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Bc. Peter Bobula

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**Influence of the interest groups on healthcare reimbursement
decree in Czech Republic**

Master's thesis

Author: **Bc. Peter Bobula**

Study programme: International Economics and Political Studies

Supervisor: Mgr. Michal Paulus

Year of the defence: 2019

Declaration

1. I hereby declare that I have compiled this thesis using the listed literature and resources only.
2. I hereby declare that my thesis has not been used to gain any other academic title.
3. I fully agree to my work being used for study and scientific purposes.

In Prague on 7 August, 2019

Peter Bobula

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Abstract

Reimbursement decree is an important part of the healthcare policy in Czech Republic. It determines how the resources will be allocated in the healthcare system the next year. According to the Czech legislature, Ministry of Health invites the representatives of insurance companies and healthcare providers to discuss and create a balanced form of reimbursement. When they are not able to agree, it's up to Ministry of Health to determine the reimbursement in corresponding segment.

We assume that this kind of organization enables the involved representatives to push their interests in order to get more favorable financing for their profession. Different groups have different positions in the bargaining process so we can expect the existence of winners and losers according to the financial arrangements they were able to enforce.

Using the content analysis of final protocols from reimbursement decree conciliations, spending of insurance companies in healthcare segments and settlements of reimbursement decree comment procedures we haven't found any indications of unfair behavior of participating actors. Another interesting outcome is a base for any further research in this area which wasn't so far researched in academia.

Keywords

healthcare, reimbursement, Czech Republic, health policy, interest groups

Length of the thesis: 90 020 characters

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Author:	Bc. Peter Bobula	Supervisor:	Mgr. Michal Paulus
E-mail:	peterbobula@yahoo.com	E-mail:	michal.paulus@fsv.cuni.cz
Phone:	00420 725 820 308	Phone:	...
Specialisation:	IEPS	Defense	June 2016
		Planned:	

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Topic Characteristics:

Goal of this master thesis is to chart the influence groups behind approval of the reimbursement edict of the Czech Ministry of Health.

Reimbursement edict determines every year how much money the providers of health care will get from the insurance company. Despite the fact that it is not a law forming the basic framework of health care legislature it influences significantly the way the large amounts of money are allocated each year. Every year it is the outcome of bargaining between various interest groups.

Reimbursement edict is something like the Law on State Budget in the health care environment and at the same time it is one of the least stable documents. When we look at the last decade, its form changed several times. There is an effort to introduce DRG payments (diagnostic-related groups) what is a system of classifying hospital cases into several groups. It supposes that patients in the same categories use approximately the same amount of hospital resources. On the other hand there are also efforts to keep the flat rate payments that are in general more preferable for hospitals.

I assume that every year this process is the result of conflict between the interest groups which fight for more profitable allocation of resources for themselves. This work will identify the best principles of allocation for different groups. This map of interest groups will be the first of its kind in Czech Republic.

In the discussion I will put the results into context using the examples of financing from different European countries where I can expect similar conditions as in the Czech environment. I will focus on the countries using the Beveridge model of healthcare financing which puts more emphasis on the role of the state.

The outcome of this work will be better understanding of the influences behind the allocation of big amount of public resources. It is in correspondence with public demand for higher transparency and fight against the clientelism.

Working hypotheses:

1. Each year the form of reimbursement edict is the outcome of struggle between various interest groups.
2. The form of reimbursement edict reflects who won the bargaining between the interest groups.
3. In year 2014 hospitals won this fight and for 2015 the Ministry of Health is not using the DRG-based system.

Methodology:

The base for this paper is qualitative analysis and public policy theory of actors generating agendas in arenas. Actors are interest groups, arena is healthcare system financing and agenda the reimbursement edict. This way I can analyze how various actors form the edict which consequently allocates public resources in correspondence or against their interests.

According to Potůček (2010), the concept of political arenas helps to theoretically and empirically understand the processes influencing the formation of public policy. These processes are competition, cooperation, conflict and consensus between the actors. Various actors prefer different costs/benefits and outcomes. This way they define their political arena. Active political actors interact within the arenas but also form relations with the members of other arenas.

After identification of the actors (patients, providers of health care, insurance companies) using the concept of actors generating agendas in arenas I can explain who and why want which form of the reimbursement edict.

Outline:

1. Introduction
2. Public policy theory
 - Actors generating agendas in arenas
3. Czech healthcare financing
 - Legislature
 - Actors
4. Reimbursement edict
 - Forms of reimbursement in selected years
 - Which allocation serves which actor
5. Discussion
6. Conclusion
7. Bibliography

References / Bibliography:

- ✦ EUROPEAN OBSERVATORY ON HEALTH SYSTEMS AND POLICIES. *Diagnosis-Related Groups in Europe*, 2011, http://www.euro.who.int/__data/assets/pdf_file/0004/162265/e96538.pdf
- ✦ EUROPEAN OBSERVATORY ON HEALTH SYSTEMS AND POLICIES. *Financing healthcare in the European Union*, 2009, <http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/financing-health-care-in-the-european-union>
- ✦ FIALA, P; SCHUBERT, K. *Moderní analýza politiky. Uvedení do teorií a metod policy analysis*. 2000, Brno: Barrister& Principal.
- ✦ FIALA, P; SCHUBERT, K. Zájmové skupiny a zprostředkování zájmů v moderních demokraciích. 1993, In *Politologický sborník III*. Brno: Mezinárodní politologický ústav.
- ✦ FUCHS, V. Economics, Values and Health Care Reforms, *The American Economic Review*, Vol. 86, No. 1, 1996, pp. 1-24
- ✦ MALÝ, I. *Problém optimální alokace zdrojů ve zdravotnictví*. 1998 Brno: Masarykova univerzita

- ⤴ MCPAKE, B., KUMARANAYAKE, L., NORAND, C. *Health Economics: An International Perspective*, 2005, Routledge
- ⤴ MINISTERSTVO ZDRAVOTNICTVÍ. *Health System Financing in the EU: Current Practices and the Aging Challenge*, 2009
- ⤴ MINISTERSTVO ZDRAVOTNICTVÍ. *Úhradová vyhláška*, http://www.mzcr.cz/obsah/uhradova-vyhlaska_2904_3.html
- ⤴ POTŮČEK, M; LELOUP, L. T; JENEI, G; and VÁRADI, L. *Public Policy in Central and Eastern Europe: Theories, Methods, Practices*. 2003, Bratislava: NISPAcee
- ⤴ POTŮČEK, M a kol. *Veřejná politika*. 2010, Praha: Sociologické nakladatelství (SLON).
- ⤴ VESELÝ, A; NEKOLA, M. *Analýza a tvorba veřejných politik*. 2007, Praha: Sociologické nakladatelství (SLON).

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Author

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Supervisor

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1. Introduction

Healthcare spending represents a considerable part of every state's GDP since these systems are big and definitely not cheap to maintain. The system of financing differs from country to country reflecting the characteristics of the state. Due to this fact the generalizations and comparisons are risky. In this paper we focus on Czech Republic. According to the Czech law, Ministry of Health invites every year representatives of health insurance companies and medical professions to negotiate the form of payments for the healthcare. The result of these negotiations is reimbursement decree for the next year. If they fail to make an agreement it is on Ministry of Health to decide.

The reimbursement decree is a controversial document often criticized in media from both legal and medical side (Kopecký, 2013, 2019). The main issues are considered to be clashes with the constitution, unclarity of the reimbursement mechanisms and imbalance between the payments across the country. Despite the large amount of resources allocated by this document and level of controversy connected to it, it wasn't given any attention in academia. This paper is the groundbreaking work in this area. It provides a basic synopsis using many primary resources from Ministry of Health for any further research regarding the reimbursement decree.

To understand the processes behind the formation of reimbursement decree we look at the theories of policy networks and also at more specific health policies. Thanks to this knowledge we can identify policy process as never-ending argumentation between the various involved actors. Reimbursement decree negotiations can be then seen as struggle for power and resources.

Citizens of the state expect healthcare provision to be balanced and fair. One never knows what kind of health problem will happen next. It is paid for mainly from the public resources and the most efficient allocation is part of the public interest. When the groups involved in the reimbursement decree negotiations follow their own interests it doesn't have to be in conflict with the public one. But since the healthcare resources for different groups of providers come from the same pool, they distribution has to be optimized. Therefore there can easily be a conflict with public interest. Groups with lower bargaining power might stay under-financed what hurts the patients needing their services.

We expected that segments better represented by actors influential in the process of reimbursement decree finalization have less motivation to find a compromise with the insurance companies. Getting their agenda through the process without a compromise means better allocation of resources for them.

This paper examined the results of negotiations between the healthcare providers and

insurance companies. That way we identified the segments that tend to reach the agreement more often. Afterwards we collected the data regarding the spending of insurance companies in various healthcare segments. This allowed us to look for patterns of more favorable reimbursement for certain segments. Then we analyzed the settlement of comment procedures by Ministry of Health. This part of the process is when other ministries and professional organizations can apply their reservations. Part of the empirical testing was also listing the former professions of Ministers of Health and Czech Medical Chamber chairman in order to test the possible connection with the interest of his former professional group.

First part of the paper identifies the basic models of healthcare financing and the reimbursements mechanisms so we get the basic orientation in the issue. Next parts are dealing with interests behind the formation of healthcare policy and the policy theory relevant for our research. Then we will introduce the Czech healthcare system. This will be followed by the application of the theory to our particular case with the construction of hypothesis. After the theoretical parts we moved to the empirical testing and the conclusions resulting from it.

Our expectations were not confirmed. After the application of content analysis on the mentioned datasets, there does not seem to be any connection between the segments that tend not to form an agreement with insurance companies and more favorable reimbursements. However our work established a foundation for future work in this area. Researchers can profit from our experience and broaden the understanding of reimbursement decree mechanisms using our unique datasets.

2. Theoretical background

2.1. Basic theory of healthcare models

This chapter provides the theoretical background for further analysis. It will describe different possible models of healthcare systems (Beveridge model, Bismarck model and out-of-pocket model) and the reimbursement mechanism in order to provide the basic intuition concerning healthcare financing process.

According to the WHO "a good health system delivers quality services to all people, when and where they need them. The exact configuration of services varies from country to country, but in all cases requires a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well maintained facilities and logistics to deliver quality medicines and technologies. (WHO, 2015a)"

Since various sources use different definitions of the universal healthcare, I will mention the

most universal one by WHO. "The goal of universal health coverage is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. This requires a strong, efficient, well-run health system, a system for financing health services, access to essential medicines and technologies; a sufficient capacity of well-trained, motivated health workers. (WHO, 2015b)" In 2009, 58 countries in the world met access, quality and outcome criteria for universal healthcare (Stuckler et al, 2010).

One of the requirements for universal health coverage mentioned in previous paragraph is "a system for financing health services." Even after a brief research of developed countries healthcare systems it is evident that they share no general characteristics. Each nation's healthcare system is a reflection of its history, politics, economy and national values (Reid, 2009, p. 16).

In general one can say that the principal choices for financing the health coverage are general revenues, social insurance financing, private insurance financing and out-of-pocket payments. Their order depends on country but it is possible to identify few general models of healthcare financing.

Less significant for our purposes is out-of-pocket financing which is used mostly in the countries without established healthcare payment system. The rule in this case is quite simple - you can get medical care if you are able to pay for it. In general the poorest countries have the highest percentage of this kind of payment for medical treatment. In contrast in Great Britain only 3% is covered by out-of-pocket payments (Reid, 2009, p. 18).

Other systems are more relevant for discussion about universal healthcare since they are based on compulsory health insurance for all citizens or at least for specific groups of citizens (for example employees). Their principles are solidarity, equality of rights and egalitarianism. Solidarity in this case means that economically active citizens pay for healthcare for other groups like children or retired. Equality of rights means that the payment of each person is determined according to the corresponding salary, not the health risk. Egalitarianism means that everyone is entitled to the same type and extent of health services regardless his payments. Two models based on these characteristics are Beveridge and Bismarck model (Čeledová and Čevela, 2010, p. 100-103). Main difference between them is in the funding - Beveridge is funded by general taxation while Bismarck by payroll contributions (Kulesher and Forresthal, 2014, p. 129).

Beveridge model is named after William Beveridge who proposed to British government a system according to which Britain's National Health Service was established. Healthcare is provided and financed by the government through tax payments (Reid, 2009, p. 17). Contracted healthcare providers with different forms of ownership ensure healthcare services for the whole population. Financing of the healthcare facilities is a task for specialized offices in government. There is no third party that collects insurance payments and through contracts reimburses healthcare providers. The most extreme form of Beveridge model was used in Soviet Union where it was

called Semashko model and was characterized by complete nationalization (Čeledová and Čevela, 2010, p. 100-103). Beveridge system is used for example in Great Britain, Ireland, Spain, Italy, Denmark, Sweden or Finland.

Bismarck model is named after Prussian chancellor Otto von Bismarck, pioneer of welfare state after the unification of Germany in the nineteenth century. It is funded by mandatory contributions from the income of insured people. Contributions are transferred to self-governed health insurance companies. In this system it is a third party that insures the citizens (not directly the state). It is funded by regular contributions, not taxes or other direct payments. Insurance company reimburses healthcare providers on the basis of contracts. The contribution is determined with respect to the level of income of the insured person. Healthcare providers are contractually bound to health insurance companies or are required by law to charge healthcare provided to clients of health insurance companies (Čeledová and Čevela, 2010, p. 100-103). Many hospitals are privately owned. It is a multiplayer model but medical services and corresponding fees are tightly regulated (Reid, 2009, p. 16-17). This model is used for example in Germany, Switzerland, Belgium, Japan or France, to a degree in Latin America and what is relevant for this analysis, in Czech Republic.

Interesting case is the national health insurance used in Canada, which has the characteristics of both models described above. The providers of healthcare are private but they are paid by government-run insurance program that every citizen contributes to. National insurance company is a single payer so it has significant bargaining power to negotiate lower prices. It also controls the cost by limiting the services it will pay for or by making patients wait to be treated. This system can be administratively simpler than private insurance systems (Reid, 2009, p. 17-18).

Comparison between the models is ambiguous. Systems with one insurance company are slightly less expensive. Their healthcare outcomes are comparable and the differences between the countries using one model are often bigger than between those using different ones (Glied, 2009).

2.2. Reimbursement mechanisms theory

Economically speaking there is a problem of asymmetric information between the provider of healthcare and the patient. Provider payment mechanisms are here to address this issue. There are contracts between the patients, providers and payers creating specific incentives to provide the healthcare and minimize the opportunistic behavior. In economic literature this kind of contract is addressed by agency theory - principal hires an agent to perform a service. There is no perfect contract but it is possible for principal to create incentives in a way that agent's best choice is to align his goals with those of principal. We can identify four main actors in this process - healthcare facilities, health professionals, insurers/payers and patients. Every of this group has its own set of

interests, which may be aligned or contrasting with that of the others. The relationships among them are shaped by their goals and how well their performance under negotiated agreements can be monitored. It is the form of reimbursement that can bring a compromise (Maceira, 1998, p. 3-4).

There are various methods of healthcare reimbursement each providing different incentives for physicians. The most basic one is simple salary. Healthcare personnel is paid fixed amount of money for predetermined amount of hours. This method is easy to administer and patients are not denied access. Doctors in this case do not care about the costs of the service. Then there is the capitation where providers get paid according to their enrolled patient's characteristics. This method is easy to administer as well. On the other hand providers are incentivized to keep the costs down. Both these methods have some disadvantages regarding the incentives to provide optimal healthcare of high quality (Boachie, 2014).

Other two systems - fee for service and case-based reimbursement - require more sophisticated administration including the sophisticated cost accounting system. Under Fee-for-Service providers are reimbursed according to the number and type of service provided to the patient. Price is set for each single service. This way physician is eager to increase both production and quality of service. On the other hand this produces more volume of services that is needed and has also tendency to induce the demand what causes cost of the healthcare to rise significantly. This issue is tackled by the case-based reimbursement where medical personnel is paid predetermined amount covering all services needed for a case or an episode of illness. Using this system providers contain the costs of treatment in every single case. When the physician is paid according to the diagnosis and not the treatment content, he can maximize the difference between earnings and cost. The problem is that using this method doctors may prefer the patients on the low-cost end of the diagnosis category and for the high-costs end they are incentivized to reduce the quantity and quality of services (Chawla et al, 1997).

In order to achieve optimized efficiency, equity and quality of healthcare some countries introduced mixed reimbursement systems combining two or more systems mentioned above. Chosen way of payment for the healthcare services depends on various factors like health management system, institutional support, management and information systems, other reforms and objectives of the government (Chawla et al, 1997).

The case-based reimbursement is the base for the diagnosis-related group system (DRG-system). DRG system uses the system of variables (principal and secondary diagnoses, patient age and sex, the presence of co-morbidities and complications and the procedures performed) to sort out patients into the predefined groups with homogenous resource consumption pattern therefore the cases within one group are economically and medically similar. This mechanism was first developed as a tool for comparing performance of hospitals; later it became the principal system in

high-income countries for the reimbursement, especially for acute inpatient care. We can also observe the low and middle-income countries introducing this system for to remunerate the healthcare providers. DRG is therefore the recent step on the long path of development and readjustment of provider payments. As already mentioned it can be combined with other mechanisms to arrive at the optimal mix of incentives (Mathauer and Wittenbecher, 2013).

Those countries, which were able to develop a universal healthcare system, are using different ways to maintain it. It is worth to stress that even when some countries use similar systems, some characteristics can be considerably different. Character of payer and provider of healthcare is different from country to country, the relation between them as well. Policy-makers were choosing from different possible solutions and were influenced by different ideologies and values. These systems are characterized by the interaction of various actors. To fully understand the issue the next chapter will provide the health policy theory behind the processes of interaction between the actors in creation of the healthcare policy.

2.3. Interests behind the formation of health policy

We went through the models of healthcare financing that are forming the base of public policy dealing with the healthcare provision. Health policy has its specifics and particular development. Without the proper understanding of its dynamics it is not possible to continue in the research. This short chapter reveals the fact that behind the formation of important public policy there is a strong tendency to push forward the interests of specific groups (Anti-Corruption Resource Centre, 2012).

The rise of the health policy is associated with the growing importance of health as a policy sector in the state indicated mainly by the rising amount of money flowing into this field. In the light of what was already mentioned about the healthcare systems it is not surprise that the practical meaning of the health policy varies from jurisdiction to jurisdiction. Therefore the framing of the policy depends on the role of the state defining its key aspects: consumption of care, its delivery and application of technology to the care. State therefore defines the character of healthcare institutions, consumption, professional labor market and medical technology. State is historically often responsible for the constitution of these markets and remains crucial for their functioning. On the other hand one needs to keep in mind that the institutions shape their environment. They are responsible for the concentration of the interests, economic activity and electoral muscle and this way influence the formation of the policy (Moran, 2006).

Suppression of market forces is similar for both Beveridge and Bismarck system. At the core of these corporatist arrangements are institutional arrangements for financing and delivery of the healthcare services. Financing is delegated to independent health insurance companies, often

occupationally based. Delivery (both primary and in hospitals) is delegated to the associations of doctors. They control the profession and the financing of the delivery is dependent on independent negotiations between the providers and payers. State is therefore locking together two of the three mentioned key aspects – healthcare consumption and delivery. The persistent theme in this kind of system is the struggle for power and resources between the two key actors of the mentioned aspects – insurance funds paying for consumption and doctors delivering the service (Moran, 2006).

Corporatist system in Germany was able to create a universal system of coverage leading to ability to give access to the technologically most advanced healthcare. However its position in workplace replicates the labor inequalities and in its heart lays a steering deficit. Since the system depends on delegating the responsibilities to autonomous public law institutions, the outcome policy depends on the bargaining power of different actors, most notably payers and medical professionals (Moran, 2006).

As the providers of healthcare, medical professionals hold a political power within the market constituted by the state. Because of this framework, medical science functions within a political context. Focused and coordinated lobbying of professional medical societies can be successful and influence a formation of healthcare policy. In the United States their effort can be in vain because of many other special interests groups in healthcare that are able to spend more resources on lobbying (Kushel and Bindman, 2004). Within frameworks where no external special interest groups are present, their bargaining power can be harnessed better.

As we know from the healthcare financing theory, the providers negotiate the prices with the financing institution. The bargaining theory has only recently found its way to the healthcare sector which often has a form of monopoly or oligopoly. In this context, the bargaining is a naturally occurring process. In countries with national health services we can see the negotiations in terms of bilateral monopoly, in private-insurance oriented countries the negotiations occur in more competitive setting. Payers (usually insurance companies) are in general bigger than the providers. On the other hand, providers can be exclusive providers of a service in their geographical or professional area what balances their negotiating strength. Timing and protocol of the negotiations can influence their bargaining power even further. The repetition over time can have some outcome implications as well (Barros and Martinez-Giralt, 2012). The result of different bargaining positions can be illustrated by the alarming between-payer and between-hospital price variations in Massachusetts. For the same procedure one can pay significantly different prices not just in different hospitals but also in the same hospital under different insurance company (Craig, Ericson and Starc, 2018).

The health policy and bargaining theory indicates the existence of political capital lying behind the formation of reimbursement mechanisms. Systems of different states are very different

from each other to make any useful generalizations. The literature about this topic is limited and when we can find something, it is state-specific. The above-cited articles mainly concern USA, where the market forces and bargaining in healthcare is studied more than in Europe. But the underlying interest of actors within the bargaining area is always to achieve the best possible outcome for himself. In order to create a methodological framework for our research we need to understand the ways the networks behind the policy formation are studied.

2.4. Policy-making and networks theory

This part provides the theory necessary for the construction of our methodological approach. It consists of the literature review describing the evolution of the policy networks theories. Knowing this process will help reader understand the way Czech reimbursement decree will be examined in this paper.

Theory of policy-making has been trying to understand the processes behind the governing for the decades. Much of the policy literature is concerned with authority, expertise and order. It deals with the activities of governments, setting up the authority relations but it also acknowledges that the policy processes are not coming out of an empty space, they can come from government itself or external sources and then they are brought together in policy. Obviously the policy should aim to solve a problem within the society. Under the rational model this process is seen from the top-down perspective and divided into sequences where the information are collected and pros and cons weighted. There can be different organizational structures but the process is similar. Dror's (1968) optimal model does not count with monolithic hierarchy. It emphasizes metapolicy-making, gradual adjustments and implementation of the new knowledge. This way professional personnel can collect the information on various levels, it can be supported by computerized systems and requires new forms of management. This model supports the idea of capability of mankind to produce science-based knowledge and incorporate it into the policy-making process.

Lindblom's (1959) work about the mutual adjustment is dealing with the empirical characteristics of policy process in a political setting. It says that the whole process cannot be understood without looking at the way politicians, administrators and representatives of interests interact about the themes of common interest. Lindblom (1959) argues that the information gained through this kind of process is as valuable as the one generated by researchers or other experts. Mutual adjustment proposes problem solving based on the authority of the agreements among the interested parties in contrast with the rational model based on the authority of expertise. Agreements do not come after a long or deep analysis and the policies are not made once and forever. It is a never-ending process where losers at one point can win at another one. Decision-

makers are not doing a comprehensive analysis they rather take few means often not too deviating from the past and then select the one that creates agreement of the participants in the policy-making process. Allison and Saint-Martin (2011) revisited Lindblom's incrementalism realizing that even after more than half a century some of the ideas connected to the incrementalism continue to drive policy process research. This fragmented process is similar to the famous invisible hand of the market from the economic theory. The two theories are adversaries both respecting the role of knowledge in policy-making. Rational model stands for the application of scientific knowledge; mutual adjustment accepts also the one coming directly out of the process (Bogason, 2006).

Within the network analysis we can observe many research branches. Hecló (1972) stressed the importance of the networks of interactions by which policies result and then the number of researchers were searching for the theoretical solutions for observed interactions of multiple actors in policy formulation and implementation. In the research of interest organizations and their relations to the state the term neo-corporatism was created. This term indicates the patterns of interaction in society giving industrial interests a crucial role in politics. These ideas were taken by other researchers in order to create the terms like negotiated economy and institutional aspects of the society. A need for the concept of coordinator in town planning of multiple agencies gave birth to the term reticulist as an actor linking various actors to each other (Bogason, 2006). These are not only examples of how the research was moving forward. We can observe many attempts to describe the observed inter-organizational networks within the society and fragmentation of the state apparatus. Three major trends labeled traditionalism, new institutionalism and governance emerged. They interacted and influenced each other. In the recent years we can see growing importance of the deliberative policy analysis. To us it is a reflection of the post-positivist trend in the social sciences taking into account discursive, deliberative and linguistic turns in policy processes. There are few important citations summarizing well the whole movement. According to Fischer and Forrester (1993) policy analysis and planning are practical processes of argumentation. According to Stone (1989) "policy-making is a constant discursive struggle over the criteria of social classification, the boundaries of problem categories, the inter-subjective interpretation of common experiences, the conceptual framing of problems, and the definitions of ideas that guide the ways people create the shared meanings which motivate them to act." Therefore the research moved more towards the openness of public sector to more participation, deliberation, dialogue, mediation and collaboration.

Contemporary policy analysis moved toward the pragmatism with less faith in theory. Just like this research, pragmatists are interested in practical consequences of affirming an idea or taking an action in the light of power relations. They perform critical analysis and see the world contextually using supplementary information based on positivism (Bogason, 2006).

Described evolution of policy analysis enables us to grasp the problem of interest groups

around the Czech healthcare reimbursement decree in a completely different way than it would few decades ago. It is possible to use the terms introduced by Lindblom (1959) and Dror (1968)¹ but at the end we will need the contemporary pragmatist methodology to see the full context of the healthcare. Positively based information analysis combined with critical analysis will be our methodological tool. This way we can grasp the analyzed policy as a practical process of argumentation within the organizational network where one group has more power than the other.

2.5. Healthcare system in the Czech Republic and its reimbursement mechanism

Until the end of 2013 there was 29 218 registered healthcare providers (e.g. ordinations, hospitals) in Czech Republic in which 47 459 physicians and 107 244 para-medical workers with professional qualification was working. Dominant part (79%) of health expenditure was financed by the public health insurance system. The rest was covered by private expenditure (15,3%) and state or territorial budgets (5,3%). Total expenditure was 290 billion CZK what represents 7,12% of Czech GDP (ÚZIS, 2014a).

As mentioned above, healthcare system in Czech Republic falls into the Bismarck category funded by mandatory contributions from the income of insured people. This system was re-introduced after the fall of Soviet Union in 1989 (Kulesher and Forrestal, 2014, 112). Currently there are seven health insurance companies operating in CR from which the General Health Insurance Company is the most significant one covering 58,5% out of 10,406 million clients (ÚZIS, 2014). Health insurance does not have the character of commercial insurance and therefore does not arise from the contract, but from the law.

Going directly to the core of what is interesting for the purposes of this work according to the first part of paragraph 17 of law 48 from 1997 concerning the public health insurance "in order to ensure substantive performance in providing paid services to policyholders, the General Health Insurance Company of the Czech Republic and other health insurers, established under other legislation, contracts with providers for the provision and payment of reimbursable services. A contract for the provision and payment of reimbursable services can be closed only for medical services provider is authorized to provide (Sb. 48/1997, 1997).

"Even more importantly the law continues in the fifth part with defining of the reimbursement negotiations: "Unless otherwise provided herein, the point values, the amount of reimbursement paid services and regulatory constraints are always for the following calendar year agreed in conciliation representatives of the General Health

¹ Despite the age, Dror's work isn't considered outdated, it is a fundamental publication for public policy studies.

Insurance Company of the Czech Republic and other health insurance companies and providers of relevant professional associations as representatives of the providers. Conveyor of conciliation is the Ministry of Health. If there is agreement, the Ministry of Health assesses the content of in terms of compliance with the law and the public interest. If the agreement is in conformity with the law and the public interest, the Ministry of Health as a decree issues it. If there is no conciliation agreement is by 30. June of the relevant calendar year, or if it the Ministry of Health finds that the agreement does not comply with the law or the public interest, the Ministry of Health sets point value, the amount of fees paid for the services, the amount of advances to cover paid services and regulatory constraints for the following calendar year by a decree until 31 October of the calendar year. The decree according to the fourth and fifth sentence will be applied if the provider and health insurance company in compliance with the health insurance plan of the health insurance companies do not agree on the method of payment, the amount of reimbursement and regulatory constraints differently (Sb. 48/1997, 1997)."

There were various changes in the legislation concerning the creation of reimbursement decree. Those of technical character are not very relevant for this study. However at the end of 2000 there was a legislator change, which significantly increased the authority of Ministry in the case of healthcare reimbursement. From then on, Ministry was able to return the agreement to the representatives for renegotiation. If it was not renegotiated, Ministry followed the previous reimbursement patterns or simply issued the new one by a decree (459/2000 Sb., 2000). An important change came in 2007 when the last sentence of the paragraph 17 (The decree according to the fourth and fifth sentence will be applied if the provider and health insurance company in compliance with the health insurance plan of the health insurance companies do not agree on the method of payment, the amount of reimbursement and regulatory constraints differently) was added (261/2007 Sb.). This sentence means that providers and payers are encouraged to reach an agreement during the conciliation. Ministry saw this addition as a change of reimbursement decree from a regulation to a "recipe" or a direction.

The legislature might be a little bit confusing especially when translated from a foreign language. To fully understand the procedure, rights and obligations of the participants the summary of 2015 conciliation's rules of procedure (SZPČR, 2015) will be shortly introduced. The participants of the conciliation are the representatives of the insurance companies and the professional associations of healthcare providers divided into 12 groups:

- Acute inpatient care and other medical services in hospitals
- Subsequent inpatient care

- General practitioners and general practitioners for children and adolescents
- Outpatient dental service
- Outpatient gynecological services
- Outpatient specialized services
- Home health services
- Physiotherapy – paramedical professions
- Out of bed laboratory and radio diagnostic services
- Ambulance, transportation of urgent patients and emergency medical service
- Medical transport services
- Spa rehabilitation care and healthcare in sanatoria

A group of providers can join an existing group or form a new one. This happened in 2010 when the institutional care was divided into the acute inpatient care and subsequent inpatient care and gynecologists parted with outpatient specialized services. In 2016 transport services formed an independent group. From 2017 the outpatient hemodialysis care stands alone just like the pharmacy care. Therefore from 2017, 14 different groups of healthcare providers participate in the reimbursement decree conciliation process with the insurance companies. The number of providers gives the weight of a vote within the group if they do not agree otherwise. Three phases of the conciliation are the preparative, the approval and the final one. In the first one the representatives discuss the technical issues and introduce the first proposals. They can reach a preliminary agreement or not. In the second phase the representatives of groups can protest against the preliminary agreements of other groups if they think that their interests are in danger. After this the concerned groups meet in order to renegotiate the agreement. The result of the final phase is “Final report on the results of the conciliation of values point, the amount of reimbursement of health care covered by public health insurance and regulatory restrictions.” In exceptional cases the agreement can be reached even in this phase. The final report must be delivered to Ministry of Health at least 120 days before the end of year. There are two permanent commissions securing the process. Mandate commission takes care of the technical issues (evidence, registration, archives, information, etc.) Members are elected for one year and there must be the equal number of representatives of insurance companies and healthcare providers. Analytic commission judges the balance of reimbursement mechanism and analyzes the values point and the amount of reimbursement. That is the reason why every single group has its representative in this commission. Members are elected within the group.

The reimbursement decree valid in 2016 sets the mechanisms as follows. For the acute inpatient care the case-based reimbursement (DRG mechanism) is used. The subsequent inpatient

care is reimbursed using the flat rate system for one day of hospitalization. General practitioners are paid according to the combination of capitation and fee-for-service. Outpatient dental services are covered by the combination of fee-for-service and out-of-pocket payments. Spas rehabilitation care is paid for by the combination of flat rate for day of care and fee-for-service. The rest of the healthcare providers are paid using the fee-for-service mechanism with the established value of point and point values of the services (273/2015 Sb.).

According to the law of CR, every single year payers of the healthcare services (insurance companies) and the representatives of healthcare providers are invited by the Ministry of Health to make a deal about how the services will be paid for. This necessarily provides opportunities for different groups (ambulant specialists, general practitioners, gynecologists, stomatologists, acute inpatient care, etc.) to use their influence and to secure more resources for their areas of action. In order to get some more insight into this issue, my work continues with some theoretical background of the networks, bargaining and power in public policy. Ministry of Health is supposed to play the role of regulator but at the same time state owns a significant part of the hospitals. This fact put Ministry into a serious conflict of interest. In the case of disagreement during the mentioned reimbursement conciliation, Ministry decides the way resources are allocated. After the reimbursement conciliation there is the comment procedure during which other ministries, regional bodies or other major actors can express their reservations. Those can be accepted by the Ministry of Health and implemented in the reimbursement decree. This style of reimbursement is specific for CR. In Germany they use collective bargaining between the healthcare providers and insurance company as well but when they do not achieve an agreement it is the arbitral tribunal, not Ministry, who decides (Šperkerová, 2016).

2.6. Application of the theory and formulation of hypothesis

Taking into consideration the old network analysis and the distinction between rational model (Dror, 1968) and the mutual adjustment (Bogason 2006), it is possible to say that in the case of Czech reimbursement decree we can observe a combination of those two. Ministry of Health in fact is a top actor but it creates a platform on which payers and providers can reach an agreement about the form of reimbursement for the next year. Ministry gives them a space for the mutual adjustment. From the contemporary pragmatic perspective we can observe a bigger scope of events. CR as many others countries faces demographic transition, population is aging. The healthcare is based on the principle of solidarity but declining amount of working people and their contributions are not able to cover the healthcare for the whole population. Health insurance companies have at their disposal limited amount of resources, which must be distributed among the healthcare providers. If

the policy-making really is “a constant discursive struggle over the criteria of social classification, the boundaries of problem categories, the inter-subjective interpretation of common experiences, the conceptual framing of problems” (Stone, 1989) and policy planning, in this case agreements leading to the reimbursement decree, really is constant process of argumentation, then those with better argumentation and more bargaining power will get bigger piece from the limited resource pie.

Looking at the health policy theory we can see basically the same thing that other authors observed in the case of corporatist arrangement in German health system. CR as a state delegates the financing of the healthcare to the insurance companies and provision of the healthcare to the medical professionals. Every year the policy redistributing around 7% of Czech GDP depends on the bargaining power of the involved actors. If they are not able to make a deal, Ministry will decide in the redistribution of resources without them. After a brief glance on the growing number of pages in the reimbursement decree, it is clear that the representatives are willing to bargain in order to achieve more resources for their profession.

The groups with more powerful representation in higher posts like Minister of Health are presumably less motivated to reach an agreement with the insurance company representatives because they can expect favorable redistribution from the ministry, which decides in the cases when the agreement is not reached. On the other hand the underrepresented professions will try harder during the reimbursement decree conciliation since they cannot expect such a strong support from the highest posts or other organs that can intervene in the comment procedure and therefore attempt to change the final form of the reimbursement decree.

Looking at the media coverage from the periods when the new decree for the next year is a hot topic, we can observe that some funds for some medical professions are getting bigger while the share of the others stays the same. Obviously, there might be relevant reasons for that (e.g. with aging population some diagnosis are more frequent and the facilities dealing with them need more resources) but taking into consideration what we learned from the theory, it can also be the consequence of the better bargaining position of the particular medical profession.

From these observations we derived the following hypothesis:

Healthcare providers expecting their interests to be represented by other organs in the comment procedure tend not to reach an agreement with the insurance companies.

Confirmation of this hypothesis might indicate that the current reimbursement mechanism has to be changed to fulfill its purpose because some parts of the healthcare system are getting less money than they need only because of the lesser power in the bargaining process or

underrepresentation in the comment procedure. This would mean gradual weakening of these sectors with the possibility of malfunction. Rejection of the hypothesis indicates that the negotiations are well configured and the funds fairly allocated.

2.7. Methodology

In order to test the hypotheses we need to collect the data from the reimbursement conciliations. We need to know which healthcare providers reached an agreement with the insurance companies. These data are obtainable from various sources depending on where the conciliation was held the corresponding year. They are called final protocols (in Czech: Závěrečný protokol o výsledcích dohodovacího řízení o hodnotách bodu a výši úhrad zdravotní péče hrazené z veřejného zdravotního pojištění). For better illustration the example of these documents is in the Appendices, Figure 1. If necessary, we are able to provide them. These data will be combined with the list of Ministers of Health and their respective professions before holding this function.

The second dataset is the spending of insurance companies in different sectors of the healthcare. This is available in yearbooks of Institute of Health Information and Statistics of the Czech Republic (ÚZIS).

The third dataset are the documents directly from the Ministry of Health with the comments of organs influential in the reimbursement decree comment procedure and whether these comments were taken by the Ministry of Health into consideration and implemented in the final version of the decree. Again, for illustration the example is in the Appendices, Table 1 and in case of deeper interest we can provide them.

Because of the insufficient extent of the datasets and nature of the the information, any quantitative research is out of question. Therefore we are using the content analysis which lies between the qualitative and quantitative traditions (Duriiau et al., 2007). Analyzing the outcomes of communication between the various actors during the phases of formation of reimbursement decrees allows us to find the patterns that will confirm or decline the hypotheses.

Summarizing the communication during the formation of reimbursement decrees is by itself and important outcome since they are not accessible in such a comprehensive form. They can therefore serve as base for another research in this field.

3. Empirical testing

3.1. Czech Ministers of Health since 2000

From the official pages of Czech government the high fluctuation and political instability is evident. However it is not to be mistaken with other forms of instabilities since the economy is

doing well enough and the business environment can be considered healthy (Laca and Ponikelská, 2013). The first independent election (after the dissolution of Czechoslovakia) was held in 1992 followed by six others. One might normally expect seven governments holding the office since then. In fact there was 15 of them including three caretaker governments (Vláda ČR, 2019). This instability influenced the health resort as well. Since 1993 Czech republic had in total 20 MH's under 15 different governments. Looking at the average time spent in the office, MH is the governmental seat with the highest turnover (Štěpán, 2014).

This work suggests that agreement or non-agreement during the conciliation procedure is connected to the person of Minister of Health (MH) in given time. Therefore the list of ministers and their previous occupations will be needed in order to prove the connection. The research starts with the reimbursement decree valid in 2000, so the relevant list starts with the MH in office in 1999 when this decree was approved. The list includes the group of profession into which minister belongs concerning his medical specialization.

The government of Miloš Zeman (July 1998 – July 2002) first put into the position of MH the psychiatrist (outpatient specialist) Ivan David. The position was shortly taken by Vladimír Špidla, who does not have any medical experience. Since the beginning of 2000 he is replaced by Bohumil Fišer, renowned researcher.

In the next election period (2002 – 2006) there are three different governments lead by the same political party (Vladimír Špidla, Stanislav Gross and Jiří Paroubek) with five different MHs:

- July 2002 - April 2004: Marie Součková, orthopedist and surgeon, outpatient specialist
- April 2004 - August 2004: Jozef Kubinyi, nuclear medicine and cardiology
- August 2004 - October 2005: Milada Emmerová, internal medicine
- October - November 2005: Zdeněk Škromach, no medical experience
- November 2005 - September 2006: David Rath, internal medicine

The election period between 2006 and 2010 was considered politically unstable. Three people were holding the post of MH.

- September 2006 – January 2009: Tomáš Julínek, ARO, hospital management
- January 2009 – May 2009: Daniela Filipiová, no medical experience
- May 2009 – July 2010: Dana Jurásková, nurse

Since then we can observe relatively stable period with only three MH's until today. After the election in 2010 under the Prime Minister Petr Nečas Leoš Heger (hospital management) held the office. After the fall of this government Martin Holcát (ORL, hospital management) followed him as a part of the interim government. Under Bohuslav Sobotka, two different people served as MH. From January 2014 to November 2016 Svatopluk Němeček (internal medicine, hospital management) and from December 2016 to December 2017 Miloslav Ludvík with experience in pharmaceutical industry and hospital management. The current MH Adam Vojtěch occupies this position since December 2017, holds a Master of Healthcare Administration and has only minor experience from supervising and governing boards in insurance companies (MZČR, 2017).

To summarize, in the observed time period there were four MHs with no medical experience – Špidla, Škromach, Filipiová and Vojtěch. Except of Vojtěch, they held the office for quite a short time and not even during the period of finishing the conciliation procedure. Their impact can be considered negligent. There were some ministers with specializations occurring only once – Fišer (research), Jurásková (nurse). The rest of the MHs were outpatient specialist and part of them had also extensive experience with the hospital management.

Another powerful figure, which can be expected to influence the final reimbursement edict, is the chairman of Czech Medical Chamber. There were four of them since its establishment in 1991 and only two of them are relevant for our case. From 1998 to 2006 David Rath held the office. The current chairman Milan Kubek followed him. They are both outpatient specialists, most of their careers internists.

As one of the hypotheses says, there might be a connection between the profession of current Minister of Health and the result of conciliations regarding the reimbursement decree. To verify this hypothesis, the next chapter examines the results of these conciliations.

3.2. Reimbursement decree conciliations results

Between the years 2008 and 2019 the representatives of healthcare providers and insurance companies were able to achieve agreements in minority of the cases. The partial agreement for the purposes of this work is seen as a non-agreement. General practitioners achieved agreement in approximately (the results were rounded to full percentage points) 42% of the conciliations, stomatologists in 50%, outpatient specialists in 8%, home care providers in 8%, laboratory and radio diagnostics service providers in 25%, ambulance and transport providers in 67%, spa and rehabilitation providers in 42%, physiotherapists in 8%, gynecologists in 75%, institutional care which was later divided into acute inpatient care and subsequent impatient care in 8% of the conciliations.

As the Table 1 illustrates we can see some divisions in the individual groups of healthcare providers. Just like the institutional care was divided into two parts in 2010, gynecologists stand alone from the same year. In 2017 the outpatient specialized was divided again when providers of outpatient hemodialysis formed a separate group in the reimbursement concentrations. From 2016 the transport services are not longer within the same group as the ambulance. From 2017, the pharmacy care stands alone since they felt underrepresented (Skopová, 2016).

It was in 2007 when the law 261/2007 Sb. changed the importance of agreement between the providers and insurance companies. Therefore the separate observations of conciliations between the years 2008 and 2019 are needed. Agreement-wise the worst years were 2008 and 2012 when none of the healthcare segments was able to negotiate the agreement with insurance companies.

After dividing the segments according to the form of the reimbursement on those paid according to the fee-for-service and others, it is possible to observe that those fee-for-service reimbursed in general do not tend to achieve agreement more or less frequently than the others. General practitioners (combination of capitation and fee-for-service, 42%), stomatologists (fee-for-service and out-of-pocket, 50%), spa and rehabilitation services (fee-for-service and flat rate, 42%) achieve an agreement at least in third of the conciliations. Specific are the segments of acute and subsequent inpatient (not paid by fee-for-service mechanism) where the agreement was only reached once. Fee-for-service paid segments have very low tendency to reach an agreement with the exception of gynecologists and ambulance/transport service providers.

If there is a connection between the person of Minister of Health and the reimbursement decree conciliations, then it is possible to expect that segments of outpatient specialized care and hospital care (acute and subsequent inpatient care) will have tendency not to reach an agreement since they expect that the final form of reimbursement decree will be in their favor. Most of a time in observed period someone with hospital management or outpatient specialized care experience holds the seat of Minister of Health. At first sight this might seem to be right. Both of the mentioned segments has 8% rate of success in reimbursement conciliations. However there are also segments of physiotherapy and home health care with the same rate of success.

Looking at the results of reimbursement decree conciliations it is possible to observe some patterns but none of them is entirely stable or has no exceptions. In order to be completely sure about the fate of the hypotheses, it is necessary to examine the issued reimbursement decrees. If there is some kind of patronage for some segments at the MH, the reimbursement conditions will change in their favor after their disagreement with insurance companies.

Following the changes in reimbursement decrees is not an easy task since every single year there are many of them. For the illustration the decree for 2008 was 61 pages long while the most

recent one from 2015 was 101 pages long. In order to simplify the observation and avoid the risk of missing the important changes this paper uses the official presentations from the pages of Ministry of Health.

In 2007 at the beginning of Julínek's reforms, the ministry organized comprehensive seminar for journalists concerning the financing of health insurance system and reimbursement system in 2008. Since then ministry publishes this kind of presentation every year. For 2008 ministry claims that for the first time the reimbursement decree does not lead to general application of the same method of payments to all healthcare providers. As it was already mentioned this was the year when the reimbursement decree respected more the agreement between the provider and insurance company. In 2008 the most visible changes were in the segments of hospitals (development of DRG system instead of confusing flat rate) and general practitioners who got the most significant payment increase since the beginning of capitation (Ministry sees it as a way of fixing one of the long-term problems). Beside that Ministry declares the support for outpatient specialized care, home care and rising of finances from public health insurance for ambulance. The controversial step was the introduction of regulation fees (MZČR, 2007). (note: general practitioners agreement)

In 2008 (reimbursement decree for 2009) Ministry complains about the slow and insufficient reactions of insurance companies. This year was under the influence of the global financial crisis. In previous years the reserves of insurance funds were rising while this year they expect to spend more money than they get. In the first half of the year they were paying significantly more money to the hospitals, general practitioners and outpatient specialists. Despite the economic problem Ministry decided to increase the funding for outpatient specialist and psychiatric treatment facilities, raise the share of hospitals on case-based reimbursement, planned to take into consideration the rise of price of work of other healthcare personnel (e.g. nurses) and conditioned another increase of general practitioners funding by the increase of availability of their work. The reason for these changes was raise the overall availability of basic treatment and on the other hand cluster the specialized treatment in order to enhance the quality (MZČR, 2008).

Year 2010 is again influenced by the financial crisis. Continued funding in at least the same scope as in 2009 is possible thanks to the reserves. Ministry warns that next year the insurance companies will run out of them and stresses that the reimbursement decree is a significant anti-crisis stabilizer which takes into consideration the system priorities. There were some minor increases in the funding of outpatient specialists, radiology, laboratory and radio diagnostic services, home care and gynecologists. General practitioners and subsequent outpatient care have the same conditions as in the previous year (MZČR, 2009).

In 2011 the situation is similar to the previous years – higher unemployment and more

citizens in unproductive age plus the financial crisis and decreasing fund reserves of insurance companies. That is why Ministry stresses the importance of restrictive adjustment of the reimbursement system. Despite the negative facts, the salaries in healthcare are still rising. Overall Ministry was planning to save 6 billion CZK in all segments. In the end after taking into consideration the conciliation agreements and remarks they decreased this number by almost 4 billion CZK. The most significant cut was in acute inpatient care where they planned to decrease the number of hospitalizations by optimizing the planning. Ministry guarantees almost the same scope of the care as in the 2010 with the continuing need to draw on reserves (MZČR, 2010).

The main characteristic of Ministry's presentation regarding the year 2012 was wide implementation of DRG mechanism in hospital. This should lead to higher efficiency and more fair reimbursement. Healthcare system expected higher revenues but the budget constraints remain significant. The result of this situation is stagnation of reimbursement in basically every segment. Minister Heger considers the economic stability of healthcare system as big success of all the participants. Nevertheless it is still important to act sparingly as possible (MZČR, 2011).

Economic stagnation continues in 2013. However healthcare is the only economic sector in Czech republic not affected by the crisis. Despite that Ministry believes that there are internal waste, which should be found and be subject of optimization. Restrictions for this year have not touched the home care, serious illness treatment, high-end care in specialized centers and acute inpatient care where the production restriction still lasts. Ministry accepted the agreement with general practitioners (MZČR, 2012).

After years restrictions the conditions got better in 2014. Revenues increased thanks to increased insurance collection and increased payments for the people insured by state. The regulation fees for day of hospitalization was cancelled what caused need for compensation in spa and subsequent inpatient care. Ministry also had to take into consideration the Constitution Court judgment regarding the form of regulations. The requirements of all the segments were not met due to insufficient funds but Minister Holcát guaranteed growth of reimbursement for all segments compared to the previous restrictive year. In the segments with financial problems (spa, acute inpatient care, children psychiatry) Ministry promised significant help (MZČR, 2013).

In 2015 the growth of available resources continues but big part of new resources is used for regulatory fees cancelation compensation. Another good news is 5% increase of tariff rate salaries of healthcare personnel. Hospitals, outpatient specialists and general practitioners enjoy some minor positive changes as well. The other segments are reimbursed on the similar base as it was in previous year. Interesting is the fact that despite the conciliation agreements between the dentists and laboratory and radio diagnostic service providers was vetoed, Ministry incorporated them into the final form of reimbursement decree (MZČR, 2014).

Reimbursement decree in 2016 again enjoys the growth of available resources. Majority of them goes to hospital and ambulatory care. Costs of segments are growing in proportion to total revenue growth of public health insurance system. There is some minor increase in every segment of healthcare except of ambulance and transportation services. The representatives of those two segments agreed on that with the insurance companies representatives. This reimbursement decree according to the Ministry ensures growth in every segment and is budget-wise neutral. Ministry stresses that it does not obstruct the individual agreements between providers and insurance companies; in some cases it is preferable (MZČR, 2015).

Under Němeček, in reimbursement decree for 2017 the growing trend continues. Almost all of the segments were given more resources and also the rise of wages of healthcare staff was enabled (MZČR, 2016).

The last reimbursement decree conciliation was and unprecedented success. For the very first time in the history all of the healthcare provider groups were able to reach an agreement with the insurance companies. Minister Vojtěch was stressing at the beginning of the conciliations that there isn't a reason for providers and payers not to agree on prices of healthcare (MZČR, 2018b). After the the agreement was reaches, Vojtěch said that in previous years the providers were counting on MH to decide and were trying to lobby the better conditions for their segment. According to him, he rejected this approach (MZČR, 2018a).

Last few pages brought some light into the issue debated in this paper. Ministry of Health seems to be economically relatively well equipped since it was able to decently withstand the crisis. From was in its own presentation it could always find a way to balance requirements of various actors in the system. After closer examination it is evident that two segments are getting more attention than the others. Hospitals and outpatient specialist are mentioned more often and in recent years they enjoyed allocation of the majority of growth in revenues their way even though they were not able to reach an agreement with the insurance companies. To avoid any premature conclusions, a brief economic analysis of healthcare system is needed to understand the structure of previously described actions.

The structure of expenditures spend by insurance companies on the segments of healthcare has not changed too much in last years. In 2013 around 47% of all the expenditures was spend on hospitals. Around 27% was ascribed to outpatient care (6% general practitioners, 4,5% dentists, 8,7% outpatient specialists and 1,5% gynecologists). Spa and rehabilitation services consumed only 0,7% of the budget. Ambulance and transport services together used up 1,7% of the resources spend on healthcare by insurance companies. Another important item were the prescription drugs. They correspond to 17,1% of expenditures (ÚZIS, 2014b). For comparison in 2008 the structure of insurance companies expenditures on healthcare segments looked as follows: hospitals 46,1%,

outpatient care 24,9% (general practitioners 5,2%, dentists 4,7%, outpatient specialists 7,7%, gynecologists 1,5%), spa and rehabilitation 1,5%, ambulance and transport services 1,5% and prescription drugs 16,9% (ÚZIS, 2010). To go even deeper, in 2001: hospitals 43,4%, outpatient care 22,4% (general practitioners 5,1%, dentists 6%, outpatient specialists 6,8%), spa and rehabilitation 2,4%, ambulance and transport services 1,6% and prescription drugs 21,7% (ÚZIS, 2008).

Table 1. Reimbursement decree conciliations results in individual healthcare segments 2008-2019²

<i>Healthcare provider</i>	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2008 - 2019	In % (rounded)
General practitioners	N	A	N	N	N	A	A	A	N (P)	N	N	A	5 of 12	42
Outpatient dental service	N	A	A	A	N	N	N	N	N	A	A	A	6 of 12	50
Outpatient specialized services	N	N	N (P)	N (P)	N	N	N	N	N (P)	N	N	A	1 of 12	8
Outpatient gynecological services			A	A	N	A	A	A	A	A	A	A	9 of 12	75
Outpatient hemodialysis care (independently since 2017)										A	N	A	2 of 12	17
Home health care	N	N	N	N (P)	N	N	N	N	N	N	N	A	1 of 12	8
Out of bed laboratory and radio diagnostic services	N	N	N	N (P)	N	N	N (P)	N	A	A	N (P)	A	3 of 12	25
Ambulance, transport services	N	A	A	A	N	A	N	A	A	A	N	A	8 of 12	67
Transport services (independently since 2016)									A	A	N	A	8 of 12	67
Spa rehabilitation care and health care in sanatorium	N	A	N	A	N	N	A	A	N	N	N	A	5 of 12	42
Physiotherapy	N	N	N	N (P)	N	N	N	N	N	N	N	A	1 of 12	8
Institutional care	N	N											0 of 12	0
Acute inpatient care (independently since 2010)			N	N	N	N	N	N	N	N	N	A	1 of 12	8
Subsequent inpatient care			N	N	N	N	N	N	N	N	N	A	1 of 12	8

² A - Agreement, N - Non-agreement, N(P) - Partial agreement, for purposes of this work non-agreement

(independently since 2010)														
Pharmacy care (independently since 2017)										N	N	A	1 of 12	33

Source: Final protocols from reimbursement conciliations (example in Appendices, Figure 1)

3.3. Spending of insurance companies in different healthcare segments

Thank to the work of the Institute of Health Information and Statistics of the Czech Republic researchers can easily follow the developments of a considerable amount of data within the healthcare system in Czech republic. For the purposes of this work we observed the development of spending of the insurance companies in respective segments of healthcare. The amounts in the Table 2. bellow are in costs per 1 insured person in CZK and between the values for the respective years index shows the growth compared to the previous year. The only possible issue is year 2011 when two following official yearbooks were stating different value. This minor problem shouldn't thwart our observations.

The general trend is spending of insurance companies is overall steadiness in majority of the healthcare segments. The exceptions are segments with smaller budgets (nursing beds, hospices, convalescent homes) where we can observe bigger index fluctuations caused even by minor budget changes. The biggest amounts of money are spend on hospitals, drugs and special outpatient care. Even in those a steady rise is observable. Table confirms the information from the previous chapter about the spending during the financial crisis.

Groups of the providers without the general agreement with the insurance companies in reimbursement conciliations according to the previous table (inpatient care/hospitals, home care, outpatient specialized care) do not significantly outperform the providers that are more successful in conciliations with the insurance companies (general practitioners, stomatologists, balneal care, transport and ambulance) in terms of rising of their income from the insurers in terms of index showing year-to-year increase.

Table 2. Costs of health insurance companies by segments of healthcare 2007-2017 in cost per 1 insured person in CZK

Type of healthcare	2007	Index (2006 = 100)	2008	Index (2007 = 100)	2009	Index (2008 = 100)	2010	Index (2009 = 100)	2011	Index (2010 = 100)	2012	Index (2011 = 100)	2013	Index (2012 = 100)	2014	Index (2013 = 100)	2015	Index (2014 = 100)	2016	Index (2015 = 100)	2017	Index (2016 = 100)
Stomatologic al care	875	106,6	883	100,9	938	106,2	956	101,9	968	101,3	948	98,2	962	101,5	966	100,4	996	103,2	1024	102,8	1044	102
General practitioners	832	104,5	980	117,8	1151	117,4	1208	105	1240	102,6	1245	100,7	1286	103,3	1305	101,5	1381	105,8	1418	102,7	1477	104,2
Rehabilitation care	160	106,7	175	109,4	210	120	214	101,9	234	109,3	241	103,4	251	104,1	274	109,2	272	99,4	291	106,8	280	96,4
Diagnostic care	642	101,4	712	110,9	866	121,6	786	90,8	801	101,9	822	102,9	839	102,1	923	110	915	99,2	956	104,5	999	104,4
Home care	99	113,8	103	104	132	128,2	127	96,2	132	103,9	132	100	149	112,9	162	108,5	162	100	182	112,7	183	100,4
Special outpatient care	1542	113,5	1721	111,6	1848	107,4	1955	105,2	2094	107,1	2101	100,6	2169	103,2	2265	104,4	2368	104,5	2610	110,2	2717	104,1
Hospitals	7935	109,8	8622	108,7	9305	107,9	9910	106,5	10001	100,9	9957	99,8	9994	100,4	10754	107,6	11176	103,9	11622	104	12439	107
Spec. therap. institutions	528	109,5	523	99,1	620	118,5	578	93,2	576	99,7	568	99	556	97,9	671	120,8	696	103,6	729	104,8	771	105,8
Institutions for long-term patients	390	116,8	329	84,4	379	115,5	214	56,5	225	105,1	228	101,3	214	93,9	260	121,3	267	102,9	277	103,6	304	109,7
Nursing beds	95	114,7	95	100	103	108,4	51	49,5	57	111,8	55	96,5	57	103,6	68	119,8	74	108,9	86	115	89	103,7
Hospic type beds				1		13	1300	14	107,7	14	100	14	100	16	110,9	15	99,5	18	116,5	19	106,9	
Balneal care	289	107,7	276	95,5	307	111,2	308	100,3	287	93,2	240	83,9	152	63,3	235	154,5	276	117,7	304	110	314	103,3
Care in convalescent home	5	83,3	4	80	5	125	4	80	3	75	2	66,7	2	100	3	133,5	3	109,3	3	97,1	3	102
Transport	123	103,4	143	116,3	143	100	140	97,9	136	97,1	127	93,4	144	113,4	145	100,5	148	102	148	100,2	147	99,2
Medical emergency service	139	127,5	137	98,6	153	111,7	164	107,2	172	104,9	192	112,3	207	107,8	218	105,2	237	108,8	249	105,1	256	102,9
Prescribed drugs	3252	98,7	3160	97,2	3534	111,8	3297	93,3	3284	99,6	3434	104,9	3328	96,9	3248	97,6	3251	100,1	3300	101,5	3370	102,1
Prescribed medical aids	501	114,6	544	108,6	576	105,9	578	100,3	606	104,8	591	97,8	582	98,5	622	106,9	654	105,1	703	107,5	715	101,7

Source: Institute of Health Information and Statistics of the Czech Republic (ÚZIS) yearbooks

3.4. Reimbursement decree comment procedures analysis 2008-2019

After the reimbursement decree conciliations between the insurance companies and healthcare providers, the Ministry of Health gives other ministries and other major actors chance to comment the reimbursement decree before it's sent to the government. This is where we can expect the influence of interest groups to show it's strength. This chapter will analyze the documents from the Ministry of Health with the settlements of the comments between the years 2008 and 2019. We were unable to get the documents from years 2009, 2012 and 2014. In these years only the short presentation reports will be used. Our analysis is limited by the understanding of complicated reimbursement mechanisms. The listed cases are the examples of explicitly mentioned groups of

healthcare providers or otherwise interesting cases.

In 2008 Ministry of Finance was concerned regarding the part of reimbursements for outpatient specialists. Ministry of Health explained it was only concerning the general practitioners and it was only an insignificant payment which wasn't revised in 10 years.

As we already mentioned from 2009, 2012 and 2014 we can only use short presentation reports. However the one from 2014 mentions a comment by Ministry of Defense regarding the acute inpatient care. This comment was only explained, not accepted.

In 2010 we can observe an interesting comment by Ministry of Interior about not respecting the results of the conciliations between the insurers and providers. Ministry of Health accepted those but rejected others mentioning outpatient specialists and stomatologists. Ministry of Labour and Social Affairs was concerned about the situation in inpatient care and nurses but the Ministry of Health didn't accept their comment.

In 2011 Ministry of Finance wasn't satisfied with the increase of payment in inpatient care but not in outpatient one. Ministry of Health didn't accept this comment claiming it was already taken care of in previous year. Ministry of Defense had a problem with conditions for hospitals and outpatient care which Ministry of Health accepted. Their comment on subsequent inpatient care was accepted only partially.

In 2013 Ministry of Interior opposed the difference between the reimbursement for transport services in capital city/other county seats and smaller cities. Ministry of Health accepted this comment. They also had some minor issues with outpatient specialists which wasn't accepted.

From 2015 the document of Ministry of Health with the settlement of comments includes not only ministries but also other professional organizations and territorial units. Institute of Clinical and Experimental Medicine, Association of hospice palliative care providers, Association of Hospitals of the Czech Republic, Association of Social Service Providers of the Czech Republic, Association of Regional Hospitals and Association of Czech, Moravian Hospitals and Trade Union of Health and Social Care of the Czech Republic were able to change few reimbursements within their agenda. Even Association of Health Insurance Companies of the Czech Republic succeeded in changing few issues after 23 essential comments. Chamber of Commerce of the Czech Republic criticized the Ministry of Health for preferential treatment of hospitals. Karlovy Vary region partially successfully reminded Ministry of Health some promises from before the financial crisis regarding outpatient care and special outpatient care. Union of Employers' Associations of the Czech Republic reminded Ministry of Health their promise about the wage and salary increases of health professionals.

In 2016 Ministry of Health accepted few comments by Czech Dental Chamber. Ministry of Finance was concerned about the motivation of the outpatient specialists to provide good healthcare

at the end of the year. Ministry of Health partially accepted this concern and changed the incriminating coefficient. Also Czech Chamber of Pharmacies tried to improve their position but Ministry of Health declined their comment.

In 2017 we can observe a significant number of comments. Only a small part of those by Czech Medical Chamber were accepted. Ministry of Finance pointed out the inefficient reimbursement of inpatient care and outpatient specialists. Ministry of Health didn't accept the comment. Czech Chamber of Pharmacies wasn't able to push their comments. Bohemian-Moravian Confederation of Trade Unions tried to unsuccessfully improve the situation of subsequent inpatient care and social services. Czech Dental Chamber mentions that one specific reimbursement doesn't even cover the cost of an output despite the agreement in reimbursement conciliations. Various actors were able to change the reimbursement for hospitals without centers of specialized care. Union of Employers' Associations of the Czech Republic applied almost 40 pages of comment on majority of the issues in the reimbursement decree with mixed acceptance.

In 2018 we can again observe significant effort of Union of Employers' Associations of the Czech Republic with more than 40 pages of comments on many aspects of the reimbursement decree. Ministry of Health replies interestingly on comment of Confederation of Industry and Transport regarding favoritism towards the inpatient care providers (hospitals). Ministry claims that it is necessary to allocate more resources in acute inpatient care to ensure the patient care since the medical staff is leaving this segment of healthcare. From the significant number of comments of Czech Medical Chamber, only small part was accepted. Czech Chamber of Pharmacies wasn't successful at all.

Year 2019 was the one when all the providers achieved an agreement with payers. Therefore this year the number of comments is lower than in previous years. The most interesting one comes from Bohemian-Moravian Confederation of Trade Unions which wants more reimbursement for the inpatient care. This time Ministry of Health claims that it won't favor one healthcare segment at the expense of others. Ministry also mentions that European Commission is currently investigating a complaint about illicit support of the Czech Republic to hospitals, as in recent years hospitals have had a significantly higher increase than outpatient specialists because of tariff increases.

This brief analysis of the reimbursement decree comment procedure shows strong interest of ministries, professional organizations and territorial unit in the formation of reimbursement decree. There are several natural tendencies we can isolate. Ministry of Finance tends to be neutral and concerned mainly about the overall balanced budget. Ministry of Defense guards the inpatient care mentioning the veteran care. Ministry of Labour and Social Affairs comments on social care and nurses. Professional organizations tend to guard their own agenda. Ministry of Health is criticized for taking side of their hospitals.

Difference between the scope of comments between the years 2018 and 2019 is staggering. In 2018 11 different subjects filed 81 pages of comments. In 2019 only 2 segments of healthcare providers achieved an agreement with insurance companies. In 2019 5 subjects needed only 8 pages to file their comments. 2019 is the first year when all the healthcare provider segments were able to find the agreement with insurers.

There is an easily observable effort of agents trying to push the agenda connected to their interest but it does not seem to be hidden at least not within the reimbursement decree comment procedure. It is well-documented along with the responses of Ministry of Health, which seems to put effort into the explanation of its steps, why they have or haven't implemented a comment.

4. Discussion and recent reimbursement decree development

According to the last OECD report about the state of health in EU, Czech Republic has made major advances in population health and has a very high level of financial protection with universal coverage. However, there are some questions about the adequacy of current health financing system which has a narrow revenue base and is vulnerable to shocks. The report states that Czech Republic allocates the resources efficiently to various sectors but there is room for improvement in technical efficiency. Primary care should become more effective gate-keeper (sending less people to specialists), hospitals could reduce bed numbers and improve in average length of stay or occupancy rates (OECD, 2017, p.16).

Minister of Health Vojtěch wants to implement the recommendations. He wants to strengthen the role of insurance companies in healthcare reimbursement conciliations and aim to cover the costs according to the performance, not using the flat rate (Czech Radio, 2018).

The OECD report doesn't really shows the full scope of issues within the healthcare reimbursement system in Czech Republic. In general the system is often considered biased, closed to the public discussion because of the nature of conciliations and level of complexity of reimbursement mechanisms. This non-transparency in reimbursements mainly in inpatient and outpatient care led some Czech senators to file a constitutional complaint about the healthcare reimbursement system. They are concerned about the whole system leading the healthcare not to care about the patient but mainly about the way the care is reimbursed. They point out the vast differences between the reimbursement for performance in different regions. General practitioners are not motivated to provide more cost-efficient treatment and outpatient specialists are not motivated to treat more patients. In general they think that this leads to the losses of some healthcare facilities, unfair distribution of resources, worsening of the quality and medical personnel shortage (ČTK, 2018).

Ministry of Health declines the complaint of 51 senators and warns against its scope. This constitutional complaint wants to cancel the whole reimbursement system. Minister Vojtěch claims that it would be acceptable if it discussed the role of Ministry of Health in issuing the reimbursement decree. He wants to support the agreement between the providers and payers (what was successful in 2018) and admits the role of decree in perpetuating the imbalances. Vojtěch claims that the crookedness of system is here for more than 20 years. In 90's the flat rate was fixed and since then only the percentage changes yearly. Ministry is finishing the “DRG restart” project which should slowly implement the corresponding costs for hospitalization including all the connected costs (MZČR, 2019a).

The very last reimbursement conciliation (for 2020) builds on the previous success. Agreement between the insurance companies and healthcare providers was achieved in 11 cases out of 14. Non-agreement in acute inpatient care Ministry of Health considers to be a partial success since 80% of hospitals agree with the proposal and therefore ministry claims to respect it. Minister Vojtěch thinks that his will not to interfere with the conciliation process is responsible for the development in the last two years. Reimbursements should be determined without the interference of political will what he thinks wasn't the case in the past. Ministry of Health should act only as an active moderator (MZČR, 2019b).

Words of Minister Vojtěch should be taken with caution however the recent development gives us hope that in future the reimbursement payment mechanisms will become more clear and won't cause such extensive troubles. Regardless of the ruling of Constitutional Court, expected cultivation of DRG payments mechanisms in hospitals should shed some light into the controversial financing of inpatient care, which was well illustrated in our analysis of reimbursement decree comment procedure. Transparent reimbursement mechanisms conciliations should be part of broader professional and public discussion.

5. Evaluation of hypothesis

Using the knowledge about various forms of reimbursement mechanisms in healthcare, public policy-making, interest groups and the healthcare system in Czech Republic we expected actors in the reimbursement decree conciliation to follow their interests by anti-intuitive rejection of agreement with the insurance company. This way an actor active in comment procedure of reimbursement decree creation can lobby and push for better conditions for the respective group of healthcare providers. Because of this expectation, a hypothesis was formed:

Healthcare providers expecting their interests to be represented by other organs in the

comment procedure tend not to reach an agreement with the insurance companies.

These two hypotheses were tested using content analysis of final protocols from reimbursement decree conciliations, spending of insurance companies in healthcare segments and settlements of reimbursement decree comment procedures. Examining the documents we created tables summarizing the non-/agreements between payers and providers and evolution of spending within the sectors. Then we analyzed extensive texts of comment settlements to understand the actions of actors within.

The hypothesis is rejected. We can follow some trends in behavior of actors in comment procedure, however we can't prove the fact that it's connected to non-agreement during the conciliation period. There are some interest groups present during the whole process but they are legally established and act exactly as they are expected to. Professional organizations are supposed to represent their profession and corresponding ministries are supposed to advocate their agenda. At the end the whole idea of reimbursement decree conciliation is the meeting of interest groups.

There is no pattern suggesting that representatives of providers deliberately don't want to agree with insurance companies awaiting support during the comment procedure. Previous profession of Minister of Health or Czech Medical Chamber doesn't seem to influence the forms of reimbursement. Spending of insurance companies in different segments shows steady growth in all of them. In comments of Ministry of Health in comment procedure we can trace the effort of Ministry to analyze the reservations of different agents representing various interests so they can meet the reasonable ones and explain issues that are not clear.

Findings of this work are limited the same way the public discussion regarding reimbursement decree is. The whole healthcare reimbursement system in Czech Republic is extremely complex and non-transparent. Deep understanding of everything in comment procedure would need far better knowledge of this environment than we are able to achieve without being part of the system. Documents regarding the whole process are hard to find and incomplete in public databases.

Another problem with the changes is reimbursement could be general issues influencing sustainability of healthcare worldwide. Aging population or high levels of preventable illnesses can be a relevant reason why Ministry of Health need to intervene in the formation of reimbursement.

In one e-mail conversation with an employee of Ministry of Health trying to make clear why there are contradictions between two documents seemingly concerning the same topic we were explained that apart from the reimbursement decree there is also a medical service list with point values linked to the reimbursement decree and usually amended annually. Therefore even if everything is alright with the reimbursement decree, change needed for a group of providers to profit can be simple done somewhere else. Influence of this side factor on the final form of

reimbursement might provide an interesting research topic in the future.

6. Conclusion

Reimbursement decree is hard to understand, creates inequalities and many people complain about it. It is a framework redistributing billions of crowns to an incredibly complex chain of relations. It looks like a big old car that people are forced to use and try to use as well as possible because they don't have anything else to drive them to a hospital. That is why we picked it as a topic of this paper. Something so important and unclear can't be completely unseen by the academia.

Focus of this work were the interest groups behind the formation of reimbursement decree. Intuition supported by the complaints of professional public in media suggested there can be an underlying mechanism behind the reimbursement decree. We used basic theory of healthcare models and reimbursement mechanisms along with theory of interests behind the formation of these mechanisms. Policy-making theory with informations about the Czech healthcare system confirmed that there is an adequate arena for various actors to influence the healthcare financing policy. Ministry of Health creates it every year when it invites representatives of healthcare providers and insurance companies to find the reimbursement for the following year. If they are not able to do so, Ministry of Health will provide the reimbursement by itself.

Our hypothesis states that healthcare providers expecting their interests to be represented by other organs in the comment procedure tend not to reach an agreement with the insurance companies. Comment procedure is the time between the end of reimbursement decree conciliations between the healthcare providers and insurance companies and sending the final decree to the government when other ministries of professional organizations can express their reservations.

The reasoning for our hypothesis was simple. If a group of providers has some powerful friends on Ministry of Health or in another organization that can influence the final form of the reimbursement decree before it gets to the government, there is no point for them to make an agreement with the insurance companies. That would mean a compromise and why would they do that when they can have their agenda pushed forward anyway.

Testing of the hypothesis consisted of putting together three different datasets. The first one were the results of reimbursement decree conciliations so we know which segments tend to agree with insurance companies more often or on the other hand almost never. The second one was the spending of insurance companies in different healthcare segments in order to capture some trends or unusual movements of resources. The third one was analysis of the settlements of comment procedures so we can see how Ministry of Health handles this part of the decree formation. We also

made a list of former professions of Ministers of Health to rule out or confirm the simplest form of lobbying - Minister of Health helping his former colleagues.

Our hypothesis was rejected. There are no patterns showing the former profession of Minister of Health affecting the conciliations. Groups of providers that tend not to agree with insurance companies do not receive comparatively bigger resource increases than those with bigger conciliation success rate. In comment procedures we can find fragments of interest groups work but in this part of the decree creation it is completely natural. Ministry of Health seems to handle the comments transparently in regard to balanced spending. In general there doesn't seem to be any pattern suggesting any group of providers seeking the non-agreement only because they know, that their interests will be taken care of later.

The main problem when we were trying to approach the reimbursement decree problematics is its incredible complexity and non-transparency. Reimbursement decree formulas are natural gatekeepers for anyone except those more deeply engaged in the processes of forming the decrees. Documents concerning the issue are scattered and incomplete. Without help from inside it is very difficult to penetrate this system. Not only the reimbursement formulas are complicated, the legislature around can be a tough nut to crack as well. In previous chapter I mentioned the e-mail communication with one employee of Ministry of Health where I realized, that there are other possibilities to influence the level of reimbursement the segment gets. Changing the value of medical service in other part of legislature changes the the final reimbursement. There is no wonder that it is so difficult for this important document to become a part of public discussion despite the fact that healthcare should be at its very core.

There are other natural reasons why the reimbursement can be biased. It does not have to be lobbying or greed of healthcare providers. The aging population, prevention and rising frequencies of some diagnoses can be a relevant reason why to allocate more resources in certain healthcare segment.

Despite the rejection of hypotheses we consider this work an academic success since it can be considered the very first research in this area. It can be used as the base for any further research trying to shed more light on reimbursement decree and mechanisms behind it. Future researchers can look into way we were proceeded, avoid the mistakes we made and simply use the data we collected. To broaden the understanding of this topic research can continue with the side documents connected to reimbursement decree (medical service list with point values) since these are the ones that can quietly change the final reimbursement as we learned. Using our knowledge one can potentially trace a relevant case for a case study or series of interview. Because of complex nature of this area talking to people directly involved in the process of creation of decree could possibly help to broaden academic understanding of healthcare reimbursement in Czech Republic. From our

experience we can say that there are people in Ministry of Health willing to help.

Hopefully in the next years reforms will change the way healthcare is financed so the Minister of Health himself does not have to say that he knows it's bad but it is the only thing we have at the moment. The public should know more about the way the healthcare is financed and any further research in this area able to bring more understanding of this issue is worth it.

7. References

Act no. 48/1997 (1997) *Zákon o veřejném zdravotním pojištění a o změně a doplnění některých souvisejících zákonů*

ALLISON, C.R. and SAINT-MARTIN, D. (2011) 'Half a century of “muddling”: Are we there yet?' *Policy and Society*, 30(1), pp. 1-8

ANTI-CORRUPTION RESEARCH CENTRE (2012) *Influence of interest groups on policy-making* [online]. Available at: <https://www.u4.no/publications/influence-of-interest-groups-on-policy-making.pdf> (Accessed: 23 April 2018)

BARROS, P.P. and MARTINEZ-GIRALT, X. (2012) *Models of negotiation and bargaining in health care* [online]. Available at: <https://pdfs.semanticscholar.org/d3af/924c1ede57ebf3a124276216376cf038180b.pdf> (Accessed: 10 May 2016)

BOACHIE, M.K. (2014) 'Healthcare Provider-Payment Mechanisms: A Review of Literature'. *Journal of Behavioural Economics, Finance, Entrepreneurship, Accounting and Transport*, 2(2) [online]. Available at: https://pdfs.semanticscholar.org/5365/02e29598e163df03488cd39bdfa7bd82cdd2.pdf?_ga=2.261702285.1447665544.1565113814-1619790212.1565113814 (Accessed: 10 May 2016)

BOGASON, P. (2006) 'Networks and Bargaining in Policy Analysis'. In: Peters B.G. and Pierre J. (ed.) *Handbook of Public Policy*, London: SAGE, pp. 97-115

ČELEDOVÁ, L. and ČEVELA, R. (2010) *Výchova ke zdraví*. Praha: Grada, pp. 100-103

CHAWLA, M., WINDAK, A., BERMAN, P. and KULIS, M. (1997) *Paying the Physician: Review of Different Methods, Data for Decision Making Project* [online]. Available at: <https://www.hsph.harvard.edu/ihs/publications/pdf/No-70.PDF> (Accessed: 23 April 2018)

CRAIG, S.V., ERICSON, K. M. and STARC, A. (2018) 'How Important Is Price Variation Between Health Insurers?'. *National Bureau of Economic Research* [online]. Available at: <https://stuartcraig.github.io/files/w25190.pdf> (Accessed: 15 July 2019)

- ČTK (2018) 'Senátoři podají ústavní stížnost na vyhlášku o úhradách péče', *Zdravotnický deník* [online]. Available at: <https://www.zdravotnickydenik.cz/2018/12/senatori-podaji-ustavni-stiznost-vyhlasiku-uhradach-pece/> (Accessed: 15 July 2019)
- MCENCHROE, T. (2018) 'OECD recommends Czech health sector focus on effectivity', *Czech Radio* [online]. Available at: <https://www.radio.cz/en/section/business/oecd-recommends-czech-health-sector-focus-on-effectivity> (Accessed: 15 July 2019)
- DROR, Y. (1968) *Public Policymaking Reexamined*. Pennsylvania: Chandler Publishing Company
- DURIAU, V. J., REGER, R. K. and PFARRER, M. D. (2007) 'A content analysis of the content analysis literature in organization studies: Research themes, data sources, and methodological refinements'. *Organizational research methods*, 10(1), pp. 5-34.
- FISCHER, F. and FORESTER, J. (1993) 'Editors' introduction'. In: Fischer F. and Forester J. (ed.) *The Argumentative Turn in Policy Analysis and Planning*, London: VCL Press, pp. 1-17.
- GLIED, S. (2009) 'Single Payer as a Financing Mechanism'. *Journal of Health Politics, Policy and Law*, 34(4), pp. 593-615
- HECLO, H. (1972) 'Review article: Policy analysis'. *British Journal of Political Science*, 2(1), pp. 83-108.
- KOPECKÝ, J. (2013) 'Hrozí omezení péče, tvrdí senátoři. Napadají u soudu úhradovou vyhlášku', *iDNES.cz* [online]. Available at: https://www.idnes.cz/zpravy/domaci/ustavni-stiznost-na-uhradovou-vyhlasiku.A130327_105415_domaci_kop (Accessed: 23 April 2018)
- KOPECKÝ, J. (2019) 'Kdyby uspěla stížnost, zhroutlí se systém úhrad zdravotní péče, řekl ministr', *iDNES.cz* [online]. Available at: https://www.idnes.cz/zpravy/domaci/vojtech-ustavni-stiznost-uhrady-zdravotni-pece.A190128_140214_domaci_kop (Accessed: 15 July 2019)
- KULESHER, R. and FORRESTHAL, E. (2014) International Models of Healthcare Financing. *Journal of Hospital Administration*, 3(4) [online]. Available at: <http://www.ecu.edu/ah/upload/Kulesher-Forrestal-2014-International-Models-of-Health-Systems-Financing.pdf> (Accessed: 23 April 2018)

KUSHEL, M. and BINDMAN, A.B. (2004) 'Health care lobbying: time to make patients the special interest'. *The American Journal of Medicine*, 116(7) [online]. Available at: [https://www.amjmed.com/article/S0002-9343\(04\)00096-8/fulltext](https://www.amjmed.com/article/S0002-9343(04)00096-8/fulltext) (Accessed: 10 May 2016)

LACA, P. and PONIKELSKÁ, L. (2003) 'No Government No Problem as Czechs Unfazed by Instability', *Bloomberg News* [online]. Available at: <http://www.bloomberg.com/news/articles/2013-06-25/no-government-no-problem-as-czechs-unfazed-by-lack-of-stability> (Accessed: 23 April 2018)

LINDBLOM, C. E. (1959) 'The science of muddling through'. *Public Administration Review*, 19(2) [Online]. Available at: <https://faculty.washington.edu/mccurdy/SciencePolicy/Lindblom%20Muddling%20Through.pdf> (Accessed: 10 May 2016)

MACEIRA, D. (1998) *Provider Payment Mechanisms in Health Care: Incentives, Outcomes, and Organizational Impact in Developing Countries* [online]. Available at: <http://www.paho.org/hq/documents/providerpaymentmechanismsinhealthcareincentivesoutcomesandorganizationalimpactin-EN.pdf> (Accessed: 10 May 2016)

MATHAUER, I. and WITTENBECHER, F. (2013) *Hospital payment systems based on diagnosis-related groups: experiences in low- and middle-income countries* [online]. Available at: <http://www.who.int/bulletin/volumes/91/10/12-115931/en/> (Accessed: 23 April 2018)

MORAN, M. (2006) 'Health Policy'. In: Peters B.G. and Pierre J. (ed.) *Handbook of Public Policy*, London: SAGE, pp. 219-231

MZČR (2008) *České zdravotnictví je finančně stabilní a zajištěné i pro rok 2009* [online]. Available at: http://www.mzcr.cz/dokumenty/tz-ceske-zdravotnictvi-je-financne-stabilni-a-zajistene-i-pro-rok_1184_870_1.html (Accessed: 10 May 2016)

MZČR (2009) *Úhradová vyhláška pro rok 2010 počítá se stejnou kvalitou péče* [online]. Available at: http://www.mzcr.cz/dokumenty/uhradova-vyhlaska-pro-rok-pocita-se-stejnou-kvalitou-i-rozsahem-pece_1537_868_1.html (Accessed: 10 May 2016)

MZČR (2010) *Úhradová vyhláška pro rok 2011 zaručí, že se české zdravotnictví nebude zadlužovat* [online]. Available at: http://www.mzcr.cz/dokumenty/uhradova-vyhlaska-pro-rok-zaruci-ze-se-ceske-zdravotnictvi-nebude-zadluzovat_4416_1513_1.html (Accessed: 10 May 2016)

MZČR (2011) *Úhradová vyhláška pro rok 2012 zachovává úroveň letošního roku* [online]. Available at: http://www.mzcr.cz/dokumenty/uhradova-vyhlaska-pro-rok-2012-zachovava-uroven-letosniho-roku_5599_2160_1.html (Accessed: 10 May 2016)

MZČR (2012) *Úhradová vyhláška pro rok 2013* [online]. Available at: http://www.sdruzeniobcan.cz/files/nosek_cerge2012_12.pdf (Accessed: 10 May 2016)

MZČR (2013) *Základní parametry úhradové vyhlášky pro rok 2014* [online]. Available at: http://www.mzcr.cz/dokumenty/zakladni-parametry-uhradove-vyhlasky-pro-rok-2014-_8427_1.html (Accessed: 10 May 2016)

MZČR (2014) *Úhradová vyhláška 2015 přidá na zdravotní služby 10 miliard* [online]. Available at: http://www.mzcr.cz/dokumenty/uhradova-vyhlaska-2015-prida-na-zdravotni-sluzby-10-miliard-_9845_3030_1.html (Accessed: 10 May 2016)

MZČR (2015) *Koncept úhrad v roce 2016* [online]. Available at: https://drg.uzis.cz/res/file/konference-drg-restart-2015/DRG-Restart-2014-06_Zilova.pdf (Accessed: 15 July 2019)

MZČR (2016) *Úhradová vyhláška pro rok 2017 přidá do systému veřejného zdravotního pojištění 13 miliard* [online]. Available at: http://www.mzcr.cz/dokumenty/uhradova-vyhlaska-2017-prida-do-systemu-verejneho-zdravotniho-pojisteni-13-milia_12802_3438_1.html (Accessed: 15 July 2019)

MZČR (2017) *Ministr zdravotnictví* [online]. Available at: http://www.mzcr.cz/dokumenty/ministr-zdravotnictvi_13034_841_1.html (Accessed: 15 July 2019)

MZČR (2018a) *Dohodovací řízení skončilo historickým úspěchem, všechny segmenty se dohodly* [online]. Available at: http://www.mzcr.cz/dokumenty/dohodovaci-rizeni-skoncilo-historickym-uspechemvsechny-segmenty-se-dohodly-_15656_3801_1.html (Accessed: 15 July 2019)

MZČR (2018b) *Ministerstvo zdravotnictví zahájilo dohodovací řízení mezi zdravotními pojišťovny a poskytovateli zdravotní péče* [online]. Available at: http://www.mzcr.cz/dokumenty/ministerstvo-zdravotnictvi-zahajilo-dohodovaci-rizeni-%C2%A0mezi-zdravotnimi-pojistovn_14875_3801_1.html (Accessed: 15 July 2019)

MZČR (2019a) *Ministr Adam Vojtěch: Ústavní stížnost senátorů by přinesla chaos* [online]. Available at: http://www.mzcr.cz/dokumenty/ministr%C2%A0adam-vojtechustavni-stiznost-senarotu-by-prinesla-chaos_16773_3693_1.html (Accessed: 15 July 2019)

MZČR (2019b) *O úhradách pro příští rok se dohodla většina segmentů* [online]. Available at: http://www.mzcr.cz/dokumenty/o-uhradach-pro-pristi-rok-se-dohodla-vetsina-segmentu_17481_3970_1.html (Accessed: 8 April 2019)

OECD (2017) *State of Health in the EU Czech Republic Country Health Profile 2017* [online]. Available at: <https://www.oecd-ilibrary.org/docserver/9789264283336-en.pdf?expires=1565082336&id=id&accname=guest&checksum=2257A4D37F5C3F22C9C893E5AF940970> (Accessed: 15 July 2019)

Ordinance no. 273/2015 Sb. o stanovení hodnot bodu, výše úhrad hrazených služeb a regulačních omezení pro rok 2016

REID, T. R. (2009) *The Healing of America: A Global Quest for Better, Cheaper and Fairer healthcare*, London: The Penguin Press

SKOPOVÁ, J. (2016) *Dohodovací řízení pro rok 2017 bude i s lékárníky* [online]. Available at: <https://www.lekarnici.cz/Sdruzeni/POLP-z-s/Dohodovaci-rizeni-pro-rok-2017-bude-i-s-lekarniky.aspx> (Accessed: 8 April 2019)

STONE, D. (1988) *Policy Paradox and Political Reason*. Glenview, IL: Scott, Foresman and Co.

STUCKLER, D. et al. (2010) *The political economy of universal health coverage. Background paper for the global symposium on health systems research* [online] Available at: <http://www.pacifichealthsummit.org/downloads/UHC/the%20political%20economy%20of%20uhc.PDF> (Accessed: 23 April 2018)

ŠPERKEROVÁ, M. A. (2016) 'Plošný nárůst platů české zdravotnictví nikam neposune', *Lidovky*, [online]. Available at: http://ceskapozice.lidovky.cz/plosny-narust-platu-ceske-zdravotnictvi-nikam-neposune-pkb-/tema.aspx?c=A160318_174406_pozice-tema_lube (Accessed: 23 April 2018)

ŠTĚPÁN, P. (2014) 'Nejmenší životnost mívá ministr zdravotnictví. Průměrně vydrží jen rok a tři měsíce', *Hospodářské noviny*, [online]. Available at: <http://domaci.ihned.cz/c1-61629740-ministerstvo-zdravotnictvi-nejvic-ministru> (Accessed: 23 April 2018)

SZPČR (2015) *Jednací řád dohodovacího řízení*, [online]. Available at: <http://www.szpcr.cz/dr2016/jr01042015.pdf> (Accessed: 23 April 2018)

ÚZIS (2014a) *Czech Health Statistics Yearbook 2013* [online]. Available at: <http://www.uzis.cz/katalog/rocenky/zdravotnicka-rocenka-ceske-republiky> (Accessed: 10 May 2016)

ÚZIS (2014b) *Zdravotnictví jako součást národní ekonomiky 2013*, [online]. Available at: <http://www.uzis.cz/katalog/zdravotnicka-statistika/zdravotnictvi-jako-soucast-narodni-ekonomiky-drive-vyvoj-financnich-ukazatelu-makroekono> (Accessed: 10 May 2016)

ÚZIS (2010) *Zdravotnictví jako součást národní ekonomiky 2009* [online]. Available at: <http://www.uzis.cz/katalog/zdravotnicka-statistika/zdravotnictvi-jako-soucast-narodni-ekonomiky-drive-vyvoj-financnich-ukazatelu-makroekono> (Accessed: 10 May 2016)

ÚZIS (2008) *Zdravotnictví jako součást národní ekonomiky 2006* [online]. Available at: <http://www.uzis.cz/katalog/zdravotnicka-statistika/zdravotnictvi-jako-soucast-narodni-ekonomiky-drive-vyvoj-financnich-ukazatelu-makroekono> (Accessed: 10 May 2016)

VLÁDA ČR (2016) *Přehled vlád ČR 1993-2013* [online]. Available at: <http://www.vlada.cz/cz/clenove-vlady/historie-minulych-vlad/prehled-vlad-cr/1993-2007-cr/> (Accessed: 23 April 2018)

WHO (2015a) *Health systems* [online]. Available at: http://www.who.int/topics/health_systems/en/
(Accessed: 10 May 2016)

WHO (2015b) *Universal health coverage* [online]. Available at:
http://www.who.int/universal_health_coverage/en/ (Accessed: 10 May 2016)

8. Appendices

Figure 1: Závěrečný protokol o výsledcích dohodovacího řízení o hodnotách bodu a výši úhrad zdravotní péče hrazené z veřejného zdravotního pojištění pro rok 2013

Závěrečný protokol o výsledku Dohodovacího řízení o hodnotách bodu a výši úhrad hrazených služeb a regulačních omezeních pro rok 2013

V souladu s ustanovením § 17 odst. 5 zákona č. 48/1997 Sb., v platném znění, se konalo dohodovací řízení o hodnotách bodu a výši úhrad hrazených služeb a regulačních omezeních mezi zástupci zdravotních pojišťoven a zástupci jednotlivých skupin poskytovatelů zdravotních služeb pro rok 2013.

Svolavatel jednání: MZ ČR
Předsedající: ZP MV ČR – Ing. Jaromír Gajdáček, Ph.D., MBA

Účastníci dohodovacího řízení:

Zdravotní pojišťovny:

ZDRAVOTNÍ POJIŠTOVNA	Zástupce ZP
Česká průmyslová zdravotní pojišťovna	JUDr. Petr Vaněk, Ph.D.
Oborová zdravotní pojišťovna zaměstnanců bank, pojišťoven a stavebnictví	Ing. Ladislav Friedrich, CSc.
Revírní bratrská pokladna, zdravotní pojišťovna	Ing. Lubomír Káňa
Vojenská zdravotní pojišťovna České republiky	MUDr. Karel Stein
Všeobecná zdravotní pojišťovna České republiky	MUDr. Pavel Horák, CSc.
Zaměstnanecká pojišťovna Škoda	Ing. Darina Ulmanová, MBA
Zdravotní pojišťovna METAL-ALIANCE	Bc. Vladimír Kothera, MBA
Zdravotní pojišťovna Ministerstva vnitra České republiky	Ing. Jaromír Gajdáček, Ph.D., MBA

Zástupci příslušných profesních sdružení poskytovatelů jako zástupci smluvních zdravotnických zařízení v jednotlivých skupinách poskytovatelů zdravotních služeb:

SKUPINA	Účastníci jednání DR
Skupina poskytovatelů akutní lůžkové péče	Ing. Jaroslava Kunová
Skupina poskytovatelů následné lůžkové péče	MUDr. Václav Volejník, CSc.
Skupina praktických lékařů a praktických lékařů pro děti a dorost	MUDr. Pavel Neugebauer
Skupina poskytovatelů ambulantních stomatologických služeb	MUDr. Pavel Chrz
Skupina poskytovatelů ambulantních gynekologických služeb	MUDr. Vladimír Dvořák

Na závěrečném jednání Dohodovacího řízení dne 21. 8. 2012 bylo konstatováno, že v rámci přípravné fáze byly dosaženy předběžné dohody mezi zástupci zdravotních pojišťoven a zástupci třech skupin poskytovatelů zdravotních služeb a to:

- skupiny praktických lékařů a praktických lékařů pro děti a dorost,
- skupiny poskytovatelů ambulantních gynekologických služeb,
- skupiny poskytovatelů zdravotnické záchranné služby, zdravotní dopravy a lékařské služby první pomoci, vyjma stomatologické,

Předběžné dohody nebylo dosaženo u osmi skupin poskytovatelů zdravotních služeb a to:

- skupiny poskytovatelů akutní lůžkové péče a dalších zdravotních služeb poskytovaných v nemocnicích,
- skupiny poskytovatelů následné lůžkové péče,
- skupiny poskytovatelů ambulantních stomatologických služeb,
- skupiny poskytovatelů mimolůžkových ambulantních specializovaných služeb, vysokoškolsky vzdělaných pracovníků ve zdravotnictví (zejména klinických psychologů a klinických logopedů) a ortoptistů,
- skupiny poskytovatelů domácích zdravotních služeb,
- skupiny poskytovatelů fyzioterapie – nelékařských profesí,
- skupiny poskytovatelů mimolůžkových laboratorních a radiodiagnostických služeb,
- skupiny poskytovatelů lázeňské léčebně rehabilitační péče a zdravotní péče v ozdravovnách,

Jednání v přípravné fázi probíhalo v souladu s jednacím řádem dohodovacího řízení.

Přílohy:

- 1) Zápis ze zahajovacího jednání DŘ
- 2) Zápis ze závěrečného jednání DŘ
- 3) Protokoly z přípravné fáze DŘ včetně návrhů účastníků:
 - skupina poskytovatelů akutní lůžkové péče a dalších zdravotních služeb poskytovaných v nemocnicích
 - skupina poskytovatelů následné lůžkové péče
 - skupina praktických lékařů a praktických lékařů pro děti a dorost,
 - skupina poskytovatelů ambulantních stomatologických služeb,
 - skupina poskytovatelů ambulantních gynekologických služeb,
 - skupina poskytovatelů mimolůžkových ambulantních specializovaných služeb, vysokoškolsky vzdělaných pracovníků ve zdravotnictví (zejména klinických psychologů a klinických logopedů) a ortoptistů,
 - skupina poskytovatelů domácích zdravotních služeb,
 - skupina poskytovatelů fyzioterapie – nelékařských profesí,
 - skupina poskytovatelů mimolůžkových laboratorních a radiodiagnostických služeb,
 - skupina poskytovatelů zdravotnické záchranné služby, zdravotní dopravy a lékařské služby první pomoci, vyjma stomatologické,
 - skupina poskytovatelů lázeňské léčebně rehabilitační péče a zdravotní péče v ozdravovnách,

V Praze dne 27. 8. 2012

Předsedající dohodovacího řízení:



Ing. Jaromír Gajdáček, Ph.D., MBA, generální ředitel ZP MV ČR

Protokol ověřili:

Za zdravotní pojišťovny:



JUDr. Vladimíra Těšitelová, tajemnice SZP ČR

Za poskytovatele:

MUDr. Pavel Neugebauer, skupina poskytovatelů praktických lékařů a praktických lékařů pro děti a dorost

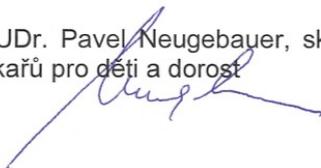


Table 1: Vypořádání připomínek uplatněných v rámci mezirezortního připomínkového řízení k návrhu vyhlášky o stanovení hodnot bodu, výše úhrad zdravotní péče hrazené ze zdravotního pojištění a regulačních omezení objemu poskytnuté zdravotní péče hrazené z veřejného zdravotního pojištění pro rok 2010

Připomínkující místo	Připomínky	Obsah připomínky	Vyhodnocení připomínky
Ministerstvo vnitra	Zásadní	<p>V rámci jednotlivých skupin poskytovatelů zdravotní péče (dále jen „segmenty“) se opět vyskytuje nejednotnost v rámci úpravy regulačních mechanismů. Zavádění dalších nesystémových výjimek též výrazně komplikuje metodiku výpočtu úhrad. Pro ilustraci těchto tvrzení uvádíme následující příklady:</p> <ul style="list-style-type: none"> • rozdílné typy regulací, • rozdílné hranice pro překročení celkové výše úhrady, • vazby na zdravotně pojistný plán i u ukazatelů, které v rámci nákladů na zdravotní péči nejsou samostatně uváděny a sledovány v rámci nákladů na zdravotní péči hrazenou ze zvláštního fondu zdravotního pojištění – např. zvlášť účtovaný materiál, zvlášť účtovaný léčivý přípravek, • další vyčleňování výkonů, které jsou hrazeny odlišně od ostatních výkonů vykazovaných příslušným segmentem, • v rámci segmentu specializované ambulantní zdravotní péče jsou při vyúčtování používány dvě hranice pro stanovení nevýznamného počtu ošetřených unikátních pojištěnců – 100 pojištěnců při stanovení hodnoty bodu a výše úhrad a 50 pojištěnců u regulačních omezení (viz příloha č. 3), • nejednotnost při vyčleňování screeningů z regulací na vyžádanou péči (např.: u praktických lékařů neuveden žádný, u ambulantních služeb uveden pouze mamograf nebo mamograf + hrdlo nebo mamograf + hrdlo + kolorektál), • celkové omezení úhrad zdravotně pojistným plánem pouze u segmentu stomatology, • bonifikace na zvýšení kvality ošetrovatelské péče je uvedena pouze pro ústavní péči, přičemž se dá očekávat velmi negativní reakce ambulantních segmentů. 	<p>Neakceptováno</p> <ul style="list-style-type: none"> • rozdílné typy regulací a rozdílné hranice pro překročení celkové výše úhrady plynou z výsledků dohod v jednotlivých segmentech zdravotní péče v minulých letech; • vazba na zdravotně pojistný plán je pouze u předepsaných léčivých přípravků a zdravotnických prostředků., nikoliv u zvlášť účtovaných; • je vypořádáno u konkrétní připomínky k Příloze č. 3; • nepoužití snížené hodnoty bodu a nepoužití regulací – každá z těchto oblastí se řídí vlastními pravidly; • je dáno druhem poskytované péče; • vyplývá z dohody daného segmentu; • v ambulantní péči nelze kvalitu poskytované péče vázat na personální vybavení.

	<p>§ 14</p> <p>K příloze č. 1</p> <p>K příloze č. 3</p>	<p>Návrh se v některých případech odchyluje od výsledků dohodovacího řízení, aniž je jakkoli vysvětlen důvod takového postupu. Jde o následující případy, kdy návrh:</p> <ul style="list-style-type: none"> • nerespektuje výsledky dohodovacího řízení se zdravotnickou záchrannou službou, kde byla dohodnuta jednotná hodnota bodu ve výši 1,06 Kč, • v odbornosti 603 a 604 respektuje výsledky dohodovacího pouze částečně. V odůvodnění návrhu není uvedeno, zda výsledky dohodovacího řízení, které se týkají uvedených poskytovatelů zdravotní péče, tj. zda uzavřené dohody, případně parciální dohody by byly v rozporu s právními předpisy nebo veřejným zájmem, • nerespektuje hodnotu bodu pro zdravotnická zařízení poskytující hemodialyzační péči, přestože v dohodovacím řízení byla hodnota bodu dohodnuta. <p>Upozorňujeme na problém s vazbou pololetních výsledků vyúčtování na roční doúčtování (např. u ambulantních služeb jsou regulace vázány na splnění zdravotně pojistného plánu).</p> <p>Stanovení výše úhrady za jeden den pobytu pro komplexní a příspěvkovou lázeňskou péči a léčbu v ozdravně doporučujeme řešit ve vztahu k referenčnímu období</p> <p>Požadujeme vypustit odst. 4, neboť je duplicitní k ustanovení § 15. Obě ustanovení upravují přednost dohody před úpravou obsaženou v navrhované vyhlášce, avšak § 15 je obecnější a zahrnuje v sobě i případ upravovaný v § 14 odst. 4</p> <p>V písm. A bodu 5 požadujeme jednoznačně vymežit vztah mezi regulacemi jednotlivých ambulantních složek, na které je odkazováno, a celkovou regulací ambulantní složky jako celku</p> <p>Výpočet regulačních opatření podle písm. C) je roční, avšak počet pojištěnců, kterým byla poskytnuta péče, je zjišťován pololetně. Požadujeme proto ujasnit postup zohlednění statisticky nevýznamného počtu pojištěnců při výpočtu</p> <p>V písm. D) této přílohy je upraveno „navýšení úhrady“, což je však pojem odlišný od pojmu „výše úhrad“, který je obsažen ve zmocňovacím ustanovení § 17 odst. 6 zákona o veřejném zdravotním pojištění. Vzhledem ke zjevnému překročení rozsahu zákonného zmocnění požadujeme tuto pasáž přílohy vypustit</p>	<p>Akceptováno</p> <ul style="list-style-type: none"> • příslušná ustanovení úhradové vyhlášky byla upravena ve smyslu výsledků dohodovacího řízení; • po dohodě se příslušnými odbornostmi upraveno; • na základě výsledku dohody upraveno. <p>Neakceptováno – regulace lze uplatnit samostatně; bylo již v roce 2009.</p> <p>Akceptováno – text upraven ve vztahu k referenčnímu období 2009.</p> <p>Akceptováno – tento odstavec byl vypuštěn</p> <p>Neakceptováno – k celkové regulaci ambulantní složky se přikročí jen tehdy, bude-li součet úhrad vypočtených podle bodů 5.1 až 5.9 nižší než 105 % nebo vyšší než 109 % hodnoty úhrady vypočtené podle bodu 5.11.</p> <p>Neakceptováno - postup je zřejmý; k neuplatnění regulace stačí, aby alespoň v jednom pololetí byla splněna podmínka podle bodu 2, písm. C).</p> <p>Neakceptováno – vzhledem k tomu, že existuje jednoznačná vazba mezi počty sester a kvalitou poskytované péče v oblasti ústavní péče, domníváme se, že stanovením navýšení úhrady souvisejícím s počtem sester nedošlo k překročení zákonného zmocnění</p>
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		<p>Rozlišení hodnot bodů pro různé zdravotnické výkony logopedů v písm. A) bod 1 písm. c) považujeme za nesystémové řešení, které může přinést technické komplikace.</p> <p>Stejně tak nevhodné a nesystémové je dle našeho názoru vyčlenění úkonů oftalmologie prostřednictvím stanovení odlišných hodnot bodu.</p> <p>Nesouhlasíme s neustálou diferenciací regulačních opatření v rámci segmentu specializované ambulantní zdravotní péče. Podle předloženého návrhu se tohoto segmentu týká již devět rozdílných regulačních omezení</p>	<p>Neakceptováno - jde o vyrovnání nehomogenity v úhradě jednotlivých výkonů (logopedie) a o podporu ambulantní péče (některé výkony oftalmologie). Diferenciace regulačních opatření je dána rozdílnou povahou jednotlivých segmentů a má historické opodstatnění</p>
<p>Ministerstvo práce a sociálních věcí</p>	<p>Zásadní příloha č. 1 § 3 odst. 2</p> <p>Příloha č. 11 - kód 00967</p>	<p>Navrhujeme znění písmene b) upravit takto: „Pro zvláštní ambulantní péči poskytovanou podle § 22 písm. c) zákona, hrazenou podle seznamu výkonů, se stanoví hodnota bodu ve výši 1,03 Kč, nikoliv 0,90 Kč s degresní hodnotou bodu.</p> <p>Odbornost 913 je odborností vytvořenou před 3 lety a jde o silně progredující odbornost, která rozhodně není co do objemu vykazované péče dosud stabilizovaná. Z těchto důvodů se domníváme, že regulace stanovením stropu objemu péče je zcela nevhodná. Upozorňujeme, že takto vytvořený negativní ekonomický tlak na poskytovatele odbornosti 913 může ve svých důsledcích vést k přesunu, především náročných pacientů, do lůžkových zdravotnických zařízení. V kritické variantě může dojít k postupnému vypovídání zvláštních smluv ze strany jednotlivých pobytových zařízení sociálních služeb.</p> <p>Na konci textu následujícího po označení výkonu je třeba se zřetelem na ustanovení § 39 odst. 2 zákona č. 187/2006 Sb., o nemocenského pojištění, nahradit slova „nemocného člena rodiny“ slovy „člena domácnosti, popř. pro ošetřování nebo péči o dítě mladší 10 let rodičem“.</p>	<p>Neakceptováno – stanovení této úhrady koresponduje se způsobem úhrady pro odbornost 911 (všeobecná sestra).</p> <p>Akceptováno – text byl změněn.</p>