Financing of Specialized Ambulatory Care

New laws approved – Czech Medical Chamber, General Health Insurance, Health Insurance Companies, Non-State Medical Facilities
Amendment of existing laws – Public Health Care Act

The law has failed to establish a network of medical facilities. Formerly, the health insurance providers were even required to contract with any medical facility that applied. Today, the official contract bidding process is already in place but it is not binding for insurance companies. Therefore, the network of medical facilities is developing chaotically, it does not meet the needs and it increases dramatically the financial requirements. The main purpose of insurance providers is not to finance the existing medical facilities but to ensure the health insurance resources are being used effectively for providing quality health care in the required extent.

Income of medical facilities: 95% from health insurance companies
5% direct payments

- no private co-insurance
- no additional collection possible on insurance covered treatments even if the cost exceeds the coverage amount (several attempts to change the law have been made with no success)
- regulated pricing for direct payments

Operational expenses (energy cost, salaries, cost of medical supplies and drugs) are growing faster than income.

State-run medical facilities receive funds for investments from their managing authorities – Ministry of Health or district authorities. By law, private medical facilities cannot be given such funds. They also make payments on loans they had to take from banks at the time of privatization (based on privatization laws). A part of funds collected for health care thus end up in the banks, without improving the quality of the health care.

Sources of health insurance – consist of premiums and state payments

-Employees pay 4.5% of the salary and employers pay 9% (it is more like a tax – mandatory by law and based on the salary)

- Self-employed individuals pay relatively low premiums but it is mostly given by the fact they work less hours (women with children, retirees)

- The state pays premiums for non-earning individuals (originally 80% of minimum wage of 2900 Kc, now of 3250 Kc)

What is important, the premium paying individuals constitute only 43% of insured but their premiums represent 76% of insurance resources. Non-paying individuals constitute 57% but the state payments on their behalf provide only 24% of the insurance resources. This discrepancy is often a cause of dispute because it will only increase as the population continues to age.

Health insurance funds by year:

1991 - 39.5 billion Kc
1992 - 45.6 billion Kc
1995 - 100.6 billion Kc
1999 - 135.1 billion Kc
2002 - ???

The huge increase of funds that still appears insufficient shows that the health care industry is able to consume more and more. However, we must take into consideration the progress of technology equipment, development of new methods, availability and adequate quantity of all drugs, number of beds that is still high, growing network of ambulatory facilitates...

Has this increase resulted in better health of population, in longer life and better quality of life?

Development in the ambulatory care financing in past 10 years

Rate Schedule Version “0” – there is just one general health insurance provider, first payments are historic amounts of former state budgets.

“Performance system” – at that time privatization of state facilities begins and brand new non-state medical facilities can open. Many ambulatory facilities used this opportunity and provided more and more services, regardless of the actual need. Patients liked that sort of care.

“Flat payments” – since 7.1.1997 – adult and pediatric practitioners are switching to per capita system, that is, payment per one birth number (individual). Some services, like vaccination or preventive check-ups, are paid for separately. Regulations of referred services (labs, X-rays) are gradually introduced, cost of drugs and referrals to a specialist are being monitored. Violations of regulations result in lower per capita payments, and conversely, those who “save money” are rewarded. Many patients complain about insufficient health care.

“Flat payments” – ambulatory specialists are also switching from the performance system to flat payments. Flat payments are slightly increased compared to the same period of previous year and are paid as a deposit. After the period the time restrictive regulations are applied, followed by regulations of referred services and prescribed drugs. Individual insurance providers still use degressive coefficients when the number of insured who received medical care increases or decreases for a specific provider, which is difficult to do because the patients can switch from one insurer to another every three months. The waiting periods are getting longer, prescriptions of medications are restricted and patients are not happy.

All these combined regulations are aimed primarily on stabilizing the expenses of insurance providers. They are not not focused on health needs of the insured, and completely ignore the issue of overall effectiveness of the system.

Our private medical facility SPEA Olomouc, s.r.o. is a proof that all difficulties described above can be overcome.

On October 1, 1996 we privatized the state outpatient clinic, we took a loan from the bank and now we are not only growing and investing, but also make regular credit payments.

We have 152 employees, with 52 physicians including practitioners for adult and pediatric patients. We cover all specialties, with the exception of lung specialists and rehabilitation but that, too, we are hoping to provide in the future.

Each separate office is a separate profit unit, which allows us to easily determine performance rewards. The employees monitor their own performance and it gives them a positive incentive to contribute to good results of the entire organization.

With best wishes for continued success,
Marie Horáková, Czech Republic