REFORM MODELS: HEALTH REFORM IN SLOVAKIA[1]

Peter PAŽITNÝ[2]
Rudolf ZAJAC[3]
Anton MARCINČIN[4]

The health market is considered to be a place where people's yearning for immortality meets the unforgiving world of finances. Although most of the reform changes are always hardly accepted by the citizens, many partial steps bring forth almost immediate palpable improvements that are important for gaining and maintaining trust of the society. Typical for its unique political success and fast commercialization of the sector, Slovakia's health care reform draws the attention of other countries.

1. Introduction

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. In 2003, Slovak health care expenditure in the volume of 6.9% of the GDP is slightly higher than the average of the seven new EU member states at 6.7 % of their GDPs.[5]

The goal of the health care policy is the fair and financially sustainable distribution of health services. Fair distribution is considered a mechanism that would provide care according to everyone's needs. A system is considered financially sustainable when it respects given budget constraints, does not create conditions for the systematic accumulation of debt, and complies with priorities of citizens and policy makers. The health care system is considered financially balanced if the following three substances are in balance (Evans, 2001):

SUPPLY = FINANCIAL SERVICES = DEMAND

2. Expectations and Options: Reasons for the Reform

The socialist health care system offered its services free at the point of delivery. However, patients were constantly under-treated and deprived of the latest advances in pharmacological technologies, diagnostics and treatment. A vast 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: 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 except the privatization of primary and secondary care on the supply side of the system happened in 1990-2002.

Also in 2002, 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 informal payments, which further deepened inequalities (OECD, 2002b).

Thanks to the generous scope of benefit package provided, free access to health care, inherited extensive supply, spreading of noninfectious[6] and chronic diseases and limited solvency (*Scheme 1*), demand as well as the supply exceeded available resources:

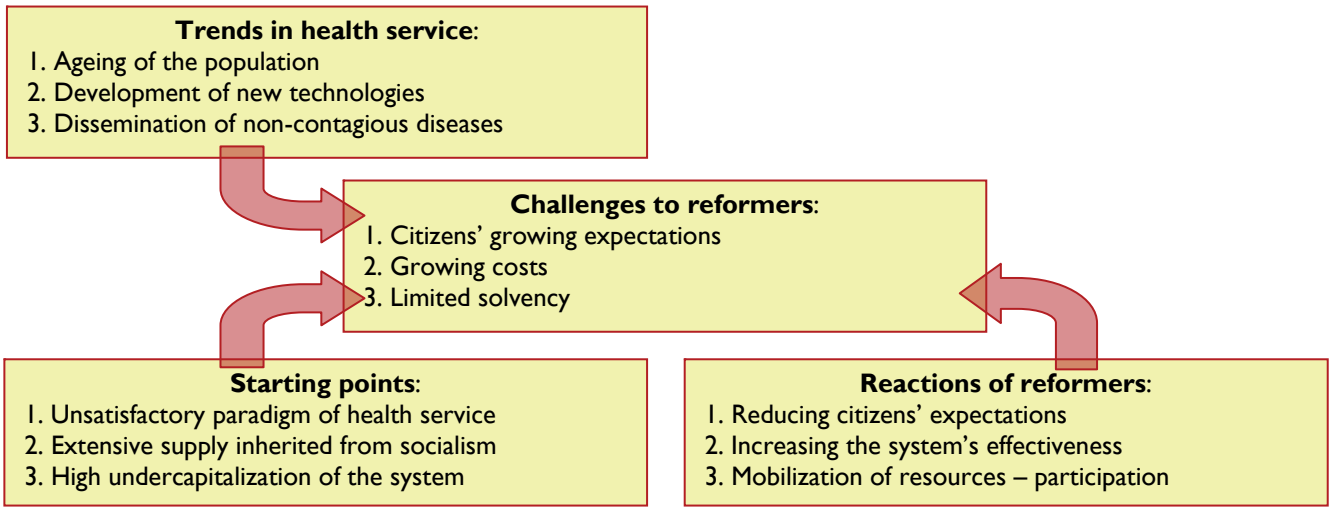
SUPPLY > FINANCIAL RESOURCES < DEMAND

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

Scheme 1: Position of Political Decisions in Health Care System Reform



Source: Health Policy, Pažitný – Zajac, 2002

These inequalities resulted in a continuous growth of deficits, increasing debts (*Table 2*) and prolonging waiting periods. The financial problems reached its top in 2002. 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 of the patients towards the publicly financed health care system.

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.
- *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 informal payments.
- *Soft budget constraints dominate the system*. The government guarantees the solvency of health care insurance companies and providers. Bailouts proved inefficient (OECD, 2002a). There is over-employment of health care personnel. 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 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).
- The system is unable to react to the changing structure of diseases. Health care systems based on the communist model, involving an extensive network of hospitals emphasizing physical accessibility, have been shown not to

Table 2: Economic Position of the Health Care System, % of GDP

	1995	1996	1997	1998	1999	2000	2001	2002*	2003e	2004f	2005f
Revenues	6.1	7.2	7.0	6.9	6.4	6.4	6.4	6.8	6.5	6.4	6.5
Expenditures	6.2	7.2	7.6	7.6	6.9	7.3	7.3	7.7	6.9	6.6	6.5
Deficit	-0.1	0.0	-0.6	-0.7	-0.5	-0.9	-0.9	-0.9	-0.4	- 0.2	0.0

Note 1: e – estimate, f – forecast
Note 2: 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)
** Revenues since 2002 including informal payments (cca. 0.6% GDP with decreasing tendencies), see also Table 14*
Note 3: The revenues in years 2003 and 2004 do not include the bailing out of hospitals and HIC approx. SKK 15 billion) via state owned company Creditor
Source: Ministry of Health of the Slovak Republic.

work. While such systems are good as handling communicable diseases, they have clearly not been efficient in fighting the non-communicable diseases that became prevalent in the second half of the 20th century as a result of the ageing of the population.

3. The Slovak Health Care Reform

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.

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

The main objectives of the reform are:

1. **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 constrains, with the risk of facing bankruptcy.
2. **Maintaining balanced financing of the health care system**.
3. **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.
4. **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.[7] 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.

4 Stabilizing Measures

Stabilizing measures consisted of introducing user 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 services related to health care (food, lodging and transportation).

The second new element was the introduction of user fees for physician consultations, for issuing prescriptions, and providing related services starting on June 1, 2003. This step increased the responsibility of patients for their own health (Table 3), and is not intended to secure massive additional resources into the system. Fees are of a symbolic nature, while certain groups of patients, like children under 1 year or chronically ill 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 from the social system of SKK 50 per household member to compensate for health expenses.

Table 3: Fees introduced effective June 1, 2003

Type of Care/Provider	User Fee	Per	Who keeps it
Primary outpatient care	SKK 20	visit	Doctor
Specialized outpatient care	SKK 20	visit	Specialist
Hospital (i.e. room and board)	SKK 50	day	Hospital
Transport	SKK 2	km	Transport
Prescription	SKK 20	prescription	SKK 5 pharmacy SKK 15 health insurance company

Source: Ministry of Health, 2003

Table 4: Number of visits in 2003 compared to 2002 – quarterly

Period	Number of visits to outpatient departments				Number of hospitalizations	
	youth doctors, pediatricians, gynecologists	dentists	first aid	specialized outpatient care	hospitals	other medical establishments
1Q 2002	3,955,031	652,062	219,141	3,391,103	206,352	33,015
2Q 2002	3,867,676	640,379	241,975	3,361,904	196,638	33,742
3Q 2002	3,457,192	558,015	254,146	2,965,542	189,765	30,987
4Q 2002	3,892,173	620,004	250,615	3,241,337	193,305	29,582
2002	15,172,072	2,470,460	965,877	12,959,886	786,060	127,326
1Q 2003	4,141,886	638,254	260,616	3,371,764	196,378	31,496
2Q 2003	3,619,596	623,961	235,854	3,302,044	199,175	34,821
3Q 2003	3,042,471	542,567	219,884	2,867,805	185,309	32,313
4Q 2003	3,596,287	621,555	219,419	3,216,420	189,156	32,197
2003	14,400,240	2,426,337	935,773	12,758,033	770,018	130,827
1Q	1.05	0.98	1.19	0.99	0.95	0.95
2Q	0.94	0.97	0.97	0.98	1.01	1.03
3Q	0.88	0.97	0.87	0.97	0.98	1.04
4Q	0.92	1.00	0.88	0.99	0.98	1.09
Year	0.95	0.98	0.97	0.98	0.98	1.03

Source: VšZP (General Health Insurance Company), 2004 – controls 67% of the health market
Note: Data supplied by other health insurance companies are very similar.

The introduction of user fees led to a 10% decline in visits to general practitioners and a 13% decline in first aid calls[8] (Table 4). Regardless of that, the public claims that these fees did not hurt the access to care: only 1.5% of respondents (FOCUS, January 2004) claimed that they stopped visiting the doctor after introduction of user fees. This means that user fees were able to reduce artificial demand with no negative impact on the patients. 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.[9]

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 %.[10] 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.[11]

The third stabilizing measure focused on pharmaceutical policy. There are many measures that support the decrease of drug expenditures both as a result of price and volume decrease:

1. Introduction of user fees for drug prescription (SKK 20)
2. Introduction of fixed ratio after categorization (Since June 2003). If pharmaceutical company decreases the price of a drug after the positive list is published, then the ratio between the reimbursement (paid by the HIC) and co-payment (paid by the patient) must remain the same.
3. Introducing personal changes in the structure of categorization committee favoring economists before doctors (Since June 2003)
4. Changes in the process of setting maximal prices
5. Price negotiations via internet – introducing transparent market mechanisms with clear rules
6. Changes in margins for wholesalers and pharmacies for "very expensive" drugs. The definition of "very expensive drug" is rather flexible than fix (depending on dosage), but approximately it corresponds with drugs more expensive than SKK 20 000 per month.
7. Higher frequency of categorization and reimbursement process – takes place four times a year, instead of once annually before 2003. The result of the categorization committee is a positive list stating the reimbursements and is published 4 times a year. Adopting these rules Slovakia tries to follow the EU legislation on drug reimbursement in terms of Transparency Directive 89/105/EEC.

Table 5: Comparison of "normal" and "fast track" regime

	Current status of drugs A,B,C	Normal price decrease of drug A before introduction of fast track	Fast track of drug A with 25% bonus	The status of drugs B and C after fast track of drug A	Result A-(B and C): Clear comparative advantage of drug A
Price	1000	800	800	1000	- 200
Reimbursement from HIC	800	640	680	680	0
Co-payment of the patient	200	160	120	320	- 200

Source: MOH, 2004

Table 6: Case study on fast track in ATC group NO5AXO8 (Risperidon)

Date of publishing of positive list	Price for DDD in SKK	Price decrease in %	Comment
15.11.2003	180,0		
1.2.2004	160,0	- 11,1	1st generic entered the market
15.3.2004	144,0	- 10,0	
1.5.2004	80,0	- 44,4	2nd generic entered the market
1.7.2004	68,4	- 14,5	
1.10.2004	44,1	- 35,5	Total decrease - 75,5%

Source: MOH, 2004

Introduction of "fast track" regime in drug policy led to significant price reduction (Table 6). If pharmaceutical company decreases the price of a product by 10 % or more compared to the cheapest drug in cluster,[12] then is processed on the "fast track". Fast track (Table 5) means no evaluation in reimbursement committee is required. The reimbursement level in cluster is automatically decreased with 25% bonus compared to fixed ratio. The 25% bonus means that the fixed ratio is changing in favor of the patient (lower reimbursement).

Data supplied by health insurance companies show a substantial slowdown in the growth of expenditures allocated to drugs. While in previous years that growth was regularly in the double digits, in 2003 it dropped to 8.9%. Figures for the first half of 2004 were also encouraging, with drug expenditures falling by 11% year-on-year (Table 7).

Third, decentralization of selected hospitals 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. Transferring hospitals to municipalities and regions led to their better monitoring and management. It seems that the changes and expectations of further changes provide good incentives for self-governments to improve public governance in hospitals. The restructuralization path can be supported by decreasing number of beds (Table 8) and by strong reduction of employment in the health sector in recent two years (Table 9).

Table 7: Drug expenditures, EUR million

	1996	1997	1998	1999	2000	2001	2002	2003	2004*
Drug expenditures	165.2	193.6	229.0	239.0	309.9	360.9	383.5	417.8	368.8
Annual growth in %		17.2	18.3	4.3	29.7	16.5	6.3	8.9	- 11.7

Source: IMS, 2004
Note: The HIC use another methodology, so the data may not be fully comparable
** End year projection after the real data in 1H2004 (EUR 180.1 mil.) with seasonal adjustment (third quarter as weakest)*

Table 8: Number of beds per 1000 inhabitants without psychiatric beds

	1999	2000	2001	2002	2003	2004*	2005*
Number of beds per 1000 inhabitants	6.6	6.2	6.1	6.0	5.8	5.6	5.2

Source: Statistical Office of Slovak Republic
** Forecast: MOH*

Table 9: Employment in Health sector in persons

	1999	2000	2001	2002	2003	2004e
Employment in Health Sector	118 473	120 773	116 938	113 734	106 523	99 900
Nominal annul change		+ 2 300	-3 835	-3 204	-7 211	-6 623
Year-on-year change in %		+ 1,9%	-3,2%	-2,7%	-6,3%	-6,2%

Note: e – estimate
Source: Statistical Office of Slovak Republic

There was a significant decline in growth of indebtedness. While in 2000-2002 the new uncovered debt was growing by the average annual rate of SKK 7.0 - 9.0 billion (approx 0.9% of GDP), despite injecting SKK 10.5 billion during 2000-2002, in 2003 there was a SKK 4.8 billion growth and in 2004 the Ministry expects only SKK 2.4 billion. The adopted reforms lead to stricter adherence to budget constraints. The stabilizing measures brought an annual savings of SKK 4.0 billion in 2003 and an estimated savings of SKK 6.4 billion in 2004, especially by reducing induced excessive demand (Table 10). After the adoption of systemic reform and its implementation in 2005 and 2006, the Ministry expects a balanced system with zero growth of debts.

5 "The Reform Puzzle" – Adopting Systemic Measures

The adoption of systemic measures in Parliament known also as "The Reform Puzzle" in such a sensitive area as healthcare when a government has a minority in Parliament cannot be described otherwise, as a great political success of the Government. Having only 68 Members of Parliament out of 150, for the 6 Reform Acts voted more than 81-88 MPs, depending on the Act. This also shows the necessity and the political consensus of the Government and the independent MPs on the Reform.

The objective of systemic 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.

The new system contains first of all definitions of insurance, insurance companies, providers, health care, and the basic package of care. The hottest political debate was initiated by the question of constitutional compatibility of the Act on Scope of health care covered by public health insurance and on the transformation of the Health Insurance Companies from public funds into joint stock companies.

5.1 Health Care Insurance

The basic function of health care insurance is to generate resources based on solidarity principle– this is inevitable to ensure the so-called collective risk: in a certain 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 following principles:

1. Universality and solidarity. Every citizen is obliged to equal treatment to equal need, and is entitled to have the need satisfied in an equal way regardless of one's social standing or income.
2. Financed from public sources that are collected on an obligatory principle and redistributed on the solidarity principle, while competitive social insurance is present. The Health Care Supervision Authority (HCSA)

Table 10: Estimated Efficiency of Stabilizing Measures in 2003 and 2004 (in SKK billion)

Measure	Effective	Savings in 2003	Savings in 2004 (estimate)
Decentralization and establishment of NGOs	January 03	1.3	1.0
New definition of health care and introducing fees for physician consultations and pharmaceuticals	June 03	2.3	3.6
Introducing amendments to contracts of hospital directors	October 03	0.1	0.5
Restructuring hospitals in Bratislava and Košice	October 03	0.1	0.4
Pharmaceutical policy	November 03	0.2	0.9
Total		4.0	6.4

Source: Slovak Republic Ministry of Health, 2003 and calculations by authors

shall supervise the redistribution of the financial resource between the Health Insurance Companies. Effective rate of redistribution shall reach 85.5 % of the prescribed insurance premiums.

3. Every insured person is guaranteed free choice of the health care insurance company, which cannot refuse insurance to anybody.
4. Contributions are 14 % of wage up to a given ceiling (three times the average wage). The state pays insurance for vulnerable groups of 4 % of average wage.

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

5.2 Health Insurance Companies and Supervision Authority

The goal is to introduce hard budget constraints, transparent financial relationships and transfer responsibility for patient management onto Health Insurance Companies (HIC). HIC must obtain a license from HCSA and are joint-stock companies - entities of private law. HIC are allowed to generate profits – however, if there are waiting lists in place, up to 100 % of the profits must be used for the benefit of those on the waiting list. The state is the 100% owner of the largest HIC (2/3 of the market) and a specialized HIC for army and policemen (8% of the market), both are also joint stock companies. There are other three HIC on the market with approx 26% market share, who have private owners.

Health insurance companies are under supervision of HCSA, which is funded by their contributions. The Authority issues licenses and supervises solvency and performance by HIC. Solvency, i.e. the ratio of own resources to revenues from insurance after redistribution, cannot fall under 3 %. If necessary, the Authority may issue fines and order a remedy plan, forced administration or liquidation of insurance companies.

The Act 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. In future, patient management shall bring about higher competitiveness and change in payment mechanisms from service mix to case mix.

The selection of providers by HIC is allowed, while respecting the minimum network and quality standards. Together with modern payment mechanisms these shall be the principal tools of competition. HIC 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.

The Act introduces clear rules for handling finances for health care to avoid inefficient and discriminatory behavior of HIC towards health care providers. The Act also changed the role of the state which is to only for formulating the health care policy and health priorities, to regulate and to control.

5.3 Health Care Providers

The goal is to increase the decision-making autonomy and responsibility of providers. At the same time, the controlling and supervisory function of the state is strengthened. The new system is based on several principles. First, when licensing, eliminate artificial barriers to entry erected by professional chambers. Second, introduce new types of health care providers, like providers of one-day care, and houses of custodian care. Third, 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 is abandoned. However, at the same time compulsory registration with the Supervisory Authority is being introduced to ensure continuous retention and renewal of professional competence.

Very important is the new definition of the public network of health care providers. HIC shall sign contracts directly with providers that must observe the condition of a minimal public network as for geographic and demographic situation. The minimal public network is set by the Ministry as the minimal number of provider in given specialization in the given geographical area. The Authority and local government authorities, shall monitor whether HIC contract 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 be reimbursed directly by the HIC and the patient will pay only a user fee (SKK 20 or 50), other providers will charge costs directly to the patients. Following a prior consultation, the patient may ask HIC for reimbursement, but only up to the amount of usual reimbursement of the contracted provider. The hospitals and other budgetary or state owned facilities providing health care will be transformed to joint-stock companies, with minimal 51% state ownership.

5.4 Scope of Benefits Covered from Public Health Insurance

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 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.

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 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 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 (pre-dominantly 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 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 11). The average co-payment of individually uninsured patients per diagnosis would reach at most SKK 200.

6. 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 (Table 12), while revenues of strong interest groups are declining (e.g. pharmaceutical industry) - many partial steps bring forth almost immediate palpable improvements that are important to win and retain the public trust.

Having people participate in bearing the costs of health care is the first step toward a true reform of health care. Health care is now viewed as a good by more than three in five respondents (61%); a similar number also believe that people should be primarily responsible for their own health. On the other hand, only one in eight respondents (13%) think the government should be primarily responsible for people's health. This finding suggests that citizens will eventually accept user fees for health care and that they are aware of the importance of this step, which is the first sign that the health care system is heading in the right direction.

Table 11: 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: HIC, calculated by the Ministry of Health care and authors

Table 12: Private household expenses for healthcare in SKK

	2000	2001	2002	2003	1st half of 2004	2004*
Monthly health consumption per capita in 1st half of the year	87	95	102	135	242	
Total Health in SKK million	6 354	7 856	8 440	10 209	7 694	15 500
Total Consumption in SKK million	519 596	577 522	623 146	667 453	356 889	715 000
Total health as a % of total consumption	1,22%	1,36%	1,35%	1,53%	2,16%	2,17%

* *forecast, Ministry of Health*
Note: These data are a bit different with the data and estimates of MOH. The "truth" lies sure between the two approaches. The most important factor that explains the differences is the informal payments. For MOH approach on co-payments see table 14.
Source: Family accounts, Statistical office of the Slovak Republic

Our analysis of the impact of user fees on the availability of medical services shows that the fees were set at the right level. On the one hand, fees have eliminated surplus demand for medical services; on the other, their impact on the availability of medical services has been negligible. At the same time, people's view of corruption as one of the most pressing problems for the country's health service has improved considerably.

User fees as marginal costs for the patients have helped Slovaks understand a simple truth: Though health care may officially be free of charge, it is not without cost. User fees as marginal costs – additional charges for services, drugs and some diagnoses – have not met with a positive response, which is understandable. Nevertheless, people are gradually beginning to understand their meaning; even more importantly, they are beginning to realize the value of their own health as well as the meaning and value of solidarity. The main political challenge is no longer the introduction of these fees but rather maintaining the political will to continue the reform. So far, no one has managed to refute the argument that the funds saved on needless expenses (e.g. overconsumption) benefit those who really need them.

It is very important, that after introduction of user fees, the access to healthcare was not hurt. Only 1.5% of population says that they stopped visiting the practitioner because of user fees. On the other hand, more than 18% said, that they decreased the number of outpatient visits to practitioners. This resulted in statistically significant decrease of outpatient visits in primary care by more than 10% without worsening the access to care. On the other hand, it is important to mention, that the according to the Association of primary care practitioners administrative costs of introducing the user fees are between SKK 7 and 9. The access to specialists and hospitals has no statistically important decrease (only by 1%) so the introduction of SKK 50 for bed-day did not represent a hurdle to in-patient treatment.

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 13), we are convinced, that the Slovak co-payment scheme as a flexible rationing tool is **intelligent**.

Table 13: 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 committees for defining the catalogue of procedures to every diagnosis 4. Establish categorization commissions that define 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

Table 14: Resources and expenditures in Health Sector, SKK billion

	2002	2003	2004e	2005f
Total resources in health care sector	**75,0**	**77,4**	**83,4**	**91,1**
HIC	57,0	58,6	62,6	71,6
MOH (without payments to HIC) and other budgetary chapters	4,7	4,8	4,8	3,5
Out of pocket – legal	6,8	9,5	12,5	13,5
Out of pocket – informal payments	6,5	4,5	3,5	2,5
Total expenditures	**84,2**	**82,2**	**85,8**	**91,1**
Deficit in SKK	**9,2**	**4,8**	**2,4**	**0,0**
GDP in SKK billion	**1096,0**	**1196,0**	**1311,0**	**1408,0**
Nominal Debt Growth, SKK billion	+ 9,2	+ 4,8	+ 2,4	+ 0,0
Health resources as % of GDP	6,8%	6,5%	6,4%	6,5%
Health expenditures as % of GDP	7,7%	6,9%	6,6%	6,5%

Notes: e – estimate, f – forecast
Note. The data in years 2003 and 2004 do not include the bailing out of hospitals and HIC (approx. SKK 15 billion) via state owned company Creditor
Source: MOH, 2004 in compliance with MOF budget proposal for 2005-2007

Both the stabilizing and systemic measures were strongly supported by the Creditor project aimed at solving the cumulative old debts of the system until 2002. Via Creditor Company the system obtained approx. SKK 15 billion which served for bailing out the old debt of providers and Health Insurance Companies after a massive control and audit of their debts (the system claimed debts in volume SKK 26 billion at the end of the year 2002). This last bail out served also as a basic precondition for ambitious structural changes in the health sector, primarily changing the legal subjectivity of health providers, the legal subjectivity of Health Insurance Companies, imposing hard budgetary constraints and new incentives mechanisms with state remaining as a regulator of the health sector in terms of benefit package, minimal network, maximal prices and patient protection. Since 2005 the fiscal position of Health sector in Slovakia is expected to be balanced (Table 14).

Endnotes

1) For former details see Zajac, R., Pažitný, P. & Marcinčin, A. (2004). Slovak Reform of Health Care: From Fees to Systemic Changes. Finance a úvěr - Czech Journal of Economics and Finance, 54, no.9-10, pp. 405-419.
2) Health Policy Institute, co-author of the Health Reform, Advisor to the Minister of Health
3) Minister of Health of the Slovak Republic, co-author of the Health Reform
4) World Bank
5) 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).
6) According to the World Bank (2003), Slovakia is increasingly less capable of managing health-related problems of industrialized countries, such as cardiovascular (53 % in Slovakia) and oncological (23 %) diseases.
7) 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.
8) Not an emergency service
9) 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).
10) Public opinion on health care related issues (Focus, November 2002 and January 2004).
11) Public opinion poll, June 2002 and October 2003.
12) Cluster is based on: active substance, route of application, pharmaceutical form and strength (the last two are not mandatory)

Literature

(1) CALLAHAN, D. (1994): *What Kind of Life – The Limits of Medical Progress*. Washington, D.C., Georgetown University Press, 1994.
(2) EVANS, R. G. (2001): Going for the Gold: Redistributive Agenda behind Market-Based Health Care Reform. Centre for Health Services and Policy Research 96:4r, University of British Columbia - Centre for Health Services and Policy Research..
(3) FOCUS (2004): Postoje verejnosti k problematike zdravotníctva. [Public Opinions on Health care Related Issues]
(4) OECD (2002a): *Economic Surveys, Slovak Republic*. Volume 11 – June 2002. Paris, OECD, 2002.
(5) OECD (2002b). *Health Data 2002*. Paris, OECD
(6) OECD (2003a): *Health Data 2003*. Paris, OECD
(7) OECD (2003b): *Health at a Glance*. Paris, OECD, 2003.
(8) OSTERKAMP, R. (2004): Patient's Financial Involvement as a Prerequisite for Financial Stability of Health-Care Systems, presented at New Healthcare as a Challenge and Opportunity Conference in Bratislava, 7 April, 2004, ifo Institute for Economic Research, Munich
(9) PAŽITNÝ, P. – ZAJAC, R. (2001). *Stratégia reformy zdravotníctva – reálnej reformy pre občana* [Strategy of Health care Reform – a True Reform for the Citizen]. Bratislava, M.E.S.A. 10, 2001.
(10) PAŽITNÝ P. – ZAJAC, R. (2002): Zdravotná politika [Health care Policy]. In: MARCINČIN, A. (ed.): *Hospodárska politika na Slovensku 2000-2001* [Slovak Economical Policy, 2000-2001]. Bratislava, SFPA, 2002.
(11) PAŽITNÝ, P. – ZAJAC, R. (2004).: Healthcare Reform in Slovakia, presented at New Healthcare as a Challenge and Opportunity Conference in Bratislava, 7 April, 2004, Ministry of Health
(12) SITA (2004): *Riaditeľ skalickej nemocnice si sám schválil plat* [Director of the Skalica Hospital Approved His Own Salary]. Available at the internet at www.sme.sk. Feb. 19, 2004.
(13) The World Bank (2001): *Overview of Social Sector Policies*. Washington, D.C., 2001.
(14) The World Bank (2002): *Budgeting and Expenditure Management in Slovakia. Improving Coordination between Departments and the Ministry of Finance*. Washington, D.C., 2002.
(15) The World Bank (2003): *Documentation for the World Bank Loan*. Washington, D.C., 2003.
(16) Štatistický úrad SR: *Štatistická ročenka SR 2003* [The Slovak Republic Statistical Yearbook, 2003]. Bratislava, Veda, 2003.
(17) World Health Organization (2003): *Health Indicators*. Available at the internet at www.who.int.