

2003/06/04 - PL. ÚS 14/02: FREE HEALTH CARE

HEADNOTES

The contested provision clearly applies only to items mutually connected as part of payment-free health care, i.e., items which, under the heading of § 11 para. 1 let. d) fall under “health care without direct payment, if ... they were provided within the scope and under the conditions provided by this Act.” The ban on accepting direct payment thus applies, above all, to the performance of payment-free health care itself. This follows from the wording of the Act: “for this health care”; from the previous sentence it is undisputed that “this” care means “health care without direct payment,” and no other. The ban also applies to connection with the provision of this care, i.e. again payment-free care. However, the text of the Act also indicates that nothing prevents collecting direct payment from insured persons for health care provided beyond the framework of conditions for payment-free care. In the Constitutional Court’s opinion, the contested provision does not change the purpose and meaning of the Act, but only emphasizes protection of the sphere of payment-free health care from attempts to infringe on its integrity and narrow its scope. This interpretation is constitutional and quite proportionate to the meaning of the Act.

CZECH REPUBLIC CONSTITUTIONAL COURT

JUDGMENT

IN THE NAME OF THE CZECH REPUBLIC

The Plenum of the Constitutional Court decided today in the matter of a petition from a group of deputies of the Chamber of Deputies of the Parliament of the Czech Republic to annul part of the second sentence of § 11 para. 1 let. d) of Act no. 48/1997 Coll., on Public Health Insurance and Amending and Supplementing Some Related Acts, as amended by later regulations, expressed by the words “or in connection with the provision of that care”, as follows:

The petition is denied.

REASONING

I.

On 17 May 2002 the Constitutional Court received a petition from a group of deputies, dated 14 May 2002, to annul part of the second sentence of § 11 para. 1 let. d) of Act no.

48/1997 Coll., on Public Health Insurance and Amending and Supplementing Some Related Acts, as amended by later regulations (the “Public Health Insurance Act”), expressed by the words “or in connection with the provision of that care.”

The Constitutional Court determined from the attached page with signatures of the deputies that the conditions specified in § 64 para. 1 let. b) of Act no. 182/1993 Coll., on the Constitutional Court, as amended by later regulations, (the “Constitutional Court Act”) have been met, and the petition was signed by 54 deputies. Deputy Marek Benda was appointed as the petitioners’ representative in proceedings before the Constitutional Court. After removing certain formal defects in the petition, which was done by a filing from the petitioners’ representative that the Constitutional Court received on 11 July 2002, the Constitutional Court could consider the substance of the petition.

The group of deputies is of the opinion that the contested provision of the Act is inconsistent with Art. 3 para. 3, Art. 4 para. 4, Art. 26 and Art. 31 of the Charter of Fundamental Rights and Freedoms. To begin with the petitioners pointed out that in their opinion the contested provision reaches into issues which stand apart the area of regulation of the act on general health insurance (they pointed in particular to its § 1). They allege that the provision has no direct connection to the other parts of the Act and in practice rules out the provision of health care and services which are not covered by public health insurance funds.

The petitioner see inconsistency with Art. 26 para. 1 of the Charter of Fundamental Rights and Freedoms in the fact that the enumerated group of persons (doctors or other expert health care workers, health care facilities) is forbidden to receive payment from another group of persons (the insured) for care or services provided which are not covered by general health insurance, if they are connected to the provision of health care which is covered by that insurance. This allegedly leads to considerable limitation of the provision of health care. Under Art. 26 para. 2 of the Charter of Fundamental Rights and Freedoms, a statute may set conditions and limitations on the exercise of certain professions or activities, but according to the petitioners the contested provision interferes in these rights in a manner inconsistent with Art. 4 para. 4 of the Charter of Fundamental Rights and Freedoms, not preserving their essence and significance. If a person is authorized to provide health care, and if there is, in addition to health care fully covered by general health insurance, also care not covered by this insurance, they say it practically rules out the right to conduct business if we prevent that person from accepting payment for that care, if it was provided to a person insured by public health insurance and if it is connected to the provision of health care which is covered by general health insurance. Thus, the contested provision allegedly also de facto rules out the operation of health care facilities which are not in a contractual relationship with health insurance companies.

Concerning the contested provision’s claimed inconsistency with Art. 31 of the Charter of Fundamental Rights and Freedoms, the petitioners stated that the ban on accepting payment for providing health care or services not covered by public health insurance also leads to limiting the health care offered to citizens - insured persons - whereby, according to the petitioners, they are prevented from exercising their right to protection of health, enshrined in the cited article of the Charter of Fundamental Rights and Freedoms.

The petitioners also stated that certain procedures, measures, healing preparations, or health care aids are not covered by public health insurance at all (e.g. acupuncture), some only in a limited number (e.g. care connected to extra-uterine pregnancy a maximum of three times in one's life), and some only partially (75% of the price for certain health care technology means). In some cases only "basic" health care is covered (e.g. the economically least demanding version of the health care means). Thus, the Act defines payment-free care under Art. 31 of the Charter of Fundamental Rights and Freedoms, but according to the petitioners the contested provision forbids health care facilities to accept payment from an insured person for care not included in that payment-free care, if it is connected with the provision of covered care. In terms of the "intensity of connection" (cf. the contested text "or in connection with the provision of that care") the petitioners divided this connected care or services into the following categories:

- inseparable care (cases where the Act provides only partial coverage by public health insurance, e.g. by a percentage, common in, for example, dentistry)
- closely connected care (a suitable preparation or treatment method exists for improving or maintaining a patient's state of health which is not covered by public health insurance, or a certain basic health care is covered, but health care of higher quality is available in the alternative, but is not covered)
- connected care (the insured person wishes to arrange the provision of further care, following the care covered by public health insurance, but this is not covered)
- loosely connected care (a health care facility provides health care covered by public health insurance, which is connected to the provision of other, non-covered services - e.g. spa care, with "contributory" spa care only the treatment procedures are covered, not housing and meals).

According to the petitioners, it is evident from the foregoing that "connections of various types of intensity undoubtedly existing between care covered by public health insurance and non-covered health care." The level of payment for non-covered health care or health care provided by a non-contractual health facility is regulated under § 6 of Act no. 526/1990 Coll., on Prices, as amended by later regulations, and is regularly updated in the Bulletin of the Ministry of Finance under § 10 of that Act. Of course, the contested provision permits accepting payment only in a case where the provided care is not connected to covered health care.

The petitioners concluded that they consider Art. 26 and Art. 31 of the Charter of Fundamental Rights and Freedoms to be violated by a situation where, in their opinion, a citizen, an insured person, practically has no opportunity to decide on the manner in which he will care for his health, and only because the method chosen by him is not fully covered by public health insurance (either because payment is ruled out or restricted, or because a given health care facility is not in a contractual relationship with the appropriate health insurance company), but is connected to care covered by that insurance. If the health care facility chosen by the insured person nevertheless provides the service and accepts payment for it, it breaks the law and exposes itself to the penalty of having the authorization for its activity revoked.

II.

In accordance with § 42 para. 3, 4 and § 69 of the Constitutional Court Act, the Constitutional Court sent the petition in question to the Chamber of Deputies and Senate of the Parliament of the Czech Republic for position statements, and also requested a written position statement from the Ministry of Health.

Statement of the Chamber of Deputies of the Parliament of the Czech Republic

The statement of the Chamber of Deputies of the Parliament of the Czech Republic of 20 September 2002, signed by its chairman, PhDr. Lubomír Zaorálek, states that § 11 of the Public Health Insurance Act contains a list of the rights of an insured person, which include the right to health care without direct payment, if it was provided to him in a scope and under conditions provided by that Act, which defines the scope and conditions under which health care is provided. The Act provides which health care is covered by public health insurance and which is not, without forbidding direct payment. Thus, health care is provided without direct payment or for partial payment, or - in the case of health care not covered by health insurance - for full payment. In order to ensure substantive performance in providing health care, health insurance companies enter into contracts on the provision of health care with health care facilities. In that case, the health care facility receives payment from the health insurance company for the care provided. An item of treatment is paid, and there is no room for further payments by the insured persons.

In the opinion of the Chamber of Deputies, the petitioners' objection that the contested provision rules out the operation of health care facilities which are not in a contractual relationship with health insurance companies is unjustified. Health care can also be provided by health care facilities, which are not in a contractual relationship with a health insurance company. Thus, health care providers can act as entities conducting business independently, in their own name, on their own responsibility, for purposes of achieving profits, and it is up to the wishes and financial ability of citizens whether they choose such health care facilities.

The purpose of the contested provision, which forbids accepting payment from the insured person in connection with providing health care which is, by law, covered by public health insurance is to prevent a situation where provision of this care would depend on the financial ability of the insured person. In the opinion of the Chamber of Deputies, annulling it would make room for medical facilities and doctors who are contractually tied to a health insurance company to require various fees (e.g. registration or entry) from insured persons for whom seeking health care is not a choice but a necessity. This would deny the right enshrined in Art. 31 of the Charter of Fundamental Rights and Freedoms, as well as the purpose of the Public Health Insurance Act, which is meant to secure it.

Statement of the Senate of the Parliament of the Czech Republic

The statement of the Senate of the Parliament of the CR of 20 September 2002, signed by its chairman, Doc. JUDr. Petr Pithart, states that the Senate discussed the draft amendment of the Public Health Insurance Act (Act no. 2/1998 Coll.), which inserted the contested provision into this Act, on 12 and 13 November 1997 at its 9th session in its 1st term of office, and passed a resolution whereby it returned the draft to the Chamber of

Deputies with amending proposals. The Chamber of Deputies discussed the returned amendment, and reconfirmed the originally passed text. During discussion of the Act in Senate bodies there was, among other things, discussion concerning the proposed treatment of § 11 para. 1 let. d). The result was passage of the “comprehensive” amending proposal, in which the Senate addressed, in particular, the issue of the legal certainty for persons who can be subject to penalties for violating the cited provision. However, as far as the contested provision is concerned, the Senate approved a text very similar to that passed by the Chamber of Deputies and merely attempted a clearer expression of its purpose (“a health care facility may not accept any payment from the insured person for this health care or in direct connection with providing that care”).

The Senate approved this text of the amending proposal in the belief that this text (and thus also the contested provision) was consistent with The Constitution of the CR and the Charter of Fundamental Rights and Freedoms. The Public Health Insurance Act distinguishes care which is covered by health insurance, non-covered, and partially covered. In those cases where care is covered, it strictly follows the wording of Art. 31 of the Charter of Fundamental Rights and Freedoms, and does not permit taking any payment whatsoever from insured persons for that care. The definition of what is non-covered or partially covered care is contained in other provisions of the Public Health Insurance Act. According to the Senate’s statement, if the petitioners’ opinion, that the contested provision forbids the relevant person from accepting payment for providing health care or services not covered by public health insurance, were correct, the second sentence of § 11 para. 1 let. d) would have to read, for example, as follows: “A doctor or other expert worker in health care or a health care facility may not accept from an insured person any payment for health care covered by health insurance, including payment for non-covered or partially covered health care, even though that care is provided in connection with covered care.”

The statement concludes by stating that the Senate is not of the opinion that the contested provision restricts the right to conduct business in health care beyond the framework of constitutional possibilities; in this regard the Senate also could not agree with the petitioners’ conclusions that citizens are prevented from exercising, according to their wishes, their right to protection of health under the cited article of the Charter of Fundamental Rights and Freedoms.

Position of the Ministry of Health of the Czech Republic

In its written position of 2 October 2002, the Ministry of Health stated, in particular, that if an insured person is provided health care within the scope and under the conditions provided by the Public Health Insurance Act, the insured person has the right to receive this care without direct payment. This right is “mirrored” by the obligation of doctors, expert workers in health care and health care facilities to refrain from conduct which would limit or negate this right. According to the Ministry, there is no practical difference in the wording of the contested provision, “for this care” and “in connection with providing this care”; both are aimed at securing the insured person’s undisputed right to health care without direct payment, if it is provided within the scope of the Act. On the contrary, the Ministry of Health believes that if the contested provision were annulled, and the text “or in connection with providing this care” were deleted, this right of the insured person could be relativized. The issues of direct payment of provided health care are

wider. This is a conceptual matter, exceeding the provision of the Public Health Insurance Act and the petition from the group of deputies. Therefore, the Ministry is of the opinion that these questions should be addressed in the context of the entire health care policy of the CR; therefore the petition to annul the contested provision is, in that regard, non-systemic.

The Ministry further noted that the contested provision does not rule out providing health care which is not covered by public health insurance. Nothing prevents taking payment for health care which exceeds the definition in the Public Health Insurance Act. Likewise, according to the Ministry, there is no inconsistency with the right to conduct business and conduct economic activity. Non-state health care facilities and doctors have the right to conduct business in accordance with Act no. 160/1992 Coll., on Health Care in Non-State Health Care Facilities, as amended by later regulations. However, according to the Ministry's position, collecting money from patients in the form of, e.g. various entry or registration fees and sponsor gifts can not be considered "doing business." It can not agree that the provision in question rules out the operation of health care facilities which are not in a contractual relationship with a health insurance company. An insured person is not entitled to health care covered by health insurance in any health care facility whatsoever, but in a facility which has entered into a contract with his health insurance company (an exception is the provision of urgent health care).

Concerning the division of care into "inseparable, closely connected, connected, and loosely connected," the Ministry stated that this is a misleading and self-serving division. One must begin with the question of to what extent and under what conditions health care is covered under the Act. Its position further observes, concerning the "analysis of intensity," that the Act distinguishes partially covered care only for medications and health care means in outpatient care. Co-payment for medications and health care means in inpatient care is ruled out by the Act. With other health care this care is paid fully or not paid (according to the appropriate appendix to the Act).

According to the Ministry of Health, doctors could understand deletion of the contested provision of the Public Health Insurance Act to mean that it is possible to collect money from patients without any limitations whatsoever, whether for health care or connected care. If health care standards existed and were published, and the Health Insurance Act clearly provided that such standard care is covered by insurance and that whatever exceeds the standard is subject to direct payment by the insured person, the situation would be different. However, the problem lies in the fact that no standards or standard medical procedures are described anywhere, and if a doctor believes that a particular item of health care provided is not covered by health insurance, because the insurance company only covers a certain procedure, health care means or medication, then the patient has no opportunity to verify whether that really is so and what the insurance company actually covers. The existing Act only states what kind of care is covered, not what procedure that care is to be provided by or which medications or health care means are to be used in providing it.

III.

The Constitutional Court first, in accordance with § 68 para. 2 of the Constitutional Court Act, reviewed whether the Act whose provisions the petitioners claim to be unconstitutional was passed and issued within the bounds of constitutionally provided jurisdiction and in a constitutionally guaranteed manner. It is evident from the statements of both houses of the Parliament of the Czech Republic, as well as from the obtained Chamber of Deputies documents, information on the course of voting and other accumulated materials, that the Public Health Insurance Act, as well as the amendment which inserted the contested provision into it (Act no. 2/1998 Coll., which amends and supplements Act no. 48/1997 Coll., on Public Health Insurance and Amending and Supplementing Some Related Acts, as amended by Act no. 242/1997 Coll.), were passed and issued in a constitutionally prescribed manner and within the bounds of constitutionally provided jurisdiction, and that the quorums provided in Art. 39 para. 1 and 2 of the Constitution were observed. The draft of the amendment to the Public Health Insurance Act was returned by the Senate to the Chamber of Deputies with amending proposals. The Chamber of Deputies discussed the returned draft on 2 December 1997 at its 17th session in its second term of office and reconfirmed its originally passed version (out of 183 deputies present, 171 were in favor and 9 were against). Similarly, the Chamber of Deputies at its 18th session on 13 January 1998 outvoted the veto of the president of the republic, (out of 192 deputies present 114 were in favor and 47 were against). For the sake of completeness, we can point out here that the reasons for which the Act was returned by the Senate and vetoed by the president of the republic basically did not concern the substance of the contested provision.

The petition from the group of deputies to annul the contested provision did not receive the necessary majority of 9 votes, and as a result the Constitutional Court denied it.

The Public Health Insurance Act provides in § 11 para. 1 let. d) that an insured person has a right to “health care without direct payment, if it was provided in a scope and under conditions provided by this Act. A doctor or other expert worker in health care may not receive any payment from the insured person for this health care or in connection with providing this health care.” In part five, in § 13 et seq. the Act defines health care which is covered and not covered by health insurance, and appendix 1 to the Act gives a list of health care items not covered by health insurance or covered only under certain conditions.

The petitioners, requesting the annulment of part of the text of § 11 para. 1 let. d) of the Act, the words “or in connection with providing this care,” take as their starting point the fact that under the Act, apart from health care fully covered by public health insurance, there is a whole series of items, means, preparations, and services which are not covered at all, or only partly, or only when conditions provided by the Act are met. The petitioners believe that broadening the formulation of the ban on receiving payment from the insured person for providing payment-free health care with the words “or in connection with providing this care” makes the text so general that it includes basically all health care, including that which is not covered, which - in their opinion - will lead to a situation where health care facilities, in order to avoid suspicion of violating the principle of payment-free health care, will also avoid such items, means and services as do not fall under the

concept of payment-free health care. In this conception, in the petitioners' opinion, the contested provision completely "rules out providing health care and services which are not covered by general health care insurance funds." From there the petitioners then conclude that there is violation both of the freedom to do business, guaranteed by Art. 26 para. 1 of the Charter of Fundamental Rights and Freedoms, and of everyone's right to protection of health under Art. 31 of the Charter of Fundamental Rights and Freedoms, because the insured person does not have the right to decide on the manner in which he will care for his health only because the manner he chooses is not fully covered by public health insurance.

This interpretation appears to the Constitutional Court to be completely self-serving and disproportionate, as the contested provision clearly applies only to items mutually connected as part of payment-free health care, i.e., items which, under the heading of § 11 para. 1 let. d) fall under "health care without direct payment, if they were provided within the scope and under the conditions provided by this Act." The ban on accepting direct payment thus applies, above all, to the performance of payment-free health care itself. This follows from the wording of the Act: "for this health care"; from the previous sentence it is undisputed that "this" care means "health care without direct payment," and no other. The ban also applies to connection with the provision of this care, i.e. again payment-free care. However, the text of the Act also indicates that nothing prevents collecting direct payment from insured persons for health care provided beyond the framework of conditions for payment-free care. In the Constitutional Court's opinion, the contested provision does not change the purpose and meaning of the Act, but only emphasizes protection of the sphere of payment-free health care from attempts to infringe on its integrity and narrow its scope. This interpretation is constitutional and quite proportionate to the meaning of the Act. As is known, if a constitutional interpretation of a statutory provision is possible, the Constitutional Court gives it priority over annulling the contested provision. That is the situation in this case. The Constitutional Court is also of the opinion that the contested provision does not address the question whether an insured person is or is not supposed to contribute payment for health care expenses or in what scope and in what circumstances he is to do so. That is another area of the public health care issue.

The Constitutional Court also did not find the contested provision to be inconsistent with Article 26 para. 1 of the Charter of Fundamental Rights and Freedoms, and inclined toward the position of the Ministry of Health, which refers in this regard to protection of doctors' freedom to do business in accordance with Act no. 160/1992 Coll. Nor can we agree that the contested provision rules out the operation of health care facilities which are not in a contractual relationship with a health insurance company. The insured person's entitlement to payment-free care, under the act on general health insurance, quite naturally concerns care provided in a health care facility which has a contract with a health insurance company.

After the Constitutional Court determined that the reasons cited in the submitted petition do not establish unconstitutionality of the contested provision, it considered whether there are other reasons which would justify the opinion that it is unconstitutional. It considered, above all, the question whether the contested provision does not exceed the framework of the constitutional authorization of Art. 31 of the Charter of Fundamental Rights and

Freedoms, under which citizens have a right, on the basis of public insurance, to payment-free health care and to health care aids under conditions specified by statute, i.e. in a scope which maybe widened or narrowed by statute; only within the bounds of that statute can one seek to enforce this constitutional right (Art. 41 of the Charter of Fundamental Rights and Freedoms). The Public Health Insurance Act, as amended by later regulations, is undoubtedly such a statute. Thus, on that basis, the provision on payment-free health care covered by public insurance, completed with the phrase “or in connection with providing this care,” is constitutional, as it is a specification which, in scope, is only a detail in the overall framework of health care and does not violate, but rather makes more precise, the principle of payment-free health care under Art. 31 of the Charter of Fundamental Rights and Freedoms. In view of its scope, the contested amendment also can not be reinterpreted as if it represented considerable interference with the principles of regulation of health insurance or as interference with the proportionate equivalence of the protection of insured persons. Deliberating the possibility that annulling the contested provision of the Act might send a signal which would make easier the reconstruction of payment-free care toward greater co-payments by insured persons (e.g. payments for hospital food, for prescriptions, for treatment items, and so on) appears to the Constitutional Court to completely deviate from the task which is now before it in connection with the petition from the group of deputies. The possible removal of the amendment, as a sort of first step to changing the health care policy of the state, would mean exceeding the jurisdiction of the Constitutional Court in the direction of a constitutionally inadmissible position of a “positive legislator,” an instigator of new regulations regardless of the fact that the contested provision is consistent with the Constitution. Such a step belongs on to the Parliament of the CR, whose task it is to weigh the abilities of public funds and evaluate the appropriateness of applying the principles of equivalence and solidarity in the overall regulation of health care in a new situation. In this situation, the Constitutional Court merely refers to its judgment of 12 April 1995, file no. Pl. ÚS 12/94, promulgated under no. 92/1995 Coll., and also published in volume 3 of the Collection of Decisions of the Constitutional Court on p. 123 et seq., and the dissenting opinions attached to it.

The Constitutional Court is aware that these questions are part of an entire complex of public health care issues, which is based on certain constitutional principles, and whose overall regulation should respond to solutions which are current in the developed democratic states and internationally agreed or recommended positions.

Therefore the Constitutional Court also considered - peripherally - premises which can, though indirectly, have an influence on the concept of the individual provision which represents only a particular detail of the overall regulation of general health insurance.

In its deliberations, the Constitutional Court begins with the constitutional concept of protection of health, which is enshrined in Art. 6 para. 1 of the Charter of Fundamental Rights and Freedoms, under which “everyone has the right to life,” and in Article 31 of the Charter of Fundamental Rights and Freedoms, which reads: “Everyone has the right to protection of health. Citizens have the right, on the basis of public insurance, to payment-free health care and to health care aids, under conditions provided by statute.”

The statutory framework for providing health care also corresponds to the Charter of Fundamental Rights and Freedoms. Act no. 20/1966 Coll., on Care for the Health of the People, as amended, in Art. III begins with the premise that a prerequisite for care for the health of the people is “immediate application of the results of scientific research in practice,” and provides in § 11 para. 1 that health care facilities shall provide health care “in accordance with the currently available knowledge of medical science.” Likewise, Act no. 123/2000 Coll., on Health Care Means and Amending Certain Related Acts, also imposes an obligation § 1 to provide health care “through suitable, safe and effective health care means.”

This sets, in accordance with constitutional principles, a developmental trend for public health care toward quality, full-value and effective care on the basis of the equality of all insured persons. For constitutional and statutory principles this care can not be divided into a kind of basic, “cheaper” but less appropriate and less effective care, and an above-standard, “more expensive” but more suitable and more effective one. The difference between standard and above-standard care may not consist of differences in the suitability and effectiveness of treatment. The law does not regulate what health care a doctor or health care facility may provide, but what kind it must provide in the general interest so that all insured persons have a right, in the same degree, to such treatment and medication as meets their objectively determined needs and the requirements of the appropriate level and of medical ethics. Thus, the developmental orientation of health care, supported by laws, is based not on shifting “better” items of health care from the sphere of payment-free care into the sphere directly paid by insured persons, but, in contrast, toward improving the items provided payment-free from public health insurance. This concept also corresponds to international conventions, such as the Convention on Human Rights and Biomedicine, and recommendations, e.g. Recommendation Rec (2001)13, of the Committee of Ministers of the Member States of the Council of Europe, which was approved on 10 October 2001. The Committee of Ministers emphasized that Article 3 of the Convention on Human Rights and Biomedicine requires that entities concluding contracts on health care ensure equal access to health care of appropriate quality. The Constitutional Court adds that Article 4 of this Convention also imposes an obligation “to perform all measures in the area of care and health in accordance with the appropriate professional obligations and standards.” The Convention entered into force for the Czech Republic on 1 October 2001 (no. 96/2001 Coll. of International Agreements).

Appendix 1 to the Czech Public Health Insurance Act gives a list of health care items not covered by health insurance or covered only under certain conditions; appendix 2 part A gives a list of medicinal substances, where it defines substances fully covered, partially covered, and not covered by public insurance, and part B gives a list of substances with limitations on indications and prescription. Appendix 3 contains lists of health care technology means, not covered and covered by health insurance, and appendix 4 concerns dentistry products identified to be covered by an insurance company, or indicating the maximum amount of coverage. It is evident from this regulation as well that the contested provision of the Act does not and can not exclude from health care the provision of services which are not covered by compulsory insurance.

It can be acknowledged that the existing framework is not sufficiently clear, so that an ordinary insured person can sometimes be asked for direct payment even when it is not justified. If public health insurance is to approach the European standard, it would evidently be necessary for the Act to clearly and understandably define the possibilities for private payment by insured persons, evidently similarly as in developed European states, Germany, Switzerland, etc. For example, in Germany, although around 10% of inhabitants have private insurance with commercial insurance companies, the quality of private care is provided on the same level as public health insurance and under common state-wide directives. Public hospitals provide the same health care items, including the same types of health care materials which are fixed to the human body, e.g. endo-prostheses, both for privately insured persons and for persons insured in statutory hospital insurance companies, including the scheduling of patients for health care items according to expert criteria, and not according to the ability to contribute to payment. In public hospitals, a private patient or a publicly insured person can order and separately pay for, as supplemental items and services, only officially approved items with officially confirmed prices, the provision of which does not affect the level of health, e.g. special accommodations, food, choice of doctor or nurse, or a different type of bandage or medication.

Nevertheless, if we turn away from the overall issues of our health care and return to the petition from the group of deputies, it is impossible not to see that the contested provision of the amendment to the Czech Act concerns only one problem, and a partial one, in the overall regulation of public health care. Therefore, the task of the Constitutional Court is not to evaluate this overall regulation of health care or the amendment of the Act as a whole. The purpose of the contested provision is undoubtedly to prevent the unlawful collection of money for those provided services which are covered by compulsory, general health insurance, whether they are various registration fees and administration fees or payments for those types of health care and treatment items which are identified as “better,” above-standard and more expensive, even though they fall into the sphere of services fully covered by public health insurance.

After reviewing the petition from the group of deputies the Constitutional Court concluded, for all the foregoing reasons, that the petition to annul the contested provision is not justified, and therefore denied it.

Notice: Decisions of the Constitutional Court can not be appealed.

Brno, 4 June 2003

Dissenting Opinion

of Constitutional Court judges P.H., J.M. V.C., V.Č., V.G., J.M., A.P., filed under § 14 of Act no. 182/1993 Coll. to the Constitutional Court’s judgment in the matter of the petition from a group of deputies of the Chamber of Deputies of the Parliament of the Czech Republic to annul part of the second sentence of § 11 para. 1 let. d) of Act no. 48/1997

Coll., on Public Health Insurance and Amending and Supplementing Some Related Acts, as amended by later regulations, expressed by the words “or in connection with providing this care.”

This dissenting opinion, filed to the verdict of the judgment of the relevant minority, which denies the petition from a group of deputies of the Chamber of Deputies of the Parliament of the Czech Republic to annul part of the second sentence of § 11 para. 1 let. d) of Act no. 48/1997 Coll., on Public Health Insurance and Amending and Supplementing Some Related Acts, as amended by later regulations, expressed by the words “or in connection with providing this care,” is based on the following arguments:

The decisive reason for the relevant minority’s vote (see judgment file no. Pl. ÚS 3/96) is the statement that the cited statutory provision’s inconsistency with Art. 26 and Art. 31 of the Charter, claimed by the petition, misses the purpose and meaning of that provision. This is because, as stated in the judgment’s reasoning in this regard, “the contested provision only emphasizes protection of the sphere of payment-free health care from attempts to infringe on its integrity and narrow its scope,” and “the contested provision does not address the question whether an insured person is or is not supposed to contribute payment for health care expenses or in what scope and in what circumstances he is to do so. That is another area of the public health care issue.”

The statutory provision in question was incorporated into the Public Health Insurance Act by an amendment passed under no. 2/1998 Coll., in the version proposed by deputy Eva Fischerová on 17 October 1997 in the second reading of the discussion of the government draft of the Act, which amends and supplements Act no. 48/1997 Coll., on Public Health Insurance and Amending and Supplementing Some Related Acts, in the Chamber of Deputies of the Parliament of the Czech Republic. Deputy Fischerová justified her proposal with these arguments: “No regulation addresses the unlawfulness of the step of accepting payment in connection with providing health care covered by public health insurance, in relation to all health care facilities. It is these now so unpleasantly familiar, psychologically extorted contributions to administration, so-called “gifts” in direct relation to provided care, or fees for illegitimate identification cards, which are required in amounts of 200-400 crowns, or registration fees, which are illegally introduced in a number of doctors’ practices. I am convinced that my proposal, which I am now presenting, is not redundant. In a situation where doctors are called on by their representatives to unlawfully require payment for care covered by public health insurance or direct connection with this care, it is necessary to use all opportunities to protect the constitutional rights of citizens by establishing appropriate penalties, even if for a limited period, in the amendment of Act no. 48 of 1997 Coll. Although the rights of the insured citizen are enshrined in the legal norms which I mentioned, the lack of penalties for accepting payment in Act no. 48 leads to a paradoxical, even absurd situation. To a certain extent penalties are optional, in the sense of an authorization for health insurance companies and state administration bodies, so that access to health care can not become worse. In these cases, a state administration body will be obliged to use its authorization to impose financial penalties.”

The meaning and aim of the statutory provision at issue thus became to remove the cited unclear interpretative points in the existing regulation and to clearly confirm that double payment for provided health care was ruled out. In response to cases appearing in practice, this meant in particular double payment for items which are not direct health care but are tied to it.

The undersigned judges (the “judges”) fully agree with that part of the judgment’s reasoning which interprets the contested provision in such a way that it does not prevent collecting direct payment from insured persons “for health [inserted by the judges] care provided above the framework of conditions for payment-free care.” The distinction in the Public Health Insurance Act between health care without direct payment and health care with the possibility of such payment can be derived just from the first sentence of the contested provision, and the amendment in question only confirms that distinction. The judges are aware that the petitioners claimed the contrary, and that thus the analysis in the judgment’s reasoning convincingly and constitutionally contradicts their claim.

However, the judges point to the settled case law of the Constitutional Court, under which this court is bound only by the proposed judgment, not the reasoning, of the petition. They concluded that the contested provision is inconsistent with Art. 31 of the Charter in connection with Art. 2 para. 2 of the Charter and Art. 1 para. 1 of the Constitution, for a different reason than the petitioners claim.

Under Art. 31 of the Charter, “everyone has the right to protection of health. Citizens have the right, on the basis of public insurance, to payment-free health care and to health care aids, under conditions provided by statute.” This statute is Act no. 48/1997 Coll. on Public Health Insurance (the “Act”), which governs public health insurance and the scope and conditions under which health care is provided on the basis of this Act (§ 1 of the Act).

The Act creates for the citizen an obligatory insurance relationship, the content of which is set by the Act. In setting the content of this relationship, the legislature is bound by the constitutional order, above all the substantive scope of the constitutional right to protection of health. In regulating public health insurance this Act can not exceed this substantive framework for “protection of health,” and may regulate only the provision of care which serves for the “protection of health” (a ban on arbitrariness). The insured person transfers to the insurance company, for payment, risks which can arise to him through danger to his health or infringement of his health. In contrast, insurance premiums may not be used to pay things, steps, procedures, or services which do not serve to protect the insured person’s health, but to satisfy other needs, e.g. in securing living conditions.

The contested provision is systemically placed in the part of the Act “Rights and Obligations of the Insured Person.” One of the obligations of the insured person is the obligation to pay premiums to the appropriate health insurance company, unless this Act provides otherwise [§ 12c)]. On the basis of the contested provision, the insured person has the more detailed right to “health care without direct payment” (“payment-free health care”). By amendment of no. 2/1998 Coll. the contested provision was supplemented to the effect that in future one can not accept any payment from the insured person not only for “payment free health care” itself, but also “in connection with providing this care,” i.e. in connection with providing payment-free health care. Therefore, the decisive factor is that the care be provided in connection with payment-free health care, without the

contested provision determining its nature in more detail. This leads to the conclusion that the obligation is imposed for care to be provided which is not “health care,” but is care provided by a health care facility in connection with payment-free health care (e.g. providing food, or cleaning). Other insured persons are also required by law to contribute to this type of care.

This type of payment-free care is a deviation from the constitutionally protected right to protection of health. Art. 31 of the Charter gives authorization for a statute to determine the conditions for providing payment-free “health” care, not care which is not health care but is a component of satisfying a person’s necessary needs independently of protection of health. In this regard the statute exceeded the limits of the constitutional order by making it impossible to collect from insured persons direct payment for care which is not health care and which, in and of itself, does not serve to protect the health of the insured person. It thus creates non-objective and unreasonable differences between insured persons to whom such payment-free non-health care is provided and those insured persons to whom it is not provided, although both categories are forced to satisfy the corresponding needs independently of any simultaneously provided health care.

Even if the legislature’s intent does not correspond to the foregoing analysis of the contested provision, the judges emphasize that in the case of a provision which implicitly imposes an obligation on an individual (the obligation to contribute to payment-free non-health care of other insured persons), one can not rely on *ratio legis* when evaluation such a provision’s consistency with the constitutional order, but it is necessary in the first place to take an objective analysis into account (see also Art. 2 para. 3 of the Constitution). One of the most important democratic European lawyers of the 20th century, Gustav Radbruch, expressed, in this regard, the thesis of “content independence of the law,” which fully applies to this case of the constitutionality of part of the second sentence of § 11 para. 1 let. d) of Act no. 48/1997 Coll., on Public Health Insurance, as amended by later regulations: “The will of the legislature is not a method of analysis, but the goal of analysis and the result of analysis, an expression for the a priori necessity of systemically not inconsistent analysis of the entire legal order. Therefore, one can state, as the will of the legislature, something which was never present as the conscious will of the author of a statute. An interpreter can understand a statute better than its creator did; the statute may be wiser than its author - it must be wiser than its author.” (G. Radbruch, *Rechtsphilosophie. Studienausgabe*. Hrsg. R. Dreier, S. Paulson, Heidelberg 1999, p. 107.)

The wording of the contested statutory provision thus opened the question of payment for care other than health care, although connected to it, from public (statutory) health insurance. It thereby opened the question of the cited provision’s inconsistency with Art. 31 of the Charter, which presumes only payment for items of health care from that type of insurance. It must be emphasized that finding part of the second sentence of § 11 para. 1 let. d) of Act no. 48/1997 Coll., on Public Health Insurance, as amended by later regulations, to be inconsistent with Art. 31 of the Charter does not automatically give rise to the necessity of direct payments for acts other than items of health care, but connected to them. The instrument of contractual insurance can be considered a more standard approach to solving this problem.

The Constitutional Court spoke on the constitutional safeguards of social security primarily in its judgment in the matter Pl. ÚS 12/94. It said the following: “ in all existing systems of social security, the principles of solidarity and equivalence are represented in varying degrees. Every system of social security brings with it the advantaging of certain social groups, depending on whether the viewpoint of solidarity is given preference or whether the principle of equivalence is given priority. This is reserved to the legislature, which can not proceed arbitrarily, but in setting preferences must take into account the public values pursued.” In other words, the court provided that it is the legislature’s obligation to transparently express the ratio of the components of solidarity and equivalence in the social insurance system (including health insurance). It also provided that this division may not be arbitrary. In the opposite case, i.e. in the absence of the element of equivalence, the institution loses its legal nature, cease to be insurance, and acquires the character of a tax.

Thus, Art. 31 of the Charter, in connection with Art. 41 and Art. 4 para. 4 of the Charter, gives rise to the insured person’s fundamental right for a component of equivalence transparently determined by the legislature in public health insurance, in such a degree as preserves the nature of the legal institution of insurance and does not change it into a tax.

The statutory provision contested by the petitioner does not meet these constitutional safeguards. Not only does it make room for coverage of care other than health care, even if connected to health care, by statutory health insurance, but it does not, either in and of itself, or in connection with other provisions of the Public Health Insurance Act, contain a transparent delineation of the ratio of the components of solidarity and equivalence from the viewpoint of covering items of health care by public health insurance.

The judges can not agree with that part of the judgment’s reasoning which anticipates their dissenting opinion and gives it the function of a signal which is to make easier “the reconstruction of payment-free treatment toward greater co-payments by insured persons,” whereby it allegedly exceeds the jurisdiction of the Constitutional Court “in the direction of a constitutionally inadmissible position ... regardless of the fact that the contested provision is consistent with the Constitution.” The dissenting opinion clearly indicates that, although the subjective intent of the legislature apparently is in accordance with the constitutional order, in contrast, the resulting objective product of its legitimate intent is not consistent with the constitutional order. The Constitutional Court is called on by the Constitution to evaluate the constitutionality of valid sub-constitutional regulations, not the aims which led to their being passed. Therefore, the part of the sentence in the contested provision expressed by the words “or in connection with providing this care” should have been annulled.

Brno, 4 June 2003