

## THE IMPACT OF REGULATORY FEES ON THE NUMBER OF PATIENT VISITS AT THE DOCTOR'S

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### Abstract

Beginning on January 1, 2008, in the Czech Republic the regulatory fees in health care were introduced. The article deals with their impact on a number of patient visits to their doctors. The author has analyzed and statistically processed the data of one of the branches of an employee managed health insurance company. This is based on the file of the author's data, in which she follows the process of an average number of visits per one insured person in selected specializations of an out-patient care in 2007 before the introduction of the fees, and compares it with the average number of visits after the introduction of the fees for the period 2008–2013.

The goal of this project was to determine whether the established regulatory fees had the regulatory effect on the consumption of health services, (i.e. whether the fees have led to the reduction of patient visits to the doctor's office). The process of a number of visits was observed in a total of 22 specialties of out-patient care. The author statistically evaluated the acquired results with the use of the so-called "t-test". The research has shown that the established fees have led to a reduction of the total number of visits at the doctor's. Sixteen of twenty-two surveyed specialties after 2008 show a statistically significant decrease in visits.

The author reflects on the future of regulatory fees and potential economic impact of their removal.

**Key words:** *fees; regulation; health care; health insurance*

## INTRODUCTION

### Current status

Effective January 1, 2008, by the amendment of the Act No. 48/1997 Coll., on public health insurance, regulatory fees for health care were introduced in the Czech Republic.

The reason for their introduction was the control the patients' behaviour in relationship to health care providers, and thus, to optimize the use of public sources. Therefore, the fees as a form of control had to limit the overuse of medical care or wasting of medication (Dostál 2008).

The goal was to increase the income of the operators of the health care facilities from sources except for public health insurance.

The fee is in the domain of public finance defined as a direct payment of a citizen for a particular service or goods provided by the public sector, which may or may not correspond to the price of the service or goods (Mertl 2008).

Legislation of regulatory fees made by § 16a and the following provisions of the Act No. 48/1997 Coll., have developed and became the subject of political debates and competition.

Three types of fees were introduced:

**1. Regulatory fees in the amount of 30 CZK**, which is paid in outpatient care **for a visit with a clinical examination** (it is an examination which meets the criteria of a comprehensive, targeted, control or consultative examination and is recognized by the authorized performances by the List of Health Services with Point Values) – § 16a of the Act No. 48/1997.

The same amount of **regulatory fees is paid to pharmacies**. Legislation up until December 31, 2011 required clients to pay 30 CZK for each issue of the public health insurance fully or partially paid medicine prescribed on a prescription, regardless of the number of items, (i.e. each prescribed medication required a regulatory fee to be paid).

Effective January 1, 2012, the amendment of the Act No. 48/1997 Coll., has changed this fee so that one prescription is paid only once, (i.e. for the prescription regardless of the number of kinds of medicaments or the number of packages (§ 16a of the Act No. 48/1997 Coll.).

**2. A regulatory fee the amount of 90 CZK** for the use of an emergency medical service or emergency services in dentistry on weekdays from 5 p.m. to 7 a.m., or on Saturday, Sunday or holiday, unless they are regular working hours. A regulatory fee for the use of emergency services is not paid if there is a subsequent admission of the patient to in-patient care (Ministry of Health of the Czech Republic 2008).

**3. By December 31, 2013, the patients also paid a regulatory fee in the amount of 100 CZK** for each day in which institutional care was provided.

This fee has undergone significant changes since its introduction. First of all, from January 1, 2008 to November 31, 2011, the fee for in-patient care was only 60 CZK. The increase to 100 CZK started on December 1, 2011.

According to the finding of the constitutional Court of the Czech Republic, file number CC 36/11 from June 6, 2013, which was published in the Collection of Laws of the Czech Republic under number 238/2013,

this fee was avoided on December 31, 2013 (Finding of CC 36/11, 2013).

## MATERIAL AND METHODS

The aim of this article was to summarize the impact of established regulatory fees on the number of patient visits in selected specializations of an out-patient care facility.

The author has used quantitative research. A content analysis of data from the Health Insurance Company of the Ministry of Interior of the Czech Republic, subdivisions České Budějovice and Plzeň for the period 2007 to 2013 was used. The average number of insured people in the above mentioned subdivision, ranged from 170,379 in 2007 to 196,049 in 2013. The research included 1,981 out-patient health care service providers with whom the subdivision has concluded the contracts. For research purposes, the number of recognized clinical examinations (comprehensive, targeted and control) was monitored during the period 2007 to 2013 in the most frequent medical specialities of an out-patient care. These were medical first aid, internal medicine, diabetology, gastroenterology, cardiology, pulmonology, allergology, neurology, paediatrics, dermatovenerology, psychiatry, surgery, gynaecology, orthopaedics, ENT, ophthalmology, urology, psychology, speech therapy and dentistry. The research could not be carried out by general practitioners who were paid a capitation payment which include stated clinical examinations and thus, they were not separately reported.

In order to achieve this goal, the author has determined the basic hypothesis which should be verified or refuted by the research, specifically:

**H: Regulatory fees had an impact on reducing patient visits at the doctor's office.**

For statistical verification were also established two working hypotheses:

**Zero hypothesis HO:** The average number of visits per one insured person after the introduction of regulatory fees (from 2008) is the same as before the introduction of the fees (2007).

**Alternative hypothesis H1:** The average number per one insured person after the introduction of the regulatory fees (from

2008) is lower than before the introduction of the fees (2007).

## **RESULTS AND DISCUSSION**

In all of the following specialities, the number of recognized clinical examinations by competent medical specialists for out-patient was monitored. There were procedures of complex, targeted and control examination. The content of the above mentioned examinations is determined by the applicable legislation – Regulation of the Ministry of Health of the Czech Republic, No. 134/1998 Coll., as amended, issuing the List of medical procedures with point values (Reg. of the Ministry of Health of the Czech Republic, No. 134/1998, Coll.). The procedures of clinical examinations are essential examinations with the help of which the health care facilities demonstrate the health care given to the insured people to the insurance companies.

The procedure of clinical examinations must adhere to medical specializations including material and costs of all devices required in the clinical examination procedures. These stated procedures show the patient's examination form which the regulatory fees are taken from January 1, 2008. During one visit, only one procedure of clinical examinations can be reported.

In all monitored cases, the starting year was 2007 (in Table 1, bold letters), this was one year before the introduction of regulatory fees. Just for comparison, as in 2007 were not significant fluctuations that could in the result affect the whole research, the data for 2006 were left in the table because the author also analyzed the data of the number of visits in this year.

In the event of an emergency medical service (after EMS) was observed the number of reported procedures:

01023 – targeted examination by a general practitioner, 01024 – control examination by a general practitioner, 02024 – targeted examination by a general practitioner for children and adolescents – child up to 6 years old, 02023 – control examination by a general practitioner for children and adolescents – child up to 6 years old, procedure 02033 – targeted examination by a general practitioner for children and adolescents – child over

6 years old, procedure 02034 – control examination by a general practitioner for children and adolescents – child over 6 years old.

In the specialization 014 – dentistry was monitored the number of examinations reported by procedures 00902 – care of registered insured person over 18 years old: 00903 – requested examination by a specialist, 00904 – dental examination of registered insured person from 1 to 6 years old in the preventive care, 00906 – dental treatment of the insured person up to 6 years old or handicapped insured person, 00907 – dental treatment of the insured person from 6 to 15 years old, 00908 – acute treatment and examination of unregistered insured person – within the emergency service, 00909 – clinical dental examination. At the time of its introduction, the procedure 00900 provoked debates in dentistry. Procedure 00900 is comprehensive examination by a dentist during the re-registration of an insured person (new procedure since January 1, 2012). As this performance is not connected with the preventive care of the patient, it was under the payment of a regulatory fee (Neubauerová 2012). Therefore, this procedure was included in the monitored file.

In all other areas of specialization, the number of reported procedures of clinical examinations was again observed – i.e. comprehensive, targeted and control examination by a competent physician of an out-patient specialized care.

The number of visits in absolute numbers of individual specializations from 2006 to 2013 is shown in Table 1.

Table 1 shows the data in absolute numbers. The number of insured people, whose doctor visits were analyzed, changed in different surveyed periods. The average number of insured people for the period 2007–2013 is shown in Table 2.

For a statistical comparison, it was not possible to develop absolute data, but instead the data on the number of visits have been transferred to the average number of visits for one insured person in given specialty. Consequently, the average number of visits for one insured person in individual specialties in 2007 was compared, and the total average number of visits in these specialties for one insured person for the period after the

**Table 1. The number of visits in absolute numbers**

Expertise	Period							
	2006	2007	2008	2009	2010	2011	2012	2013
EMS*	18,036	17,955	10,816	12,351	10,907	10,937	11,421	11,510
Stomatology	47,774	57,168	57,043	61,672	65,472	57,363	63,313	66,658
Internal medicine	57,890	55,819	44,820	47,027	49,442	50,857	52,753	53,807
Diabetology	19,461	19,299	18,194	19,361	20,547	20,797	21,540	22,086
Gastroenterology	16,589	16,574	15,769	15,485	15,004	14,957	15,533	15,589
Cardiology	12,701	12,874	13,386	15,369	16,052	17,632	19,212	19,807
Pulmonology	21,579	21,193	16,083	17,120	17,559	18,223	18,628	19,210
Allergology	22,578	22,594	18,545	20,058	20,610	20,200	20,488	19,257
Neurology	35,292	34,541	30,613	33,021	34,749	35,507	36,370	37,652
Paediatrics	10,502	10,086	9,442	10,167	9,599	9,583	9,462	10,068
Psychiatry	26,694	26,903	24,021	25,469	27,114	30,370	31,499	32,055
Child psychiatry	1,001	990	1,005	1,154	1,510	1,600	1,806	1,797
Dermatovenereology	69,658	68,449	53,292	59,745	60,740	61,145	62,300	65,499
Surgery	112,708	112,086	96,320	104,341	101,763	102,154	107,677	116,357
Gynaecology	151,090	150,059	108,158	106,608	106,186	104,342	103,002	104,323
Orthopaedics	56,325	57,120	50,554	53,423	56,280	56,852	59,614	60,457
Otorhinolaryngology	51,409	54,171	43,621	45,172	45,058	45,693	44,788	48,589
Ophtalmology	66,868	69,491	60,672	63,752	66,761	67,091	69,898	79,429
Urology	27,762	28,981	22,760	25,174	26,706	27,404	27,890	28,597
ARD**	14,831	16,448	19,700	21,438	23,012	23,179	24,565	25,645
Clinical psychology	5,795	5,707	5,744	5,635	6,395	6,323	5,986	6,088
Clinical speech therapy	4,477	4,659	4,460	5,405	5,653	5,792	6,203	6,419

\* emergency medical service

\*\* anaesthetic-resuscitation and intensive care department

**Table 2. Average number of insured people of Health Insurance Company of the Ministry of Interior of the Czech Republic, subdivisions České Budějovice and Plzeň for the period 2007–2013**

Period	2007	2008	2009	2010	2011	2012	2013
Average number of insured people	170,739	178,351	183,575	186,730	188,735	193,802	196,049

introduction of regulatory fees, namely for the years 2008–2013.

In order to test this set of hypotheses, it was necessary to verify whether the observed differences in the average number of visits for different specialties are statistically sig-

nificant. For testing, the so-called “t-test” was used.

For evaluation, the significance level 0.05 (5%) is commonly used. Zero hypothesis is rejected if the *p*-value is less than (chosen by us) significance level 0.05.

**Table 3. Comparison of statistical significance of differences in the number of visits**

Specialty	Average number of visits in 2007	Average number of visits in 2008–2013	Result	p-value	Is statistically significant?
EMS*	0.1054	0.0603	decrease	0.0000	YES
Stomatology	0.3355	0.3297	decrease	0.2042	NO
Internal medicine	0.3276	0.2647	decrease	0.0000	YES
Diabetology	0.1133	0.1086	decrease	0.0178	YES
Gastroenterology	0.0973	0.0820	decrease	0.0001	YES
Cardiology	0.0756	0.0897	decrease	0.0088	YES
Pulmonology	0.1244	0.0947	decrease	0.0000	YES
Allergology	0.1326	0.1058	decrease	0.0000	YES
Neurology	0.2027	0.1842	decrease	0.0008	YES
Paediatrics	0.0592	0.0518	decrease	0.0002	YES
Psychiatry	0.1576	0.1509	decrease	0.1221	NO
Child psychiatry	0.0058	0.0078	increase	0.0116	YES
Dermatovenereology	0.4017	0.3215	decrease	0.0000	YES
Surgery	0.6579	0.5573	decrease	0.0000	YES
Gynaecology	0.8807	0.5620	decrease	0.0000	YES
Ortopaedics	0.3353	0.2988	decrease	0.0001	YES
Otorhinolaryngology	0.3179	0.2422	decrease	0.0000	YES
Ophtalmology	0.4079	0.3610	decrease	0.0020	YES
Urology	0.1701	0.1405	decrease	0.0001	YES
ARD**	0.0965	0.1218	increase	0.0002	YES
Clinical psychology	0.0335	0.0321	decrease	0.0351	YES
Clinical speech therapy	0.0273	0.0030	increase	0.0307	YES
All expertises in total	5.0662	4.2238	decrease	0.0000	YES

\* emergency medical service

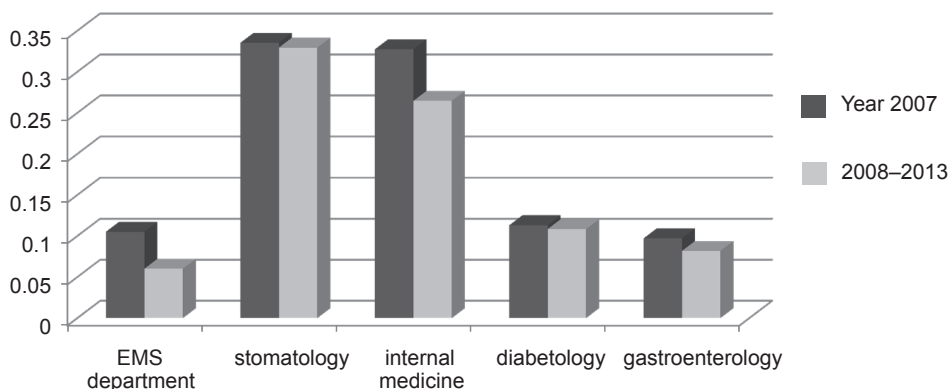
\*\* anaesthetic-resuscitation and intensive care department

From Table 3, it is clear that a statistically significant increase of visits occurred only in cardiology, child psychiatry, department of anaesthesia and intensive care medicine and clinical speech therapy. There was a decrease of visits in dentistry and psychiatry, but it was not statistically significant.

For illustration, the differences in the number of visits in some selected fields are represented graphically, in charts 1 to 3.

It is evident from the data in Chart 1 that the number of visits of emergency medical

services, after the introduction of regulatory fees, significantly dropped. While in 2007 (which was used as a starter for comparison) the clients of the previously mentioned subdivision of Health Insurance Company of Ministry of Interior of the Czech Republic visited emergency medical service in 17,955 cases. In 2008 the number of visits decreased to 10,816. The average number of visits for one insured person in 2007 was 0.1054, while during the period 2008–2012 the average was 0.063 visits for one insured person.



**Chart 1. An average number of visits in selected specializations of out-patient specialized care – a comparison of 2007 with 2008–2013**

This result corresponds with the data of the Institute of Health Information of the Czech Republic, according to which, in 2008 the number of those treated for emergency medical service decreased in total by 41.1% when compared to 2007. In the same period the number of treatments at EMS for children and adolescents decreased by 25.0%. The number of acute dental treatments decreased by 36.7%.

For the period 2007 to 2012, according to Institute of Health Information and Statistics of the Czech Republic (IHIS of the Czech Republic), this substantial reduction of the number of treatments under EMS remained stable. The number of treatments at EMS for adults in 2012 was by 45.0% lower than in 2007 and the number of treatments of children and adolescents was by 20.6% lower. The exception to this is in dental emergencies, even with an increase to 107.3% of the year 2007 for the entire period until 2012. However, the number of ambulance actions of EMS has increased, specifically from 686,000 cases in 2007 to 795,000 cases in 2012 (IHIS of the Czech Republic, Current information, No. 47/2012). Therefore, it is possible that some patients with the regard to the impact of regulatory fees, in some cases used the ambulance service rather than visiting the EMS department.

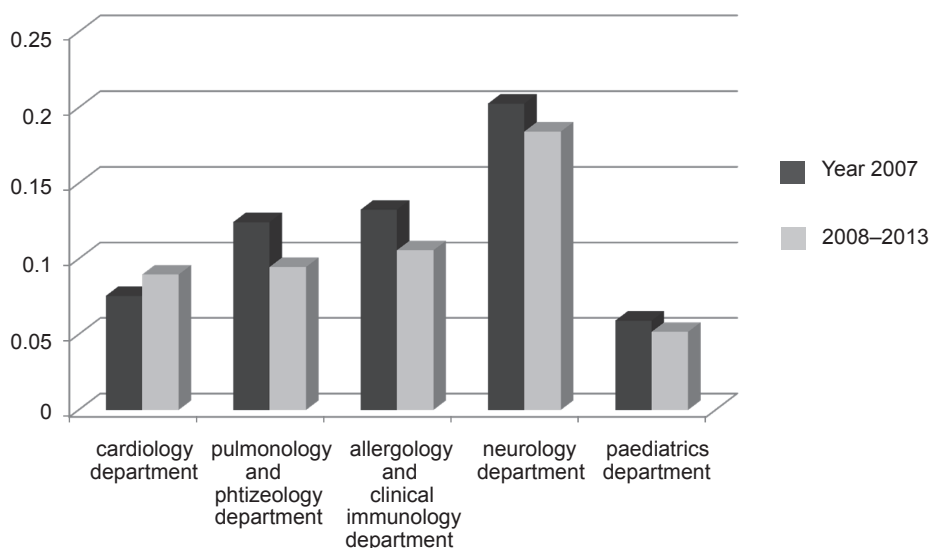
As for the work of a clinical dentist, it is clear from the reported data that the introduction of the regulatory fees only slightly decreased the number of visits, but it was not significant.

This result again correlates with the finding of the Institute of Health Information, according to which the number of visits to dental clinics after the introduction of the regulatory fees has not experienced a significant decrease compared to the decrease with the out-patient visits in other disciplines. The reason can be some established tacit acceptance of necessary participation when visiting the dental office, like an achievement of a certain stable level of dental care needs (IHIS of the Czech Republic, Current information No. 47/2012 and 40/2013). The decrease in the number of visits appeared in internal medicine, diabetology and gastroenterology.

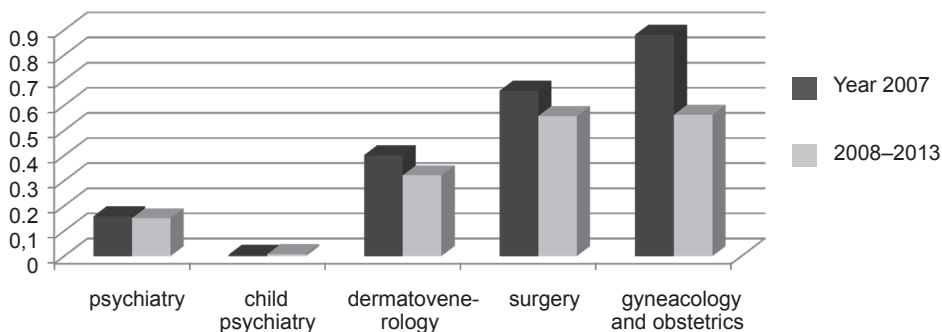
The development of attendance in other specializations is shown in Chart 2 and 3.

The decrease in the number of visits did not appear in cardiology, where on the contrary, there was a slight increase. The growth was detected in child psychology, anaesthetics, intensive medicine and clinical speech therapy.

In the case of cardiology and anaesthetics, the increase of visits can be explained that in serious diseases the fees did not result in the reduction of care availability. In cardiology, some role was played by public education which led to registration of cardiovascular diseases in a higher number of patients. It is possible to presume that the decrease in clinical speech therapy did not appear, mainly because the patients are aware that the therapeutic effect is based on the consistency of visits. Thus, lengthening the intervals



**Chart 2. Average number of visits in selected specializations of out-patient specialized care – comparison of year 2007 with 2008-2013**



**Chart 3. Average number of visits in selected specializations of out-patient specialized care – comparison of year 2007 with 2008-2013**

between the visits would destroy the effect of the previous treatment. In the case of child psychiatry, the author believes that some role was played by the fact that effective April 1, 2009, children up to 18 were exempted from the payment of regulatory fees.

In other surveyed specializations, the number of visits decreased. This result corresponds with the analyses of the Institution of Health Information, according to which the total number of out-patient treatment/examination (without dentistry,

without ENS) in 2008 decreased by 17.0% compared to 2007, while in previous years these numbers decreased only by 2 or 3% a year. By 2012, according to the Institute of Health Information and Statistics, the number of out-patient treatment/examination again increased to a total number 115,455,000, i.e. 89.6% of the year 2007 (IHIS of the Czech Republic, Current information No. 47/2012 and 40/2013).

Of the 22 out-patient specialties surveyed, a statistically significant decrease in the

number of visits after the introduction of the regulatory fees appeared in 16 cases. In summary, a statistically significant decrease of the number of visits in all analyzed specialties appeared during the period of 2008–2013 compared to 2007.

Based on these results, it was possible to reject the zero hypothesis and to confirm alternative hypothesis stating that an average number of visits for one insured person after the introduction of the regulatory fees (from 2008) is lower than before introduction the fees (2007). With the help of zero and alternative hypotheses, the set hypothesis  $H$  was confirmed: ***Regulatory fees had an impact on reducing of patient visits.***

The topic of regulatory fees in health sector is currently a hot topic, as the current government declared in its government declaration that its goal is to annul on January 1, 2015, all types of fees except for those used during hospital emergency services. The first step towards the abolition of the fees was made by the constitutional Court of the Czech Republic. Based on its findings, they declared on June 20, 2013, the fees for hospitalization would be abolished on December 31, 2013. The constitutional Court justified its decision by the fact that the fee in its essence should be the payment for the hotel service. It has to be the equivalent of the costs that the patient would have to spend outside the medical facilities. The constitutional Court criticized the absence of any limits to the construction of the fee. The fee involved both employed and unemployed people. It was paid in full, regardless of the length of hospitalization. Thus, conceived legislation deviates from the context of the fee paid for hospitalization in neighbouring countries, where a limited maximum amount of time for which is paid is mostly specified. The constitutional Court in its finding stated that by the cancellation of the fee effective from January 1, 2014, the legislator was given sufficient time to set parameters in terms of the quoted finding (Finding of the CC 36 2013). The constitutional Court, therefore, did not consider the complete cancellation of the fee, but it gave impetus to changing it, which includes a possible reduction and limitation. The new government, however, in accordance with its governmental statement did not change the law and did not restore the fee. Paradoxically, the majority of the

population agreed with this type of fees. The latest survey of STEM/MARK agency shows, 60% of the Czech population does not mind the payment for the hospital stay (STEM/MARK 2014). Cancellation of the regulatory fee for a hospital stay, brought a significant reduction of income for in-patient health facilities, as the fee represented for these providers in total approximately 2 CZK per year. The government decided to compensate for this loss by increasing in revenues for state-insured people which should occur effective on July 1, 2014 (Czech Press Agency 2014b). The Chamber of Deputies approved a draft amendment on the Health Insurance Act, according to which monthly payment for state-insured people will increase by 58 CZK from July 2014. This increase should add into the public health insurance system in 2014, about 2.1 billion CZK and each following year about 4.2 billion CZK (Citores Kût 2014a). The amendment specifies that health insurance companies are obliged to compensate for the loss of income from the hospital regulatory fees to the providers of in-patient health facilities. The compensation will be in the form of monthly payments on their accounts. The insurance company will pay the provider an amount equalled 7/12th in July, and each following month of the year 2014 an amount of 1/12th of the total fees recognized in 2013 to the qualified health insurance company (Czech Press Agency 2014a).

As might be expected, segments of out-patient care will require compensation. Czech Medical Chamber has already declared that it is unacceptable to completely abolish all the fees. However, the Chamber would agree with their amendment, and limitation, etc. (Kubek 2009). General practitioners are also against the abolition of the fees (Citores Kût 2014b). It is, therefore, likely that if the abolition of the fees happens effective January 1, 2015, this step will require additional resources from an already very tight state budget, as the above mentioned increase of payments for state insured people will not cover the total loss of income from regulatory fees, which annually ranged from 5.2–5.7 billion CZK. Although the regulatory fees represent some burden for households, this burden is not so high as to cause drastic changes in the consumption of a certain type of care or to discourage from this consumption (Krůtilová 2010). The most



problematic and generally the worst accepted by the public, seems to be the fee for the prescription (Pražmová and Dušek 2011). This fee was purely regulatory in nature and its purpose was to lead to the regulation of drug consumption. The introduction of this fee led to significant savings especially in 2008, when the number of prescriptions paid in full or in part from health insurance, decreased to 73.3% in 2007. The payment from health insurance companies for prescription drugs decreased to 97.6% of the year 2007, i.e. by 820 million CZK (IHIS of the Czech Republic, Current information No. 63/2009). In the following years, the number of prescriptions slightly increased, but it did not reach the level of 2007. As the total consumption of drugs in the financial statement in the period 2009–2012 was more stable between 58 to 59 billion CZK and drug consumption expressed by defined daily doses in the same period was slightly rising, in this case, it was not so much a decrease in the consumption of drugs, but apparently it was impact of regulatory fees on prescribing larger packaging on the prescriptions (IHIS of the Czech Republic, Current information No. 47/2012).

## CONCLUSION

As revealed by the research, regulatory fees represented a reduction of the number of visits in many out-patient facilities. So, they prevented unnecessary health care utilization and enabled doctors to devote more time to patients with more serious diagnoses. However, the fees brought additional private sources which represented about 5.5 billion CZK a year. Their announced cancellation, effective January 1, 2015, is unsystematic step according to the author's meaning.

In the context of the aging population, with increasing diagnostic and treatment options, it will be necessary to deal with the maintenance of demand for health services at an acceptable boundary and with possibilities of the increase of income flowing into health care. It probably means more pressure on the sources of the state budget but at the same time it will be necessary to look for further system savings.

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## REFERENCES

1. Citores Kůt F (2014a). Poslanci schválili peníze na kompenzaci poplatku za hospitalizaci [The deputies agreed the money for compensation of the hospitalization fee]. *Zdravotnictví a medicína*. 10: 1–3 (Czech).
2. Citores Kůt F (2014b). Praktici žádají zachování regulačních poplatků [General practitioners ask for the preservation of regulatory fees]. *Zdravotnictví a medicína*. 8: 3 (Czech).
3. Česko (1997). Zákon č. 48/1997 Sb., o veřejném zdravotním pojištění v platném znění [Act No. 48/1997 Coll., on public health insurance as amended]. In: *Sbírka zákonů České a Slovenské federativní republiky*. Částka 16, p. 1185–246 (Czech).
4. Česko (1998). Vyhláška Ministerstva zdravotnictví ČR č. 134/1998 Sb., kterou vydává Seznam zdravotních výkonů s bodovými hodnotami [The notice of the Ministry of Health Care of the Czech Republic No. 134/1998 Coll., published in the List of health services with point values]. In: *Sbírka zákonů, Ministerstvo vnitra*. Částka 46, p. 5674–5690 (Czech).
5. [Czech Press Agency]. ČTK (2014a). Většině Čechů platba za pobyt v nemocnici nevádí, ukazuje průzkum [Most Czech inhabitants do not mind the payment for the hospitalization stay, according to research]. [online] [cit. 2014-01-04]. Available from: <http://www.ceskatelevize.cz/ct24/domaci/261023-vetsine-cechu-platba-za-pobyt-v-nemocnici-nevadi-ukazuje-pruzkum/?mobileRedirect=off> (Czech).
6. [Czech Press Agency]. ČTK (2014b). Vláda se dohodla na penězích pro zdravotnictví [The government agreed the money for the health care]. *Zdravotnictví a medicína*. 8: 1–3 (Czech).
7. Dostál Z (2008). Nález ÚS č. Pl. ÚS 1/08 ze dne 20. 5. 2008 [Finding of CC No. P1. CC 1/08 from May 20, 2008]. *Zdravotnictví a právo*. 7–8: 617–636 (Czech).
8. [Finding of the constitutional Court..., 2013]. Nález Ústavního soudu ČR sp. zn. Pl. ÚS 36/11 ze dne 20. června 2013. In: *Sbírka zákonů, Ministerstvo vnitra*, 2013, částka 92, p. 2220–2246 (Czech).

9. [IHIS of the Czech Republic]. ÚZIS ČR. Aktuální informace č. 63/2009 [Current information No. 63/2009]. [online] [cit. 2014-04-18]. Available from: <http://www.uzis.cz/rychle-informace/spotreba-zdravotnickych-sluzeb-letech-2005-2008> (Czech).
10. [IHIS of the Czech Republic]. ÚZIS ČR. Aktuální informace č. 47/2012 [Current information No. 47/2012]. [online] [cit. 2014-01-11]. Available from: <http://www.uzis.cz/rychle-informace/spotreba-zdravotnickych-sluzeb-letech-2007-2011> (Czech).
11. [IHIS of the Czech Republic]. ÚZIS ČR. Aktuální informace č. 40/2013 [Current information No. 40/2013]. [online] [cit. 2014-01-11]. Available from: <http://www.uzis.cz/rychle-informace/spotreba-zdravotnickych-sluzeb-letech-2007-2012> (Czech).
12. Krůtilová V (2010). Dopady regulačních poplatků na domácnosti [The impact of regulatory fees on household]. *Zdravotnictví v České republice*. 1/13: 168–172 (Czech).
13. Kubek M (2009). Upravit systém „regulačních“ poplatků – nikoli zrušit [The correction of “regulatory fees” system, not abolition]. *Tempus medicorum*. 1/18: 38–39 (Czech).
14. Mertl J (2008). České regulační poplatky [Czech regulatory fees]. *Zdravotnictví v České republice*. 4/11: 120–123 (Czech).
15. [Ministry of Health of the Czech Republic]. Ministerstvo zdravotnictví ČR. Metodický pokyn pro zdravotnická zařízení, zařízení lékárenské péče a zdravotní pojišťovny k aplikaci novely zákona č. 48/1997 Sb. v oblasti regulačních poplatků a doplatků na léčivé přípravky nebo potraviny pro zvláštní lékařské účely (2008) [Methodological guideline for health care facilities, facilities of pharmaceutical care and health care insurance company to apply the amendment to Act No. 48/1997 Coll., in the area of regulatory fees and additional charges for medicines or food for special medical purposes]. [online] [cit. 2013-12-10]. Available from [http://www.mzcr.cz/Odbornik/dokumenty/regulacni-poplatky-metodicky-pokyn\\_1821\\_1197\\_3.html](http://www.mzcr.cz/Odbornik/dokumenty/regulacni-poplatky-metodicky-pokyn_1821_1197_3.html) (Czech).
16. Neubauerová L (2012). Kód 00900 a regulační poplatek [Code 00900 and regulatory fee]. *Zdravotnické noviny*. 16: 40 (Czech).
17. Pražmová V, Dušek K (2011). Outcome of regulatory fees in healthcare. *Journal of nursing, social studies and public health*. 1–2/2: 60–72.
18. STEM/MARK. Poplatky v nemocnici ano, u lékaře a za recept ne [Yes for the hospital stay fees, no for the fees at the doctor’s office and in pharmacies]. [online] [cit. 2014-05-06]. Available from: <http://www.stemmark.cz/poplatky-v-nemocnici-ano-u-lekare-a-za-recept-ne/> (Czech).

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