User fees have become a very sensitive political issue in the Czech Republic, sparking debate in Parliament, the media and the general public. Their introduction and the ongoing discussions on their continuation have played a key role during the last three regional and national elections and were widely seen as a major contributor to the collapse of Prime Minister Mirek Topolánek’s centre-right coalition in spring 2009.

This seems quite remarkable given that private households’ out-of-pocket payment on health as a percentage of total health expenditure in the Czech Republic has been relatively modest from an international perspective. In 2008, this percentage stood at 13.7% (compared to 13.2% in 2007, the year before user fees were introduced), which is slightly lower than the EU15 average of 14.5% and substantially lower than the percentages for Hungary (25.2%), Poland (24.2%) and Slovakia (26.2%) for that year.\(^1\) In the present review, we describe the introduction of user fees, the political controversy surrounding them, and their impact on health care utilisation in the Czech Republic.

**Background**

Since 1993, the Czech Republic has had a system of social health insurance (SHI) based on compulsory membership in one of a range of health insurance funds. Eligible residents may freely choose among these and among health care providers. SHI contributions are mandatory and calculated as a percentage of wages. Compared to Western Europe, the health system is characterised by relatively low total health care expenditure as a share of gross domestic product (GDP), low out-of-pocket payments and plentiful human resources, albeit with some substantial regional disparities. The population enjoys virtually universal coverage and a broad range of benefits. Some important health indicators are better than the EU15 and EU27 averages (such as mortality due to respiratory disease and infant mortality rates). On the other hand, the standardised death rates for diseases of the circulatory system and malignant neoplasms are well above the EU27 average. A range of health care utilisation rates, such as outpatient contacts and average length of stay in acute care hospitals, are also above this average. Overall, there is substantial potential in the Czech Republic for efficiency gains and improved health outcomes.\(^2\) This was recognised by the centre-right coalition led by Prime Minister Mirek Topolánek’s Civic Democratic Party (ODS) from 2007 to 2009, forming the rationale for the introduction of the user fees in 2008.

Prior to 2008, inpatient and outpatient health services were free of charge at the point of use, with the exception of some co-payments for prescription pharmaceuticals and medical aids. From the perspective of the centre-right coalition, this had in many cases led to high utilisation rates and the inappropriate use of scarce health resources. Indeed, the number of outpatient contacts per person in the Czech Republic (15.0 per year) was
the highest in the WHO European Region in 2006. Moreover, an estimated CZK 10 billion (€144–360 million) worth of prescribed pharmaceuticals were being wasted or went unused each year. The chief aim of user fees was to reduce overconsumption and inefficiencies in the health sector by encouraging people to use health services responsibly. The Public Budgets Stabilisation Act, passed in August 2007, introduced small user fees for a variety of health services and changed the system for setting prices and reimbursement rates for pharmaceuticals.

Introducing the user fees
A range of user fees were introduced on 1 January 2008, amounting to flat rates of CZK30 (€1.20) per doctor visit, CZK60 (€2.40) per hospital day, CZK90 (€3.60) per use of ambulatory services outside of standard office hours, and CZK30 (€1.20) for prescription pharmaceuticals.

Some vulnerable groups were exempted from the fees, including people living below the poverty line, neonates, chronically ill children, pregnant women, patients with infectious diseases, organ and tissue donors, and individuals receiving preventive services. Moreover, an annual ceiling of CZK5,000 (€200) per insured individual was established for selected user fees (excluding user fees for hospital stays and the use of ambulatory services outside of standard office hours), as well as for co-payments on prescription pharmaceuticals with a price exceeding the reference price in a particular pharmaceutical group.

As early as March 2008, user fees began to play a major role in the campaigns for the regional and Senate elections planned for October that year. On 28 March 2008, the Chamber of Deputies for the first time rejected the Social Democrats’ (CSSD) proposal to repeal user fees. The CSSD then pledged to eliminate user fees in regional hospitals and pharmacies if they regained power. Furthermore, on 28 May 2008 the Czech constitutional court rejected the CSSD’s claim that the user fees were unconstitutional.

A large proportion of the population opposed the user charges, and the CSSD could be assured of their backing. Indeed, many people in the Czech Republic were not bothered by the amount they had to pay (that is, €1.20–3.60), but by the principle of having to pay user fees, which went against the idea of free health care delivery— one of the main tenets of the Czech health care system. Furthermore, the sensitive political nature of the subject and negative media coverage may have led to general uncertainty about the new system among insured individuals. This was reflected in a public opinion poll in which a third of respondents stated at the time that they did not know the purpose of the user fees nor feel that they were necessary.

The unrest begins
It thus came as no surprise that the results of the regional and Senate elections in October 2008 were a disaster for the governing centre-right coalition. Thirteen of the fourteen regions were lost to the opposition. The aftermath of the autumn elections was chaotic. In December 2008, members of the CSSD voted in the Chamber of Deputies in favour of abolishing user fees for health services altogether. This was rejected by the Senate in January 2009, which instead preferred to reduce the burden on the young and the elderly.

The political landscape remained volatile. In March 2009, in the middle of the Czech Presidency of the European Union, the centre-right coalition led by Mirek Topolánek lost a vote of confidence. An independent, Jan Fischer, was selected to become the Prime Minister of a caretaker government in April. His government, nominated by both major parties (the ODS and the CSSD), was inaugurated on 8 May 2009, and new elections were scheduled for May 2010. Again, the CSSD pledged to repeal user fees if they regained power in the Chamber of Deputies in the 2010 elections.

Under enormous political pressure, the new caretaker government adjusted the user fee system in April 2009. Although the annual ceiling had been reached by only approximately 0.2% of insured individuals in 2008, the ceiling was lowered. As of 1 April 2009, a new annual ceiling of CZK2,500 (€100) was set for persons under 18 years or over 65 years of age; moreover, those under 18 years were also exempted from user fees for doctor visits. In June 2009, the Czech Senate rejected new efforts by the Chamber of Deputies to abolish user fees.

The regions revolt
In the meantime, the regions, which by February 2009 were all governed by the CSSD with the exception of Prague, had decided on the 1st of that month to pay the fees from their own budgets on behalf of patients. To achieve this end, the regions implemented their own reimbursement systems, leading to a different system in almost every region. In several regions, patients were automatically reimbursed for user fees, while in other regions patients had to file a written request for reimbursement.

Since January 2009, great uncertainty has prevailed. For example, some public hospital pharmacies have tapped into regional budgets to reimburse patients for the user fees, whereas privately owned pharmacies have not. In some cases, actions like these have been prohibited by the courts on the grounds of unfair competition after complaints made by the private pharmacies. Furthermore, the Czech Ministry of Health began an administrative proceeding against four regions in January 2010, and nine sickness funds protested openly against regional hospitals and their pharmacies that had not been collecting user fees.

As a countermeasure, the CSSD launched a ‘struggle against fees’ campaign and filed two complaints with the Constitutional Court in February 2010. The European Commission voiced the informal view that the current system, in which regional authorities pay the fees, is discriminatory and, if formally investigated, might be deemed as conflicting with European state-aid rules. Another problem is the costs: reimbursing patients for the fees places a great burden on regional budgets. After one year, approximately two thirds of patients in regions governed by the CSSD took advantage of user-fee reimbursement, leading to a total cost of CZK478 million (€19 million).

Have the user fees worked?
Data from the Czech Institute of Health Information and Statistics show that the number of visits to ambulatory specialists fell by 17% in 2008. The decrease in the use of ambulatory care services outside of standard office hours was even more pronounced at 41%; importantly, this was not accompanied by an increase in the use of emergency services.

Looking at hospitalisations in 2008, the number of hospital days decreased by 4.4% in acute care hospitals and by 3.2% in non-acute care hospitals even though the number of hospitalised patients increased by 3% and 5%, respectively, during the same period. This suggests a reduction in the average length of stay, which is confirmed by Health for All (HFA) data, which show a reduction of 0.6
days (to an average of 7.4 days) between 2006 and 2008 for all hospitals observed.\textsuperscript{1} It should be noted, however, that a decrease in the average length of stay was already visible in 2007, the year prior to the introduction of user fees.

Finally, the number of prescribed pharmaceuticals and the number of unit packs of prescribed pharmaceuticals fell by 26.7\% and 7.4\%, respectively. At the same time, SHI expenditure on prescribed pharmaceuticals rose by 8.3\%, indicating a shift in SHI reimbursement from less expensive, everyday pharmaceuticals to more costly pharmaceutical treatments and bigger unit packs.\textsuperscript{11}

For 2009, utilisation data for health services show a moderate reversal of the trend seen in 2008. For example, the number of prescribed pharmaceuticals increased by 6\%.\textsuperscript{12} Although the number of unit packs of prescribed pharmaceuticals fell by 1.8\%, expenditure on prescribed pharmaceuticals rose by 9.6\%.\textsuperscript{13} The average number of hospital bed days increased slightly, by 1.3 days to 255.5 days, while the average length of stay remained at 7.4 days.\textsuperscript{14} Also, the number of visits to ambulatory specialists and the use of ambulatory care services outside of standard office hours in 2009 increased by 9.2\% and 10.1\%, respectively.\textsuperscript{13}

The 2009 statistics may reflect the effect of the reimbursement of user fees by the regions, which likely undermines the effectiveness of the system. It should also be noted, however, that measuring both the short- and long-term effects of user fees is notoriously difficult. Even decreasing utilisation rates may give an incomplete picture of the cost-saving potential of user fees, with costs arising elsewhere in the system. For example, patients may forgo necessary treatment or fail to adhere to treatment, which could lead to the need for costlier treatments at a later time. International evidence on the effectiveness of user fees, especially over the long term, is inconclusive.\textsuperscript{15,16} More data will be needed in the coming years to make useful interpretations about the effectiveness of the measures taken in the Czech Republic.

**Latest developments: the unrest continues**

Against all expectations, the ČSSD won the May 2010 elections of the Chamber of Deputies with only 22\% of the vote, followed closely by the ODS with 20\%, the newly founded TOP 09 party with an unexpected share of 16.7\%, the Communists (KSČM) with 11.3\% and the newly established Public Affairs party (VV) with 10.9\% of the vote. The success of TOP 09 and VV was unparalleled in the political history of the Czech Republic. The elections were a political earthquake in which the established parties suffered heavy losses. As a result, another centre-right coalition was formed, this time with the ODS, TOP 09 and VV.

Opinions about user fees remain divided. It seems unlikely that the new centre-right coalition will abolish or significantly reform the user fee system. On the contrary, the new coalition inherited a health system affected by the financial crisis and with a large deficit (CZK 10 billion in 2009, €400 million) and is currently looking at ways to increase out-of-pocket payments and the responsibility of patients to share in costs.\textsuperscript{17} The opposition ČSSD and Communist Party continue to call for the repeal of the user fees. Since June 2010, health facilities in some regions have abolished the reimbursement of user fees to retain more resources and to lessen their administrative burden.\textsuperscript{18}

**Conclusion**

User fees remain a divisive issue in Czech politics. Although out-of-pocket spending is still low from an international perspective, the concept of having to pay for something that has been historically provided for free has led to a great deal of public debate and played a large role in several elections since 2008. The introduction of user fees is widely thought to have contributed to a change in political leadership, which if true shows the ability of this relatively small measure to pack a big punch. Other countries contemplating the introduction or expansion of user fees might want to consider the Czech experience.

Good evidence is essential when deliberating whether to introduce user fees. Although evidence from the first year after the fees were introduced suggests a decrease in resource utilisation, the second year data already show a slight increase for some important indicators. When interpreting these data, however, it is important to keep in mind that the mechanisms on which the system was based were undermined by the regions that chose to reimburse patients for the user fees from the regional budgets. Several more years of data are needed before any definitive conclusions can be drawn on the impact of user fees in the Czech Republic.

**References**

Providing a solid evidence base for policy makers: ECHI initiative

Marieke Verschuuren, Pieter Kramers and Gudrun Kr Gudfinnsdottir and Arpo Aromaa

Summary: With the aim of providing a solid evidence base for policy making, the European Commission initiated a European public health monitoring policy a decade ago. The European Community Health Indicators (ECHI) projects have played a central role in the development of this policy. ECHI currently is in its fourth phase (Joint Action for ECHIM). Twenty-four EU Member States are engaged in an effort to implement the ECHI shortlist (88 indicators). One of the major challenges will be to find sustainable solutions for public health monitoring, both at Member State and at European level.

Key words: evidence-based policy making, public health monitoring, indicators, European Union.

The need for international public health comparisons

The gap between the Netherlands and the European Union (EU) average is widening for rates of female cancer mortality. The Netherlands has higher than average rates of smoking while relatively few mothers breastfeed their babies. The 30-day in-hospital fatality rate for stroke in the Netherlands is high compared to other European countries. On the other hand, injury-related mortality is very low in the Netherlands compared to other European Union countries. The gap between the Netherlands and the European Union is widening for the 30-day in-hospital fatality rate for stroke.

Summary: With the aim of providing a solid evidence base for policy making, the European Commission initiated a European public health monitoring policy a decade ago. The European Community Health Indicators (ECHI) projects have played a central role in the development of this policy. ECHI currently is in its fourth phase (Joint Action for ECHIM). Twenty-four EU Member States are engaged in an effort to implement the ECHI shortlist (88 indicators). One of the major challenges will be to find sustainable solutions for public health monitoring, both at Member State and at European level.

Key words: evidence-based policy making, public health monitoring, indicators, European Union.

Detailed text continues...

The need for international public health comparisons

The gap between the Netherlands and the European Union (EU) average is widening for rates of female cancer mortality. The Netherlands has higher than average rates of smoking while relatively few mothers breastfeed their babies. The 30-day in-hospital fatality rate for stroke in the Netherlands is high compared to other European countries. On the other hand, injury-related mortality is very low in the Netherlands, and it is among the best scoring countries when looking at health determinants such as levels of physical activity and overweight.

These are some of the main conclusions of the report Dare to Compare! Benchmarking Dutch health with the European Community Health Indicators (ECHI), written by the Dutch Public Health Institute (RIVM) in 2008. The indicator information presented in the report raises questions: why do so many Dutch people smoke? Are the anti-smoke policies in countries with a lower smoking rate different than the policies applied in the Netherlands? Are there other factors, such as cultural differences, which may explain the different smoking rates in the EU countries? The same kind of questions may be asked of the indicators for which the Netherlands is doing relatively well.

These examples illustrate the usefulness and necessity of international public health monitoring by means of indicators for policy making. Through international benchmarks, authorities may be made aware of good practice examples in other countries. Moreover, this international orientation may draw attention to some of the causes of avoidable health inequalities between European citizens, achievable health gains and the efficient use of

Marieke Verschuuren is Senior Researcher and Pieter Kramers Senior Advisor, Dutch National Institute for Public Health and the Environment (RIVM). Gudrun Kr Gudfinnsdottir is Policy Officer, European Commission, DG SANCO, Health Information Unit and Arpo Aromaa, Professor, Finnish National Institute for Health and Welfare (THL). Email: marieke.verschuuren@rivm.nl