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Equitable Access to Health care of Appropriate Quality as a Human Right: an Analysis of the Present Czech Health care System and its Planned Reform

One of the roles of the state is to ensure the financial affordability of health services for all citizens, public health protection, provision of accessible and comprehensible information about the quality of health care and, of course, identification of rules for the operations of health insurers and health care facilities, including supervision over their compliance. In addition to ensuring effective provision of quality health services it is necessary to provide for their sustainable funding.

The health care system in the Czech Republic offered historically universal access to health care, free of charge at the point of delivery. Due to the medical progress and rising costs of technologies, the public system is getting into financial difficulties.

These difficulties compromise the access to the health care in the public system. There are regional differences in access to care, differences in waiting times for a covered procedure and differences in safety and quality of health services. These differences often lead to corruption, in order to "jump the queue" or ensure the quality of an intervention. This development is particularly detrimental to poor and sick citizens who do not possess the necessary funds or influence to obtain the

service they need.

In near future, politicians will have to take hard decisions on what to exclude from the broad entitlement in order to keep the public health care system affordable. These decisions however should not be arbitrary. The rules for this decisionmaking are determined by international obligations of the Czech Republic in the field of economic and social rights. Among these obligations, the primary guideline for the planned reform is included in article 3 of the Council of Europe Convention on Human Rights and Biomedicine. This Article requires the Czech Republic to guarantee its citizens a health care system that provides services that are adequate to the Czech Republic's economic possibilities and are provided on a nondiscriminatory, transparent basis. This paper describes several issues, which will arise in its implementation.

This paper is concerned largely with the development of the health care system in the Czech Republic. I begin my paper with a legal analysis of the recent history of the system, in order to provide a foreign reader with an insight into the cultural differences and peculiarities of the transformation from Communism to modern marketbased economy. In the next part, the paper summarizes the international and Constitutional obligations the Czech government has to respect in reshaping of the system. Following that, the paper describes several ideas for system changes, which would be consistent with the economic and social rights binding upon the Czech Republic.

Reference list

1. For more details, see Hrobon, P., Julinek, T., Machacek, T: Health care 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

2. The accumulated debt of the social health insurance scheme was over 9 billion CZK (360 million USD) in 2004. It is estimated to reach over 600 million USD at the end of 2005 and over 800 million CZK in of 2006. Debt at this level means that payments to health facilities are on average 50 to 60 days overdue. This means that health facilities receive money as late as three months after they have provided health care. Such a delay causes major financial problems in all health facilities and, particularly, to independent doctors' practices, and, consequently, leads to deteriorating standards of accessibility to health care. *Cit. id.*
3. Hohfeld, W., Fundamental Legal Conceptions as Applied in Judicial Reasoning, Edited by Walter Wheeler Cook, New Haven: Yale University Press, 1964.
4. Boguszak, Èapek, Gerloch, "Teorie práva", ASPI, Prague 2003
5. *Id.*
6. *Id.*
7. *Id.*
8. The following history and development of the Czech health system is adopted from the 2005 Health Systems in Transition (HiT) Czech Republic report by the WHO European Observatory on Health care Systems and from the publication Czech Health care System – Delivery and Financing, Czech Association for Health Services Research, OECD Study 1999
9. 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 10/05/2006
10. *Id.*
11. The system proved itself reasonably effective in dealing with the post-war problems of the early 1950s. During that time, a high infant mortality rate, tuberculosis, other serious infections, and malnutrition diminished rapidly. By the beginning of the 1960s, Czechoslovakia had very good health status in international terms. From the late 1960s, these positive trends reached a turning point. Such a centralist and, in many cases, rigid system was not able to respond to new health problems in a flexible manner, caused mainly by the lifestyle of the population and by the environment. Thus, both the health care system and health status indicators stagnated from the late 1960s to the late 1980s. However, taking into account the limited resources, the health outcomes were not so bad; in several indicators, such as neonatal mortality, the system performed relatively well.
12. There was no legal right to get information on medical alternatives; actually, the physicians were taught that the patient is one who trusts, not the one who bears the weight of knowing and making hard decisions. Therefore, most patients were quite satisfied with the system. This belief was perhaps not wholly mistaken — the mandatory prevention and rationing-out of cost-ineffective care kept the overall health outcomes favorable despite the lack of available funding; in several indicators, such as neonatal mortality, the system performed quite well even in comparison with Western states.
13. The term "under-the-table payments" has to be interpreted broadly in this context, because the social capital of the patient played often a greater role than an actual financial payment. Important features of the Socialist economy were regulated prices and absence of market. Because the government kept the regulated prices low, there was insufficient supply of many goods and services. Therefore, various kinds of black market and informal exchange flourished. On a small community level, being in charge of a local car

repair facility or grocery store brought with itself a control over access to faster car repair services or imported fruits. Similarly, being a physician brought with itself a control over access to better quality health care — which were often the “goods”, which were traded. Therefore, the“payment” to a doctor could be in fact no payment at all but, instead, a reference to someone who would recommend the doctor to the grocery store manager, who will keep for him some spare bananas and oranges when they arrive in limited stock before Christmas. These systems of“mutual help”, however, are not a distinct feature of Socialist economies, but rather of any system that over-regulates the market. As such, these under-the-table payments survived the democratic revolution and even now are successfully used to bypass government regulation and avoid taxation. It seems that the market always finds a way through.

14. The same was true in Slovakia. The new Constitution and Charter of Basic Rights and Fundamental Freedoms were passed shortly after revolution, but before the former Czechoslovakia split into two states. Both countries kept the Charter without any changes.
15. Contributions are defined by law as a pre-tax percentage of wages, of which employees pay 4.5% and employers 9% (13.5% altogether), with a ceiling on contributions. The self-employed pay the same total percentage (i.e. 13.5%) but only on 35% of their profits. There is also a legally defined minimum contribution for the self-employed, which may be adjusted according to the inflation rate. This was approximately 40 USD per person per month in 2004. Since almost 80% of the self-employed are not declaring any annual profit, they only pay this minimum contribution. For the state-insured, the Ministry of Finance contributes the same percentage (13.5%) from monthly minimal wage set by statutory order; in 2003, it was approximately 20 USD per person per month.
16. The insurer is chosen by individuals (rather than by their employer) and the insured person may change funds on an annual basis. There are now nine insurance funds, of which the largest one, the General Health Insurance Fund, controls around 66% of market. The insurance funds are legally required to insure any applicant. The General Health Insurance Fund covers almost all of the state insured persons. Since the Czech Republic is now a member of the European Union, those insured by Czech health insurance funds are entitled to demand services in other European countries and *vice versa* according to European law. Opting out of the insurance system is not permitted in the Czech Republic.
17. Act 47/1997 Coll. On Public Health Insurance
18. Constitutional decision Pl.ÚS 35/95, Czech Constitutional Court
19. This right is a consequence of the primary European Communities law that stipulates free movement of services. The primary European Communities law takes precedence over national law of member states. Under the free movement of service rule, it is not possible to service providers only due to the fact that they are from a different member state.
20. These brief visits are often accompanied by a prescription of a drug covered by the health insurance, in order to make the patient believe that a sufficient level of care is provided. Because the patient pays neither for the office visit nor for the prescription, the system suffers from a massive over-use of drugs. A study by the Czech Health care Forum (www.czf.cz) discovered that at elderly patients in average 1,3 drug prescription is filled per visit. That means that every time an elderly patient sees the doctor, she gets one and sometimes two drugs prescribed.

21. The physicians are not required by law to provide a 24-hour emergency service and are unwilling to do this service on a contract basis. The patients who need attention at night have therefore rely on the emergency hospital service; in the Czech Republic, even the emergency transportation is unpaid. Since the patients have a right of choice of health care provider anyway, they sometimes ignore the general practitioners and go directly to a specialist or to a hospital.
22. Act 1/1993 Coll., Czech Constitution, Article 10
23. International Covenant on Economic, Social and Cultural Rights, http://www.unhchr.ch/html/menu3/b/a_cescr.htm,last accessed on 03/27/2006
24. 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, Treaty 96/2001 Coll. of the Laws of the Czech Republic
25. *Id.,* Especially Articles 3–10
26. *Id.,* Articles 11-22
27. *Id.* Articles 23-25
28. *Id.* ,Article 29
29. *Id.,.*Article 30
30. Convention for the Protection of Human Rights and Fundamental Freedoms, http://conventions.coe.int/Treaty/en/Treaties/Html/005.htm, last accessed on 03/27/2006
31. International Covenant on Economic, Social and Cultural Rights, http://www.unhchr.ch/html/menu3/b/a_cescr.htm, last accessed on 03/27/2006
32. Act 2/1993 Coll., Charter of Fundamental Rights and Basic Freedoms of the Czech Republic
33. *Id.,* Article 31, second sentence
34. *Id.,* Article 41
35. *Id.,* Article 4
36. *Id.,* Article 1
37. *Id., A*rticle 4 paragraph 3
38. Biomedicine Convention, *cit. supra.,* Article 3
39. *Id.,* Article 4
40. *Id.,* Article 5
41. Charter of Fundamental Rights and Basic Freedoms of the Czech Republic, *cit. supra,,* Article 17
42. European Convention on Human Rights, *cit. supra,* Article 6
43. Biomedicine Convention, *cit. supra.,* Article 23, 24 and 25
44. Furrow, B., Greaney, T., Johnson, S., Jost, T., Schwartz, R.,"The Law of Health Care Organization and Finance", 5th edition, West Publishing 2005
45. The payment is nominal, less than one USD
46. Pavel Hroboò, Tomáš Julínek, Tomáš Macháèek:"Health care Reform for the Czech Republic in the 21st Century Europe", 2004, http://healthreform.cz/index.php?oid=documents, last accessed 03/27/2006
47. Furrow, B., Greaney, T., Johnson, S., Jost, T., Schwartz, R.,"The Law of Health Care Organization and Finance", 5th edition, West Publishing 2005
48. Mason, J.K., McCall Smith, R.A., Laurie G.T., "Law and Medical Ethics", 6th edition, Butterworths 2002, p. 305

49. This approach of course does not solve the problem completely; there is still a value judgment in what constitutes a"quality life". For critique, see *id.*
50. Old people have the ratio prescription/visit of 1.3; this means that on every visit an old patient gets at least one prescription and some patients get two!
51. There are even cases of repeated admissions of notorious alcoholics to emergency wards; perhaps the least favorite part of emergency ambulance night shifts is transportation of aggressive alcoholics or people found unconscious on the streets because of severe alcohol poisoning.
52. Only further research, however, will prove whether the patients forego unnecessary services or vital prevention.
53. These cases might be also "rationed out" from the public system. Various views were put forward in an interesting debate in the British Medical Journal on whether or not coronary bypass surgery should be offered to smokers. Mason, J.K., McCall Smith, R.A., Laurie G.T.,"Law and Medical Ethics", 6th edition, Butterworths 2002, see notes on p. 308
54. A textbook example of application of this theory is a situation when a company concludes an independent contractor agreement with a worker who does not work on an independent basis, instead of employment contract in order to bypass the labor law employee protection provisions and/or tax regulation. Such contract has to be correctly judged as an employment contract despite the parties´ attempt to pretend it is not one.
55. However, in reality, such prohibited contracts are only seldom prosecuted with any success. The reason is that they are perceived as beneficial both by the buyers-patients and sellers-providers, and both parties have an interest in keeping these contracts unchallenged. Upon an investigation, it is therefore very hard to prove that the intent of parties was to contract for a covered service unless one of the parties, usually the patient, becomes really dissatisfied with the other party's performance of the "real" contract duties.
56. This perception may be incorrect, however; a recent IOM study shows that the medical malpractice litigation costs less then 0,5% of the overall health care expenditure.
57. Faure, M., Koziol, H.,"Cases on Medical Malpractice in Comparative Perspective", Springer 2001
58. Harrer, F. a kol.,"Ärztliche Verantwortung und Aufklärung" (Physician Responsibility and Disclosure Duty), Wien, ORAC 1999
59. Giesen, D.,"International Medical Malpractice Law: a Comparative Law Study of Civil Liability Arising from Medical Care", Mohr/Nijhoff 1988