Slovak Health Reform

Reform Laws

Health Policy Institute
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Health Policy Institute

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1. Health Care Act

(Act 576/2004 on Health Care, services related to the provision of health care and on the amendment and modification of some other laws)

The Health Care Act governs the health care itself and the forms of its provision, defining services related to health care, stipulating the rights and obligations in the provision of health care with emphasis on informed consent and health records, defining the procedure after death and outlining the powers of state administration and local government in the area of health care.

While the definition of health according to the World Health Organization is rather extensive (*"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."),* the Act defines health care while focusing on differently formulated goals:

- prolonging life,
- improving quality of life,
- healthy development of future generations.

In addition to the goals the new definition of health care also redefined the content. Health care consists of health services and provision of medicines, medical aids and dietetic food. This definition enables a standardization of procedures and development of guidelines.

In the area of diagnostics for the first time the Act defines the **relationship between health care and a diagnosis** or disease. The International Classification of Diseases of the World Health Organization is an appendix to the law. Every contact of the citizen with the health system is coded in the International Classification of Diseases, even when no disease in the traditional sense is involved. Many codes are used to statistically monitor some factors affecting health rather than just for medical purposes (e.g. traffic accidents under codes V01 to V99). The link between provision of medical assistance and a disease code enables a better assessment of the diagnostic and therapeutic approach of the medical professional.

The Act lays down the duty of obtaining **informed consent of the patient** before providing health care (i.e. demonstrable approval preceded by the provision of clear information). Border cases are also covered when medical assistance can be provided without informed consent.

The right to select provider (known also as 'free choice of doctor') is not related to the payment for the health care provided. The conditions for enforcing the right to payment are provided for by the Health Insurance Act in the extent as determined by the Act on Extent. The patient may also choose a provider who has no contract with the patient's health insurance company. In such cases the payment for the health care provided is born by the patient (with exceptions enumerated in the mentioned laws).

In addition to affecting the health state of the patient the provision of health care has legal consequences. The law defines the legal relationship between the patient and the provider of the health care. This relationship constitutes a **contract between the parties.** This contract may either be concluded in writing or verbally, for a single occasion or a certain period, etc. The law specifies details only in case of contract for the provision of general out-patient care: such agreement must be written and concluded for a period of at least six months. The law also provides for a termination mechanism of the contract for the provision of general out-patient care – while the provider's reasons of termination are limited the patient may terminate the agreement without stating any reasons. The law does not provide for a period of notice which may be stipulated in the agreement itself.

The term of **'services related to health care'** was first introduced in our legislation with the amendment of the Health Care Act No. 138/2003. It is used to distinguish between health care and some activities which are related to it but are not its constituent part. These may include accommodation and catering during in-patient care, processing of data for the purposes of the health insurance, transport, accommodation of a guardian in an in-patient facility, production of a medical report and extract from the medical records.

Medical records constitute a summary of data (name and surname, anamnesis, extent of the provided health care, identification of the provider, etc.) which is maintained as part of the provision of health care. Every item in the medical records must be unambiguously identifiable and therefore the records need to be maintained in such format which enables reliable identification. The written format used at present may be superseded over time by a digital format which will need to comply with electronic signature requirements and other conditions related to data security and data backup.

Medical records are not subject to ownership and hence cannot be sold or bought, or inherited with medical practice. If the patient portfolio of a practice is being transferred, each patient must express prior consent either in person or through an authorized representative.

When the patient changes his/her general practitioner the previous provider of general out-patient care is obliged to hand over medical records (or their copy) demonstrably to the provider taking over within seven days from the request. The previous provider has the right to keep a copy of the records.

The law also defines how health records are to be consulted (as this constitutes provision of personal data in terms of personal data protection). In addition to the patient himself/herself the right to see and make notes or copies of the medical records belongs to an authorized third person (e.g. lawful attorney-in-fact). Medical records can also be accessed by other persons by virtue of their profession (medical reviewer of the Health Insurance

Company, employees of the Health Market Authority, medical assessors for the purposes of their assessments for social insurance, etc.). There are exceptional cases when the exercise of the right to consult medical records may place the health state of the person in danger (psychiatric patients). In such case the provider is entitled to deny a request to consult the medical records. Inasmuch as the assessment of the possible negative impact of making the medical records available is the responsibility of the provider, the law enables the person in question to exercise the right to consult the medical records by a court order.

The law also provides for **'secret childbirths'.** The woman who produces a written request of anonymity during delivery is entitled to special protection of her personal data. Her medical records are archived under seal at the Ministry of Health and can only be opened on court order.

One whole section of the law is devoted to **biomedical research.** Here the law is using the Convention on Human Rights and Biomedicine as the basis. It governs the mechanism of research approval, specifying who may not be involved in the research and to what extent a potential research participant must be informed before providing informed consent.

Similar attention is devoted to the issues of **transplants** – from defining the donor (living or deceased) and recipient to the rules of the process.

The legislation governing **sterilizations** was not sufficient in the past. The law now unambiguously imposes the duty of written informed consent and specifies a 30-day period between the sterilization request and the treatment. This period reduces the chance of misuse, if for example the person decided for the treatment under pressure of environment or due to a temporary situation. It affords an opportunity to reassess the decision and possibly retract the informed consent. Since sterilization is an elective treatment (it is no urgent care), the 30-day postponement does not threaten the health state of the person concerned.

Definition of the **procedure at demise** is closely linked to the determination of the powers of the Health Market Authority which guarantees independent confirmation of demise and decides on further procedure once death was confirmed; there is also a link to transplant issues.

The most sensitive point of the procedure at demise is **determination of death.** This includes the determination of 'brain death' after which resuscitation should be stopped. Exceptional cases are when the person after brain death is a potential donor of organs for transplantation – in such case the organism may be maintained in vegetative state until the transplant operation takes place.

The law also provides for the management and organization of the health care system. It defines the **health care information system** as a system of

standards which is interoperable using defined interfaces. It stipulates the authority of the Health Ministry and local administration in matters of health care.

The powers of the Ministry contain less operational tasks than in the past – the Ministry no longer defines the network of health care facilities, nor does it decide about the construction of health care facilities or acquisition of medical equipment. The authority to supervise health care has also been transferred by the Act on Providers and the Act on Health Insurance Companies and Surveillance from the Ministry to the newly established Health Market Authority. The Ministry still has the basic coordination and policy tasks in the health care sector.

Local state administration of health care in a region is performed by the regional authorities. Their powers are based on the provisions of the Health Care Act (ethical committees, choosing provider when a proposal health care provision agreement is rejected, archiving of medical records, approval of biomedical research in out-patient care, assuring representation) and the Act on Providers (licensing, supervision). For further tasks of the state administration the regional authorities act in cooperation with the Ministry of Health.

The issues related to spa treatment are still governed by the original Act 277/1994 because the Ministry of Health is working on a new Act on Spas.

2. ACT ON EXTENT

(Act 577/2004 on the Extent of Health Care Paid by Public Health Insurance and on the payments for services related to the provision of health care as amended by subsequent regulations)

The Scope of Benefits is derived from the principle that an insured person has the right to equal treatment in case of an equal need. Due to the infinite nature of needs it is however necessary to define a certain maximum extent of care – a flexible Benefit Package – based on the list of priorities that is in line with the fiscal capacity of the Slovak economy. Therefore a clear policy of rationing has to be implemented.

The Act on Extent is based on Article 40 of the Slovak Constitution, stipulating the conditions for the provision of free health care on the basis of health insurance (the extent of insurance benefit based on public health insurance). Article 40 of the Constitution stipulates:

"Everyone has a right to health protection. On the basis of health insurance the citizens are entitled to free health care and medical aids at conditions stipulated by law."

The Constitutional Court Ruling No. 13/1994 adds to this issue:

"Application of the constitutional right to free health care includes the conditions, extent and manner of its provision."

The Constitution does not stipulate that health care is free in its full extent. It specifies that the conditions of free care (i.e. its extent – as confirmed by the Ruling of the Slovak Constitutional Court) must be determined by law. The care which is not fully free does not need to be stipulated by law and may be determined by other legal standards of lower level. The law specifies rules of how these standards are created.

The need to specify the extent of the insurance benefits is based on the requirement of sustainability of the system. Changes to the structure of diseases, demographic factors, technological advances and growing expectations of citizens can no longer be fully covered by the resources available. If the system of solidarity-based health insurance is to be sustainable, unlimited free health care cannot be available to all of its clients. This leads to the necessity of restrictions (rationing). The 'silent' rationing has become a serious ethical issue and a source of corruption. Decision making is done on a micro-level system, i.e. by physicians. The solution is to replace it by explicit rationing, i.e. to specify clear and transparent rules applicable to all members of the system while respecting certain medical, ethical and economic criteria and maintaining the quality of health care. The Act on Extent defines such rules.

This is possible only when priorities are set! 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 the user fees (SKK 20 or 50). Other diagnoses not listed could be co-paid by patients. However, this will only concern the treatment itself, not diagnostics procedures. The list of priority diagnoses was adopted by the Parliament on Government proposal.
2. **Mechanism of cataloguing**. All diseases shall be subject to the process of cataloguing 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 Catalogue shall be compiled by the catalogization commission (predominantly physicians) nominated by the Minister of Health.
3. **Mechanism of categorization**. For diseases not listed on the priority list, categorization shall determine the extent of patient co-payment for interventions. The categorization 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 **Categorization process** determines the financial participation of insurance holders on the basis of medical and financial criteria. This pertains to (1) medical treatments for non-priority diagnoses as well as (2) drugs, (3) medical aids and (4) dietetic food. The categorization process enables priorities to be set on a lower level. The main purpose of the defined criteria in the categorization of medical treatments, drugs, medical aids and dietetic food is to **provide maximum benefit at 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 10. Provided constant prices and demand, patients would pay in total almost SKK 3 billion, which creates a market for individual insurance in commercial Health Insurance Companies (Table 1). The average co-payment of individually uninsured patients per diagnosis would reach at most SKK 200.

Table 1: Break-down of Diagnoses to the Priority List and Others (in SKK million)

Diagnoses	Present volume of payments by insurers in SKK billion	% of total cases	% of total costs	% of new payments from public insurance	New volume of payments by HIC	New volume of co-payments by patients	Average annual payment by patients in SKK
Priority List	19,990	41	67	100	19,990	0	0
Non priority list	9,989	59	33	0-95	6,992	2,997	50-200*
Total	29,979	100	100		26,982	2,997	

*Note: * per diagnosis based on complexity*
Source: Health Policy Institute, special software

The law uses priority-setting, **dividing the diagnoses into (1) priority and (2) non-priority ones**, where the treatment for priority diseases is fully paid by public health insurance and for non-priority diseases financial participation of the patients can be considered. Priority treatments, specified and defined in detail in attachments to the Act, include those provided as part of urgent care, chronic diseases, costly treatments or preventive checks.

Similarly the law specifies **115 ATC groups of drugs** which are provided to the insured without financial participation and groups of medical aids are also specified, basic types of which are provided to patients without financial contribution.

Balneal care is a specific case of treatment. An indicative list of balneal treatments divides the indications into three categories by severity – A, B and C. Category A includes indications for which health care is fully paid by public health insurance and services are partly paid by public health insurance. Category B consists of indications for which health care is also fully paid by public health insurance but services are not. For indications in Category C health care is partly paid by public health insurance and services are not paid.

The health insurance company is responsible for ensuring that adequate health care is provided (patient management). The health insurance company may, according to the law, pay for health care and related services even beyond the extent specified by law.

Reduced demands on public health insurance are related to increased payments from patients through individual additional insurance or by direct payments.

Services related to health care are a relatively new element in the legal system – they enable the introduction of marginal fees to the health care system (for a visit at an out-patient department – SKK 20, visiting a doctor on duty – SKK 60, for prescription – SKK 20, non-emergency transport – SKK 2 per km and for bed-day of a patient or guardian in hospital – SKK 50 for a day). The fees for services are specified by a government resolution. The law enumerates exceptions.

The health insurance company may contribute towards the payment of non-urgent care provided to its client by a non-contract provider. The precondition is a previous agreement and compliance with criteria for the provision of such contribution which must be known beforehand. The objective of the provision is to prevent the emergence of a thick division line between contracted and non-contract providers. Payment from solidarity resources should also be available – at specific conditions – to the insured who receives care at a non-contract provider. The amount of the contribution from the insurance company may not exceed the usual price for the treatment in question.

The law also **enables the health insurance company to seek recourse of an insurance holder** if the insured demonstrably violated the treatment regime or the health damage was caused by a habit-forming substance, and **conversely, is entitled to offer advantages** if the insurance holder leads a healthy life-style and subjects himself/herself to prevention. Hereby the health insurance company receives an important tool to implement a fair health policy.

2.1 Intelligent Co-payment Scheme

In line with the health reform, the reform team prepared "The Slovak Co-payment Scheme", which is linked to the definition of Benefit Package. The Slovak reform team developed the Slovak co-payment scheme at the very same time as Osterkamp (2004) presented his *"Elements of an intelligent design of co-payments"*. Analyzing the Osterkamp proposal (Table 2), we are convinced, that the Slovak co-payment scheme as a flexible rationing tool is intelligent.

Table 2: Comparison of the two proposals and reform approaches

Slovak Reform Team Definition of Benefit Package and the Co-payment Scheme	Dr. Osterkamp, ifo Institute Munich, 2004 Intelligent Design of Co-payments
1. Separation of non-health care services (setting small, flat user fees) 2. Definition of the national priority list (uninsurable risks that are costly, rare and severe diagnosis) with no co-payment only user fees that are approved by the parliament. Currently 6700 diagnosis. 3. Establish catalogization commission for defining the catalogue of procedures to every diagnosis 4. Establish categorization commission that defines the financial co-payment on the non-prior diagnosis. Currently 4300 diagnosis, which are cheap and insurable 5. Increase patient's responsibility and involvement by setting rules on compliance and misuse of care	1. High co-payments (may be 100%) for small, frequent, cheap and every day diseases 2. Low (or non) co-payments for rare, severe and costly diseases 3. Lower co-payments for the poor than for the wealthy. 4. Upper limit of health-care costs as a % of individual annual income 5. Disburdening the employer: once-and-for-all increase of wages by former employer contribution

Source: Presentations made by Dr. Rigmar Osterkamp and MUDr. Rudolf Zajac, Bratislava, 2004

3. Act on Providers

(Act 578/2004 on the Providers of Health Care, medical staff, professional organizations in the health care sector and on the modification and amendment of some acts, as amended by subsequent regulations)

The Act on Providers defines the position of health care providers, medical staff and professional organizations (chambers).

A Provider may be a natural or legal person who must own a **permit and a license** to provide health care. The permit is issued by regional authorities (or the Ministry of Health in some specific cases) if the standards of equipment and staffing are met. The license is issued by the appropriate professional association (criteria: integrity, professional competence, medical fitness). Both documents are enforceable when the legal conditions are met. The Ministry is the body of appeals against the resolutions of the regional authorities or the chambers**.**

In some specific cases the medical worker only needs the license to provide health care (independent medical practice license), and not the permit. These are situations where the medic as provider does not have or need own premises to execute his/her profession – e.g. visiting services in home-nursing.

The network of providers is defined in a new manner, while new terms including **public network of providers and minimal public network of providers** are introduced. The public network consists of providers with whom a health insurance company has a contract on the provision of health care, i.e. the number of providers is not limited (and the only restriction or condition being that the providers must have a contract with at least one health insurance company), and the definition of the minimal public network includes an ideal number of providers for a given area so that efficient, accessible, continuous and systematic health care is guaranteed.

The difference between a minimal public network and public network is that the health insurance companies are obliged to conclude contracts on the provision and reimbursement of health care and services related to the provision of health care with at least such number of providers as is stipulated by the standard for minimal public network – this is a required condition. According to the Act on Health Insurance Companies and supervision of health care it is the full responsibility of the health insurance company to choose which providers it will contract in order to comply with the minimal network condition.

The emergency ambulance service network is a special case of a public network of providers. This is the only fixed network (in this case public network = minimal public network) and the Ministry grants permits for four years based on the results of a selection process.

The law **restricts the right to strike for medical workers.** If the protection of life or health of people is directly threatened by the strike then the government of the Slovak Republic orders its termination.

The law provides for **recognition of proofs of professional qualification** for the performance of a medical job acquired outside of the Slovak Republic (the treatment is different for European Union member states and non-members).

The law further provides for **continued education of medical workers and systematic education** (continuous re-newal and maintenance of acquired professional qualification in accordance with developments in the professional areas).

The law recognizes five chambers as professional associations:

- The Slovak Medical Chamber (Slovená lekára komora),
- Slovak Chamber of Dentists (Slovená komora zubných lekárov),
- Slovak Chamber of Pharmacists (Slovená lekárnická komora),
- Slovak Chamber of Nurses and Midwives (Slovená komora sestier a pôrodných asistentiek),
- Slovak Chamber of Other Medical Staff, Assistants, Lab Workers and Technicians (Slovená komora zdra-votníckych pracovníkov, asistentov, laborantov a technikov).

The chambers received the first-instance power to grant licenses and to register medical workers. **While membership in the chambers is voluntary, registration is compulsory for all medical employees.** It is the basis for monitoring professional qualifications and training of a medical employee.

Obligations of medical workers and providers are enforceable through possible **sanctions** – from financial penalties to suspension or withdrawal of permit or license. Supervision is performed by the body which issued the license or permit and by the Health Market Authority.

A significant part of the provisions is dedicated to **the transformation of state-owned medical facilities to joint-stock companies.** This will enable equal access to resources in health care and their use (hire-purchase will now be possible for medical facilities which were previously state-owned) and the managers of the facilities will have stronger autonomous responsibility for decisions concerning the operation of the medical facility. The state is the founder of the joint-stock company. The transformation is scheduled to finish on December 31, 2006.

The government may decide to conclude a contract on free transfer of the shares of the transformed medical facility to public universities, the Slovak Medical University in Bratislava, regional authorities or municipalities. Such contract must include a clause prohibiting the sale or transfer of the shares for a period of ten years. The stake of state in the equity of these companies may not decrease below 51%.

In transitory provisions the law stipulates the obligation of all medical facilities to obtain a license according to the new regulations by June 30, 2006 and a permit by December 31, 2006, at the latest.

4. ACT ON EMERGENCY AMBULANCE SERVICE

(Act 579/2004 on Emergency Ambulance Service and on the modification and amendment of some acts)

The emergency ambulance service has two positions. Firstly, it is a health care provider of a special type, and secondly, it is one of the basic elements of the integrated emergency system together with the fire departments and the police. Its **specific position** is based on the fact that it is the only provider of health care who benefits from a guaranteed fixed price for its 'stand-by' availability.

A new organization of emergency ambulance service is being established. The emergency ambulance service is provided by (1) **operational centers** of the emergency ambulance service and (2) **providers** of emergency ambulance service who operate in accordance with a permit issued by the Ministry. The emergency ambulance service providers are the basic emergency element of the integrated emergency system.

The emergency ambulance service is not only seen as an institution, but as a service. In this case the provision of urgent medical care is to a person in a situation where the person's life or health is directly in danger and the person needs to rely on the assistance provided.

Establishment of operational centers of the emergency ambulance service as budget-funded organization is fully justified by the responsibility of the state to guarantee emergency ambulance service. The operational centers of the emergency ambulance service are established in the precincts of the integrated emergency system coordination center.

The Ministry of Health Care issues a regulation to specify where emergency ambulance service stations should be located and how large their precincts should be, while observing that:

1. any point of the road network of the Slovak Republic is accessible **within 15 minutes**.
2. this accessibility is achieved by the **lowest number of stations**.

The result of the optimization is 207 stations and 257 emergency ambulance vehicles. There are 6 additional precincts for air ambulance service and 10 stations for boat ambulance service.

5. Act on Health Insurance

(Act 580/2004 on Health Insurance and on the modification and amendment of Act 95/2002 on the Insurance Industry and on the modification and amendment of some acts as modified by subsequent regulations)

Existence of health insurance is directly founded on Article 40 of the Slovak Constitution. Public health insurance is compulsory and gives the insured the right to reimbursement of health care to the extent specified in the Act on Extent. Unlike individual health insurance the public health insurance is based on the solidarity principle. Laws specify who is obliged to pay premiums irrespective of whether the insured individual actually receives health care in the specified extent or not. The solidarity is exhibited in the fact that certain categories of insured persons who are not able to pay the premiums are still entitled to reimbursement of the health care provided to them, on the principle of public interest. The law specifies who is insured under the public health insurance.

The first obligation of an individual insured under public health insurance is to **submit an application for public health insurance.** By submitting the application to a health insurance company and having it confirmed a legal relationship is created between the insured and the health insurance company which will thenceforth manage his/her public health insurance policy. The application may only be submitted to one insurance company and the insurance company may not be changed more frequently than once per year (by January 1), in which case a new application must be submitted by September 30 of the previous year. The insurance company is obliged to confirm the application and send it back to the client together with an insurance holder ID card.

In case the insurance holder is a bad payer (has not paid premiums for three months in a calendar year or is in arrears after the annual settlement of accounts) they are only entitled to reimbursement of urgent health care.

Those persons who failed to submit the application have a restricted right to one reimbursement of urgent health care. Any subsequent provision of urgent health care is paid to the insurance company with the largest number of insurance holders by the natural or legal person who failed to submit the application.

Insurance premium payers include employees, employers, self-employed and the state. The state pays premiums on behalf of those insurance holders who are neither employees nor self-employed, nor have an annual income exceeding the amount of 12-times the minimum wage.

The amount of the premium is calculated as ***premium = rate * assessment base.***

The current rate is 14% (split 4:10 between the employee and the employer, respectively), and is halved in case of disabled persons. The assessment base is the person's income in the calculation period (calendar year) from the activity in question (employment and/or business). The maximum assessment base is 36-times the average monthly wage; minimum assessment base is 12-times the minimum wage.

The state pays a special rate (4%) on a special assessment base (12-times average monthly wage). Before now the state was only paying as much as was approved in the state budget act. This latest modification has made the financing of the health care sector less dependent on the political will and is directly linked to the performance of the economy. The premiums paid by the state are transferred to health insurance companies by the Ministry of Health.

The premiums are paid in advance and then after an annual settlement of accounts. The advance payments are paid continuously every month and after the calculation period has ended a **yearly settlement** is performed. The purpose of the newly introduced concept of annual settlement of premiums for public health insurance is to ensure that premiums for public health insurance are paid on all income received not only in a particular calendar month, but in the whole calendar year.

In case that premium payers are not paying advance payments on time and in due amount or fail to pay the outstanding balance discovered by the annual settlement of insurance premiums the health insurance company may **claim premiums from payer** in a special procedure at the Health Market Authority. In this procedure the health insurance company may claim interest on late payments in addition to the principal and the Health Market Authority may impose a penalty on the payer.

One of the conditions for appropriate execution of public health insurance is accuracy and timeliness of the data needed for the execution. The entities involved (insured individuals, payers and insurance companies) are subject to **reporting duties** specified by law. Failure to report is penalized by the Health Market Authority.

Redistribution of premiums transfers the collected premiums among insurance companies according to the structure of their portfolio. The goal of the redistribution is to balance for different risks indexes (statistical costliness) of insurance holders inscribed in different insurance companies. The **redistribution base** is 95% of the total statutory/prescribed insurance premiums (i.e. the premiums which must be paid by the payer to public health insurance). When the redistribution base falls below 95% of prescribed premiums, than the Health Insurance Company has to fill the gap from their own sources; when the base exceeds the 95% threshold, the HIC can keep the money. This has a motivational

effect driving the efficiency of premiums collection by insurance companies.

The **redistribution rate** is 90% of the redistribution base. This means, that the effective rate of redistribution is 85.5% of fully collected prescribed premiums. The redistribution is supervised by the Health Market Authority and the procedure also simplifies the cross-settlement of liabilities and receivables.

Individual health insurance is voluntary, contract-based insurance. It is facultative and offers insurance holders the opportunity to benefit from a broader extent of health insurance than that provided by public health insurance. Individual health insurance is used to pay for the provision of health care to the extent as specified in the contract. Individual health insurance is a product which will be offered by insurance companies (whether or not they operate exclusively in the health care sector) as one of their activities. This activity will be supervised by the Financial Market Authority.

6. ACT ON HEALTH INSURANCE COMPANIES

(Act 581/2004 on Health Insurance Companies, Supervision of Health Care and on the modification and amendment of some acts, as amended by subsequent regulations)

The act is based on the knowledge that the market economy rules are universal enough to be applicable to health insurance under precisely defined conditions and promotes the principle of **effective regulation** as the basic tool of the health policy.

The state abandons the inefficient positions of producer and insurer and will focus on its dominant task which is health policy formulation, definition of the rules, regulation and control of specified conditions for the execution of public health insurance.

The law introduces substantial changes on the previous system of operation of health insurance companies. It comes with **hard budgetary constraints**, transparent financial relationships, financial and personal responsibility, transparent bookkeeping and obligatory external audit. It also anticipates greater competition and application of market rules in the provision of health insurance and health care.

The law defines the position of health insurance companies and the conditions for executing public health insurance which is subject to a separate Act on Health Insurance. From this point of view the Act on Health Insurance defines a '**product**' to be provided by health insurance companies and the Act on Health Insurance Companies and on the Health Market Authority defines the '**institutions**' which are authorized to perform public health insurance (health insurance companies operating as joint stock companies) and supervision of public health insurance (Health Market Authority).

From this institutional viewpoint the law exactly defines the activity, organization, management and husbandry of health insurance companies and the Health Market Authority. Supervision of health care is divided into two areas:

1. **Supervision of health insurance companies** and public health insurance,
2. **Supervision of health care provision**.

The law also provides the transformation path for health insurance funds which were established under the previous legislation to health insurance companies operating under Business Code.

6.1 Position of a Health Insurance Company

One of the main foundations of the law is the position of health insurance companies as joint-stock corporations, i.e. companies established under **Business Code with hard budgetary constraints**. This is a

substantial change from the previous arrangement which stipulated that health insurance is offered by health insurance funds operated under special public law in soft budgetary constraints.

To enter the market, Health insurance companies need a special permit from the Health Market Authority (HMA, or Authority) to offer public health insurance. The existing Health Insurance Funds can transform themselves into Health Insurance Companies after meeting the criteria of the Authority.

The activity of the health insurance companies will be generally governed by the Business Code (lax generalist) with the exception defined by this Act (lax specialist).

The fact that a sensitive activity like health insurance is entrusted to corporations under Business Code is justified by the need to create a legal environment and conditions which will ensure that health insurance operates in a professional, effective and efficient manner and that appropriate protection against personal data misuse is guaranteed, and embezzlement of the funds for public health insurance is prevented.

The law creates an environment for the operation of health insurance companies in which the insurers will compete for insurance holders by the quality of their insurance services and by purchasing of health care from providers while observing the conditions stipulated by the law. If the health insurance company generates a profit through sound management, it can use it legally like any other business entity, while respecting certain specific restrictions (e.g. patients on waiting lists).

Under this concept of public health insurance provision the state retains the opportunity to offer public health insurance through a solely state-owned health insurance company.

6.2 Health Insurance Company Operation

Purchasing health care for its insurance holders from health care providers is the key task of a health insurance company. To this end the health insurance company concludes contracts with health care providers and reimburses them for the health care provided.

The health insurance company assumes full responsibility for **patient management** (while it may delegate patient management to the provider). It is therefore expected that the health insurance company will participate in the decision-making to include the patient in dispensarization after proposal of a specialist who also proposes the length of such dispensarization.

Another important tool in patient management is a **contribution** towards the payment of health care if the patient chooses a provider who has no contract with the health insurance company. In such case the patient pays the full price of the health care to the provider and the

health insurance company then, upon receipt of a bill confirming the payment of health care, contributes an amount equal to a price which it would pay for the treatment to its regular contracted provider. This step strongly reinforces the patient's options to choose the provider.

In individual cases the health insurance company **may acquire medicines and medical aids** specified by the Ministry of Health Care. Such acquisition, mainly in case of expensive drugs and aids and large scale purchases, will bring the insurance company returns of scale, which in turn will contribute to reducing the transaction and logistic costs for drugs and aids as the wholesale and retail links in the drugs chain are by-passed. The insurance company will be obliged to supervise the supply of the drug or aid to the provider who applies the drug or aid to the patient.

The health insurance company may also offer **sickness insurance**.

In order to retain equality of chances and equal opportunities on the health insurance market the health insurance company **may not provide false or misleading information** or promote benefits which it cannot provide.

6.3 Waiting Times

Waiting times are addressed for the **first time in the legislation** and the process of creating waiting lists is also controlled. The provisions introduce the obligation to create a list of insurance holders awaiting health care if the health insurance company is unable to reimburse health care when it is due, i.e. at the time contractually agreed with the providers of health care.

It is extremely important that the list of insurance holders and the waiting times are **managed by the insurance company** which is the only entity with a clear overview of free capacities and possibilities available to providers. The provision also increases transparency of the system, placing a requirement on the health insurance company to (1) maintain lists sorted by diagnosis, (2) inform the insurance holder about his/her inclusion on such list and (3) observe the sequence. On such lists the insurance company may not include those insurance holders who must receive urgent health care, and those insurance holders who are on the list but their health state demands urgent health care should be removed from the list without delay.

To **prevent excessive accumulation of profits** from the health insurance through an excessive increase of the number of insurance holders on the health care waiting list or by increasing waiting times the health insurance company is liable to create technical reserves for all patients on the waiting lists, in other words all unpaid and provided, but undelivered liabilities to health care providers.

The health insurance company must set aside a technical reserve for each insurance holder on the list such as will be sufficient to pay for the health care, and

the sum of these reserve amounts enters the bookkeeping of the health insurance company as an expense.

If the technical reserves created (or due to their incorrect estimate) is not enough to cover all costs related to the waiting list (there is still at least one insurance holder on the waiting list) and the health insurance company has generated a profit in the period, then it is obliged to **use 100% of this profit for the benefit of insurance holders on the waiting list**. In this way there is a double guarantee that the resources of insurance holders will be used for purchasing health care. Shareholders of the health insurance company may only freely decide about the distribution of profit if all their health care liabilities have been met and there are no insurance holders on the waiting lists, or if there are, then the liabilities related to the provision of health care are covered by technical reserves.

There are exceptions from the regulation on profit distribution in case that the waiting list consists exclusively of insurance holders who are awaiting the availability of a suitable organ, tissue or cells for transplantation. This exception is based on the knowledge that the health insurance company has sufficient resources for such treatments but that a suitable donor or organ is often not available.

6.4 Contracting the Provision of Health Care

Contracting the provision of health care and services related to the provision of health care is one of the key activities of a health insurance company due to the fact that through these contracts the health insurance company provides health care and related services to its insurance holders in the extent as specified by the Act on Extent of Health Care Paid by Public Health Insurance and on the Payments for Services Related to the Provision of Health Care.

Market should become the most important tool for determining the prices of health care and related services, while respecting the availability of health care and guaranteeing a minimal public network. The proposed legislation creates the basic conditions for a competitive environment not only for the health insurance companies but also for providers of health care and providers of services related to the provision of health care.

From the economic point of view the contracting is a function of quantity, quality and price which subsequently determine availability, efficiency and quality of health care. **Availability** for patient is defined by the minimal network. **Quality** is determined by the use of quality indicators and **efficiency** is a function of regulated price competition with price caps.

6.5 Availability and Selection of Provider

The **minimal public network** is a standard which must be achieved by the health insurance company using its contracting process. The health insurance company is free to conclude contracts beyond the extent of the minimal public network, finances permitting. A generally binding regulation of the Ministry of Health Care has defined the minimal public network which guarantees the availability of health care to individuals insured under the public health insurance.

Free choice of provider by the insurance holder is guaranteed because the health insurance company is liable to conclude a contract with any general practitioner who has a contract with the company's insurance holder.

Free choice of pharmacy is also assured. The health insurance company is obliged to conclude contracts with all providers of pharmaceutical care.

General practitioners and pharmacists are therefore special cases of the minimal public network where the minimal network is identical to the full public network.

6.6 Quality

The legal provisions create equality of opportunity not only for all health insurance companies but also all providers of health care and providers of services. The health insurance company is obliged to define and publish the contracting criteria pertaining to (1) staffing and equipment available of the provider, (2) quality indicators and (3) quality system certificate.

This approach is based on the Donabedian concept of quality which contains three pillars – (1) **structure**, (2) **process** and (3) **outcome**. In our case the structure is the knowledge and equipment basis of the provider, the process is represented by a quality certificate and outputs are represented by quality indicators.

Using these criteria as the basis the health insurance company is required to build a **ranking of providers** according to their rate of success in meeting the criteria. Subsequently the health insurance company must reflect this ranking in the contracting of the providers and building the minimal public network.

6.7 Prices

Even though the price is not the main criterion for the provision of health care and related services, it is an important tool in terms of reducing inadequate costs of health care. Due to these reasons the law creates room to apply this indicator when concluding or terminating contracts, **but only as long as the specified quality criteria are met**.

In addition to quality, extent of services and due dates the next important parameter in the contract for the provision

of health care is the total payment for health care. This should not exceed the maximum price stipulated by a price regulation. The price cap has a twofold motivation. On the macro-economic level it is used to estimate costs of the health care system and on the micro-economic level it should prevent favoritism in the contracting process and acceptance of much more favorable prices for some types of providers.

6.8 Payment for Health Care

The law addresses payment for health care on the basis of the contracts concluded by the health insurance companies with the health care providers with an agreed price. Payments are due within 30 days unless the parties agree otherwise. The due date is important for defining the ability of the health insurance company to pay its liabilities and is also crucial in setting up the waiting list.

The law also addresses payment **in case** when the **provider has no contract with the insurer**. In practice these will be cases of urgent health care when an insurance holder is treated by a provider who does not have a contract with the insurance company of the patient. In this case the provider is entitled to a **price common** at the time and place where the health care was provided. This gives the patient a guarantee that they will be treated in urgent cases by any health care provider. The health insurance company determines within 24 hours whether the treatment was really urgent. The due period for payment is also 30 days.

Emergency ambulance service is a completely specific type of provider. Health insurance companies are liable to pay these providers for their readiness for action. For this reason the price regulation specifies an advance payment in fixed prices. This price is split among health insurance companies according to the proportion of their insurance holders in the total number of insurance holders.

6.9 Inspections

The health insurance company is obliged to adhere to effective, efficient and sound usage of public health insurance funds. It should also operate so as to provide its insurance holders with health care and related services in the extent specified by the Act on Extent of Health Care Paid by Public Health Insurance and on the Payments for Services Related to the Provision of Health Care.

This obligation includes the right of the health insurance company carry out inspections of:

1. Health care providers contracted,
2. Health insurance premium payers.

6.10 Solvency of the Health Insurance Company

One of the main pre-requisites for an operational system of public health

insurance is continuous solvency of health insurance companies. Due to the aforementioned reasons there is an obligation of health insurance companies to continuously ensure, using **their own resources,** the payment of liabilities arising from confirmed applications for public health insurance, concluded contracts for the provision health care and contracts for the provision of services related to the provision of health care.

The **statutory rate of solvency at 3%** of the public health insurance premiums after redistribution for the past 12 months is a reserve lasting approximately 2 weeks of health care payments. Some countries require a higher rate of solvency, as much as 8%, or approximately 4 weeks of contract liability coverage. Such reserves are unnecessarily high and counterproductive.

Failure to meet the statutory solvency rate is the first indicator that the health insurance company may be facing problems. If a health insurance company **fails to meet the minimum solvency rate**, the Health Market Authority is obliged to introduce sanctions which may range from a recovery plan to the withdrawal of the public health insurance permit.

The health insurance company is obliged to maintain the minimum solvency rate for the whole time it offers public health insurance.

In order to apply the provision unambiguously in practice **own resources** of the health insurance company are defined as the difference between assets, and liabilities with items which reduce assets. The assets include: (1) paid-up equity capital, (2) reserve fund, (3) capital funds and (4) undistributed profit of previous years. On the other side, the items reducing assets are comprised by: (1) intangible property, (2) unpaid loss from previous years and (3) loss of the current period.

Due to the importance of health insurance solvency in the performance of public health insurance the health insurance company is obliged to demonstrate the minimum rate of its solvency to the Authority every month by the specified date and in the required manner.

6.11 Responsibilities of Health Insurance Companies

The law addresses the responsibilities of the health insurance company which need to be fulfilled if public health insurance is to be provided in an effective, efficient and economic manner. The key responsibilities are:

1. ensure availability of health care to the extent of the minimal public network,
2. create technical reserves,
3. evaluate quality indicators and use them in ranking providers,

4. verify whether health care provided in specific cases defined by law was urgent,
5. maintain minimum required solvency,
6. manage files of insurance holders,
7. maintain bookkeeping in accordance with applicable regulations,
8. pay contributions for the operation of the Authority,
9. pay advances to providers of emergency ambulance service.

6.12 Records

Transparent performance of public health insurance requires that the health insurance company maintains **records**. Records include any and all documents which are relevant for public health insurance.

Another important part of record-keeping in a health insurance company is the insurance holder file which enables accurate identification of the provided health care and related services as well as other important data pertaining to the health care and services provided to a particular insurance holder by a particular provider at a given price.

In order to **enable efficient control** the health insurance company has the obligation to send the insurance holder upon written request data from the personal file and **make the data available to the insurance holder on the Internet**. The condition of such access to data is that the personal insurance file is only accessible via the Internet to the person to whom it pertains while protection of personal data is ensured. In this manner the insurance holders are able to participate in the control and checking of public health insurance, of health insurance companies and health care providers.

6.13 Establishment and Field of Reference of the Authority

A special authority is established to ensure supervision of health insurance companies in the performance of public health insurance on one side and of health care providers on the other. The Health Market Authority is a legal person and its activity will focus on continuous supervision of compliance with the standards of public health insurance and supervision of the extent and quality of provided health care.

These standards include mainly the conditions for the establishment of a health insurance company and subsequently the conditions for maintaining continuous solvency while meeting all obligations of the insurance company towards the contracted health care providers.

The Health Market Authority was also entrusted with authorizations, on the basis of which it will be able to supervise health care providers, i.e. check whether they provide the health care in the extent and quality as required by law.

The Authority is governed by the law as **an independent, sui generis institution**, not included in the system of state administration bodies. The state entrusted it with public supervision of health care. The state power is public and public powers are executed by state bodies (of the legislative, executive and judiciary branches) as well as territorial self-government bodies and other bodies (institutions and organizations) which are authorized by law to decide about the rights and legally protected interests and obligations of other persons.

The Health Market Authority is established as a legal person operating nation-wide, headquartered in Bratislava.

Independence of the Health Market Authority will be ensured by not placing it in the system of state administration bodies, and it will not be subordinated to any higher body. It will be accountable to the Parliament and the government only for activities entrusted to it by this law. The Authority shall **not be dependent on the state budget**, being mostly financed from the contributions of the health insurance companies.

The reason for defining the Authority as an impartial and independent body is the need to ensure rapid and professional decision-making in matters relating to

- public health insurance,
- provision of health care,
- performance of obligations related to the payment of premiums by public health insurance payers,
- fulfillment of obligations by insurance holders, and
- redistribution of public health insurance premiums.

6.14 Bodies of the Authority

The governance bodies of the Authority include the **chairman**, board of administration and supervisory board. The structure of the bodies is not conceived to express any hierarchy but is instead based on a division of responsibilities and authority which is clearly defined for each of the bodies. The structure of the bodies should guarantee professional, timely and efficient performance of the Authority's activities.

6.15 Permit and Prior Consent of the Authority

Health insurance is based on continuous flow of funds (contrary to pension insurance which is based on savings). The reasons include the nature of health risks and distribution of risks among insurance holders. In general, approximately **10% of insurance holders consume 75% of all resources**.

The health insurance enables immediate transfer of funds from insurance payers to those who need the payments. This is a guarantee of the solidarity principle inasmuch as the drawing of funds is not determined by the amount of money paid but mainly by the health needs of the insurance holder. This philosophy

constitutes the basis of the Act on Extent of Health Care Paid by Public Health Insurance (hereinafter 'Act on Extent') which guarantees **equal care for equal needs** for every insurance holder and uses the list of priorities as the main parameter for defining the extent of free health care.

Public health insurance is not based on the saving principle and it would not be rational to expect more if one contributes more. It is also not rational to expect that the funds contributed by an individual will be accumulating on his/her personal savings accounts. All funds are immediately used for the benefit of those who have a health need classified as a disease pursuant to the Act on Extent.

Due to the fact that **funds do not accumulate in time** the resources of insurance holders are not endangered even if a health insurance company declares bankruptcy or is liquidated, because the insurance holders would be seamlessly transferred to another health insurance company and would contribute to their new insurer. To prevent these situations from occurring it is desirable that the performance of public health insurance is only entrusted to reliable entities and reliable individuals.

6.16 Conditions for Granting a Permit

The main condition for the performance of health insurance is paid-up equity capital of at least **SKK 100 million** which can only have the form of a money deposit. Paying the equity capital is an important indicator of financial stability and commitment of the applicant to perform public health insurance in the long term. This criterion simultaneously eliminates insolvent applicants.

Another requirement for obtaining a permit is the condition that the **equity capital and other financial resources arise from legal income**. The applicant must prove that the funds invested in the public health insurance business are transparent and were not acquired illegally.

The third requirement is that **persons with a qualified participation** in the health insurance company must be suitable and their relationships with other persons as well as shares in the equity capital and voting rights should be transparent. In addition to other facts the applicant will need to demonstrate the suitability of the persons who are qualified shareholders in the health insurance company. This requirement is justified by the fact that the ownership structure of the health insurance company is assessed during surveillance anyway.

6.17 Health Care Surveillance

The main task of the Authority is surveillance of public health insurance and supervision of health care provision. The Authority operates to discover short-comings in the activity of health insurance companies, health insurance premium payers, health care providers, and to

discover their reasons and consequences. For these purposes the supervised persons or bodies are liable to enable the Authority to execute its supervision and render the necessary cooperation.

The Authority performs both remote surveillance and on-site surveillance.

Remote surveillance is performed by collecting and evaluating information which is submitted by the supervised entity to the Authority in a manner determined beforehand, either as reports or as notices.

On-site surveillance involves collecting information on the premises of the supervised entity or from its employees, followed by evaluation.
When performing surveillance it will probably be necessary, depending on how complicated the surveillance is, to invite professionals not directly employed by the Authority. The law therefore specifies that it is possible to invite employees of state bodies and employees of other legal persons or natural persons who will participate in the supervision. If the Authority decides to invite such persons, they are entitled to a compensation of salary or to remuneration according to the remuneration rules of the Authority.

6.18 Sanctions

The main task of the **Health Market Authority** is to make sure that public **health insurance is performed properly** and that **health care is provided adequately**. Surveillance would not be effective is the Authority did not have sufficient tools of punishment in case that defects are discovered. It may impose sanctions depending on the degree of significance, blame and the nature of the disclosed defects.

The sanctions are aimed at entities which participate in the operation of the health insurance and provision of health care (health insurance companies, payers of insurance premiums and health care providers) are: (1) **preventive** – as a possible sanction; and (2) **repressive** - in case of violation of an obligation – by imposing sanctions and penalties.

In case that defects are discovered in the performance of **public health insurance** the Authority may consider the degree of significance, blame and the nature of the defects, and mainly:

1. impose a pre-emptive measure,
2. impose the obligation to produce a recovery plan,
3. impose receivership on health insurance company,
4. order transfer of insurance portfolio,
5. temporarily suspend the authorization to receive and confirm applications for public health insurance and conclude contracts on the provision of health care,
6. withdraw a permit,
7. impose the obligation to offset operational losses from equity capital after losses are offset against retained profit from previous years and reserve funds created from profits.

If the Authority discloses defects in the activity of a **health care provider** it cannot intervene directly because it is not authorized to withdraw the license or permit. This can only be done by the bodies which issued the license or permit. The Authority may, depending on the significance, blame and the nature of the disclosed defects, petition the appropriate body to:

1. impose a penalty,
2. temporarily suspend or withdraw a license,
3. temporarily suspend or withdraw a permit,
4. start a disciplinary procedure,
5. suspend or withdraw business license,
6. dissolve organization or execute other measure against the organization within the power of the Ministry of Health Care.

6.19 Transformation of the Current Health Insurance Companies

The Act respects the continuity of activities of the current health insurance companies. It allows the existing health insurance companies to produce a **transformation project**; a transformation project resolution means that the insurance company or its founders have decided to transform it to a joint-stock company. The law allows for the possibility to take this decision, unless provided otherwise. This exception applies to the General Health Insurance Company (Všeobecná zdravotná poisťovňa) and Common Health Insurance Company (Spoločná zdravotná poisťovňa) which **must transform by law**.

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7. ACT ON DRUGS AND MEDICAL AIDS

(Act of the Slovak Parliament No. 140/1998 on Drugs and Medical Aids, on the amendment of Act 455/1991 on Self-employment (Small Trade Act) as amended and modified by subsequent regulations and on the modification and amendment of the Slovak Parliament Act No. 220/1996 on Advertising, as amended by subsequent regulations)

Although this Act is not part of the 'reform package', the reform extensively amended this legislation as well. The Act on Drugs and Medical Aids defines the conditions for the handling of drugs and medical aids, testing of drugs, registration of drugs, approval of medical aids, quality assurance and control, effectiveness and safety of drugs and medical aids and the tasks of state administration in the area of pharmaceutics.

The Act provides for **clinical testing of drugs, production, registration and handling of drugs and medical aids** in accordance with the law of the European Union and requires that quality, safety and effectiveness of drugs and medical aids introduced to the market in Slovakia is guaranteed.

Pharmaceutical care in a public pharmacy or its branch may be provided by a natural or legal person pursuant to a regional authority permit, provided that the person has demonstrated compliance with requirements pertaining to equipment, premises and staffing including a professional representative. The professional representative demonstrates professional Skills by a graduation diploma in pharmaceutics and a proof of practice of at least five years in a public pharmacy or hospital apothecary, or a diploma in specialized pharmaceutics studies.

When providing pharmaceutical care paid partly or fully by public health insurance the holder of permission to provide pharmaceutical care must have a **contract on the provision of pharmaceutical care** with the health insurance company of the insurance holder. Both parties, the provider of the pharmaceutical care and the health insurance company, are obliged to agree in the contract on the conditions for the provision of pharmaceutical care, e.g. by defining the extent of provided pharmaceutical care including emergency services, margins of the pharmacy on dispensed drugs and medical aids, terms of payment of invoices for dispensed drugs, etc. The parties may terminate the contract if one of them violates the contract conditions.

Drugs, medical aids and dietetic food which comply with the conditions for release on the market **must be delivered by the** pharmaceutical care provider **without unnecessary delay.** The wholesale distributor of drugs and medical aids is obliged to ensure that drugs and medical aids paid by public health

insurance are delivered on the territory for which the distributor is licensed **within 24 hours** from receiving an order from the pharmacy.

The law specifies that both the prescribing doctor and the pharmacist dispensing the drug must inform the patient about **alternative generic drugs.** These are therapeutically equivalent drugs paid by public health insurance which contain the same active substances as the prescribed drug, but carry a different additional payment for the patient. If requested so by the patient the doctor may prescribe the alternative generic drug or allow the pharmacist to replace the prescribed drug for the alternative.

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Mission

(1) Against the backdrop of growing medical care costs driven by high expectations of citizens, ageing of the population, changing structure of illnesses and technological advances it is the mission of **Health Policy Institute** to:

- promote values which support financially sustainable health systems responding flexibly to the needs of the population;
- promote innovative solutions at the level of health systems, the level of health insurance companies and the level of providers in order to achieve a higher efficiency in the provision of health services;
- promote client-oriented approach to the insured and patients.

(2) The first assumption to promoting these values is the understanding of health as an individual good. **Health Policy Institute** will promote such health policy which motivates every citizen to improving his or her own health status.

(3) The second assumption is the highest possible decentralization of decision-making. **Health Policy Institute** supports market mechanisms in the health sector wherever they are demonstrably more efficient than state intervention. **Health Policy Institute** will therefore promote efficient regulation of the extent of provided health care, flexible setting of the minimum network, and maximum prices which are sufficiently motivating, as basic tools of the health care policy. It will be the task of the private sector to give content to these regulations.

(4) Solidarity is the third most important value. **Health Policy Institute** promotes a system of mandatory public health insurance which gives every insured the right to equal care at equal needs. Due to the fact that in health care the unlimited desire for immortality meets the strict world of economy, solidarity must have clearly defined boundaries to prevent its abuse and to prevent the wasting of scarce resources for medically ineffective and economically inefficient interventions.

(5) **Health Policy Institute** will therefore advocate such operation of health care systems in Slovakia and elsewhere which promote the responsibility of the patient, responsibility of the provider and responsibility of the health care purchasers.

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Graduate of the Faculty of Management at the Comenius University, Bratislava (2002). Majors: Financial Management, Banking and Insurance; Final thesis: Financing of Health Care System in Slovakia. One semester (2002) at the Institute Universitaire Professionnalise de Management, Universite C.Bernard, Lyon 1 in France. She participated in various courses (e.g. 3-weeks Flagship Course on Health Sector Reforms and Sustainable Financing, Harvard School of Public Health, Boston and World Bank Institute, USA in 2004, 2-weeks Regional Flagship Course on Health Sector Reforms and Sustainable Financing, Health Service Management Training Centre, Semmelweis University, Budapest and World Bank Institute, Hungary in 2003, 2-weeks Summer School of Liberalism, Liberec, Czech Republic in 2000). Currently she is doing her Masters in Health Policy and Management at the Brandeis University in Boston, USA.

At the Ministry of Health of the Slovak Republic she was Health Care Reform Team Member (X/2002 – VI/2004) responsible for economic analysis of impact of health sector reform steps, health sector budgeting and analysis of health insurance companies budgets, Ministry of Health budgeting, participation on preparation of new health sector legislation in health insurance mainly and she was OECD Delegate.

In 2004 – 2005 she was Local individual consultant/Analyst of health care providers of the World Bank Project - Health Care Sector Modernization Technical Assistance to the Ministry of Health. Objective of her assignment was to develop the system of monitoring of performance and financial indicators of health care providers under the governance of the MoH.

In January 2005 Henrieta Maďarová co-founded the *Health Policy Institute*, a think-tank which analyzes the health policy in the Central European countries.

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Graduate of the University of Economics in Bratislava (1999). Postgraduate MSc. studies at the Semmelweis University in Budapest (2003) with Healthcare management and Health policy as the main fields.

He started as analyst in the think-tank *M.E.S.A. 10* (Centre for Economic and Social Analyses) in 1997. Along with macroeconomic development, economic transformation and fiscal policy analyses, he paid attention mostly to the systemic changes and reform process in the healthcare sector.

Together with current Minister of Health Rudolf Zajac, he is the co-author of the publication "Healthcare Reform Strategy – Real Reform for the Citizen" that served as main source for the health care reform implemented in Slovakia in 2004. From October 2002 until December 2004 Peter Pažitný served as the minister's principal advisor. He was fully responsible for the expert part of the health reform, for daily management of the Reform Team and for operative tasks linked to the ministry (e.g. state budget, health insurance, project of reducing debts and others). His assignment also contained many presentations about the Health Reform in Slovakia on various international conferences and workshops. These included presentations for foreign governments (Netherlands, Island, Czech Republic, Slovenia) or conferences held by global organizations like OECD, WHO or World Bank.

In January 2005, together with other members of the Reform Team, he founded *Health Policy Institute*, an independent think-tank which analyzes the health policy in the Central European countries.

Beyond this Peter Pažitný has very specific experience from the neighbouring countries (esp. Hungary and Czech Republic), about their health system, health reforms and reform proposals. Personally, many of the decision and policy makers are his good friends.

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After finishing the studies Tomáš Szalay worked as a journalist and TV anchor in biggest Slovak private broadcasting company TV Markíza (1996 – 2002). He gained managerial skills as managing director of an internet content provider company (2000 – 2001).

He joined the reform team in November 2002 as the spokesperson of the Ministry of Health responsible for the external communication and public relations. Since 2003 he began to preparate and coordinate new health care legislation (definition of the Basic Benefit Package – Treatment Act (Scope of the Health Services Covered by the Public Health Insurance Funds) and contributed to the analysis and modelling of reform impacts. In 2004 – 2005 he was individual World Bank Consultant, responsible for co-ordination of the Quality of Care Component of the World Bank Health Sector Modernization Support Technical Assistance Project at the Slovak Ministry of Health.

In January 2005 Tomáš Szalay with his reform team colleagues co-founded the *Health Policy Institute*.

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Graduate of the Faculty of Medicine, Comenius University, Bratislava (2000). Specialization: General Medicine. Studied also Psychology at the Faculty of Arts of Comenius University (1993 – 1995). Postgradual study in Clinical Pharmacology at the Faculty of Medicine of Comenius University (2000 – 2005). Angelika Szalayová participated in many courses and training residences (e.g. 2002 – 2003 Health Outcomes Research, Moduls I., II. and III. – EBM and its applications to Drug Utilization, Pharmacoeconomics, Pharmaceutical pricing and reimbursement, Vienna School of Clinical Research, Austria).

Since 2000 she is assistant professor of the Farmacology Department Faculty of Medicine, Comenius University. She worked in 2003 – 2005 at the Ministry of Health in the Drug Policy Department; she has been head/deputy of the Drug Reimbursement Committee.
Angelika Szalayová is author and co-author of many publications and scientific reports on pharmacotherapy quality evaluation, especially in the area of cardiovascular diseases, neurology, psychiatry, endocrinology and antimicrobial therapy.

Angelika Szalayová is one of the co-founders of *Health Policy Institute* (2005).