5	21.6	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	3.8	4.7	6.5	6.7	5.2	2.0	-5.1	2.2	2.0	-1.1	-1.0	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	4.2	1.3	7.0	3.0	2.5	6.7	9.2	-3.3	3.0	-0.4	-5.1	3.2	-0.2	-0.4
<b>Expenditure on health*</b>												<b>2009</b>	<b>2011</b>	<b>2013</b>
Total as % of GDP	7.1	6.9	6.9	6.7	6.5	6.8	7.9	7.4	7.5	7.6	7.2	10.4	10.1	10.1
Total current as % of GDP	6.9	6.7	6.7	6.5	6.3	6.7	7.6	7.2	7.4	7.4	6.9	9.8	9.6	9.7
Total capital investment as % of GDP	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.3	0.6	0.5	0.5
Total per capita PPS	1071	1132	1211	1255	1332	1448	1615	1536	1573	1589	1535	2828	2911	2995
Public as % of GDP	6.4	6.2	6.1	5.8	5.6	5.6	6.6	6.2	6.3	6.3	6.0	8.1	7.8	7.8
Public current as % of GDP	6.1	5.9	5.8	5.6	5.3	5.5	6.4	6.0	6.2	6.2	5.8	7.9	7.7	7.7
Public per capita PPS	883	931	970	1005	1043	1111	1252	1196	1324	1334	1279	2079	2218	2208
Public capital investment as % of GDP	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.2	0.2	0.2	0.1
Public as % total expenditure on health	89.8	89.1	87.3	86.8	85.3	82.6	83.7	83.7	84.1	84.0	83.3	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	14.8	16.2	16.0	16.4	16.8	16.8	17.2	17.8	18.1	17.5	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	10.0	10.4	10.7	11.3	13.2	15.7	14.6	14.9	14.7	15.0	15.7	14.1	14.4	14.1
Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.														
<b>Population and health status</b>												<b>2009</b>	<b>2011</b>	<b>2013</b>
Population, current (millions)	10.2	10.2	10.2	10.2	10.3	10.3	10.4	10.5	10.5	10.5	10.5	502.1	504.5	506.6
Life expectancy at birth for females	78.6	79.1	79.2	79.9	80.2	80.5	80.5	80.9	81.1	81.2	81.3	82.6	83.1	83.3
Life expectancy at birth for males	72.0	72.5	72.9	73.5	73.8	74.1	74.3	74.5	74.8	75.1	75.2	76.6	77.3	77.8
Healthy life years at birth females	:	:	60.0	59.9	63.3	63.4	62.7	64.5	63.6	64.1	64.2	:	62.1	61.5
Healthy life years at birth males	:	:	58.0	57.9	61.4	61.3	61.1	62.2	62.2	62.3	62.5	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	154	132	128	119	97	94	95	88	193	187	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	3.9	3.7	3.4	3.3	3.1	2.8	2.9	2.7	2.7	2.6	2.5	4.2	3.9	3.9
Notes: Amenable mortality rates break in series in 2011.														
<b>System characteristics</b>												<b>EU- latest national data</b>		
<b>Composition of total current expenditure as % of GDP</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2009</b>	<b>2011</b>	<b>2013</b>
Inpatient curative and rehabilitative care	2.36	2.18	2.11	2.08	1.95	2.00	2.28	2.17	2.20	2.16	2.05	3.13	2.99	3.01
Day cases curative and rehabilitative care	0.07	0.07	0.07	0.08	0.08	0.12	0.11	0.12	0.13	0.13	0.13	0.18	0.18	0.19
Out-patient curative and rehabilitative care	1.49	1.50	1.49	1.51	1.59	1.75	2.12	2.05	2.13	2.16	2.12	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	1.73	1.71	1.72	1.52	1.40	1.39	1.69	1.48	1.50	1.59	1.39	1.60	1.55	1.44
Therapeutic appliances and other medical durables	0.22	0.22	0.23	0.22	0.23	0.24	0.21	0.22	0.22	0.21	0.20	0.31	0.31	0.32
Prevention and public health services	0.12	0.14	0.12	0.14	0.14	0.18	0.17	0.18	0.17	0.15	:	0.25	0.25	0.24
Health administration and health insurance	0.20	0.24	0.23	0.22	0.23	0.24	0.25	0.24	0.24	0.23	0.24	0.42	0.41	0.47
<b>Composition of public current expenditure as % of GDP</b>														
Inpatient curative and rehabilitative care	2.31	2.14	2.06	2.04	1.90	1.94	2.17	2.08	2.12	2.05	1.97	2.73	2.61	2.62
Day cases curative and rehabilitative care	0.07	0.07	0.07	0.08	0.08	0.12	0.11	0.12	0.13	0.13	0.13	0.16	0.16	0.18
Out-patient curative and rehabilitative care	1.37	1.35	1.33	1.36	1.39	1.43	1.69	1.71	1.79	1.84	1.82	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	1.31	1.31	1.30	1.08	0.92	0.86	1.21	0.94	0.94	1.02	0.86	0.79	1.07	0.96
Therapeutic appliances and other medical durables	0.09	0.09	0.09	0.09	0.09	0.08	0.07	0.07	0.08	0.08	0.08	0.13	0.12	0.13
Prevention and public health services	0.13	0.12	0.10	0.12	0.12	0.20	:	:	0.14	0.13	0.14	0.25	0.20	0.19
Health administration and health insurance	0.17	0.21	0.20	0.20	0.20	0.22	0.23	0.22	0.22	0.21	0.24	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.6.2: Statistical Annex - continued – Czech Republic

Composition of total as % of total current health expenditure												EU- latest national data		
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Inpatient curative and rehabilitative care	34.5%	32.6%	31.5%	32.0%	30.9%	30.1%	29.9%	30.0%	29.9%	29.1%	29.5%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	1.0%	1.0%	1.0%	1.2%	1.3%	1.8%	1.5%	1.6%	1.7%	1.7%	1.8%	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	21.8%	22.5%	22.3%	23.3%	25.2%	26.3%	27.8%	28.3%	28.9%	29.1%	30.5%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	25.3%	25.6%	25.7%	23.4%	22.2%	20.9%	22.1%	20.4%	20.4%	21.4%	20.0%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	3.2%	3.3%	3.4%	3.3%	3.6%	3.6%	2.8%	3.0%	2.9%	2.9%	2.9%	3.2%	3.3%	3.3%
Prevention and public health services	1.8%	2.1%	1.8%	2.2%	2.2%	2.7%	2.2%	2.5%	2.3%	2.0%	:	2.6%	2.6%	2.5%
Health administration and health insurance	2.9%	3.6%	3.4%	3.4%	3.6%	3.6%	3.3%	3.3%	3.3%	3.1%	3.5%	4.2%	4.3%	4.9%
<b>Composition of public as % of public current health expenditure</b>														
Inpatient curative and rehabilitative care	37.7%	36.1%	35.5%	36.4%	35.6%	35.5%	34.2%	34.5%	34.4%	33.0%	33.8%	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	1.1%	1.1%	1.2%	1.3%	1.6%	2.2%	1.8%	1.9%	2.1%	2.0%	2.2%	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	22.3%	22.8%	22.9%	24.3%	26.0%	26.2%	26.6%	28.4%	29.0%	29.6%	31.3%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	21.4%	22.1%	22.4%	19.3%	17.2%	15.8%	19.1%	15.6%	15.2%	16.4%	14.8%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	1.5%	1.6%	1.6%	1.6%	1.6%	1.5%	1.1%	1.2%	1.3%	1.2%	1.3%	1.6%	1.6%	1.6%
Prevention and public health services	2.1%	2.0%	1.7%	2.1%	2.2%	3.7%	:	:	2.3%	2.1%	2.4%	3.2%	2.7%	2.5%
Health administration and health insurance	2.8%	3.5%	3.5%	3.5%	3.8%	4.1%	3.6%	3.7%	3.5%	3.4%	4.0%	1.4%	3.5%	3.5%
<b>Expenditure drivers (technology, life style)</b>														
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data		
MRI units per 100 000 inhabitants	0.24	0.28	0.31	0.38	0.44	0.50	0.57	0.63	0.69	0.69	0.74	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	0.5	0.5	0.6	0.6	0.7	0.8	0.8	0.8	0.7	0.8	0.8	0.9	0.9	0.8
CTS per 100 000 inhabitants	1.3	1.3	1.2	1.3	1.3	1.3	1.4	1.4	1.5	1.5	1.5	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Proportion of the population that is obese	:	:	:	:	:	17.1	:	21.0	:	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	27.2	25.4	24.3	23.4	24.0	21.8	:	:	:	:	:	23.2	22.4	22.0
Alcohol consumption litres per capita	13.0	13.2	13.2	13.0	13.4	13.3	13.2	12.7	12.7	12.8	12.5	10.3	10.0	9.8
<b>Providers</b>	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Practising physicians per 100 000 inhabitants	353	352	356	357	357	356	358	360	364	367	369	329	335	344
Practising nurses per 100 000 inhabitants	797	810	809	805	800	794	806	808	803	806	799	840	812	837
General practitioners per 100 000 inhabitants	:	:	73	72	71	71	71	70	70	70	70	:	78	78.3
Acute hospital beds per 100 000 inhabitants	557	540	534	525	518	508	499	488	470	456	437	373	360	356
<b>Outputs</b>	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Doctors consultations per capita	13.0	13.1	13.2	13.0	12.6	11.4	11.2	11.0	11.1	11.1	11.1	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	21.1	21.5	21.5	20.8	20.6	20.2	20.0	19.7	19.4	19.3	19.5	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	305	312	343	364	378	440	439	466	524	585	642	6368	6530	7031
Acute care bed occupancy rates	:	:	78.0	:	:	:	75.3	73.8	72.8	73.1	73.9	72.0	73.1	70.2
Hospital curative average length of stay	:	:	7.1	:	:	:	7.1	7.0	6.8	6.6	6.6	6.5	6.3	6.3
Day cases as % of all hospital discharges	1.4	1.4	1.6	1.7	1.8	:	2.1	2.3	2.6	2.9	3.2	27.8	28.7	30.4
<b>Population and Expenditure projections</b>														
<b>Projected public expenditure on healthcare as % of GDP*</b>	2013	2020	2030	2040	2050	2060	Change 2013 - 2060				EU Change 2013 - 2060			
AWG reference scenario	5.7	5.9	6.2	6.5	6.6	6.7	1.0				0.9			
AWG risk scenario	5.7	6.1	6.7	7.1	7.4	7.5	1.7				1.6			
Note: *Excluding expenditure on medical long-term care component.														
<b>Population projections</b>	2013	2020	2030	2040	2050	2060	Change 2013 - 2060, in %				EU - Change 2013 - 2060, in %			
Population projections until 2060 (millions)	10.5	10.7	10.8	10.9	11.1	11.1	5.4				3.1			

Sources: EUROSTAT, OECD and WHO

## The Czech Republic

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Long-term care systems

## 2.6. CZECH REPUBLIC

### General context: expenditure, fiscal sustainability and demographic trends

GDP per capita in PPS is at 21,600 and below EU average of 27,900 in 2013. The Czech Republic has a population of 10.5 million inhabitants. During the coming decennia the population will remain roughly constant at 10.5 million.

### Health status

Life expectancy at birth for both women and men is respectively 81.3 years and 75.2 years in 2013 and is below the EU averages (83.3 and 77.8 years respectively). Healthy life years at birth are with 64.2 years (women) and 62.5 years (men) above the EU-averages (61.5 and 61.4, respectively). The percentage of the Czech population having a long-standing illness or health problem is slightly lower than in the Union (31.5% in the Czech Republic versus 32.5% in the EU). The percentage of the population indicating a self-perceived severe limitation in its daily activities stands at 6.4%, which is lower than the EU-average (8.7%).

### Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 840 thousand residents living with strong limitations due to health problems in 2013, an increase of 52% is envisaged until 2060 to slightly more than 1.28 million. That is a steeper increase than in the EU as a whole (40%). Also as a share of the population, the dependents are becoming a bigger group, from 8% to 11.6%, an increase of 44%. This is more than the EU-average increase of 36%.

### Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the AWG reference scenario, public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 0.7 pps

of GDP by 2060. <sup>(361)</sup> The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 5.3 pps of GDP by 2060. This reflects, that coverage and unit costs of care are comparatively low in the Czech Republic, and may experience an upward trend in future, driven by demand side factors.

Over the long run, medium sustainability risks appear for the Czech Republic. However, these risks derive primarily from the projected impact of age-related public spending (notably health care and pensions), and not primarily long-term care. <sup>(362)</sup>

### System Characteristics

Funding and also provision of long-term care is not completely separated from health and social care. Home care services are provided by special providers contracted by health insurers and reimbursed by public health insurance system only if indicated by a general practitioner. Institutional care is provided in specific facilities or in residential social care establishments, predominantly providing social care and nursing care to a limited extent only. Reimbursement for home and institutional care is based on fee-for-service.

Public spending on LTC reached 0.7% of GDP in 2013 in the Czech Republic, below EU average of 1.6% of GDP (Based on the 2015 Ageing Report). The Czech Republic seems to have a high usage of cash benefits. In fact, 63% of public LTC spending is done via cash benefits (EU: 20%).

In the EU, 53% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC. This share is with 91% much higher in the Czech Republic. It means that 9 out of 10 individuals aged 15 or more and declaring themselves as severely dependent, would receive some kind of formal care (at home or in institution, in kind or in cash). Overall, 7% of the population (aged 15+)

<sup>(361)</sup> The 2015 Ageing Report: [http://europa.eu/epc/pdf/ageing\\_report\\_2015\\_en.pdf](http://europa.eu/epc/pdf/ageing_report_2015_en.pdf)

<sup>(362)</sup> Fiscal Sustainability Report 2015: [http://ec.europa.eu/economy\\_finance/publications/ceip/pdf/ip018\\_en.pdf](http://ec.europa.eu/economy_finance/publications/ceip/pdf/ip018_en.pdf)

receive formal LTC in-kind and/or cash benefits (EU: 4%).

The expenditure for institutional (in-kind) services makes up 82% of public in-kind expenditure (EU: 61%), 18% being spent for LTC services provided at home (EU: 39%). Thus, relative to other Member States the Czech Republic has a focus on institutional care, which may not always be cost-efficient. As institutional care is relatively costly, Member States with shares well above the EU levels may benefit from efficiency gains by shifting some coverage (and thus expenditure) from institutional to other types of care. However, in the Czech Republic a significant part of the costs of institutional care is covered by the care recipients themselves. Thus, shifting from institutional long-term care to home care may not heavily decrease public costs, but may improve quality of life of recipients who receive care at home rather than in institutions.

#### *Types of care, eligibility criteria and user choices: dependency, care needs, income*

Recipients of care are differentiated on a four level scale according to the recipient's care needs, which is specified in the law. Care allowance is not means-tested except for patients below age of 18 years. The highest care allowance amounts to roughly half of the average salary.

Social care services are mostly provided by informal carers, but also by professional social services. Formal carers of social services can be registered or unregistered. If registered they are bound by administrative maximum prices. If a person is unregistered, then free pricing of services applies to be fully covered by private payments. Some services, such as social prevention or rehabilitation are provided without private co-payments. For institutional care, recipient's income (up to 85%) can be used to cover costs accommodation and food for residential care. Reimbursement of other social services is limited by the recipient's care allowance. Any remaining costs have to be covered privately, either by the recipient or his family. However, in some cases, a top-up from the Ministry of Labour and Social Affairs and the municipalities to cover nursing care can be made available.

#### **Recently legislated and/or planned policy reforms**

There have been no recent reforms of the long-term care system. As for the future, an interdepartmental working group was created, which aims to find solutions to the problems of social and health care borders. Following the results of the survey an amendment to existing legislation is planned.

#### **Challenges**

The main challenges of the system appear to be:

- **Improving the governance framework:** To establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities with respect to the provision of long-term care services; To set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; To strategically integrate medical and social services via such a legal framework; To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; To establish good information platforms for LTC users and providers; To share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes; To deal with cost-shifting incentives across health and care.
- **Providing adequate levels of care to those in need of care:** To adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the breadth of coverage, that is, setting the extent of user cost-sharing on LTC benefits; and the depth of coverage, that is, setting the types of services included into the coverage.
- **Encouraging home care:** To develop alternatives to institutional care by e.g.

developing new legislative frameworks encouraging home care and regulation controlling admissions to institutional care or the establishment of additional payments, cash benefits or financial incentives to encourage home care; to monitor and evaluate alternative services, including incentives for use of alternative settings.

- **Ensuring availability of formal carers:** To determine current and future needs for qualified human resources and facilities for long-term care.
- **Supporting family carers:** To establish policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.
- **Facilitating appropriate utilisation across health and long-term care:** To arrange for adequate supply of services and support outside hospitals, changing payment systems and financial incentives to discourage acute care use for LTC; To steer LTC users towards appropriate settings.
- **Improving value for money:** To invest in ICT as an important source of information, care management and coordination.
- **Prevention:** To promote healthy ageing and preventing physical and mental deterioration of people with chronic care; To employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 2.6.1: Statistical Annex – Czech Republic

GENERAL CONTEXT																
GDP and Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
GDP, in billion euro, current prices	88	96	109	124	138	161	148	156	164	161	157	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	18.5	19.0	20.0	21.2	22.3	21.3	19.9	20.6	21.6	21.5	21.6	26.8	27.6	28.0	28.1	27.9
Population, in millions	10.2	10.2	10.2	10.2	10.3	10.3	10.4	10.5	10.5	10.5	10.5	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	0.3	0.2	0.2	0.2	0.3	0.2	0.3	0.3	0.3	0.3	:	1.0	1.0	1.0	1.0	:
Per capita PPS	42.2	40.3	44.2	48.5	55.8	47.2	54.2	57.1	61.8	62.6	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	0.5	0.5	0.6	0.6	0.5	0.6	0.6	0.7	0.7	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	78.6	79.1	79.2	79.9	80.2	80.5	80.5	80.9	81.1	81.2	81.3	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	72.0	72.5	72.9	73.5	73.8	74.1	74.3	74.5	74.8	75.1	75.2	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	:	:	60.0	59.9	63.3	63.4	62.7	64.5	63.6	64.1	64.2	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	:	:	58.0	57.9	61.4	61.3	61.1	62.2	62.2	62.3	62.5	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	:	30.3	29.8	27.7	27.8	29.7	29.0	30.7	30.0	31.5	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	:	7.4	6.8	5.4	5.6	6.2	6.0	6.1	6.2	6.4	:	8.1	8.3	8.6	8.7
SYSTEM CHARACTERISTICS																
Coverage (Based on data from Ageing Reports)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
Number of people receiving care in an institution, in thousands	:	:	:	:	51	71	91	111	113	115	345	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	120	112	104	96	99	101	94	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	1.7	1.8	1.9	2.0	2.0	2.1	4.2	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	:	:	:	:	:	257	276	281	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	38	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.6.2: Statistical Annex - continued – Czech Republic

PROJECTIONS								
	2013	2020	2030	2040	2050	2060	MS Change 2013-2060	EU Change 2013-2060
<b>Population</b>								
Population projection in millions	10.5	10.7	10.8	10.9	11.1	11.1	5%	3%
<b>Dependency</b>								
Number of dependents in millions	0.84	0.92	1.05	1.13	1.20	1.28	52%	40%
Share of dependents, in %	8.0	8.6	9.7	10.4	10.8	11.6	44%	36%
<b>Projected public expenditure on LTC as % of GDP</b>								
AWG reference scenario	0.7	0.9	1.0	1.2	1.2	1.4	87%	40%
AWG risk scenario	0.7	1.0	1.5	2.4	3.7	6.0	698%	149%
<b>Coverage</b>								
Number of people receiving care in an institution	344,785	375,221	416,670	459,044	483,889	516,950	50%	79%
Number of people receiving care at home	94,305	108,781	140,239	167,912	183,870	216,051	129%	78%
Number of people receiving cash benefits	328,989	375,036	458,512	542,079	584,165	676,382	106%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	7.3	8.1	9.4	10.7	11.3	12.7	74%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	91.2	93.4	97.1	100.0	100.0	100.0	10%	23%
<b>Composition of public expenditure and unit costs</b>								
Public spending on formal LTC in-kind ( % of tot. publ. spending LTC)	36.9	36.4	35.8	34.4	34.6	33.1	-10%	1%
Public spending on LTC related cash benefits ( % of tot. publ. spending LTC)	63.1	63.6	64.2	65.6	65.4	66.9	6%	-5%
Public spending on institutional care ( % of tot. publ. spending LTC)	81.6	80.7	78.3	76.7	75.9	73.8	-9%	1%
Public spending on home care ( % of tot. publ. spending LTC in-kind)	18.4	19.3	21.7	23.3	24.1	26.2	42%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	6.9	7.1	7.3	7.3	7.5	7.4	7%	-2%
Unit costs of home care per recipient, as % of GDP per capita	5.7	5.9	6.0	6.1	6.2	6.2	10%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	15.1	15.4	15.2	15.4	15.4	15.4	2%	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".