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Slovak Reform of Health Care: From Fees to Systemic Changes

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Although most of the reform changes do not have clear winners in the short term (direct expenditures by patients are increasing, while revenues of strong interest groups are declining), many partial steps bring forth almost immediate palpable improvements that are important for gaining and maintaining trust of the society. Typical for its fast commercialization of the sector, Slovakia's health care reform draws the attention of other countries.

In this paper we briefly describe initial conditions of the reform, its reasons, a brief theoretical background, stabilization measures adopted and systemic measures proposed. In the conclusion we offer an assessment of the early impacts of the reform, and experience of its makers.

1. Introduction

1.1 Allocation of Health Care Resources

Every society decides how much of its scarce resources shall be allocated to providing health care. OECD countries spend on average 8.4 % of their GDPs (OECD, 2003a) on health care, of which 72 % constitute public expenditures. Slovak health care expenditure in the volume of 7.0 % of the GDP is lower compared to the OECD average, yet higher than the average of the seven new EU member states at 6.7 % of their GDPs.¹ The situation gets worse when it comes to utilizing private resources: while in Slovakia these constitute only 11 % of the overall costs, in other new EU states it is as much as 27 % (*Figure 1*). Since health care expenditures in general grow faster than GDP,² it seems obvious that maintaining the current ra-

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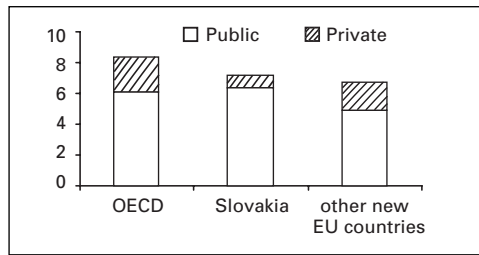
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¹ Seven new EU member countries on average spend 6.7 % of their GDPs, of which 73 % are from public sources (the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland and Slovenia). EU-15 states spend on average 8.1 % of GDPs, of which 78 % come from public sources. (World Health Organization, 2003).

² Average health care costs in OECD reached 7.3 % GDP in 1990 and 8.4 % in 2001. Average annual GDP growth in 1989–99 was 2.0 %, while average health expenditure growth reached 3.3 %. In 1999–2001, the trend was even more distinct: 2.5 % GDP growth and 4.0 % health care expenditure growth (OECD, 2003b).

FIGURE 1 Total Health Care Expenditures (in % of GDP)



Source: (OECD, 2003a)

tio between public and private resources would result in cutting funds for other public services.

The goal of the health care policy is the fair and financially sustainable distribution of health services. Fair distribution is considered to be either a mechanism that would provide health care to everyone according to his or her income, or such that would provide care according to everyone's needs. A mechanism is considered financially sustainable provided it respects given budget constraints, does not create conditions for the systematic accumulation of debt, and complies with priorities of citizens.

Setting social priorities in health care is complicated in the political, technical and ethical aspect; however, the principal complication is the presence of strong interest groups in the system. Defining publicly-funded diagnoses (diseases) could be approached from three different angles:

1. According to the seriousness of the disease (e.g. the Oregon Model)
2. According to the urgency of the need to provide health care (see e.g. the system of waiting lists as in the United Kingdom)
3. According to the age of the patient (see e.g. (Callahan, 1994))

In the first system, diagnoses are listed according to their seriousness, social priority or economical requirements – there is a list of priority diagnoses. Patients pay for those diagnoses that are not funded by public sources. Fairness of the system is based on the guarantee of equal care for equal needs, and different care for different needs. The system supports high solidarity with chronic, financially demanding or uninsurable diseases. On the other hand, in less severe diseases the responsibility is transferred directly to the patients.

In the second system, waiting lists are created. Urgent cases are treated first, based on the availability of public funds. This system was unofficially in place in Slovakia. Its serious drawback is the piling up of unperformed procedures, meaning the system is financially unsustainable. As for fairness, the system is easily manipulated by corruption and unclear rules for making placements on the lists.

The third system differentiates according to the age of the patient and assumes various packages for different age groups of citizens. From an ethical point of view it is based on the assumption that in every age of life, one is entitled to a different health care package, while health care-related costs increase with age. The principle of age-based packages presumes that the ex-

TABLE 1 Mean Life Expectancy and Average Growth in Mean Life Expectancy per annum

		1960	1970	1980	1990	2001	2002
Mean life expectancy at birth	males	67.70	66.73	66.75	66.64	69.51	69.86
	females	72.47	72.92	74.25	75.44	77.54	77.63
Average growth in mean life expectancy per annum	males	..	-0.10	0.00	-0.01	0.29	0.03
	females	..	0.05	0.13	0.12	0.21	0.01

Source: (Statistical Yearbook of the Slovak Republic 2003)

tent of fully reimbursed health care decreases with age, and focuses more on symptomatic treatment than on removing the cause of the disease. There is a high level of fairness of health care distribution, since everyone who lived into old age lived so long thanks to health care provided in their youth, when one was fully entitled to health care reimbursements. This system is also supported by the utilitarianism principle that prefers higher health-related benefits calculated as years lived in full health. It thus prefers saving a younger life over an older life.

2. Expectations and Options: Reasons for the Reform

The socialist health care system offered its services free of charge. However, patients were constantly under-treated and deprived of the latest advances in pharmacological technologies, diagnostics and treatment. A network of physically available, yet inefficient hospitals was built. Excess demand was balanced by nepotism and corruption.

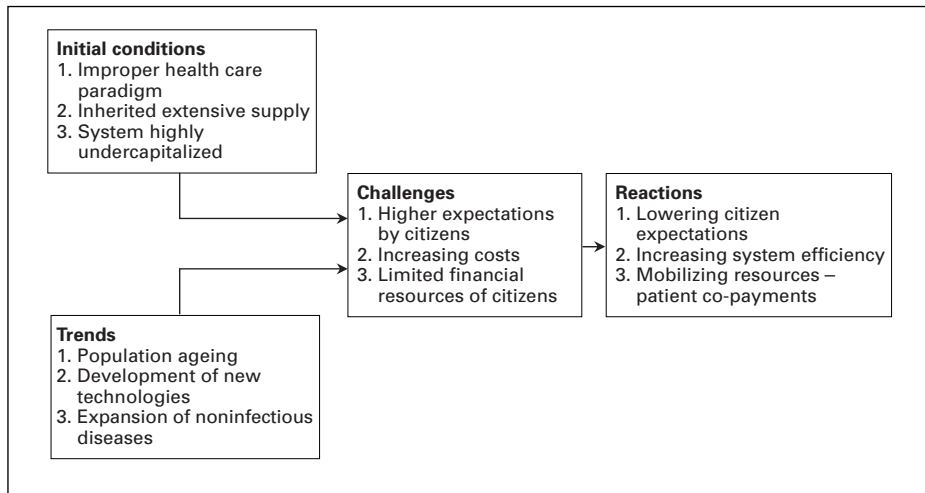
At the present time, treatment in Slovakia has already become more effective. This is shown by a significant growth in the mean life expectancy (*Table 1*): over 1990–2002, the annual growth was 0.18 years for females (in 1960–90 only 0.10 years annually) and 0.27 years for males (previously -0.04 years annually).

This improvement was driven mainly by increased expenditures on new technologies and pharmaceuticals, because no significant structural changes on the supply side of the system happened in 1990–2001. Nobody had the courage to change the inefficient structure of the supply and relationships within the system (Pažitný – Zajac, 2001), (Pažitný – Zajac, 2002). The inherited structure of the health care system has, however, become financially unsustainable, due to the ageing of population, spreading of non-infectious³ and chronic diseases, the development of new, more expensive technologies, and increasing expectations of patients. The reform thus became unavoidable.

Thanks to the wide extent of free health care – *Scheme 1* – excess of the demand was induced by existing capacity on the supply side, while

³ Noninfectious diseases such as cardiovascular (53 % in Slovakia) and oncological (23 %) diseases. According to the World Bank (2003), Slovakia is increasingly less capable of managing health-related problems of industrialized countries.

SCHEME 1 Position of Political Decisions in Health Care System Reform



Source: according to (Pažitný – Zajac, 2002)

the demand as well as the supply exceeded available resources (Evans, 2001):

$$\text{SUPPLY} > \text{FINANCIAL RESOURCES} < \text{DEMAND}$$

The health care system used to pride itself for providing a high level of equality in access to care, which was, furthermore, delivered for free. In reality, none of these were true. Disequilibrium on the market was corrected by corruption and nepotism, which further deepened inequalities (OECD, 2002b). On the level of the system, no charges to patients resulted in increasing debts (*Table 2*) and prolonging waiting periods.

If public finances are not capable of covering the actual costs of health care, it is possible to react on the revenue side by increasing private financing (co-payments by patients via private insurance and cash payments), on the supply side by increasing system efficiency, and on the demand side by lowering expectations, patients have from the publicly financed the health care system.

Politically, a health care system reform is a complex issue because in the short-term there are no clear winners: patients lose free health care, providers of health care are deprived of soft budget constraints, and producers of technologies and pharmaceuticals lose part of their market.

3. The Slovak Health Care Reform

The reform aims to lower the expectations of citizens associated with the health care system, and to strengthen their responsibility for their own health. From the public finance perspective, it means the introduction of

TABLE 2 Economic Position of the Health Care System

	1997	1998	1999	2000	2001	2002	2003 ^e	2004 ^f	2005 ^f
Revenues (% GDP)	7.0	6.9	6.4	6.4	6.4	6.4	6.3	6.4	6.6
Expenditures (% GDP)	7.6	7.6	6.9	7.3	7.3	7.0	6.7	6.5	6.6
Deficit (% GDP)	-0.6	-0.7	-0.5	-0.9	-0.9	-0.6	-0.4	-0.1	0.0
Debt (SKK billion)									
Sources from privatization				3.5	3.4	3.6	3.4	0.0	0.0
One-time settling of debts								13.8	14.8
New debts	4.2	5.6	4.4	4.4	4.2	3.1	0.0	-11.8	-14.8
Debt, cumulative (SKK billion)									
Sources from privatization				3.5	6.9	10.5	13.9	13.9	13.9
One-time settling of debts								13.8	28.6
Debt Total	4.9	10.5	14.9	19.3	23.5	26.6	26.6	14.8	0.0

Source: Ministry of Finance of SR; Ministry of Health of SR; calculations by authors

Notes: Revenues and expenditures in 2004 and 2005 reach relatively lower shares of GDP also thanks to a high growth rate of Slovak economy. We expect that in the longer term, revenues and expenditures shall return to the 7 % of GDP level. (^e = expectations; ^f = forecast)

a clearly defined system in three categories: fully covered, partially covered and non-covered health care.

The reform is based on the following assumptions:

- *Moral hazard*. Free health care discourages clients from investing in their health. A health care system can influence the health status of the population by only one quarter. Further factors include lifestyle, biological factors (genetics) and the environment. Patients must take care of their health by themselves.⁴
- *The present coverage of care is not sustainable*. There is a significant financial imbalance in the system (both the demand and supply exceed available resources). The consequences are the accumulation of debts, compromised quality and growth of corruption.
- *Soft budget constraints dominate the system*. The government guarantees the solvency of health care insurance companies and providers. Bailouts proved inefficient.⁵ There is over-employment of health care personnel.⁶ The system lacks competition and the private sector is discriminated.
- *The whole sector is managed by physicians*. Thus utilizing even basic management tools like strategic management, change management, financial and economical planning, and health care technology management is still quite rare (The World Bank, 2001).
- *There are logical errors in the system*. For instance, a physician is obliged to provide health care, a citizen has the right to receive it free of charge, yet an insurer is not obliged to pay for it.⁷

⁴ To compare, in Slovak survey 61 % agreed with this, yet as many as 35 % respondents claimed that the state and the Ministry of Health should take care of their health (Focus, 2004).

⁵ See also (OECD, 2002a).

⁶ High number of physicians is not only a burden for the health care system, but it also presents a risk of driving artificial demand (The World Bank, 2002).

– *The system is unable to react to the changing structure of diseases.*

The goals of the reform are:

- Creating an environment supportive to incentive mechanisms to improving the health of the population. Increasing the safety of treatment and trust of patients in the health care system.
 - Position of the state shifts from a health care services producer, a price maker, a network manager and a distributor of finances to the position of a regulator.
 - A patient, as an individual owner of a health commodity, takes over higher responsibility for her or his own health status, including covering some prevention as well as treatment costs.
 - The provider takes over higher responsibility for correct provision and quality of health care, including the possible risk of penalties.
 - A health care insurer takes over responsibility especially for the management of patients within the system, and solvency in purchasing health care complying with hard budget constraints, with the risk of facing bankruptcy.
- Maintaining balanced financing of the health care system.
- Increasing the flexibility of the health care system that would respond to the needs of citizens, changing environment, shifts in structures of diseases, and technological progress.
- Providing financial protection of individuals from so-called catastrophic expenses on health care.

The reform consists of stabilizing and systemic measures:

- The goal of the stabilizing measures is to stop the accumulation of debts and limit excessive consumption of health care services and pharmaceuticals. While the annual number of physician consultations in OECD countries was 5.6, the number in Slovakia was 9.2.⁸ According to estimates by the Slovak Ministry of Health, 41 tons of prescribed and unused drugs are wasted each year.
- The goal of systemic measures is to create a new system for providing health care that would be fair and financially sustainable.

3.1 Stabilizing Measures

Stabilizing measures consisted of introducing fees, changes in pharmaceutical policies and pilot projects of hospital restructuring. To start any changes it was first of all necessary to create a modern definition of the term “health care” and define relevant services (food, lodging and transportation).

The second new element was the introduction of payments for physician consultations, for issuing prescriptions, and providing related services starting on June 1, 2003. This step increases the responsibility of patients for

⁷ For instance, excessive number of patients for specialists, or not contracted surgeries of in-patients.

⁸ The OECD figure is for 2000 (OECD, 2003b). The Slovak figure is an estimate based on the number of visits by out-patients covered by the General Health Care Insurance in 2003.

TABLE 3 Estimated Efficiency of Stabilizing Measures in 2003 (in SKK billion)

Measure	Effective	Estimate of Savings in 2003
Decentralization and establishment of NGOs	January	1.3
New definition of health care and introducing fees for physician consultations and pharmaceuticals	June	2.3
Introducing amendments to contracts of hospital directors	October	0.1
Restructuring hospitals in Bratislava and Košice	October	0.1
Pharmaceutical policy	November	0.2
Total		4.0

Source: (Slovak Republic Ministry of Health, 2003)

their own health by financial co-payment⁹, and is not intended to secure additional resources into the system. Payments are of a symbolic nature (SKK 20 per physician consultation and SKK 50 per one day stay in a hospital), while certain groups of patients are exempt. Poor patients first paid lower fees; however, this proved to be administratively complicated; exemptions were thus canceled and the poor receive a monthly contribution for health care of SKK 50 per household member to compensate for health expenses.

The third stabilizing measure focused on pharmaceutical policy changed composition of the categorizing commission and definition of pharmaceuticals (these are currently defined based on active ingredients in 122 anatomic and therapeutic groups), and fixed the portion of the cost paid by patients for partially reimbursed drugs. New administrative procedures of the categorizing commission increased transparency, standards and flexibility in the pharmaceutical policy.

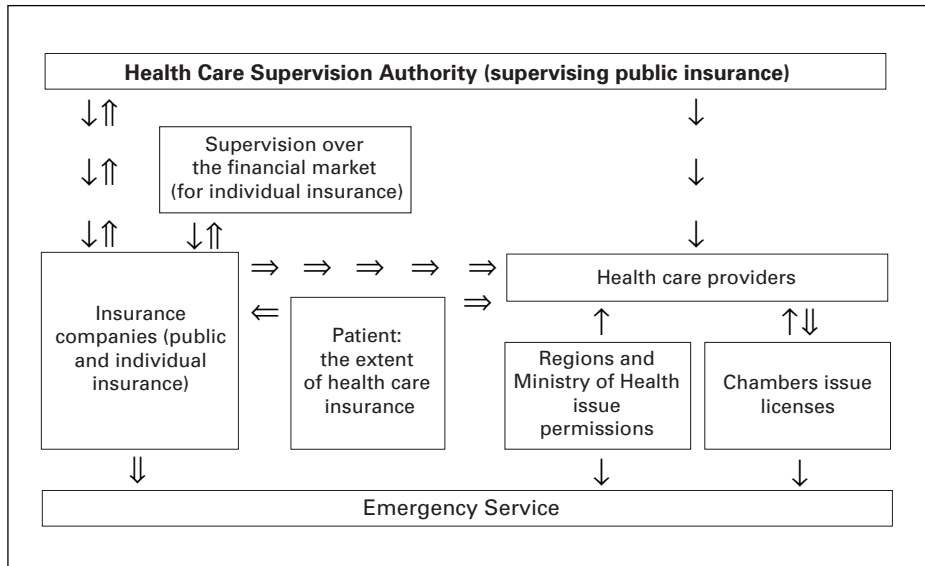
De-nationalization of selected hospitals (by their decentralization) made their restructuring faster. At the same time, big hospital complexes in two large cities Bratislava and Košice were consolidated, resulting in the sale of several buildings. The Ministry expects the stabilizing measures to bring an annual savings of SKK 4 billion, especially by reducing induced excessive demand (*Table 3*).

3.2 Systemic Measures

The goal of systemic (or concept-focused) measures is to create a new system of providing health care, fair in distributing health care commodities and financially sustainable in the long-term. Unlike in other areas of public finances, there is no list of best practices for health care. Therefore, this concept has to be innovatory, and its introduction is being closely watched by many countries.

⁹ The fees work similarly like co-payments in any other insurance to reduce the risk of moral hazard. In future, significant incentives to patients could be provided by declining contribution load. Some social groups and diagnoses are exempted (Law Nr. 98/1995).

SCHEME 2 System of Health Care



Explanations: \updownarrow illustrates financial flows, \uparrow illustrates permissions and licenses

The new system contains first of all definitions of insurance, insurance companies, providers, health care, and the basic package of care (*Scheme 2*). The hottest political debate was initiated by the question of constitutional compatibility of the law on the extent of health care covered by public health insurance, and on compensation of services related to the provision of health care.

3.2.1 Health Care Insurance

The basic function of health care insurance is to create a package of resources based on solidarity – this is inevitable to ensure the so-called collective risk: in a great part of the population, insured events have already occurred and they are not insurable under market bases (or insurable for the sum that is equal to costs of treating the disease). Public health care insurance is based on these principles:

- Universality and solidarity. Every citizen has equal access to equal needs, and is entitled to have the need satisfied in an equal way regardless of one's social standing or income.
- Financed from public sources that are collected on an obligatory principle and redistributed on the solidarity principle. The Health Care Supervision Authority shall supervise the distribution of the funds. Effective rate of redistribution shall reach 85.5 %.
- Every insured person is guaranteed free choice of the health care insurance company, which cannot refuse insurance to anybody.

BOX 1 Conditions for Development of Individual Health Care Insurance

1. Clear definition of solidarity package financed from public sources.
2. Insurability of risks: an insured event has not happened yet.
3. Wide enough base of diagnoses and insureds to enable good distribution of the risk.

- Contributions of 14 % are linear up to a given ceiling (three times the average wage) and then regressive. The state pays insurance for vulnerable groups of 4 % of average wage.¹⁰
- Introducing contributions paid on the basis of an annual income establishes equality between the self-employed and employees and prevents abuse.
- The environment is competitive for all players on the health care market.

Individual health care insurance allows the reimbursement of treatments that are not paid from public health care insurance (*Box 1*). Individual health care insurance is the product that shall be offered by commercial insurance companies. These will be supervised by the Financial Market Authority.

3.2.2 Health Care Insurance Companies and Supervision Authority

The goal is to introduce hard budget constraints, transparent financial relationships and transfer responsibility for patient management onto health care insurers. Health care insurance is entrusted to licensed entities of private law (joint-stock companies). Profits and its use are a matter of the insurers – however, if there are waiting lists in place, 50 % of the profits must be used for the benefit of those on the waiting list. The state has the option of providing public health care insurance by a public insurance company.

Health care insurance companies (HICs) that provide public health care insurance and health care providers will be supervised by the Health Care Supervision Authority¹¹. The Authority shall be funded by contributions from HICs.

The new legislation is focused on:

- Higher competitiveness and introducing market rules in operation with health care insurance and provision. Currently, health care providers claim finances from HICs for services provided, regardless of their quality, efficiency or competitiveness. Patient management shall bring about

¹⁰ Roughly two fifths of the population (economically active) creates two thirds of resources in the system; while the state creates the remaining one third for the remaining three fifths of people. Growth of employment could help public finances and the health care sector – a 1% employment growth results in a 1.24% increase in insurance revenues.

¹¹ The Authority monitors adherence to public health care insurance standards, and the extent and quality of health care; it shall issue licenses and supervise solvency and performance by insurers. Solvency, i.e. the ratio of own resources of insurance companies and revenues from insurance after redistribution, cannot fall under 3 %. The Authority may issue fines and order a remedy plan, forced administration or liquidation of insurance companies.

- higher competitiveness and change in payment mechanisms – with focus on individual cases, not on services provided.
- The selection of providers, while respecting the minimum network and quality standards, together with introducing more up-to-date payment mechanisms shall be the principal tools of competition. HICs shall not compete in collecting contributions for public insurance, but in the efficient purchasing of health care. We presume that managed care will appear, as well as organizations similar to HMO.
 - Clear rules for handling finances for health care to avoid inefficient and discriminatory behavior of HICs towards health care providers. Non-public HICs are able, under equal legislative conditions and with an identical structure of insured persons, reach balanced budgets.
 - Higher competition of providers that provide insured persons with care ordered by HICs. The performance of providers is currently not influenced by the market, but by the ability of the management to obtain money for operation from HICs – regardless of use of existing capacity, labor efficiency, structure of employees or operating costs.
 - Defining the role of the state which is to formulate the health care policy, to regulate and to control.

3.2.3 Health Care Providers

The goal is to increase the decision-making autonomy and responsibility of health care providers. At the same time, the controlling and supervisory function of the state is strengthened. The new system is based on several principles:

- When licensing, eliminate artificial barriers to entry erected by professional chambers.
- Introduce new types of health care providers, like providers of one-day care, and houses of custodian care.
- Regulate the number, position and tasks of professional organizations in health care. Compulsory registration and membership of all health care professionals in chambers as the condition for practice shall be abandoned. However, at the same time compulsory registration with the Supervisory Authority is being introduced to ensure continuous retention and renewal of professional competence.
- The public network of health care providers shall be defined by insurance companies, and a network of licensed employees by chambers. Providers shall sign contracts directly with HICs that must observe the condition of a minimal availability of health care as for geographic, demographic and other situations.¹² The Supervisory Authority, or other government authorities in the area of health care, shall monitor whether HICs observe the pre-defined minimum number of health care providers.
- There will be contract-based and other providers functioning within the system. While a contract-based provider will settle the cost directly

¹² Minimum availability is defined by the Ministry of Health care in the form of a minimum public network of health care providers.

with HICs and the patient only paying a fixed fee (SKK 20 or 50), other providers will charge costs directly to patients. Following a prior consultation, the patient may ask HICs for reimbursement, but only up to the amount of usual costs.

- The transformation of health care facilities that have existed as contributory state organizations to joint-stock companies. Facilities should be decentralized to municipalities, districts, regions and other entities.

3.2.4 Health Care

Health care is defined as, provided health care, forms of providing health care, rights and obligations resulting from its provision, handling health care records and relevant services. Health care is provided in the correct manner if a correct diagnosis is made without undue delay, and the correct preventive or therapeutic treatment is provided.

3.2.5 Extent of Health Care Covered from Public Health Insurance

The extent proposed is derived from the principle that an insured person has the right to equal care in case of equal needs. Due to the infinite nature of needs it is however necessary to define a certain maximum extent of care – a flexible basic package – based on the list of priorities.¹³

The presently applied “silent” rationing is becoming a serious ethical problem and source of corruption. Decision making is done on a micro-level system, i.e. by physicians. The solution would be to replace it by explicit rationing, i.e. define clear and transparent rules binding for every participant in the system while respecting medical, ethical and economical criteria; while the quality of health care must be maintained.

Definition of priorities is calculated by three mechanisms:

1. The mechanism of defining the priority list of covered diseases. The priority list is a positive list of diagnoses where there is zero co-payment of insured patients and the patient only pays for services connected with the treatment (SKK 20 or 50). Other diagnoses not listed could be co-paid by patients. However, this will only concern the treatment itself, not diagnostics. The list of priority diagnoses shall be adopted by Parliament based on a proposal by the Government.
2. Mechanism of cataloging. All diseases shall be subject to the process of cataloging where they would be assigned a list of interventions fully reimbursed from public health care insurance. Standard diagnostic and therapeutic procedures are thus created. The Catalog shall be compiled by the cataloging commission (predominantly physicians) nominated by the Minister of Health.

¹³ similar to the US state of Oregon, the Netherlands, New Zealand, Sweden and the United Kingdom

TABLE 4 Break-down of Diagnoses to the Priority List and Others (in SKK million)

Area	Diagnoses	Present volume of payments by insurers	% of total cases	% of total costs	% of new payments from public insurance	New volume of payments by HICs	New volume of payments by patients	Average annual payment by patients
I.	Priority	19,990	41	67	100	19,990	0	0
II.	Other	9,989	59	33	0-95	6,992	2,997	SKK 50–200*
	Total	29,979	100	100		26,982	2,997	

Note: * per diagnosis based on complexity

Source: HICs, calculated by the Ministry of Health care and authors

3. Mechanism of categorization. For diseases not listed on the priority list, categorization shall determine the extent of patient co-payment for interventions. The categorizing commission (predominantly economists) shall be nominated by the Minister of Health. The principal goal of the defined criteria for categorizing interventions and pharmaceuticals is to provide the maximum effect under the most efficient conditions.

The list of priority diseases contains approximately 6,700 diagnoses, which is almost two thirds of the total list of diagnoses (11,000) listed in ICD 10¹⁴. Provided constant prices and demand, patients would pay in total almost SKK 3 billion, which creates a market for individual insurance in commercial HICs (*Table 4*). The average co-payment of individually uninsured patients per diagnosis would reach at most SKK 200.

4. Conclusion

Reforming the health care system requires to have a clear concept and to execute a number of detailed steps, the description of which is beyond the scope of this article. Yet even immediate changes in management could lead to substantial savings and improved care. However, any concept could not be successful without the public and subsequently political support. Although the majority of changes do not have clear winners in the short term (direct expenditures by patients are increasing, while revenues of strong interest groups are declining), many partial steps bring forth almost immediate palpable improvements that are important to win and retain the public trust.

The introduction of fees led to a 10% decline in visits to general practitioners, a 13% decline in emergency service calls and a transfer of in-patients from hospitals to other institutions (*Figure 2* and *3*).¹⁵ Regardless of that, the public claims that it visits physicians as frequently as before.¹⁶

¹⁴ International Classification of Diagnoses

¹⁵ Comparison of data from the General Health Care Insurance. Since fees were introduced starting the second half of 2003, we are comparing with the second half of 2002. The number of all out-patient visits declined by 6 % and the number of in-patients in hospitals (and other institutions) by 1 %. When 2003 to 2002 are compared, the drop is 3 % and 1 % respectively.

FIGURE 2 Number of Out-patient Visits

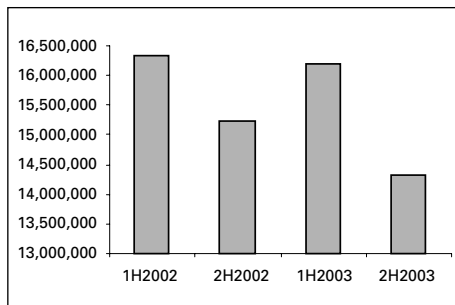
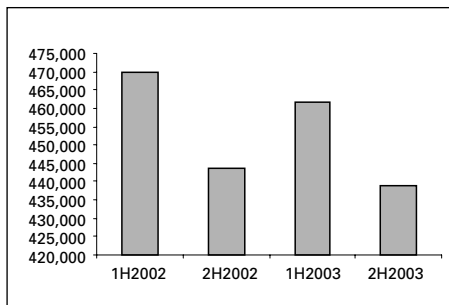


FIGURE 3 Number of Hospitalizations



Source: General Health Care Insurance

This means that minimum fees were able to reduce artificial demand with no negative impact on the vulnerable. The lower number of visits could have also been reflected in higher quality of care. Fees thus started to reduce excessive demand, while concerns about compromised availability of care proved to be unjustified.

The introduction of fees improved cash income of physicians by SKK 7,000–9,000 per month. Payments in hospitals for food and lodging provided patients with incentives to demand higher quality of services. The significant immediate effect is that patients started to feel that health care is not free of charge.¹⁷

Another likely impact of introducing fees was a drop in corruption. While in November 2002 as many as 32 % of respondents associated health care with corruption, in January 2004 it was only 10 %.¹⁸ There was a drop in the frequency of providing bribes and gifts – to specialists from 18 % in summer 2002 to 14 % in the autumn 2003, and in hospitals from 14 % to 11 % respectively over the same period.¹⁹

There was a significant reduction of the growth of pharmaceuticals. Following the introduction of payments for prescriptions, lower frequency of physician visits (95 % of visits result in issuing prescriptions) and the new categorization of pharmaceuticals, the growth of total expenditures on pharmaceuticals was reduced to 3 % (*Box 2*)²⁰. In comparison, in 2000–2002 the average annual growth reached 10 %. While expenses on pharmaceuticals of providers dropped down by almost 30 %, additional payments by patients increased only by 6 %. This was caused by a gene-

¹⁶ Polls claim a slight increase in visits to general practitioners and dentists, and slight decline in visits to specialists and hospitals. Public opinion poll, June 2002 and October 2003.

¹⁷ 61 % of respondents agree that one has to take care of one's own health, yet 35 % think that the state and the Ministry of Health care should primarily take care [of one's health] (Focus, January 2004).

¹⁸ Public opinion on health care related issues (Focus, November 2002 and January 2004).

¹⁹ Public opinion poll, June 2002 and October 2003.

²⁰ Expenditures on pharmaceuticals by HICs dropped by 13 % in the 1Q2004.

BOX 2 Growth of Expenditures on Pharmaceuticals, %

	2000	2001	2002	2003
Insurance companies	17.9	10.5	15.9	6.4
Health care providers	9.5	4.3	-5.5	-29.4
Patients (co-payments)	6.3	-11.8	21.6	6.0
Total	15.7	7.8	13.8	2.9

Note: consolidated

Source: calculations by authors based on Ministry of Health care data

ral tendency to prescribe fewer pharmaceuticals that require co-payments, and price cuts by pharmaceutical companies compensating for reduced demands.

There was a decline in growth of indebtedness (Table 2). While in 1997–2002 the new uncovered debt was growing by the average annual rate of SKK 4.3 billion, despite injecting SKK 10.5 billion, in 2003 there was a zero growth. The greatest success was reducing debt generation by decentralized providers and introducing a monitoring program of the efficiency of directors in large facilities. Moreover, there was a number of positive examples where transformation to non-profit organizations resulted not only in halting the build-up of debt, but it also resulted in a budget surplus.²¹ These hospitals have undergone a significant restructuring in the last 12 to 18 months and nowadays have access to commercial loans to purchase health care technology to increase the quality of their services. The adopted reforms and expectations created thus started to lead to stricter adherence to budget constraints.

Transferring hospitals to municipalities and regions led to their better monitoring and management. For instance the Trnava region found violations in several hospitals that could be classified as fraud.²² It seems that the changes and expectations of further changes provide good incentives for self-governments to improve public governance in hospitals.

Another important systemic change included de-politicization of activities by HICs, and imposing on them stricter budget constraints. Based on the current legislation, the insurers started to defend their interests, vis-à-vis providers more efficiently and extend budget constraints on them.

In addition to the plan of reform changes it is also necessary to create a study assessing the impact on different social groups. Here the reform encounters problems lying beyond the scope of the health care sector – low quality of statistical data due to sample selection bias, and limited human resources. Since reform is thus inevitably in a certain sense a step into the unknown, it is necessary to adequately compensate vulnerable social groups.

²¹ most significantly the Hospital Bardejov

²² See “Director of the Skalica Hospital Approved His Own Salary”, SME daily, Feb. 19, 2004.

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SUMMARY

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Slovak Health-Care Reform: Greater Privatization

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The paper summarizes recent health-care reform in Slovakia and the reform's general rationale, provides a brief theoretical background, and describes the reform measures both adopted and proposed. The authors assess the early experience and the impact of the undertaken reform.

The main feature of Slovak health-care reform has been the commercialization of the sector. While much of the reform is still in process, and is thus hard to quantify (for instance, direct expenditures by patients are increasing, while the revenues of certain interest groups are declining), many early steps have produced concrete improvements important toward securing social legitimacy.