Health system reform had significantly contributed to stabilising public finance

One of the major problems of the Slovak health system before passing the reform acts in 2004 was an imbalance of motivations. The core of the problem had rested in the fact that while one part of the sector did have the opportunity to make profit (pharmaceutical sector, distributors, pharmacies, private physicians and hospitals); the other portion of the providers did not have this luxury (state hospitals). In addition, and which is more important, profit could not been made even by the health insurance companies, since according to the law they had operated under soft budget constraints.

Thus the health market was divided into three sectors having unequal macroeconomic and legislative conditions and system of motivations, which was established essentially another way (**Chart No 1**). The result of such setting of motivations was a unilateral pressure of entities being "entitled to profit" upon the entities with "no entitlement to profit", while neither the health insurance companies nor the hospitals had motivation or strength to face the given pressures. It was easier to transfer the financial risk to the public finance. In addition, under such constellation, the State was strongly encouraging them in doing so by creating soft budget constraints for the health insurance companies and the hospitals (**Frame No 1**), and by not enabling the creditors to seek the settlement of their receivables and regularly and non-systemically redeeming the debts of all, while maturity periods would reach 180 to 270 days as a standard.

The health system was thus being credited by entities being "entitled to profit", while the real financial accountability was borne by the public finance. The growth of new debt in 2000 to 2002 had reached 7 to 9 bn SKK annually and toward the end of 2002 the external debt had accumulated to the amount of 26.6 bn SKK. From fiscal point of view the entire health system was ready for bankruptcy.

HEALTH REFORM HAD EQUALISED MOTIVATIONS ON THE HEALTH MARKET

Equalising the motivations of all market participants, introducing hard budget constraints, standard economic conditions and non-discriminatory rules is the key ingredient of the 2004 health reform. Previous entities being "entitled to profit" had thus collided with an equal opponent also being "entitled to profit." The conditions had matched with one another. Motivations are equal (**Chart No 2**).

A struggle for equilibrium is coming into being, between legitimate requirements of all entities, while the health insurance companies can no longer shift their financial problems to the public finance.

Frame No 1: Soft budget constraint

The term *soft budget constraint* was first coined by János Kornai in the seventies of the twentieth century. The syndrome of soft budget constraint for a certain organisation occurs when there is a supporting institution existing in a given environment (such as the State), which is ready to financially cover the entire deficit of the given organisation. It could either be a direct "support", "assistance", or "compensation". Other benefits guaranteed to the health insurance companies or hospitals by the State in the form of "softening up" the environment, in which they operate (i.e. no property seizures), may also be considered an indirect form of soft budgetary limits.

Source: Health Policy Institute, 2006 according to article Kornai, J., Maskin E., Roland G.: Understanding the Soft Budget Constraint, 2002 http://post.economics.harvard.edu/faculty/kornai/papers/understanding.pdf

An equal fight for scarce resources is happening, which is characterised by the following trends:

- The total amount of resources for health is fixed by available resources of the health insurance companies, which do not have the possibility of shifting their financial insolvency to the State.
- Individual segments may only grow at the expense of another segment (for instance outpatient treatment will oust medications), while the dynamics of such forcing out will be driven by the purchasing strategy of the health insurance companies and the willingness of the providers to adapt their behaviour to this purchasing strategy (for instance outpatient physicians will receive bonuses for not exceeding the agreed amount for medications, however at the same time they will be sanctioned if they won't be able to explain any volume excess in a trustworthy manner).
- Providers, which are more efficient and have higher quality of services will prove themselves within individual segments, while the dynamics of this struggle within a segment will in part be driven by market parameters (marketing of providers towards the patients and obtaining clients) and in part by purchasing strategy of the health insurance companies (dismantling limits for treatment and transition to a reduced price of a point after having reached the specified limit).

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Table No 1: Contribution of health system deficit to the public finance deficit in the ESA95 methodology in % of GDP

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Health system deficit	-0,5	-0,9	-0,9	-0,6	-0,3	-0,3	-0,1	-0,1	0,0	0,0	0,0	0,0
Public finance deficit without the health system	-6,1	-5,2	-5,5	-6,6	-3,4	-3,5	-2,8	-2,8	-3,0	-2,7	-2,4	-2,4
Total public finance deficit	-6,6	-6,1	-6,4	-7,2	-3,7	-3,8	-2,9	-2,9	-3,0	-2,7	-2,4	-2,4

Forecast for 2006 – 2010 with maintained health system reform
Source: Health Policy Institute, 2006

ONLY CONTINUED REFORM CAN GUARANTEE THE STABILITY OF PUBLIC FINANCE

Stabilising measures of 2003, adopting hard budgetary constraints, creating a motivating and financially accountable environment in 2004 and transparent debt redemption through the Creditor joint stock company in 2003 to 2005 had played an important role in decreasing the health system deficit and had made a significant contribution to stabilising the public finance (**Graph No 1**).

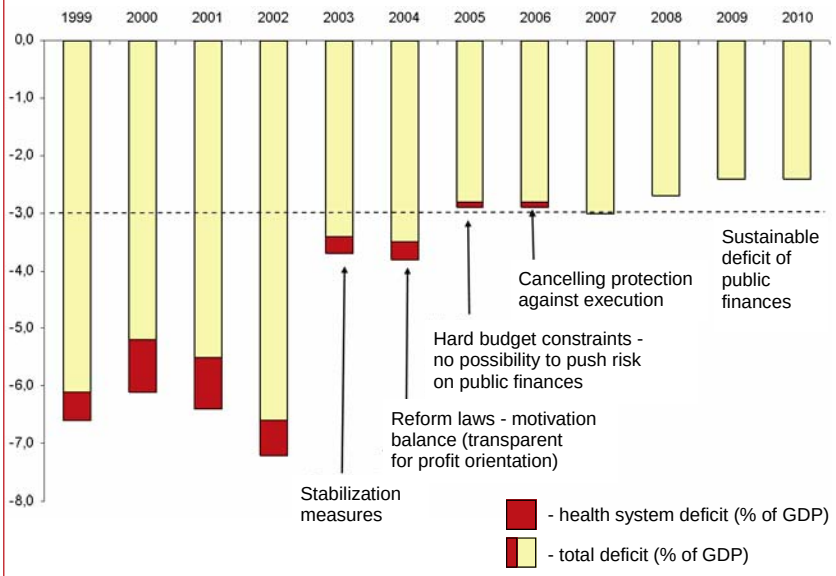
In a system, where only some entities were "entitled to profit" and health insurance companies as public institutions were able to transfer the risk to the public finance the health system deficit would reach 0.6 to 0.9% of GDP, which was unsustainable and irresponsible in terms of further development. Health reform had reversed this dangerous trend and the entire system had gradually become more financially stable, while maturity periods would drop to the standard 30 to 60 days and the growth of new debt is reaching 0.1% of GDP.

Only continued health reform based on balanced motivations without the option of transferring financial risk to the public finance is the guarantee for public finance stability, so that the entire public finance deficit would continue to drop and the "contribution" of the health system to the public finance deficit would reach minimum levels (**Table No 1**).

Therefore any change in the system aimed at **(1)** removing the hard budgetary constraints, **(2)** creating imbalance on the side of motivation, and **(3)** unreasonable requirements upon the public finance automatically establishes the risk for maintaining public finance stability. Any implementation of the agenda of the political party SMER - Direction (public insurance companies, abolishing the profit function), or of the Slobodné fórum - Free Forum agenda (abolishing fees in the health system, requirement for an additional 56 bn SKK from the State budget) directly endangers the public finance stability in the future.

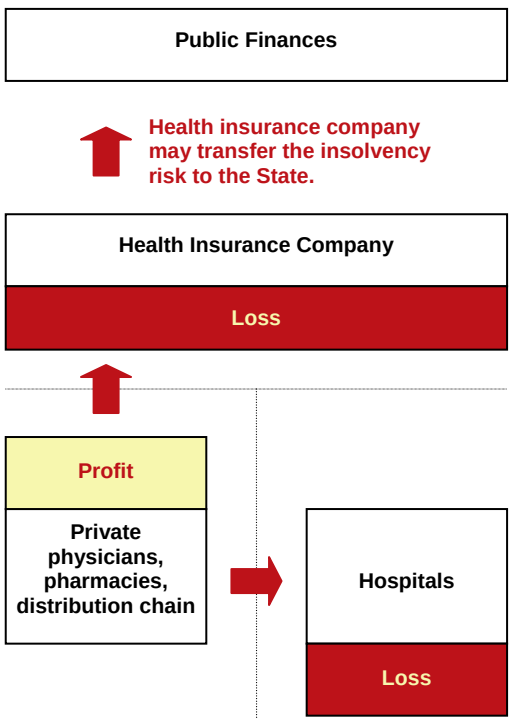
PETER PAŽITNÝ

Graph No 1: Contribution of the health system reform to stabilising the public finance



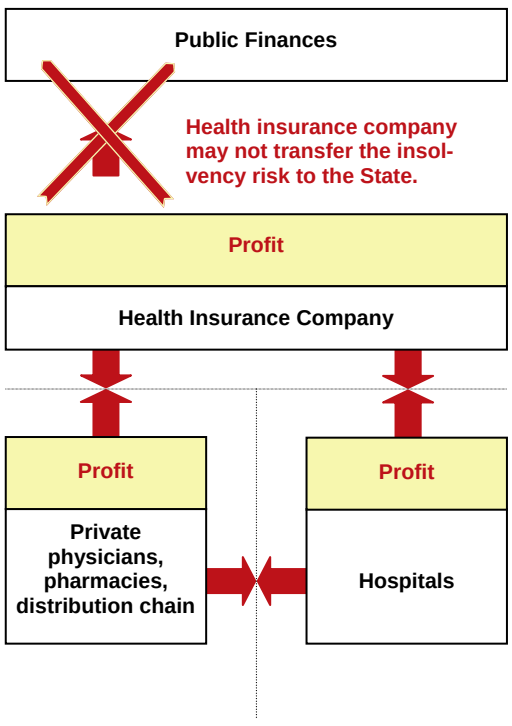
Source: Health Policy Institute, 2006

Chart No 1: System with no equal motivations



Source: Health Policy Institute, 2006

Chart No 2: System with equal motivations



Source: Health Policy Institute, 2006

HPI - Health Policy Institute
Hviezdoslavovo nám. 17
811 02 Bratislava
Slovak Republic

Phone: +421 2 54 643 051
E-mail: hpi@hpi.sk
http://www.hpi.sk