EFFICIENCY MANAGEMENT OF THE CZECH HEALTH CARE

Irena Jindřichovská
***Radka Pešková**
****Ivana Funková**
*****Eva Nesládková**

University of Economics and Management
Nárožní 9a, Praha 5, 150 09, Czech Republic
irena.jindrichovska@vsem.cz
* University of Economics and Management
Nárožní 9a, Praha 5, 150 09, Czech Republic
radka.peskova@vsem.cz
** University Hospital Motol, Praha
V Úvalu 84, 150 06 Praha 5 – Motol, Czech Republic
ivana.funkova@fnmotol.cz
*** Technical University of Liberec
Studentská 2, 461 17 Liberec1, Czech Republic
eva.nesladkova@tul.cz

Abstract

This paper concentrates on the assessment of health care efficiency in the Czech Republic. The health care sector is a special industry. For that reason, efficiency measurement calls for special approaches and methods. Drawing partially from international experience this paper presents two approaches of efficiency measurement illustrated by two university hospitals in the Czech Republic. In our study to lay some common ground we firstly compare the funding system and then we apply financial measures for measuring effectiveness and subsequently we employ non-financial indicators. The case studies illustrate that both kinds of measures are necessary to capture the complex environment and diverse activities in the health care system. Moreover, combination of both methods provides better outcome for efficiency measurement.

Introduction

This paper concentrates on assessment of efficiency of health care in the Czech Republic. The health care sector is a special industry. For that reason, efficiency measurement calls for special approaches and methods. The first problem of health care management is the measurability of results and therefore finding the real price of outputs.

Cost controlling and efficiency measures were not the main worry of the day when the health care developed in the post-war era. The prices of health care were not important. What was important was the capacity. The premise of previous era was to provide a good health care to broad population. Even though the market system did not operate well, some of the specialities were on a top world level e.g. neonatal care, treatment of tuberculosis and other highly infectious diseases combated by compulsory vaccination.

In the Czech Republic the healthcare program is based on a model of a welfare state. This concept is a heritage given by the historical development after the Second World War that was maintained and developed for several decades until the Velvet Revolution in 1989.

After the 1989 the system has changed. There was not a steady flow of financial resources directly from the state budget but hospitals and other medical facilities started to be

reimbursed for health care provided by newly established health insurance companies. Stream of revenues that goes to health care institution is a combination of direct payments and payments in form of reimbursement by the Ministry of Health established by legislation.

The structure of our paper is as follows: After the introduction and motivation the paper presents brief characteristics of health-care funding in the Czech Republic. To gain more international perspective the second part introduces a summary of approaches to health care funding in Germany. The third part characterises methods of health care efficiency management using financial measures and non-financial indicators. The fourth part introduces the case study of efficiency management of two university hospitals the UH Motol and the UH Brno. The last part provides conclusion and recommendations.

1 Description of Funding of the Health Care System in the Czech Republic

The health care legislation in the Czech Republic is regulated mainly by the Act No 48/1997, on Public Health Insurance. This law gives an opportunity to every Czech citizen to use any medical institution supplying urgent care (emergency and ambulance) or to institution with a valid contract with Insurance Agency to provide medical treatment. There is an element of solidarity and equity in the Czech health care. In the Czech Republic the healthcare program is based on a model of a welfare state. This concept has been inhereited from the historical political development after the Second World War. This system developed for several decades until the Velvet Revolution in 1989. Both funding and budgeting systems in medical care are specific due to particularities of the sector. This means that a patient does not pay directly for medical services provided.

The health care system is set up for the public provision of treatment. Therefore, it has been very difficult to implement private medical facilities that could by the scope of provided services be similar to the established public hospitals.

The impossibility to compete basically gradually divided the market into services which are almost exclusively provided by the private clinics (e.g., laser eye surgery, aesthetic surgeries, assisted reproduction, etc.) and the overwhelming majority of the rest of medical services provided by public hospitals. Private clinics provide particular medical services, because the level of reimbursement is making them profitable and these services are almost solely provided by them. Private medical facilities mostly provide services for direct cash payments. This system of funding makes them independent on the insurance companies, and thus leaves them the space for standard non-regulated way of competition. The public hospitals cover all other types of medical treatments.

Even though the standard of supplied services differs vastly among the public facilities across the Czech Republic, the providers are basically not allowed to compete. The reimbursement for particular treatment is specified by the Ministry of Health and it is the same for everybody. In other words, hospitals always get the same contribution, no matter the quality provided. This aspect is recently changing with new reforms that bring more concentration in the sector and closures of regional medical facilities. This is very different from the approach of private commercial entity and it also partially explains why at the same market there is usually no space for both public and private medical facilities.

In the Czech Republic the health care expenditures represented about 7.2 – 7.1 per cent of total GDP expenditures in the period from 2004 to 2008. This is comparable to European standard, as it can be seen in Chart 1. As it concerns the budgeting of individual hospitals and health care institutions the current reimbursement system in the Czech health care is unfavourable to the private medical facilities in the sense that the amendments to the contracts with insurance companies are signed retroactively for the given year.

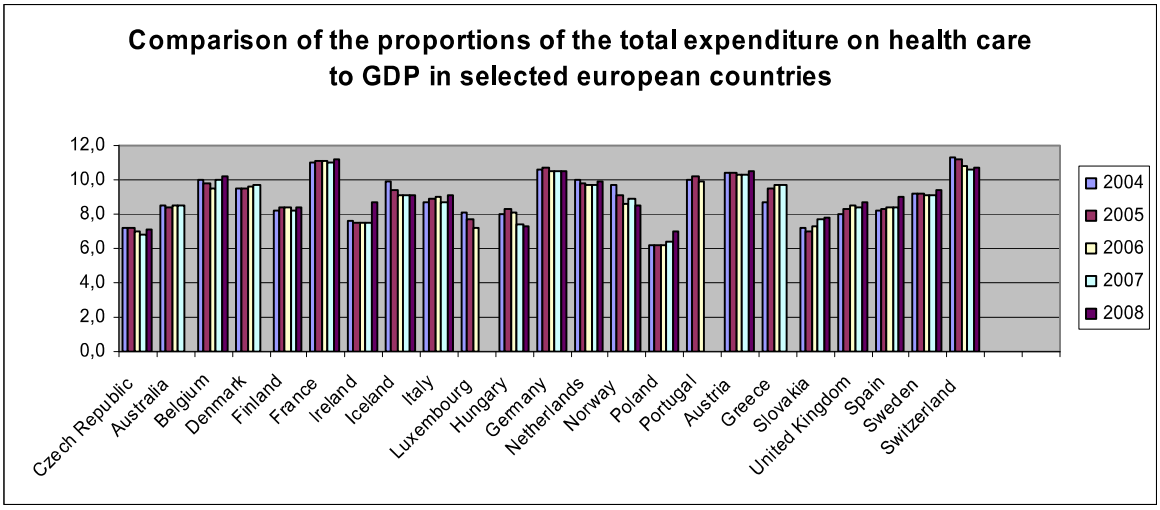

Fig. 1 Proportions of health care expenditures on country GDP (Europe in years 2004-2008)[1]

An important feature of the Czech health-care expenditures is that despite the general economic crisis there was a growth of expenditures on health care funding. To illustrate, in 2009 the GDP declined by 1.7 per cent in standard prices and the proportion of health care expenditures on total GDP increased to 7.9 per cent.

In the Czech Republic the direct and indirect sources of funding are distinguished. Indirect funds are represented by public budgets (both state and municipal ones), the compulsory insurance, the voluntary insurance, the employee insurance, the charity and the international help. Direct funds from health service recipients are assembled by direct funds of health care. The proportion of main sources can be seen in Chart.2.

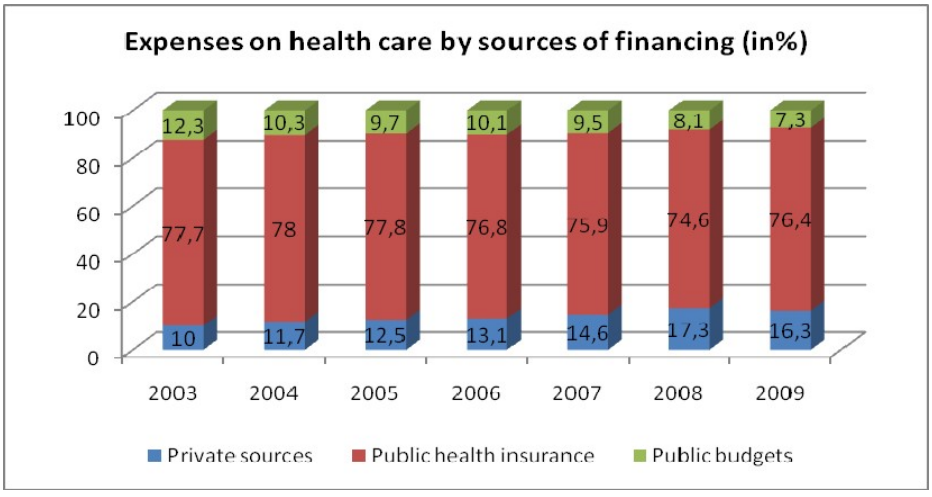

Fig. 2 Proportions of main health care funding sources in the Czech Republic in the period from[2] *2003 to 2009*

[1] Economic Information on Health Care 2009; http://uzis.cz [consulted on 20.2.2011]

[2] Economic Information on Health Care 2009; http://uzis.cz [consulted on 20.2.2011]

2 General Approach to Health Care Funding in Germany

To get the international perspective we have decided to compare the funding of our country health care system to other countries. For this reason we have chosen Germany for its geographical nearness and numerous historical analogies. Broader research on funding in Europe was undertaken by the Health Policy Consensus Group funded by British HNS. This research compared and examined 11 healthcare funding systems. Related research has appraised the systems by asking about eight key features by which the important relations between individuals as potential patients, third-party payers and healthcare providers were assessed.

In Germany a combined funding system is used, where the social health insurance is paid both by the employer and the employee, whilst insurers are competing.[3] German statutory healthcare system is not universal. Rather, the funding is divided into three parts: 74 per cent of the population are mandatory insured under the statutory system (in 2010 it was about 65 to 70 per of population), a small number including most of self employed citizens and certain civil servants are excluded and usually choose to purchase private insurance, and a third group earning above an income threshold may choose between statutory insurance and private health insurance.

Tab. 1 Contributions to statutory Health care in Germany

Monthly contributions to statutory health care insurance (based on gross salary of the employee)	**2010**	**2011**
With entitlement to sickness payments during the sickness leave	14,9 %	15,5 %
Without entitlement to sickness payments during the sickness leave	14,3 %	14,9 %
Pension insurance	19,9 %	19,9 %
Unemployment insurance	2,8 %	3,0 %
Contribution for child care insurance premium (the beneficiary has at least one child)	1,95 %	1,95 %
Contribution to health care insurance (the beneficiary does not have any children)	2,20 %	2,20 %

Source: Health Policy Consensus Group (2003) Options for Healthcare Funding. http://www.civitas.org.uk/pdf/hpcgSystems.pdf pp. 11-12. [consulted on 22.2.2011]

Approximately equal parts of the above contributions are paid by employer and employee, e.g. employer pays 7,5% and employee contributes 8% of the salary.

2.1 Lessons from the German funding system

We can find similarities and differences between the systems in the Czech Republic and Germany. Important features that characterise the German system are:

1. Price consciousness: In Germany, the health care cost is also expressed as a percentage of income and employers and employees pay about half each. The average cost represents 13.5 per cent of income. The money does not go to the government budget, but to independent sickness funds “c.450”, which pay for the care chosen by their members. There is some

[3] Source: Health Policy Consensus Group (2003) Options for Healthcare Funding. http://www.civitas.org.uk/pdf/hpcgSystems.pdf pp. 11-12. [consulted on 22.2.2011]

concern that social insurance patients consume too much health care. Exceptions are: pharmaceuticals that are subject to partial direct payment ranging from € 5.00 to € 10.0 per pharmaceutical and majority of dental care, where patient must pay € 10.00 each 3 month in case of dentists visit. Patients are not aware of the real cost of medical treatment.

2. Social solidarity: The poor are very well cared for. In most cases the unemployed have their insurance premium paid for by the government. However, in what is an openly two or three tiers system, there is a concern in some quarters regarding stigmatization of the poor.

3. Consumer empowerment and patient satisfaction: Patients may choose providers and have a particularly wide range of health care specialists. The gate-keeping function is weak in Germany, though it is likely to be strengthened. Patient's satisfaction was high, but it has decreased in recent years and it is currently less then before reorganization in 2009. One of the causes may be a rise in insurance premiums.

4. Quality of care: Germans provide and receive one of the highest quality of medical care in the world. This is obviously higher than in several non EU countries, USA etc. However, there is better quality care in Switzerland, France, Sweden, Norway, UAE, Japan and Hong Kong. Competing providers usually treat all patients but they have an incentive to attract the high paying privately insured patients, which has a 'leveling up' effect on the quality of care available to all citizens.

5. Clinical autonomy: Key features of corporatism and subsidiarity dominate the German health care. Accordingly, regional physicians' associations and sickness fund associations determine the level of treatment budgets. A series of Federal Acts have focused on cost containment since 1977. Pricing of pharmaceuticals is controlled by a short-list and reference prices, but the spending cap was abolished in 2002. There is an increasing concern that new medical technologies are not being made available to those who may benefit from them. There is a geographical restriction over the freedom to set up a medical practice, coming from local authorities.

6. Conflicts of interest with the third party payer: Most of the independent sickness funds are run by boards representing employers and employees. However, the major weakness of the German system is that sickness funds have to sign a contract with all physicians and hospitals. That means,that they have to pay 'all willing providers' (AWPs) which prevents them from selecting approved lists of cost-effective, safe, or consumer-friendly practitioners or hospitals. This is likely to change with a shift towards greater freedom to contract. Insurers must also offer the same extensive package of benefits to all needed citizens, which is further weakening their position.

7. Responsiveness: The supply of physicians is high, and waiting lists are almost unheard of. Hospital treatment capacity is high, partly because German regional governments provide for capital investments. There are concerns, however, that current cost control measures will limit the capacity of the system to adapt to future needs.

3 Health-Care Efficiency Management

Health carte institutions are not excluded from the general rules of financial management. Planning budgeting and control are part of their financial management. The starting point of planning is the goal setting and choice of appropriate strategy. The medical institution must analyse the market where it operates. When setting up a budget the organisation has to consider economic and legal rules as well as recent internal development in the company. Medical institutions should be able to identify the scope and range of medical services they are providing using own resources and care which is provided by suppliers. Furthermore there needs to be a specification of research and educational activities including allocation of

relevant resources.[4] Financial planning needs to focus on long term issues, whilst budgeting deals with short term issues. To set up a good budget one needs to use the financial information contaitning data from recent past and partially enables to predict further development. Organisations need to establish, which sources they need – (both material and medical). Number of personnel is determined by insurance companies on the basis of registration sheets of medical outputs per department. Research activity and new technology development is usually financed from grants. Education of new physicians and nurses is coordinated with medical faculties and secondary medical schools and it is financed from the sources of ministry of education.

We can speak about the efficiency of the Health care system in relation to introducing so called DRG (Diagnosis-related-group). This is a classification system that creates limited number of clinically and economically homogeneous groups of cases of acute hospitalisation and thus it enables to compare the relative demand for sources in cases that are classified in these groups.[5]

The diagnostic related group can be used for:

- Funding acute bed care
- Tool for hospital management
- Tool for communication between the doctors and economic management both inside and outsider the hospital
- Tool for measuring the medical production
- Tool for measuring quality of health care.

3.1 Financial Measures

Even though the public healthcare providers are predominantly funded by public resources some standard measures of financial health are useful indicators of their overall economic standing. In our study we use three basic financial measures looking into liquidity of financial means.

Net Working Capital

An important measure of corporate financial health is the size of net working capital. The greater the net working capital, the better the liquidity of the company in concern. Liquidity measures the firm's ability to pay its financial obligations as needed. If the indicator is negative, the company displays unsecured short term debt and thus the long-term resources are lower than fixed assets. The implication is that a part of long term assets is financed by short-term funds.

Receivables turnover

This financial ratio shows how long it takes to collect receivables, or how long it takes to convert receivables into cash, that can be used elsewhere in the company. The recommended values are determined by payment terms on company's invoices. If the receivables turnover is longer, it indicates a poor payment discipline of clients.

Payables turnover

This financial ratio shows how long it takes to pay-off the short term debts of the firm. To maintain a comfortable financial balance in the firm the payables turnover period should be a

[4] Robert A. Vraciu: Programming, Budgeting, and Control in Health Care Organizations: The State of the Art, 1979, Health Services Research [p.128 and follows]

[5] http://www.nrc.cz/cs/drg; [cit. 30-03-2011]

bit longer than the receivables period examined above, however this depends on payment conditions provided by company suppliers.

With the use of the data employed above we can perform liquidity analysis and assess the short term financial stability by analyzing the trade deficit, which is a comparison between terms of payment of receivables and payables. This is practically illustrated in part 4 where we provide a comparison of two important hospitals in the Czech Republic.

3.2 Non Financial Instruments and Indicators

Quality is essentially a subjective concept. It is perceived differently by the practitioner and by his client. The quality has two dimensions – subjective, i.e. how satisfied the client is, and objective, keeping up to exact criteria - outputs of measurement are so called ISO 9001 metrics.

Hospitals can apply two systems of quality measurement: either ISO norms or Czech norms. There are several certification authorities of ISO, whilst there is only one accreditation agency providing accreditation for the whole hospital in the Czech Republic.

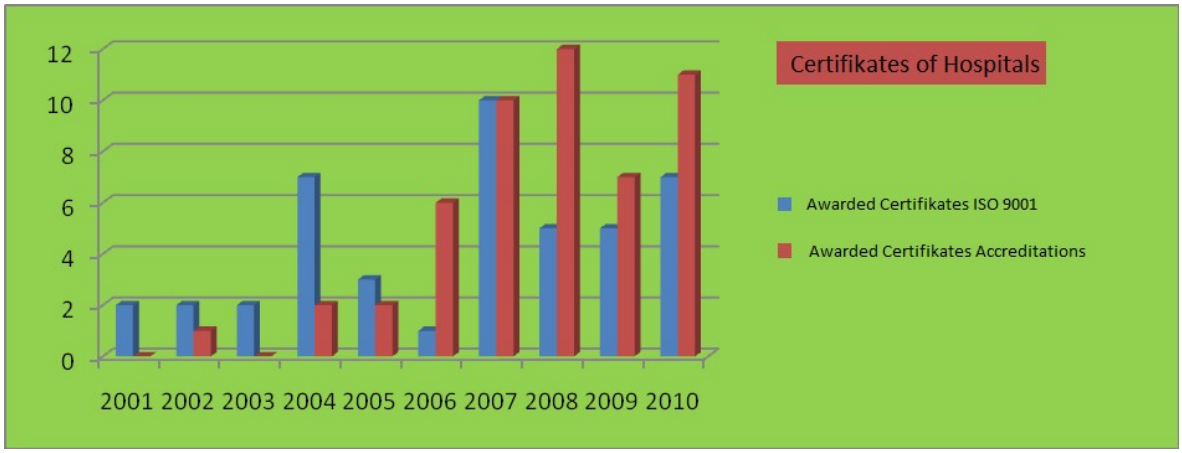

Fig. 3 Awarded Certificates and Accreditations in the Czech Republic[6]

3.3 Further measures of quality management in hospitals and health care organisations

Quality management systems are being introduced in health-care institutions; this increases efficiency and improves economic results in health care institutions. It improves the organisation of process management in order to improve the satisfaction of patients. This results in improved competitiveness of health care institution and prestige of the hospital. Systems of quality management are adopted in public and private institutions. Quality management systems are voluntary, and they asses from the external point of view whether the activity of individual health care institutions is in accordance with preset standards of duality and safety. The goal of certification is to ascertain permanent improvement of healthcare. At the start of every year health insurance companies require accreditation before signing agreement with hospitals.

Accreditation standards are defined by International Association of Quality (ISQua) in health care in cooperation with the world healthcare organisation. (WHO). In accordance with accreditation principles of ISQua and WHO there is also international organisation Joint Commission International (JCI), certifying health care institutions outside the USA.

[6] http://www.howtogermany.com [consulted on 15.1.2011]

In the Czech Republic the accreditation programme for health care provides Joint accreditation committee (Spojená akreditační komise, o.p.s. - SAK), National authorisation centre for clinical laboratories (Národní autorizační středisko pro klinické laboratoře - NASKL), Czech institute for accreditation of clinical calibration laboratories and further activities.

The international accreditation JCI was awarded to several Czech medical institutions, e.g. the Central Military Hospital Prague (Ústřední vojenská nemocnice) The Institute of Hematology and Blood Transfusion (Ústav hematologie a krevní transfuse), Na Homolce Hospital (Nemocnice na Homolce), Masaryk Memorial Cancer Institute (Masarykův onkologický ústav), University Hospital in Ostrava (Fakultní nemocnice Ostrava).

Individual medical institutions can be accredited according to the above listed international standards JCI, or individual parts of institutions can be accredited according to norm ISO 9001:2008, which helps to organise and systemize processes focussing on their management and improvement.

University hospitals and joint stock companies and other organisations funded by contributions are accredited in accordance with standards of Joint accreditation committee (SAK ČR).

Quality improvement concentrates on the needs and safety of patients. It assesses measurable quality indicators and assures patient's satisfaction. By gaining the information on quality the organisation manages the quality of processes and procedures and human resources. Quality indicators are following the requirements of international standards JCI and national quality standards in management of processes in medical institutions (SAK CR).

Accreditation process enables institutions to improve the organisation and management of processes, to increase clients' satisfaction and improve economic results of performed care. Last but not least it improves the competition and prestige of medical institution in the eyes of patients and enables reactions to patients' requirements with the use of internal audits.

4 Comparative Case Study of the UH Motol and the UH Brno

4.1 Financial Measures

Net working capital (hereinafter NWC) is one of traditionally used differential indicators. The substance of this measure is that it represents a part of company's current assets that is financed with long-term capital sources. The development of net working capital at the University Hospital Motol is satisfactory.

In comparison, our analysis of net working capital at the University Hospital Brno shows that this hospital does not have a sufficient amount of current assets, which could be used by the hospital management to implement its short term plans. The main cause of the negative net working capital in the University Hospital Brno is an unsecured suppliers' debt that is effectively used as a long-term resource. In general, in Brno the long term financial resources are lower than fixed assets employed, therefore, some long term assets must be funded from current resources. In such circumstances there is a danger that due to the repayment obligations part of the corresponding fixed assets would have to be sold off.[7]

[7] Funková I. (2010) Financial analysis of University Hospital Motol and prediction of future development. Bachelor Dissertation, VŠEM 2010

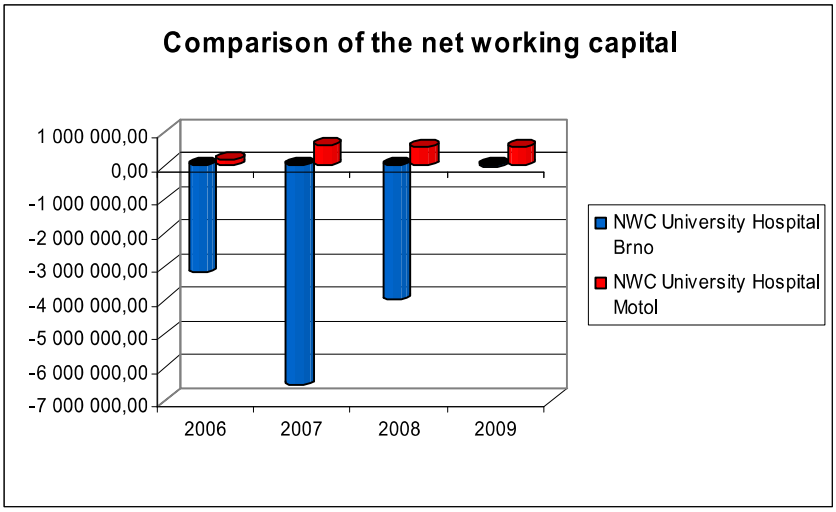

Fig. 4 Comparison of the net working capital

Short term activity ratios

When comparing the selected indicators of activity of both hospitals we come to the conclusion that the University Hospital Motol is in a better position concering receivables and payables turnovers in the period under review. In UH Motol the set term are 60 days for receivables and 90 days for payables as agreed with customers and suppliers respectively. For University Hospital Brno we have calculated the actual values in 2006 as 310 days, in 2007 538 days and in 2008 297 days and up until 2009 when the results improve to 71 days. Fore more details see *Tab. 2* and *3*.

Tab. 2 Key Activity Ratios in UH Brno

Key Activity Ratios	2006	2007	2008	2009
Asset turnover	1	2	2	1
Inventory turnover	8	6	8	7
Receivables turnover	8	6	6	50
Payables turnover	310	538	297	71
Trade deficit	-302	-531	-291	-20

Source: Funková I. (2010) Financial analysis of University Hospital Motol and prediction of future development. Bachelor Dissertation, VŠEM 2010, p. 51

Tab. 3 Key Activity Ratios in UH Motol

Key Activity Ratios	2006	2007	2008	2009
Asset turnover	1	1	1	1
Inventory turnover	7	8	8	6
Receivables turnover	29	10	12	29
Payables turnover	68	37	39	38
Trade deficit	-39	-28	-27	-9

Source: Funková I. (2010) Financial analysis of University Hospital Motol and prediction of future development. Bachelor Dissertation, VŠEM 2010, p. 40

4.2 Non-financial measures: quality management in the University Hospital Motol and the University Hospital Brno

The presented hospitals are certified according to different norms and methods. Faculty hospital Motol is accredited in accordance with standards published by SAK ČR. Part of the University Hospital Motol - the Institute of Biology and Clinical Genetics - is certified in accordance with the norm ČSN EN ISO 15189:2007 and the Institute of Biochemistry and Clinical Batobiochemistry is certified in accordance with the norm ČSN EN ISO 9001:2009 in the area of providing laboratory services for development of new methods in biochemistry. The remaining laboratory departments are undergoing accreditation process according to NASKL.

In the University Hospital Brno all medical and non-medical institutes are independently certified (that is more than 150 institutes). The University Hospital Brno as a complex unit is also accredited in accordance with the norm ČSN EN ISO 9001:2008. This means that Faculty Hospital Brno is the only medical institution that obtained such accreditation since 2007. Further accreditation of Faculty Hospital Brno is ĆSN EN ISO 14001:2004. This is a certificate of the technical department.

Conclusion

This paper concentrates on health care efficiency management and funding in the Czech Republic. Providing health care is not only a budgeting question, but it is related to many ethical issues. Up to now, the Czech state and municipal hospitals were not really forced to be cost effective and to be responsible for their results.

It can be seen from our short comparative case study how the financial and non-financial indicators operate in two important Czech hospitals. The general recommendations for efficiency improvements in health care sector in the Czech Republic are as follows: Hospitals could significantly reduce their costs, with use of outsourcing. The cost of medical materials can be reduced with the use of electronic auctions for procurement of medical materials. Further measure can be a decrease of the headcount, this, however, requires a change of regulations provided by insurance companies. Good information system is indispensable in medical organisations and it helps efficiency management. The system must be able to respond to generating information that helps better planning and more efficient use of resources. The system of control, which is used in organisations, contributes to reducing inefficiencies and improves quality of provided medical services and also efficient use and allocation of financial resources. The system of control can be used as a non-financial indicator, which can serve to evaluation of medical institutions.

On a more general level, patients in the Czech Republic need to be aware of the costs of medical care they receive. As we have learned in the case of Germany, patients receive a bill summarizing the cost of their treatment. Therefore they have an opportunity to become cost conscious. The case studies of selected hospitals illustrate that both kinds of measures - financial and non-financial - are necessary to capture the complex environment and diverse the nature of activities in the health care system.

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Ing. Irena Jindřichovská, CSc., Ing. Radka Pešková, Ph.D.,

Bc. Ivana Funková, Bc. Eva Nesládková

MANAGEMENT VÝKONNOSTI ČESKÉHO ZDRAVOTNICTVÍ

Tento článek se zabývá hodnocením efektivnosti specifické části českého zdravotnictví. Zdravotnictví je specifický obor. Proto jsou nástroje a přístupy k měření jeho efektivnosti rovněž speciální. Tento článek částečně čerpá ze zahraničních zkušeností a představuje dva přístupy k měření efektivnosti na příkladě komparace dvou českých fakultních nemocnic. Článek se nejprve zabývá systémem financování, posléze finančními ukazateli měření efektivnosti a nakonec také nefinančními indikátory. Uvedené případové studie ukazují, že oba způsoby měření jsou nezbytné k postižení komplexního prostředí a různorodých aktivit zdravotnického systému. Navíc je kombinace obou metod užitečná, protože poskytuje detailnější obrázek o měření efektivnosti.

MANAGEMENT DER LEISTUNGFÄHIGKEIT DES TSCHECHISCHEN GESUNDHEITSWESENS

Dieser Artikel befasst sich mit der Bewertung der Effektivität von spezifischen Teilen des tschechischen Gesundheitswesens. Das Gesundheitswesen ist eine besondere Disziplin. Deshalb sind die Instrumente und Ansätze zum Messen ihrer Wirksamkeit auch etwas Besonderes. Dieser Artikel basiert teilweise auf internationaler Erfahrung und stellt zwei Arten der Messungen der Wirksamkeit anhand des Vergleichs von zwei tschechischen Kliniken vor. Der Artikel beschreibt zuerst das Finanzierungssystem, dann Messung der Wirksamkeit mit finanziellen Indikatoren und schließlich auch mit nicht-finanziellen Indikatoren. Diese Beispielstudien zeigen, dass beide Messmethoden zum Erfassen des komplexen Umfeldes und vielfältigen Aktivitäten des Gesundheitssystems notwendig sind. Darüber hinaus erweist sich die Kombination der beiden Methoden als nützlich, da sie ein detaillierteres Bild der Messung der Effektivität an bietet.

ZARZĄDZANIE WYDAJNOŚCIĄ CZESKIEJ SŁUŻBY ZDROWIA

Niniejszy artykuł poświęcony jest ocenie efektywności specyficznej części czeskiej służby zdrowia. Służba zdrowia to branża specyficzna. Stąd też narzędzia i podejścia do pomiaru jej efektywności są szczególne. Niniejszy artykuł korzysta częściowo z doświadczeń zagranicznych i przedstawia dwa podejścia do pomiaru efektywności na przykładzie porównania dwóch czeskich szpitali klinicznych. W pierwszej części artykułu poświęcono uwagę systemowi finansowania, następnie wskaźnikom finansowym pomiaru efektywności a pod koniec również wskaźnikom niefinansowym. Przedstawione studia przypadków pokazują, że oba sposoby pomiaru są niezbędne w celu ujęcia kompleksowych uwarunkowań oraz różnorodnych działań podejmowanych w systemie służby zdrowia. Ponadto połączenie obu metod jest korzystne, ponieważ pokazuje szczegółowy obraz pomiaru efektywności.