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ANALYSIS

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CZECH HEALTHCARE AGAIN BEFORE THE STORM

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Summary

The summer holidays were again marked by a sharp discussion between the Ministry of Health and doctors. Not only the remuneration of health care workers is being discussed, but also the total amount of funds to pay for state-ordered health care. Overall, the funds spent on this area in the Czech Republic are below average in relation to GDP. On the other hand, the Czech Republic has the highest share of public expenditure on health care financing of all EU countries. However, increasing public funds for this system must always be accompanied by a discussion about its effectiveness.

Highlights

- The dramatic differences in the impacts of the proposed variants between the health unions and the ministry are determined by the difference in average wages in recent years and the fact that the ministry sets the calculation according to wages two years retroactively.
- Total health expenditure in relation to GDP (even in terms of purchasing power) is below average.
- The system has a low participation of private resources in health care.
- The number of doctors, nurses and nursing staff is slightly above average within the EU countries, as is the number of graduates of medical faculties.

The year 2024 is a crisis year for the entire Czech healthcare system, and at the end of the holidays, a sharp discussion between the Ministry of Health and doctors culminates again. Tensions escalated at the end of last year after doctors quit overtime en masse. The doctors demanded a reduction in the amount of overtime to a level where they would be able to lead their personal lives while performing professional practice, and at the same time an increase in funds for the health sector. The agreement reached between the Ministry of Health, the Czech Medical Chamber, the Medical Trade Union Club – Union of Doctors, the Trade Union of Health and Social Care of the Czech Republic and the General Health Insurance Company of the Czech Republic in December last year averted the threat of restrictions on care, postponement of surgeries and an overall deterioration in the availability of services at the last possible moment.

In reality, however, the agreement between the government and medical organizations represented a quick firefighting rather than a thoughtful and systematic approach to solving problems. Although it was possible to achieve an increase in the remuneration of health workers, which was a demand of the protesting doctors, the actual solution of the situation was only postponed. From the doctors' point of view, the agreement was therefore a necessary compromise, which brought them some improvements, but at the same time revealed deeper structural problems that have not been addressed or often discussed in the long term.

The current summer negotiations between health unions and the ministry, which deal with the conditions for the remuneration of healthcare workers and the total amount of funds for the payment of state-ordered health care (the so-called reimbursement decree), are at a freezing point. A common intersection cannot be found in either of the two main points of the discussion.

In the case of the reimbursement decree, health professionals argue that payments for individual procedures must respond to the dramatic rate of inflation of the last two years. The Czech Medical Chamber points out that either the income of health insurance companies must be increased or their financial reserves released; Alternatively, the only solution may be to limit the scope of care covered by insurance companies. The Ministry of Health, on the other hand, argues that the state treasury resources are limited.

It seems that finding a compromise on the remuneration of healthcare workers is more realistic, unlike the reimbursement decree. The compromise proposal of the Czech Medical Chamber is based on the fact that the salaries of doctors for basic working hours should be 1.5 to 3 times the average wage in the economy (a graduate doctor 1.5 times, a doctor with a basic educational stem 2 times, a doctor after attestation 2.5 times, a doctor after attestation and achieving a total experience of 10 years 2.7 times, a doctor after attestation and achieving a total experience of 15 years 3 times the average wage in the economy). These requirements would mean that the minimum wage for a doctor with attestation and 15 years of experience would be CZK 129,360 for basic working hours in 2024. On the contrary, the ministry's proposal envisages 1.5-3 times the average wage in the national economy two years retrospectively with an average range of 8 hours per week. The total cost of the Ministry of Health option is estimated by the ministry itself at CZK 5 billion. CZK, while the total cost of the Czech Medical Chamber variant is estimated at CZK 40–50 billion. The dramatically different impacts of these two options will be determined by the difference in average wages in recent years, when, as a result of double-digit inflation, nominal wages have developed extremely dynamically, despite the fact that their real value has fallen significantly. A minor amendment to the determination of the salary base two years back could also cause a difference of CZK 19,000 per month for one certified doctor (ČLK, 2024), (Ministry of Health of the Czech Republic, 2024).

Table 1: Average nominal gross monthly wage in CZK

2018	2019	2020	2021	2022	2023	2024 Prediction	2025 Prediction	2026 Outlook	2027 Outlook
32051	34578	36 176	38 277	39 932	43 120	46 246	49 233	51 761	54 179

Source: Ministry of Finance of the Czech Republic, 2024

However, a discussion on the generosity of remuneration of healthcare workers or specific performances should, by its very nature, be accompanied by a comprehensive discussion on the state of the Czech healthcare system. Financially demanding requirements from doctors, coupled with the state's sluggish attitude, completely ignore the current efficiency of the entire system, the possibilities of digitization offered by 2024, and also the possibilities of savings not only through the prevention of health care. It is alarming that this group of discussants focuses on the symptoms of the disease that the healthcare system suffers from, but does not address the causes themselves.

The health system of the Czech Republic is largely regulated by the government. This fact is clear not only from the global comparison, but also from the comparison within the entire European Union. In terms of total expenditure, expenditure in the Czech system has long been below the EU average, both as a percentage of gross domestic product and when converted per capita. Money spent on health care as a percentage of GDP accounted for a total of 9.5% of economic output in 2021. Despite the fact that a tenth of the output may seem like a significant part of the economy's output sacrificed for health care, this ratio is not above standard in comparison with other countries of the European Union. It is even more than 1 percentage point lower than the European Union average. According to the latest available information on total expenditure on health systems, Germany spends the most, at 12.9% of GDP, followed by France with 12.3% of GDP and Austria with 12.2% (Eurostat, 2024a.).

When recalculating health system expenditure per capita, adjusted for differences in purchasing power, health expenditure in the Czech Republic totalled EUR 2,993 per capita in 2021. This was a quarter less than the EU average, which was 4,028 euros. Despite the fact that a significant amount of funds are paid into the Czech healthcare system and the healthcare system often appears to be a black hole of public finances, from the point of view of international comparison, a below-average amount of funds is invested in this area (OECD, 2024).

Table 2: Total health expenditure as a percentage of GDP

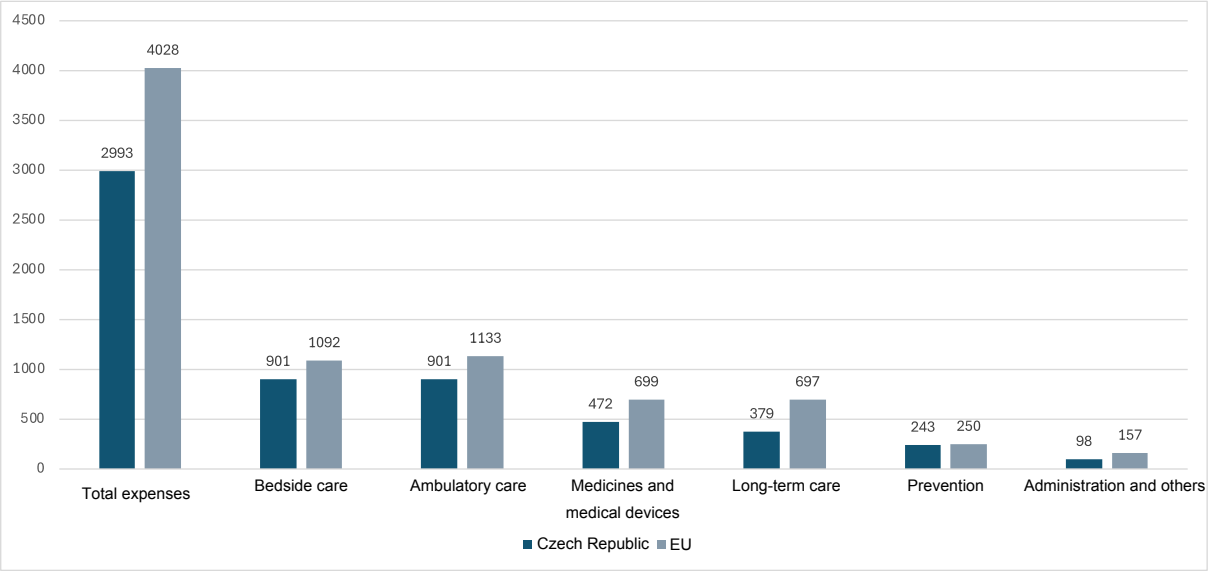
	2014	2015	2016	2017	2018	2019	2020	2021	2022
EU 27	9,98	9,94	9,94	9,87	9,86	9,91	10,84	10,88	:
Belgium	10,61	10,80	10,79	10,80	10,86	10,76	11,27	11,04	10,76
Bulgaria	7,68	7,39	7,46	7,50	7,33	7,09	8,48	8,62	7,66
Czech Republic	7,61	7,37	7,45	7,38	7,47	7,60	9,21	9,49	:
Denmark	10,31	10,34	10,25	10,10	10,10	10,15	10,57	10,63	9,38
Germany	11,03	11,19	11,24	11,33	11,47	11,72	12,69	12,90	12,61
Estonia	6,36	6,64	6,70	6,60	6,69	6,77	7,59	7,54	7,02
Ireland	9,49	7,32	7,48	7,11	6,86	6,72	7,06	6,60	6,03
Greek	7,89	8,22	8,45	8,14	8,12	8,20	9,52	9,18	8,50
Spain	9,08	9,12	8,95	8,94	9,00	9,15	10,74	10,60	:
France	11,54	11,45	11,47	11,35	11,21	11,09	12,09	12,30	:
Croatia	0,87	0,88	0,89	0,88	0,89	0,89	1,02	1,06	7,39
Italy	8,87	8,86	8,73	8,68	8,68	8,66	9,62	9,35	8,95
Cyprus	6,93	6,79	6,65	6,62	6,83	7,07	8,76	9,48	8,87
Latvia	5,46	5,65	6,13	5,97	6,19	6,64	7,29	9,11	7,62
Lithuania	6,19	6,49	6,64	6,46	6,53	6,98	7,47	7,76	7,24
Hungary	7,05	6,85	6,99	6,74	6,58	6,28	7,30	7,38	6,79
Malta	9,09	8,90	8,97	8,73	8,51	9,08	10,60	10,39	:
Netherlands	10,57	10,32	10,29	10,11	10,02	10,14	11,22	11,12	10,10
Austria	10,37	10,37	10,35	10,38	10,35	10,49	11,32	12,15	11,16
Poland	6,32	6,35	6,53	6,58	6,31	6,46	6,50	6,44	6,70
Portugal	9,34	9,32	9,39	9,31	9,41	9,51	10,55	11,12	10,47
Portugal	5,03	4,94	5,08	5,19	5,52	5,71	6,23	6,47	:
Slovenia	8,50	8,52	8,48	8,18	8,28	8,49	9,43	9,48	9,15
Slovakia	6,88	6,76	6,97	6,76	6,67	6,92	7,13	7,76	:
Finland	9,78	9,65	9,38	9,13	9,04	9,17	9,63	10,14	:
Sweden	11,03	10,88	10,88	10,88	11,02	10,87	11,37	11,15	10,71

Source: Eurostat, 2024a.

However, the Czech healthcare system differs significantly in another indicator. Throughout Europe, public funding for health care is significantly prevalent, with no EU country having a share of public expenditure on health care falling below 60%. Despite the continental system set up in this way, the Czech system has a specific feature in the low participation of private sources. The Czech Republic has the highest share of public budgets in health care expenditures of all EU countries. Private household expenditure consists mainly of surcharges for outpatient medicines and their share is below 13% (while this expenditure exceeded 14% of total healthcare expenditure between 2010 and 2019). Even Czech creditworthy patients are not used to paying extra for health care out of their pockets. After all, the regulatory 30 crown fees for doctors have a separate chapter in the history of Czech politics. In 2008, Mirek Topolánek's cabinet introduced fees for doctor's visits, outpatient clinics, prescriptions and hospital stays, which all citizens had to pay. The enforcement of this reform not only cost the then Minister of Health, Tomáš Julínek, his ministerial seat, but also became one of the main reasons for the fall of the then Topolánek cabinet.

Looking at the individual categories of health care, it is clear that in the main segments of the system, the funds we spend are always below the average spending in other countries of the European Union. There is a significant difference in the case of long-term care, where the expenditure of the EU average is almost double. On the other hand, the almost same level of funds invested in organized prevention programs in the Czech Republic and the European Union can be evaluated positively.

Graph 1: Expenditure on individual segments of health care



Source: OECD, 2024

A mere increase in funds for individual segments of health care, with regard to the current state of public finances, is not possible. It is therefore necessary to address the situation comprehensively and not to take one specific point out of context. The Czech healthcare system clearly offers opportunities for saving common resources. Room for increasing the efficiency of care can be found in improving the ratio of the number of beds in combination with a relatively low occupancy rate. Despite the fact that exact data after the pandemic are not yet available, long-term time series (both before and during the pandemic) show that the Czech Republic has a relatively low bed occupancy rate. The closure of some less busy departments, in combination with ensuring quality health care at a sufficient distance, can lead not only to an increase in the efficiency of the finances spent, and thus to a reduction in public budget expenditures, but also to an increase in the quality of health care. Larger hospitals are often better prepared to deal with unexpected complications in patients, and the staff is often significantly more experienced due to the frequency of individual situations.

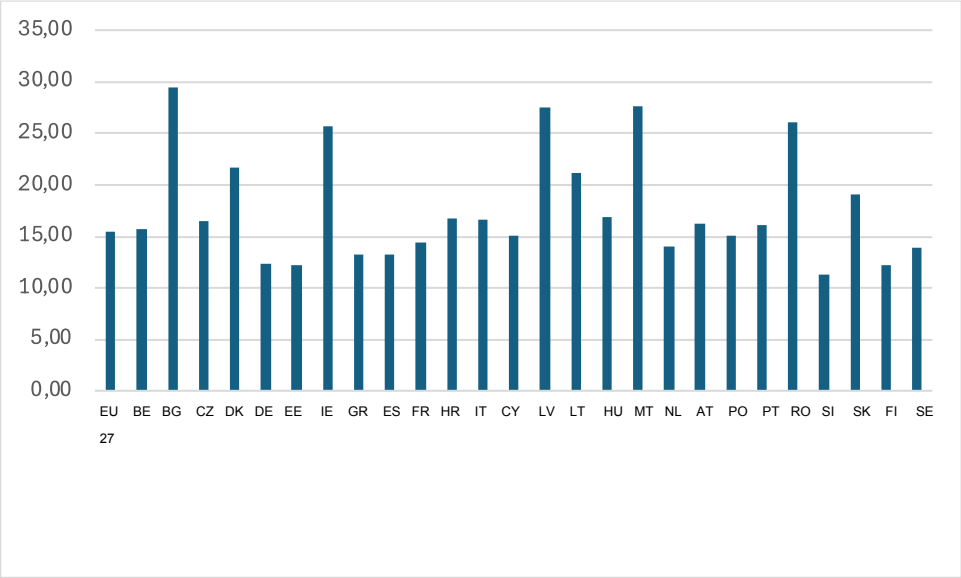
The Czech system must also work more intensively with the risk factors associated with deaths. These are significantly more evident in the Czech Republic than in the European Union average. Specifically, these are eating habits, smoking, alcohol consumption, air pollution and low levels of physical activity. The obesity rate among adults has risen significantly, reaching almost 20%. At the same time, problems with being overweight are more common in boys than in girls, which is sadly reflected in mortality statistics. Risky eating habits contributed to 23% of deaths, significantly higher than the EU average of 17%. Smoking contributes to up to 20% of deaths (EU average is 17%), alcohol 6% (exceptionally in line with the EU average), environmental pollution 6% (EU average 4%) and low physical activity contributes to 3% of deaths in Czechia (EU average 2%) (OECD, 2024).

Healthcare workforce

While the current discussion focuses primarily on the financial side, the Czech healthcare system will be significantly more troubled by the problem of a lack of quality workforce in the coming decade. According to current figures, the number of graduates of medical faculties has increased to 16.55 graduates per 100,000 inhabitants, which is slightly above the EU average (15.47), but this number still does not seem to be sufficient in the long term. On the one hand, it is necessary to perceive the ageing

of employees in the health sector. On the other hand, the trend of an ageing population and the departure of the so-called Husák children's retirement will mean a significant increase in the future required health care.

Graph 2: Number of medical school graduates per 100 thousand inhabitants in 2022



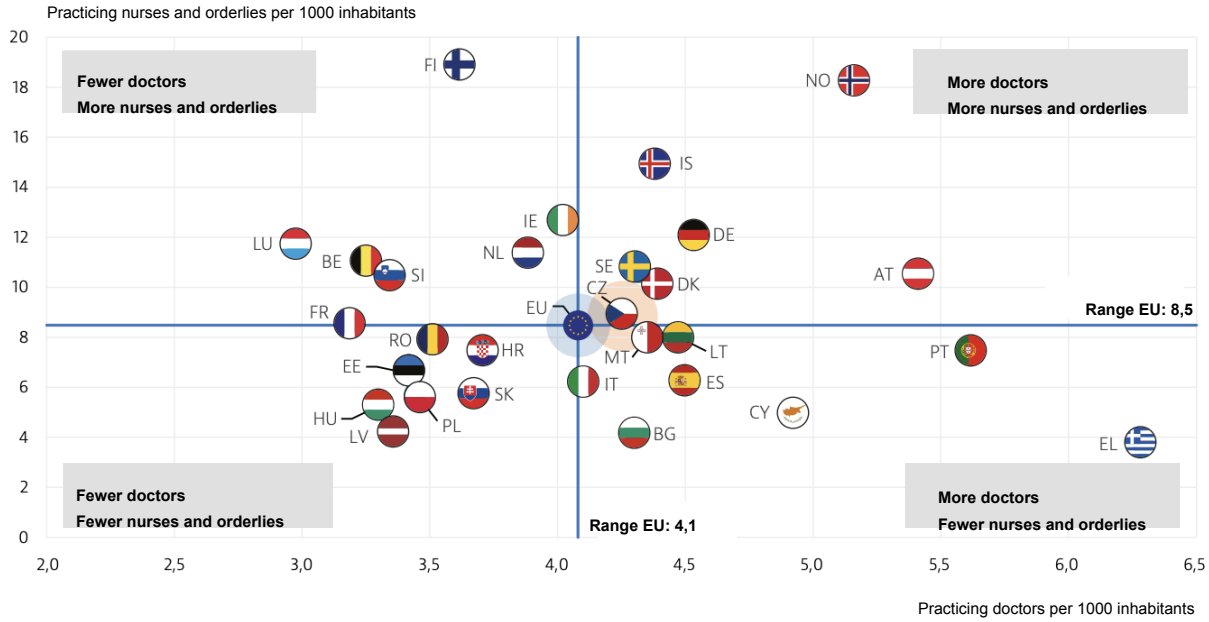
Source: Eurostat, 2024b.

*Data as of 2021.

**Data as of 2020.

However, the current number of doctors, nurses and nursing assistants is slightly above average in European comparison. In the long term, the Czech Republic can draw on labour migration primarily from the Slovak Republic, where there is less language barrier but also a cultural perception of life values. The opposite problem, which every single health minister must reckon with, is the proximity of the German economy, and thus the migration of Czech graduates to this most important economy of the Old Continent.

Figure 3: Ratio of doctors, nurses and nursing staff per 1,000 inhabitants in EU countries



Source: OECD, 2024.

*The EU average is not weighted. Data on nurses include all categories of nurses. In Portugal and Greece, the data refer to all doctors licensed to practice, which leads to a large overestimation of the number of practicing doctors (e.g. by around 30% in Portugal). In Greece, the number of nurses is underestimated, as it only includes those working in hospitals.

Conclusion

Czech healthcare is one of the best in the world. One of the main pillars of this successful system has been doctors, nurses and medical staff for many decades. In order to ensure this quality in the future, we must ensure not only sufficient funds for the operation of hospitals and the remuneration of their employees, but also enough medical staff themselves. However, increasing funding for this system, which is financed primarily from public sources, must always be linked to a discussion on the efficient use of these resources. An important factor of the Czech healthcare system is that it has the highest share of public resources of all EU countries.

Resources

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