PATIENT RIGHTS PROTECTION IN CZECH REPUBLIC: CHALLENGES OF A TRANSITION FROM COMMUNISM TO A MODERN LEGAL SYSTEM

Ondrej Dostal

Center for Health Law, Association for Medical Law and Bioethics

Introduction

The health care became one of the most problematic fields in the post-revolutionary development of the Czech Republic and Slovakia. The problems are not only of economic nature, but have also important legal and social aspects. Before the 1989 «Velvet Revolution» in which the Communist regime was overthrown, the health care was directed by state. In 1990 and 1991, a dramatic change of the centralized health care system took place and the system began moving towards a compulsory social insurance model with a number of health insurance funds financing health care providers on the basis of contracts[1].

In this process, a multitude of patient rights was introduced by law. Shortly after the Revolution, Czechoslovakia adopted the Charter of Fundamental Rights and Basic Freedoms as a part of the new constitutional order. The Charter gives citizens the right, on the basis of public insurance, to free medical care and to medical aids under conditions provided for by law. This provision, stipulating on constitutional level the entitlement to free access to medical care, passed after the break-up of Czechoslovak federation into both Czech and Slovak legal orders. The reformed law also gives every citizen the right to choose his or her physician and health care provider. In 2001, Czech Parliament has also ratified the Council of Europe Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine[2]. According to the Czech Constitution, promulgated treaties, to the ratification of which Parliament has given its consent and by which the Czech Republic is bound, form a part of the legal order; if a treaty provides something other than that which a statute provides, the treaty shall apply[3]. Therefore, the patient rights provisions of the Biomedicine Convention are directly applicable and have precedence over the patient rights regulation described in the existing laws that came into existence more than thirty years ago, under different social conditions. Finally, the European Union accession brought several important legal changes that will influence Czech health care system. The most important ones relate to the common market of health products and services, trans-border movement of patients and transparency regulations.

---

[1] For further information on history and development of the Czech health system see the 2005 Health Systems in Transition (HiT) Czech Republic report by the WHO European Observatory on Health Care Systems, http://www.euro.who.int/observatory/Hits/20050623_1, last accessed on 2/24/2006

[2] Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Council of Europe, ETS No. 164, 1997

[3] Article 10 of the Czech Constitution, Act No.1/1993 Coll.of Laws of the Czech Republic

Медичне право України: правовий статус пацієнтів в Україні та його законодавче забезпечення (генезис, розвиток, проблеми і перспективи вдосконалення). Матеріали II Всеукраїнської науково-практичної конференції 17—18.04.2008, м. Львів

Equitable Access to Health Care

According to the Biomedicine Convention, together with the anti-discriminatory provisions in the Czech Constitution, every patient should have equitable access to health care of appropriate quality. According to the Charter of Fundamental Rights and Basic Freedoms[4], medical care and medical aids are provided free of charge; this entitlement can be limited only by law. The health care benefits package is very broad in the Czech Republic[5] and includes almost all health care needs, only a limited number of services are excluded by law from the statutory health care system, in a form of a negative list (for instance, cosmetic surgeries for non-medical reasons; a number of services require co-payment, including certain kinds of dental care)[6]. In theory, any indicated medical care that is not excluded from the basic benefits package should be available freely for every patient. However, due to the swift development of medicine and rising costs of modern technologies, this soon became financially unsustainable. Furthermore, the uncontrolled development of health care facilities in the period shortly after revolution created regional differences in equipment and treatment possibilities; the specialised centres are sometimes superfluously concentrated in Prague and several other big cities whereas other regions lack the adequate coverage. This causes concerns especially in the case of acute hospital care, e.g. acute cardiovascular interventions where the patient needs immediate care, and time-losses due to referral to a specialized centre in other region can endanger his or her chances of survival. Theoretically, patients with similar health needs and similar diagnosis should get equal amount of care from the solidary system, in which every citizen equally participates. In reality, however, the extent of care provided to a given patient differs, depending on various factors such as region, possibilities of a given healthcare facility etc[7]. There is no comprehensive system of quality standards and guidelines yet. The health care providers cannot accept co-payments from patients for care which is covered by the public health insurance; however, due to the limited availability of resources and vague indication criteria, there is an open space for corruption. Experience shows existence of informal payments in various semi-legal or illegal forms.

Other issue concerning the access to care is the fact that Czech citizens mostly perceive the health care as an unpaid service that "belongs to no-one". This limits the patient willingness for prevention, responsibility for own health and reasonable usage of health care benefits. There are no restrictions on patients' choice of primary health care physicians and on access to them. Due to this, the number of patient-physician contacts is among the highest in Europe. Since there are no «gatekeeping» regulations in the system, some patients by-pass their general practitioner and contact directly specialists or hospitals. It often happens that a patient visits several physicians that do not know of each other, repeatedly undergoes the same examination and gets multiple drug prescription, thus creating avoidable expenses and sometimes endangering himself. The system fails to counter that so far.

---

[4] Constitutional Act No.2/1993 Coll.of Laws of the Czech Republic

[5] The ratio of public to private health care spending in the Czech Republic is 90:10, a highest ratio amongst the European Union countries.

[6] Act on the Public Health Insurance No. 48/1997 Coll.of Laws of the Czech Republic

[7] For more details, see Hrobon, P., Julinek, T., Machacek, T: Healthcare Reform for the Czech Republic in the 21st Century Europe, 2005, http://www.healthreform.cz/content/files/en/Reform/1_Publications/EN_publikace.pdf, last accessed on 2/24/2006

Another problem is the divergence of social security system and health insurance system; especially the situation of elderly or mentally retarded citizens is often medicalized in order to locate these people in a health care facility, where the care is financially covered in full by the health funds, whereas the social security facilities often require significant payments.

The possibilities of remedy lie in several steps:

- **Re-definition of the health care benefits package.** The scope of medical care and medical aids that are available free of charge has to be limited by law to an extent which would be financially sustainable for the system. This basic benefits package should be made available for all citizens, without delays and undue discrimination. More advanced services, not covered by this basic package, should be available on a basis of private health insurance.
  2008 update: *In recent years, the system continued to go into deficits, despite cost-conservation measures employed by the regulator. The redefinition (limitation) of basic benefits package is universally accepted necessity. However, the criteria for including/excluding interventions, drugs and medical aids is subject to hot debates, partly because of economic interest of providers, pharmaceutical firms and other actors to have their specific product publicly reimbursed.*
  The system of drug reimbursement setting was especially non-transparent. European Commission repeatedly warned the Czech state that such situation violates EU law, especially the so-called "Transparency directive", which requires that states decide on public reimbursement of medicinal products using "objective and verifiable" criteria. In connection with that, Czech Constitutional court abolished the old decisionmaking system, forcing the legislator to adopt new legislation on a speedy basis. Since 1.1.2008, we have a set of criteria in law, according to which a Government authority decides on reimbursement of each drug. These criteria include "cost-effectiveness", but also "severity of the disease for which is the drug intended", "budget impact analysis" etc.; the new system is subject to considerable critique for vagueness and impracticality; implications are however not known so far.
  The reforms proposed for 2009 include similar system of criteria also for interventions and medical aids.
- **Proper information for patients.** The patients have to be informed on the scope of their health care entitlements. The indication criteria for utilization of free-of-charge benefits should be made publicly accessible and subject to legal review in order to remove any space for corruption. The statistics of quality and effectivity of health care providers should be made public in order to give the patient-consumer means to make an informed choice of provider.
  2008 update: The information on the real scope of health care entitlements is still scarce, patients still get varying levels of care. However, in 2007, the Supreme Administrative Court decided that the General Health Insurance Fund, as a public institution, which manages public funds (here: the mandatory insurance premiums) is a subject of the 1999 Law on Free Access to Information, therefore has to disclose any information about its activities. Therefore, any citizen can request this insurance company to disclose how much money flows to various regions, types of hospitals, types of interventions, numbers of rehospitalization for the same problem etc., of

course in the form of anonymized data; from this data, valuable information about quality of care, equal distribution of funds etc. can be inferred.

- **Motivation for rational use of health care services.** Patient co-payments should be introduced by law as a regulatory mechanism, albeit in limited scope compatible with the Constitutional entitlement to free medical services. Systems of social and health security should co-operate in order to avoid perverse incentives on the side of its users and/or their families.
  2008 update: the right-wing government adopted a law which subjects the formerly free health care interventions to "regulatory payments". These payments (1,50 USD for a primary care examination and for a recipe, 3 USD for a day in a hospital, 4,50 USD for emergency call) have a purpose to limit "unnecessary" consumption of care. The providers have a duty sanctioned by a severe penalty (sic!) to require these payments from patients. The amendment, in force since 1.1.2008, is currently subject to a constitutionality review.
  Similar legislation, enacted in 2002 in Slovakia, survived a Constitutional court challenge, but was abolished by a new left-wing government in 2006. The experience showed a significant reduction of primary care visits, the public health impact is however so far unknown.

Patient Rights, Patient Duties and Legal Remedies

The adoption of the Biomedicine Convention significantly strengthened the patient autonomy in a traditionally paternalistic health care system. The most important of the rights reaffirmed and reformulated by this Convention is the informed consent. The patient has the right to be properly informed about the purpose and consequences of an intervention, its risks and alternatives, and a right to disagree with the proposed treatment. However, even after four years, neither physicians nor patients become fully aware of this legal development; especially the physicians often limit communication with patients, claiming that the facts are too complicated for a layman and there is never enough time for explanations. This view is accentuated by the fact that the increased time needed for communication with patient is not calculated into the physician reimbursement mechanism. Therefore, the patient right to informed consent is often limited to a formal acceptance of a vague consent form.

On the other hand, since the patient does not carry any responsibility for consequences of the refusal of a proposed treatment, it may happen that patient refuses a recommended effective treatment, only to require much more costly intervention that becomes necessary later when the health of patient further deteriorates. The system, however, does not discourage such adverse choice by any form of co-payment.

According to the 1997 Act on Public Health Insurance, the insured has a duty to follow the curative regime recommended by the physician (including dietary regime, limitations on alcohol consumption, regular follow-up examinations etc.); this duty, however, cannot be legally enforced and is commonly disregarded by the non-compliant, which leads to ineffective consumption of health services (however, a violation of these duties by a patient can result in limitation of potential compensation in case of harm to health, since a civil law doctrine of contributory negligence can be invoked by the defendant hospital).

The slow process of patient rights implementation in large part results from a low frequency of medical litigation, compared to other European states or the USA.

Psychological barriers from past still remain, citizens are not used to assert their rights against institutions and enforce them in court proceedings. This is accentuated by the restraints in access to justice, especially the long delays on the side of the courts, high proceeding costs and attorney fees, strict burden of proof rules and limited amounts of damages. The average length of a case in civil proceedings is around two years, but sometimes the courts decide as late as after five or six years. In the civil process, the courts require the plaintiff to prove the facts of the case with very high probability, especially the causal link between the negligent conduct of the defendant and the damage suffered.

The position of plaintiff in bearing the burden of proof is complicated by several factors. Firstly, the patient does not have the right to inspect directly the medical records and to make copies thereof. According to the Biomedicine Convention, the patient has the right to information collected about his health[8], but this right is interpreted very restrictively. This makes it hard to obtain a second opinion from an independent physician, especially when families want to review the correctness of care which was provided to their deceased relative prior to the death; here, the records are not shown to the families for the reason of protection of privacy of the deceased. ***2008 update:*** *In 2007, the patient himself and the relatives of a deceased gained a legal right to inspect their health records and/or request copies. This significantly improved the position of the plaintiffs in medical malpractice cases and enabled the patient attorneys to submit the medical data to external experts before initiating a lawsuit in order to examine the chances of success.*

Another typical problem is the situation of negligent documentation of care; unlike the German or Austrian jurisprudence, where in cases of missing or insufficient records, the burden of proof is transferred from the plaintiff to the defendant (sometimes referred to as *beweislastumkehr)*, the courts in Czech Republic still did not develop such procedural rules, which makes the position of plaintiff in the field of evidence very difficult. ***2008 update:*** *Several recent academic publications recommend adoption of the Austrian/German approach, we can therefore expect a corresponding change in jurisprudence soon.*

During the proceedings, the records are made available to an expert appointed by court, whose opinion often determines the success or failure of the lawsuit; many experts are however somewhat reluctant to denounce their professional colleagues. ***2008 update:*** *The new rules of court procedure allow so-called "private experts", that is experts called upon by the parties, not appointed by the court itself. Furthermore, an initiative for standardization of expert statements has been started, in order to eliminate low-quality, biased, vague and un-scientific expert statements.*

The law also places a limit on the amount of compensations for immaterial damage, especially the compensation for pain and suffering. The amounts of damages set by a government decree[9] are in some cases less than one tenth of amounts common in the «old» EU countries. Court can award greater damages only in exceptional situations. ***2008 update:*** *the courts in recent years spontaneously started to utilize (perhaps even over-utilize) the "exceptional situations" exception, which lead to a small explosion of malpractice suits, both in number and in compensation amount. This brought media*

[8] Article 10 of the Biomedicine Convention, *cit. supra*

[9] Currently, Decree No. 440/2001 Coll.of Laws of the Czech Republic

(and attorney) attention to patient rights and their violation, a negative effect is however a significant legal uncertainty on the side of providers.

Finally, the costs of the court proceedings and attorney fees are often higher than the malpractice victims can afford. The bar association regulations do not as a rule allow the attorneys to offer their services on a basis of contingency fees in order to avoid speculative lawsuits; this method of attorney remuneration would be, however, most acceptable for an impoverished plaintiff with a good case. ***2008 update:*** *the Czech Bar Association recently approved that attorneys can contract on the basis of "pactum de quota litis", or contingency fees, up to 25% of the potential compensation award. The attorneys utilize this possibility in full. The problem is however that unlike in the United States, the Czech attorneys usually do not agree to bear also the proceedings costs in case of a loss; if a case is lost, the attorney gets nothing for his/her work, but the plaintiff (usually a poor one) still has to cover the court and opposite party costs, if these are not waived by the court decision.*

Mediation possibilities are limited, especially by the fact that the professional liability insurers tend to accept only court decisions; the compensations agreed upon extrajudicially are usually borne by the health care provider himself, and therefore this method of settlement is usually applicable only in cases of exceptional failures when a hospital wants to avoid negative publicity. ***2008 update:*** *A significant barrier is often the negative attitude to extrajudicial settlements from malpractice insurance companies, which usually do not agree to cover the compensation, if it was not awarded by a court decision (allegedly speculating that the potential plaintiff might not be able to bring enough evidence, pay all the costs and survive long enough to get the positive court verdict).*

On the other hand, the malcontent patients tend to charge the physicians using the criminal law instead of civil law procedure, because the investigation of crimes is done by state authorities and the patient can still come up with a compensation claim, using the evidence gathered by the police. This, however, brings a negative element into the physician-patient relationship, the physicians feel unjustly exposed to socially degrading criminal charges. ***2008 update:*** *The providers are however slowly learning to defend themselves, using mechanisms such as libel/slander actions and criminal charges of false accusation.*

Due to the aforementioned complications, the patient rights are not properly enforced and often fail to be respected in daily practice.

This situation could be remedied by the following:

- **Balance of rights and duties. S**trengthening of patient autonomy is a good step. Nevertheless, together with the right to decide about own health, the patients must assume responsibility for the consequences of their choices. Introduction of co-payments, especially in cases of medically adverse behaviors, could help. ***2008 update:*** *The current regulation that imposes "regulation payments" on a flat basis, irregardless whether the patient really needs the service or abuses the system, is by no means ideal.*
- **Emphasis on rights assertion mechanisms.** The situation when the rights exist on paper but are disregarded in daily life is not consistent with the rule of law principle. Access to justice has to be simplified, especially by removing the financial barriers. After this, the system could benefit from the independent review by the courts, which would in consequence encourage providers to prevent lawsuits by controlling quality of care and by respecting patient rights.

- **Changes in malpractice litigation rules.** The bill on access to the medical records is currently being prepared; similar legal right already exists in Slovakia. The pain and suffering compensation amounts have to be at least partly adjusted to the level usual in Western Europe. The position of patient-plaintiff has to be strengthened, especially by the burden of proof transfers in typical cases, such as missing medical records. Finally, more possibilities for arbitration or mediation should be introduced in cooperation with patient organizations and physician associations.

European Law

The new EU member states have to keep their legal systems compatible with the requirements of the European law. Although the competence of organization of health care system remains so far on national level, the states have to conform with common market rules, especially concerning unrestricted movement of health products and services (with regard to the recent decisions of the European Court of Justice on the trans-border provision of health services), free movement of persons and transparency of decision-making procedures (the last of these issues has recently become actual in the Czech Republic in connection with licensing of pharmaceuticals and allocation of drugs for reimbursement, which is done by the Ministry of Health). The movement of patients between EU member states will probably lead to greater unification in the field of medical standards and patient rights protection.

Conclusion

The experience of post-revolutionary development in the field of health care shows that mere enactment of rights is not sufficient for the change of traditional patterns of behavior. The transition from the paternalistic model to a system that promotes patient autonomy and responsibility lasted several decades in Western Europe. The attempt to jump over this process of evolution just by a swift adoption of new laws succeeded only in part. Since the «new» patient rights are not accepted naturally on the basis of a consensus, especially in the time period shortly after their enactment, they have to be defined very precisely and must be accompanied by effective mechanisms of protection and individual enforcement. At the same time, the patients are not used to individual responsibility with regard to their duties; the notion of «free» health care may lead to adverse choices. Therefore, physicians and especially patients have to be motivated for efficient consumption of resources; the introduction of co-payments might be an effective solution, as shown by the recent reforms in Slovakia. ***2008 update:*** *Questionable.*

The politicians should avoid making unrealistic promises concerning the comprehensiveness of the basic benefits package, available freely on the basis of public health insurance. This can result in situation when such extensive benefits cease to be available to every citizen, factual inequalities arise and a space for corruption opens. From the legal point of view, citizens should be in such situations encouraged to claim their rights in lawsuits instead by providing under-the-table payments to health care providers. Ideally, the extent of benefits should be reduced to the level at which it is financially sustainable to provide the necessary service to everyone, regardless of region or social status and without undue delay.

The Czech Republic and Slovakia share the historical experience and have similar legal systems. Slovakia has recently introduced radical health care reforms, whereas the Czech Republic still hesitates. The Slovak reform has many of the features described above, especially co-payments for visits and recipes, narrower definition of basic benefits package, more precise definition of patient rights including the right to inspect and copy medical records etc. The initial experiences with the Slovak system are positive in nearly every aspect, whereas the Czech system continues to face grave difficulties. No definitive conclusions can be done so far, but the comparison of recent development in the Czech Republic and in Slovakia shows relatively clearly the benefits of undertaking of the aforementioned reform steps. ***2008 update:*** *Also questionable.*