POLITICAL ECONOMY OF MIGRANT HEALTH CARE IN THE CZECH REPUBLIC

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The present time is marked by flux in the conceptualization of social relations and the organization of health care. The last couple of decades have witnessed fundamental changes in health insurance systems worldwide. Despite the fact that Western European countries have experienced an unexpected number of problems with their systems of social insurance combined with the private sector, the post-communist countries have largely followed the suit of adopting private-sector reforms to their formerly socialist health care systems while keeping the concept of national health care. However, the private health care policies adopted by some of the post-socialist governments directly breach basic human rights and are in conflict with the current EU non-discriminatory principle of foreign law. They are, in fact, conceptualized as primary boosters not for private but for national economies. In the Czech Republic this tendency is played out by state policies towards migrants from non-EU countries. While general health insurance is available to all EU citizens and migrants with permanent residency, migrants from non-EU countries who do not have the status of an employee or who are students not covered by international agreements are excluded from participation in the Czech national health care system. Drawing on the author's ethnography carried out among Russian-speaking migrant parents living in the Czech Republic and on case studies and information gathered by the Consortium of Migrants Assisting Organizations in the Czech Republic (of whom the author is a member), this contribution opens a crucial debate on the process of individual responsibility for health becoming enmeshed with privatization and commodification of health care based on ethnicity and migrant status.

The phenomenon of migration in the Czech Republic has gained a new significance since the change of the political regime in 1989. In 2012 the Czech Statistical Office registered close to 438,000 foreigners in the country. Only

about 160,000 migrants come from EU member states.[1] This means that approximately 64% of all migrants come from countries outside the EU – the so-called third nations. About half of these people are migrants with permanent residency and their number has remained relatively stable over the past several years. The rest are foreigners with a long-term residency visa – a population that is growing annually. Therefore, the socio-economic and cultural integration of this pool of migrants has been one of the major focuses of immigration policies. The integration policy in the Czech Republic has gone through three stages that have some bearing on the development of the migrant health care policies. According to Baršová and Barša's analysis (2005: 231–237), the first stage (1990–1998) spurred out of socio-political changes in Europe when the Czech Republic repatriated some 1,800 Volynian Czechs in the years 1991–1993 from the Ukrainian and Belorussian areas, especially those affected by the Chernobyl nuclear power plant explosion of 1986 on the Ukrainian side. The second stage also included the period of the Bosnian War (1992–1995) when close to 11,000 people found temporary refuge in the Czech Republic. Consequently this stage was marked by providing immediate medical assistance to the Bosnian and Herzegovinian refugees and victims of war as well as temporary housing, courses in the Czech language and orienteering in the Czech Republic. This period was formative for the later creation of bilateral agreements including state-covered health care for citizens of selected countries. For example, people from the former Yugoslavia who currently reside in the Czech Republic can participate in the national health care system even though the country is not part of the EU.

It was not until the second stage (1999–2003) that a more holistic integration strategy on the governmental level was formed, including more specific roles of individual ministries and state departments. For the first time in the post-communist era state funds were allocated to the building of the non-profit, non-governmental sector and the first NNOs were founded. The government approved a seminal document defining the principles of the integration policy for the Czech Republic.[2] These principles were further developed in the official *Conception for Migrant Integration in the Czech Republic* that was passed in 2002. The Conception defines the specific measures in all the areas of integration

1 Czech Statistical Office. 2013. *Foreigners in the Czech Republic* 26–63.

2 The document is titled *Zásady koncepce integrace cizinců na území České republiky/ Principles of the Conception for Migrant Integration in the Czech Republic*.

(i.e., residency status, citizenship eligibility, migrant political participation, employment and entrepreneurship, social welfare and health care insurance, education, minority rights, and preservation of distinct traditions).

The third stage (2004–present) saw the incorporation of an additional factor into the integration policy – the European Union guidelines that were approved in 2006 as part of an amendment of the 1999 Immigration Law. This process encouraged a more systematic approach to immigration issues and several strategic documents were passed by the government targeting the most pressing issues identified recently as well as during the previous stages (Dorůžková 2007: 31–32). For instance a large-scale study titled Analysis of the socio-economic status of long-term residency foreigners was initiated, as well as updating of the 2002 *Conception for Migrant Integration in the Czech Republic*. The updated version of the Conception version included a section calling for improvement in areas of failing integration practices (Jelínková 2006). One of the major areas listed in Czech governmental Resolution #126 of the year 2005 was the inability of third-country nationals to participate in the Czech public health care system, including migrants' family members and children. In August 2008, the Czech Ministry of Interior assumed back the responsibility for coordination of realization of the updated Conception overtaking the role of the Ministry of Labor and Social Affairs (note: the Ministry of Interior originally handled immigration policies but the Ministry of Labor and Social Affairs was appointed to take over the responsibility in the 1990s) and synchronize the process of integration policies among NNOs and all appropriate departments within the Ministry of Education, Youth, and Sports, Ministry of Regional Development, Ministry of Culture, Ministry of Commerce and Industry, and Ministry of Health. All departments are to abide by the principle of so-called *integration mainstreaming*, which is a policy approved in the third integration stage requiring that each department's policies, regulations, and measures need to be evaluated in terms of their potential impact on the integration of foreigners. This goal, however, remains highly underachieved and so far is mere lip service paid in order to satisfy the EU's standards in migrant integration policy. The case of migrant exclusion from the state policy of public health care access stands out as a striking example of integration mainstreaming failure.

The integration mainstreaming has been adopted to prop up the harmonization of EU priorities with domestic socio-economic needs. In relation to the domestic interests, one of the roles that migration was assigned by long-term governmental planning is to balance out the Czech demographic structure in

terms of its ageing population, due to which the state will inevitably struggle with ensuring a large enough number of working people actively contributing to the national social security system in the near future (Horáková 2005). Additionally, since 2000 the Czech government has announced its intention to increase the numbers of migrants with higher and/or specialized education. In order to achieve this goal, the process of making amendments to the current immigration policy especially needs to focus on migrants in active age with an interest in staying in the Czech Republic. This involves people applying for citizenship and having or applying for permanent residency and a long-term residence permit (for 12 months and longer). As migrants from the other EU states have basically the same rights to employment and residency as Czech citizens, they are not typically included in integration policies, like asylum applicants, whose situation is regulated by the State Integration Program, which complies with the EU provisions and unlike the regular integration programs it includes state funding for housing. While the state recognizes that the targeted group are long-term residency non-EU migrants and has come up with the Four Prioritized Areas of Integration for them – including (a) Czech language proficiency, (b) economic self-sufficiency, (c) socio-cultural self-sufficiency, and (d) integration into the mainstream society – it is not making adequate pragmatic steps to achieve them. The following text that analyzes the impact of excluding people that belong to the most vulnerable population groups in the state from the national public health care highlights the prominent gaps between theory and practice in Czech migration integration policy that characterizes the status quo in this area.

Having valid health insurance is one of the preconditions of being eligible for a long-term or permanent-residency permit. Upon request by the foreign police and associated law enforcement officials, every foreigner in the Czech Republic is required to present his/her current health care coverage at any time during the stay in the country. This requirement is fulfilled either by obtaining national health insurance or commercial health care coverage. In addition, the (emergency) commercial health care coverage must be purchased from one of the Czech-Republic-based private companies.[3] Which one of the two types of

[3] This law amendment was passed by the Czech government in 2009 and clearly reflects Czech commercial insurance companies' self-interest in gaining a monopoly in the sector of selling commercial emergency health care coverage equaling travel health care coverage. The argument given for passing the amendment was that foreigners often buy travel insurance abroad from unreliable or fake companies and in case of accident and need to use the insurance no or limited expenses are covered for Czech hospitals.

health cares is accessible to a migrant solely depends on his/her residential and employment status. One can participate in public health care only if he/she is a resident of another EU country, or if he/she has already obtained permanent residency. The other criterion of eligibility for national insurance is being employed by a Czech employer. In all other cases migrants have to purchase commercial coverage. This means that equal rights to access public heath care are applied only to Czech and EU residents and their family members. Third-country nationals who are not employed by a Czech company or institution can stay in the country legally only if they become clients of one of the private health insurance companies, which are currently represented by six main players who monopolize the Czech field of private health insurance – PVZP a.s., Uniqa a.s., ERGO a.s., Slavia a.s., Axa Assistance a.s., and Maxima a.s. In practice those who are left with only this choice are all third-country nationals who are self-employed, entrepreneurs, or study in Czech or attend Czech-based schools. Most importantly, this group includes all family members who often come to the country under the "Family Reunification Act" and are dependent on one bread winner in the family. Typically these are wives and children of current or former guest workers, teachers, artists, scientists, or small business owners. The majority of them come from Vietnam (as the Vietnamese have the largest network of self-employed foreigners in the country), Ukraine, Russia, Moldavia, Mongolia, China, Kazakhstan, Belorussia, and the United States.[4] A selection of foreign countries benefit from bilateral agreements thanks to which residents from these countries fall under a special governmental program covering their health care. These include quite numerous migrants from Bosnia and Herzegovina, Serbia, Croatia, and other former Yugoslavian countries whose residents form rather miniscule groups in the Czech Republic, also Japan, Israel, or Turkey. While statistical data on the number of migrants depending on commercial health insurance coverage are scarce and inconsistent, the figures provided by VZP ČR (the largest national and commercial health insurance company in the country) in 2007 and by the Czech Statistical Office in 2008 were 100,000 – 130,000 people. The most recent figure stated by Hnilicová and collective in the Analysis of Commercial Health Insurance for Foreigners written for the Committee for Migrants' Rights is 100,000 people (Hnilicová et al. 2012: 6).

4 Czech Statistical Office. 2010. *Foreigners in the Czech Republic* 32–35.

While the requirement of mandatory commercial health insurance can be met by the purchase of two sorts of coverage neither of them is conducive to the larger governmental goal of creating viable living conditions for migrants interested in permanent residency and/or migrants with higher and/or specialized education nor are they meeting any of the Four Prioritized Areas of Integration. Instead of promoting socio-economic self-sufficiency they turn dependent family members into an economic burden on those family members who are legally employed or discourage them from participating in the benefits of the Family Reunification Act altogether, especially if a family is presented with no choice but to shell out dozens of thousands of Czech crowns to buy basic health insurance for two or more children. Instead of creating a deeper sentiment of belonging, the current immigrant health care provision divides Czech society into segments where Czech and EU citizens enjoy first class citizenship, employed third-country migrants are second class and their unemployed family members are third class citizens. The first type of commercial insurance is so-called *complex health coverage* that is currently provided only by the PVZP company (a commercial wing of the main national health insurance company VZP ČR). This insurance is costly and can be afforded by a small percentage of migrants. For example, a 36-year old Russian mother interviewed for this study who came to Prague with her husband six years ago from Kazakhstan and who was pays 38,000 CZK every two years for her six-year-old son to ensure he has complex health care coverage. From her first marriage she has a 19-year-old son for whom the family can afford to pay only *emergency health care coverage* that is about 25,000 CZK for two years: "When my older son came down with a viral infection the other month," the young mother shared, "the doctor told him that there was nothing he could do for him (unless he paid for the visit out of pocket). Luckily I came down with the virus first and have better health coverage, so I gave him my antibiotics and finished treating my strep throat during our summer vacation back in Kazakhstan where one can buy antibiotics over the counter." She smiles: "It is very easy to buy antibiotics in the former Soviet Union. People bring dozens of boxes with drugs with them here."

Not everyone can afford to buy complex health coverage for all members of their family. Rather than making a personal choice, people are often left with no other option but to buy just emergency health care coverage and when they are hospitalized with cases of chronic disease complications they are forced to leave large debts with the hospitals. In recent years the total annual debt

made by the inability to cover the costs of health care as well as by commercial insurance companies' refusal to compensate hospitals for their health service despite initial approval to go ahead with the treatment,[5] amounts to 8% (about 44 million CZK) of all cost of migrant health care on average (e.g., 10.4% in 2007, 7.9% in 2008, 8.5 in 2009, and 6.9% in 2010).[6] A part of this amount is legally mandated treatment of patients with serious infectious diseases, such as TB and STDs.[7] The commercial insurance companies have the right to decline any client and typically they do not insure (or only partly) a person with a severe chronic disease or somebody suffering from a condition that is likely to progress. Thus a refusal on the basis of pre-existing conditions is a common practice and a source of producing a pool of so-called "uninsurable migrants," who are often children, single parents, or persons who suddenly lost their job. Once migrant parents cannot afford to purchase health insurance for one or more of their children or they are denied by the commercial company, they are faced with the complicated decision either to stay and risk the illegal status of their child/children or leave the country – whether to relocate the entire family or split its family members. Another precarious type of situation in which migrant parents can find themselves is when they have a prematurely born child or the child is born with defect. The social and economic impact of such a discriminatory policy is illustrated by the narrative recorded by Ukrainian parents:

> "Our son was born prematurely by several weeks. He had to be placed in an incubator in one of the Prague hospitals. We wanted to sign a contract with the PVZP health insurance company to cover his health care. The company refused and told us they were not in a position to pick up the cost of his probably demanding health care. The hospital bill grew by each day our son was in the Prague hospital amounting to a total of 1,386,000 Czech crowns. We paid all we could but are in no position to cover this expense. I turned for help to several non-governmental and humanitarian organizations. Some of them had no advice for us, but one lady eventually told us to apply for long-term residency for our son for humanitarian reasons. After long months of stress and fear of having to move out of the country and being persecuted we obtained it. The hospital, however, has just sued our son for the unpaid expenses .... "

5 Hnilicová, Helena and Karolína Dobiášová. 2009. "Zpráva o stavu zdraví a zdravotní péči pro migranty v ČR", p. 14-16, www.zdravotnípojistenimigrantu.cz.

6 Czech Statistical Office. 2008-2001. *Foreigners in the Czech Republic* (Chapter 6).

7 The *Act about Public Health Protection #205* and *#258/2000*.

Besides the threat of being refused coverage because of pre-existing conditions, commercial coverage – including the complex type – does not cover relatively frequent health conditions with which patients can lead an active life provided that they have access to quality health care. These include diabetes with insulin treatment or hemodialysis to name the more frequent ones, but also HIV and AIDS treatment (unless contracted or discovered in the country – then the treatment is mandated and covered by the state). The standard list of covered procedures typically excluded therapies in any kind of specialized medical institute or sanatorium, which means that institutional therapeutic programs for people with depression or substance abuse problems are exclusively marked off for Czech and EU citizens only. The commercial complex health care packages include some psychotherapeutic treatment but only when provided by regular hospitals. The burden of complying with the requirement of commercial health care is further deepened by the fact that most agreements between the company and a client are signed at least for one but more frequently for two years, which means paying at least 26,000 crowns for one family member for only emergency health care coverage (for the duration of two years). The insurance companies require the payment of the entire premium at once upon signing the contract. The network of doctors contracting with the six commercial insurance companies is very small and migrants are thus limited in their choices and forced to seek out and contact a suitable doctor ahead of time, in fact, as a kind of preventive measure in case of possible accident or illness. This creates an environment open to corruption on behalf of the relatively few doctors who "take foreigners." A Russian-speaking entrepreneur from Kazakhstan shared her personal experience on this theme:

> "When I was pregnant and needed to enroll with a doctor for prenatal care, the man who was recommended to me by friends, because he was Russian, worked in Motol hospital. He smiled and said that he could take me on for 1,000 CZK paid in cash to him for each visit on top of my health coverage. He said that I needed to know that he had a large clientele and did not take everybody!"

When asked whether she agreed to pay the Motol obstetrician the regular extra "fee," she replied:

> "Yes, at the beginning I paid this money. A couple of visits. Then I needed to travel back to Kazakhstan and I needed a medical certificate that I was all right to travel.

> I was seven months pregnant and wanted to make sure I was okay to do it. I called him to make an appointment. He told me that I did not need to come in at all, that his nurse would give me the certificate upon payment ... of the 1,000 CZK. Then I decided to change doctors. I found a Czech doctor who spoke Russian. He had his clinic outside of Prague but that was OK. He did not ask for any extra "fees" but our agreement was that he was the one to deliver the baby and his private clinic was going to be paid $1,000 for the birth. It was part of the contract we made (Note: The interviewed mother had relatively luxurious PVZP health coverage where her husband paid $2,000 for a special pregnancy program on top of the regular PVZP fees). When I was close to my due date he needed to travel abroad for a holiday. To speed up the due date he painted this black scenario of what all can happen during vaginal birth and I got so scared that I agreed to have a .... what do you call it? ... C-section."

Two of her friends had a similar experience with paying their gynecologists this "personal bonus." In one case a Czech female doctor in Prague 5 charged 500 CZK that went directly to her pocket and similarly a Czech female gynecologist in Prague 1 asked for 600 CZK each visit without providing her Russian client from Kazakhstan with any receipt. The growing numbers of similar narratives illustrate the social and economic negative consequences of excluding a group of people from the public health care system. While the profit of commercial insurance companies grows by astronomic figures (for instance, in 2010 PVZP collected 56 million CZK more in insurance premiums than in the previous year[8]; the total sum collected from selling commercial insurance grew between the years 2008 and 2011 from approximately 200 billion CZK to 450 billion CZK), the growth of the extent of the coverage reflects a disproportionately miniscule change (the costs that the PVZP insurance company had to pay annually grew only from 6% to 10% of the collected sum between the years 2008 and 2011) (Hnilicová et al. 2012: 29–37). More importantly, the policy clearly produces a social and economic hierarchy of higher and lower class foreigners, rendering EU migrants as worthy of stress-free participation in national health care while using non-EU migrants as a source of income and support for the national health care system while barring them from its benefits. This is carried out in a publicly open way when the 2010 Annual Report of the PVZP company cites the Head of the Board of Directors stating that the 2010

8 Annual Report of PVZP a.s. 2010. *Commercial Activities*, p. 8.

"historically most successful" monetary gain is thanks to "insuring foreigners".[9] A portion of the PVZP income is periodically allocated back to public insurance pool of the VZP ČR's capital. The discriminatory policy of the requirement to purchase commercial health insurance is in direct conflict with the previously mentioned principle of integration mainstreaming approved by the Czech government during the third integration stage. It was no later than in 2005 that the updated *Conception for Migrant Integration in the Czech Republic* identified the inability to participate in the national public health care system as one of the principle obstacles in the process of socio-economic integration of third-country nationals.[10] The governmental resolution in which this identification was made also appointed the Czech Ministry of Health to formulate recommendations for a legislative change that would allow children and youth under 18 and self-employed migrants who are holders of a long-term residency visa to participate in the public health care system. The data for the recommendation were to be gathered in collaboration with the Institute of Health Policy and Economy founded during the second integration stage in 2000. However, the Institute was closed down by the decision of the Ministry of Health's leadership (lead by David Rath at the time) and up to this date the criteria of migrant eligibility to enroll in the Czech national health system remain the same.

In June 2014 a group of deputies of the Czech Republic lead by Jaroslav Krákora submitted a proposal for a new amendment to the existing law of mandatory commercial insurance (Krákora et al. 2014) that is highly controversial and adamantly resisted by the Consortium of Migrants Assisting Organizations in the Czech Republic and other institutions. While it calls for commercial insurance companies' acceptance of migrant clients to be obligatory, the opponents state that this obligation can be easily avoided by asking for high premiums that migrants will simply not be able to pay. The opponents are further concerned about the proposal to extend the ability of insurance companies to define exceptional cases in which they have the right to refuse to compensate health-related costs and to establish a minimum annual insurance premium paid by migrants to be 25,000 CZK per person (Čižinský 2014). This, they rightfully claim, may yield existential catastrophes for migrant families with multiple children and lower income. At the time of publishing this article, the jury is out on whether or not the bill will pass. The development can be followed at

9 Annual Report of PVZP a.s. 2010. *Commercial Activities*, p. 8.

10 Resolution of the Government of the Czech Republic # 126/2006.

the web page of the Consortium of Migrants Assisting Organizations in the Czech Republic specially made for the campaign for equality in migrant health care: www.zdravotnipojitenimigrantu.cz. All in all, the history of the medical health care system for migrants coming to the Czech Republic from non-EU countries serves as a point in the social science call for the need to deconstruct market-based medicine by dissecting assumptions about international heath care, risks, choices, and responsibilities that undergird the insurance industry. Only through such a process can we determine how the inefficiencies and inequalities of market economy-based medical care are created and reproduced. With the increasing numbers of migrants worldwide and within the EU region every year, the need to evaluate how old and new social and political disparities in quality health care access are enacted becomes essential.

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References

Baršová, Andrea and Pavel Barša. 2005. *Přistěhovalectví a liberální stát. Imigrační a integrační politiky v USA, západní Evropě a Česku*. Brno: Masarykova Univerzita v Brně

Čižinský, Pavel. 2014. Připomínky k poslaneckému návrhu Zákon o soukromém zdravotním pojištění cizinců – Sněmovní tisk 243. Praha, [online]. Available at: http://migraceonline.cz/cz/e-knihovna/poslanci-predlozili-navrh-zakona-o-zdravotnim-pojisteni-migrantu-nahravaji-tak-komercnim-pojistovnam

Dorůžková, Lucie. 2007. *Vzdělávání dětí cizinců na základních školách v České republice* (diplomová práce). Praha: Katedra veřejné a sociální politiky FSV UK.

Jelínková, Marie. 2006. *Koncepce integračních politik* (diplomová práce). Praha: Katedra veřejné a sociální politiky FSV UK.

Hnilicová, Helena et al. 2012. "Analýza komerčního zdravotního pojištění cizinců." [online] Available at: www.zdravotnipojistenimigrantu.cz

Hnilicová, Helena and Karolína Dobiášová. 2009. "Zpráva o stavu zdraví a zdravotní péči pro migranty v ČR." Pp. 14-16 [online]. Available at: www.zdravotni-pojistenimigrantu.cz

Horáková, Milada. 2005. *Proměny trhu práce v České republice po roce 1989 se zřetelem na pracovní migraci*. Praha: Výzkumný ústav práce a sociálních věcí.

Krákora, Jaroslav et al. 2014. Zákon o soukromém zdravotním pojištění cizinců na území České republiky a o změně zákona č. 326/1999 Sb., o pobytu cizinců na území České republiky a o změně některých zákonů. Praha: Sněmovní tisk 243/0, část č. 1/4 [online]. Available at: http://www.psp.cz/sqw/text/tiskt.sqw?O=7&CT=243&CT1=0