

Introduction

Government and recent political history

Since the Czechoslovak Republic's velvet revolution in 1989, the country has undergone substantial transformation towards a multiparty democracy and a social market economy. Since 1993 the Slovak Republic has been divided constitutionally from the Czech Republic. Slovakia has been a member of the Organisation for Economic Co-operation and Development (OECD) since 2000 and of the European Union (EU) since May 2004.

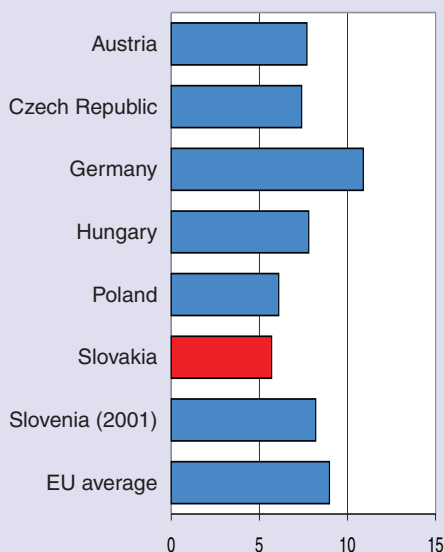
Population

Slovakia has 5.4 million inhabitants. In 2001 49.6% were economically active, 19% were below 14 and 18% over 65 years of age. In 2003 the unemployment rate was 17.1% compared to the 9.1% average of the 25 countries that are EU members after 1 May 2004 (EU average).

Average life expectancy

Life expectancy at birth has increased continuously since 1991 and was 69.8 years for men and 77.6 for women in 2002. Yet, while ranking above the average of the ten countries that became EU members on 1 May 2004 during the 1990s, growth has slowed in recent years. In 2002 life expectancy (73.9 years) ranked below the average of the new EU Member States (74.2 years).

Fig. 1. Total health care expenditure as % of GDP, comparing Slovakia, selected countries and EU average, 2002



Source: WHO Regional Office for Europe health for all database, June 2004.

Leading causes of death

In 2002, diseases of the circulatory system accounted for 55% of all deaths, 22% of deaths were due to cancer. Mortality from ischaemic heart disease ranked well above the average of the new EU Member States but cancer related causes of death were similar. Infant mortality was 7.6 per 1000 live births in 2002 and ranked above the average for the new EU countries.

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Recent history of the health care system

The Slovak health care system has undergone substantial and stepwise change from an integrated tax-based system with a state monopoly on providing care and socialist central planning to a pluralistic social health insurance system with multiple health insurance companies and a public-private mix of providers.

Reform trends

Decentralization has been pursued in several reform waves and hospitals have been involved only recently. Since 1997 cost-containment has become the dominant rationale of health care policy. Since October 2002, the re-elected government has initiated an encompassing reform agenda consisting of short-term cost-stabilization measures (2003) and a reform package of six major laws (enacted in October 2004). The 2004 reform, which takes effect from November 2005, provides for a wide-ranging reorganization of the financing, delivery and governance of health care.

Health expenditure and GDP

In 2002 Slovakia spent 5.7% of gross domestic product (GDP) on health care, ranking below the EU average of 9.0% and the average of the new EU Member States of 6.5% (Fig. 1).

Overview

Slovakia has managed largely to transform its health care sector into a pluralistic and decentralized social health insurance system. However, many reforms have not materialized in the way the population or policy-makers had expected. Most notably, the aspired increase of financial resources, accountability and quality of care has not been realized. Increasing internal and external debts have created a perception of financial and organizational crisis that paved the

way for comprehensive reforms since 2002. The 2004 reform has set out to restructure health care, limit the scope of publicly funded benefits and increase the role of private funding.

Organizational structure of the health care system

The Ministry of Health is the key policy-maker and regulator in the system, collaborating closely with the Ministry of Finance. Since 2002, municipalities and “higher territorial units” at regional level own, operate and supervise a significant proportion of hospitals and outpatient facilities for secondary care. There is free choice of currently five health insurance companies. They act as collectors, purchasers and third-party payers in the health system. Primary care physicians practise mainly in private single practices, while almost all specialists and other health care professionals are salaried employees.

Physicians, dentists, pharmacists and nurses are mandatory members of professional chambers. Besides professional development and supervision they are involved in carrying out inspection and control of both state and private health care facilities, in developing mandatory legal regulations and a performance related pay scheme.

The 2004 reform virtually redefines the roles and competencies of all health care actors and their interrelations to clarify responsibilities.

Planning, regulation and management

Until 2001 the planning, regulation and management of health care financing and delivery largely was centralized at the Ministry of Health, which also owned most of the hospitals and many outpatient specialist facilities. Since then the ownership of most hospitals and clinics for secondary outpatient care, including

competencies to plan, regulate and operate, have been devolved to self-governing municipalities and higher territorial units at regional level.

The five not-for-profit health insurance companies are governed by bi-partite self-governing structures with little discretion over their operations since, for example, parliament defines uniform contribution rates. Parliament also approves the amount and structure of the annual budgets of the two major statutory health insurance companies.

Decentralization of the health care system

Decentralization has been pursued in three waves, while a fourth has recently been enacted. In the early 1990s, health care financing was delegated to social health insurance companies. Almost all primary care physicians, pharmacies, spas and pharmaceutical industries were privatized. From 1995, multiple insurance companies were introduced to compete for insured persons while pooling financial risks. In practice, competition was limited.

Until January 2002, the Ministry of Health owned and operated almost all inpatient health care facilities. Since then, most secondary care hospitals and adjacent polyclinics have been transformed into non-profit public benefit entities or devolved to self-governmental municipalities or higher territorial units at regional level; and some outpatient clinics have been sold to private providers. Tertiary care hospitals continued to be owned by central government.

The 2004 reform provides for a gradual privatization of state-owned hospitals and other health care facilities into for-profit joint stock companies supervised by the Office of Health Care Supervision.

Health care financing and expenditure

Main system: social health insurance

All permanent residents and economically active immigrants are eligible to in-kind benefits from mandatory social health insurance which accounted for 86% of total health expenditure in 2002, 49% being derived from employers and employees and 37% from tax transfers.

In 2003, employees paid 4% and their employers 10% of gross earnings, while employers of people with disabilities contributed only 2.6%. There is an upper limit on the individual's income on which contributions are paid. This was set at 32 000 Slovak koruny (SKK) per month in November 2003 (equal to €778; €1=SKK 41). Self-employed individuals paid 14% of their assessed income. National government pays contributions on behalf of family dependants, pensioners, and most other economically inactive residents, at a rate of less than 14% of the minimum wage. The national government guarantees the operations of the two largest health insurance companies, which covered together 78% of the population in 2002, and the payment of any debts. In turn, these two must submit their annual budgets to parliament for approval. Contribution rates are uniform and are defined by law.

Since 1995 each health insurance company has been obliged to transfer a legally-defined share of income to a special mandatory account. This is reallocated by an administrator in order to adjust for differences in age- and gender-related risk and the income of insured members. Since October 2002 this share has been set at 85%.

From 2005, health insurance companies, currently operating on a not-for-profit basis, shall be transformed gradually into for-profit joint stock companies.

Health care benefits and rationing

Health care benefits are defined by law and have been very comprehensive. The health insurance companies cover a statutory catalogue of health services and medical products for curative, palliative, preventive and rehabilitative care, including certain spa treatments. Sick pay is financed via the separate Social Insurance Company.

The 2004 reform package determines that the range of services reimbursed fully by mandatory health insurance will be restricted to priority diseases (“solidarity package”), defined by a ministry of health task force. Several other conditions may also be fully reimbursed on the basis of a decision of the Ministry of Health Categorization Committee, which will categorize “non-priority conditions” and specify the level of required co-payments. On the other hand, screening benefits shall be enhanced and matched with major national programmes for circulatory system diseases and neoplasms.

Complementary sources of financing

Taxes accounted for 3% of total expenditure in 2002 (transfers to health insurance companies not included). Derived mainly from the national budget, state expenditures on health include most capital investments, full operation of the remaining state-owned facilities and some preventive health programmes.

Private sources accounted for 11% of total expenditure in 2002 which were contributed almost entirely by private households through formal out-of-pocket payments, including direct payments for non-covered services and products and co-payments. The latter applied to very few benefits until June 2003 when co-payments were introduced for virtually all services or products, e.g. SKK 20 (€0.50) per office visit,

SKK 50 (€1.25) per prescription or per hospital day. Persons in material need, children under six years, blood donors, patients with mental illness and long-term ill patients are exempt from co-payments. Informal out-of-pocket payments for health services presumably are substantial, but accurate data are unavailable and not accounted for in the national health accounts.

Voluntary health insurance used to be limited to travel insurance. According to the 2004 reform it shall be extended substantially to help cover the expected increase of co-payments and excluded benefits. Voluntary schemes shall be offered by established health insurance companies as well as new, for-profit health insurance houses.

Health care expenditure

In 2002 Slovakia spent a total of SKK 62.4 billion (defined as a thousand million) on health care. Per capita adjusted for purchasing power (PPP) the country spent US \$698, less than the average of the new EU Member States of US \$PPP 756 (2001). Health care was also substantially cheaper than the EU average of US \$PPP 2128.

Slovakia is one of the few countries where health care expenditures as a share of GDP (Fig. 1) did not increase since 1997. In contrast, the share even decreased slightly following policies to contain health insurance contributions as well as health expenditures. The share of public expenditure accounted for 89% of total expenditures in 2002 ranking higher than in most EU countries.

National accounts do not adequately reflect either the annual deficits of health insurance companies (about 10% of revenues since 1995) nor their cumulative debts. Although partly settled by government, total health care debt reached SKK 33 billion by the end of 2003 (SKK 16 billion internal debts, SKK 17 billion external debts).

From 1997 until 2002 an increasing share of total expenditure was spent on pharmaceuticals (34% in 2002) and hospital care (40%), while the share of primary care (10%) and ambulatory secondary care (5%) decreased.

Health care delivery system

Public health services

The responsibility for public health services was devolved to a network of 37 state health institutes at regional and district level in 1995. These were coordinated by the chief hygienist at the Ministry of Health and central control remained strong. Since 2004 public health tasks have been performed by a network of 36 offices of public health at the level of higher territorial units and municipalities. The 2004 reform strengthens their role in national programmes to prevent non-communicable diseases and seeks to improve cooperation between public health services and primary care.

Primary and secondary outpatient care

Four types of first contact doctors deliver primary medical care – general practitioners for adults, general practitioners for children and adolescents,

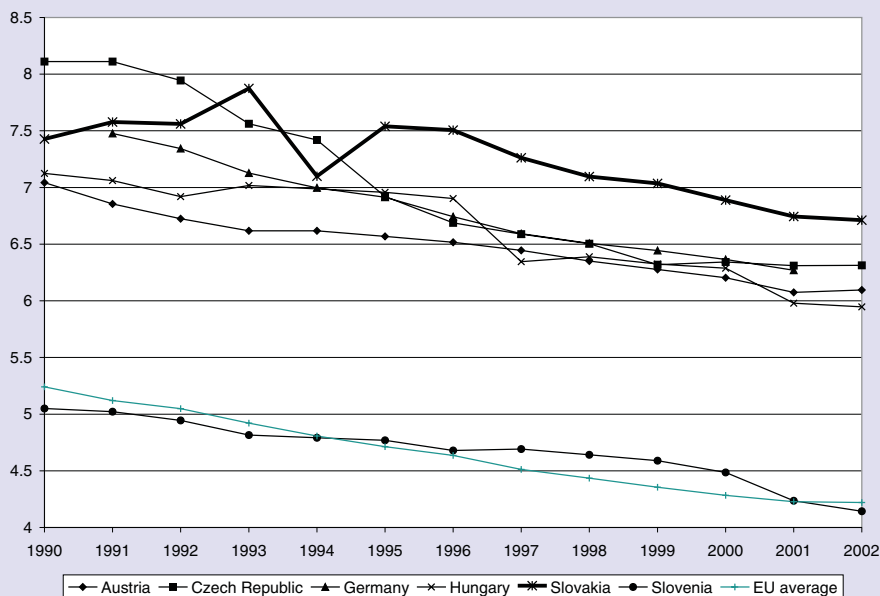
gynaecologist-obstetricians and dentists. These primary care doctors accounted for only 38% of the 16 897 physicians practising in 2002. Despite primary care doctors' gate-keeping role, patients with certain conditions may self-refer to psychiatrists, geneticists and specialists in sexually transmittable diseases. Moreover, direct specialist access also is available to chronically ill patients who are registered in specialist clinics. Altogether, the number of outpatient contacts (14 per capita in 2002) ranks substantially higher than in all but one EU Member States.

The 2004 reform package provides for a redefinition of health care providers' roles and their competencies in contracting and negotiating with health insurance companies and coordinators of care to higher levels of care.

Secondary and tertiary hospital care

In 2002 there were 137 inpatient facilities with 41 365 beds in Slovakia. Of the 7.6 hospital beds per 1000 population, 6.7 were in acute care.

Fig. 2. Hospital beds in acute hospitals per 1000 population, Slovakia, selected countries and EU average, 1990–2002



Source: WHO Regional Office for Europe health for all database, June 2004.

Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2002 or latest available year

	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Austria	6.1	28.6	6.0	76.4
Czech Republic	6.3	19.7	8.5	72.1
Germany	6.3 ^a	20.5 ^a	9.3 ^a	80.1 ^a
Hungary	5.9	22.9	6.9	77.8
Slovakia	6.7	18.1	8.8	66.2
Slovenia	4.1	15.7	6.6	69.0
EU average	4.2	18.1 ^a	7.0 ^a	77.1 ^a

Source: WHO Regional Office for Europe health for all database, June 2004.

Notes: ^a 2001.

Although acute beds had been reduced from 7.5 per 1000 in 1995, Slovakia still had the highest rate among EU countries (Fig. 2). Slovakia also had one of the lowest occupancy rates (66%). The acute hospitals' admission rate of 18 per 100 inhabitants was the average for the EU Member States, while the average length of stay in acute hospitals was comparatively high at 8.8 days (Table 1).

Social care

Capacities for social care have been developed since the early 1990s. About 1000 acute beds have been transferred to long-term care and 1500 to social care, mainly homes for the elderly. Psychiatric care is delivered partly in specialized hospitals and partly in departments of general hospitals. Also community-based projects such as harm reduction in drug users have been introduced in recent years.

Home care agencies have been promoted only since the end of the 1990s, their number increased to 173 in 2003. The 2004 reform allows nurses and midwives to obtain independent provider status.

Human resources and training

In 2002, 6% of all employees worked in the health sector, two thirds in state facilities and one third

in private settings. In the same year, the density of active physicians (3.2 per 1000) was above the average for the new EU Member States (2.7) but below the EU average (3.4). In contrast, the number of nurses (7.1) ranked lower than the average for the new EU countries (8.1) as well as the EU average (7.7, data for 2001). The number of physicians increased slightly throughout the 1990s but the number of nurses remained fairly static (Fig. 3). From 2001 to 2002, the number of nurses decreased from 39 973 to 38 066 in the course of the decentralization of health care facilities and migration abroad.

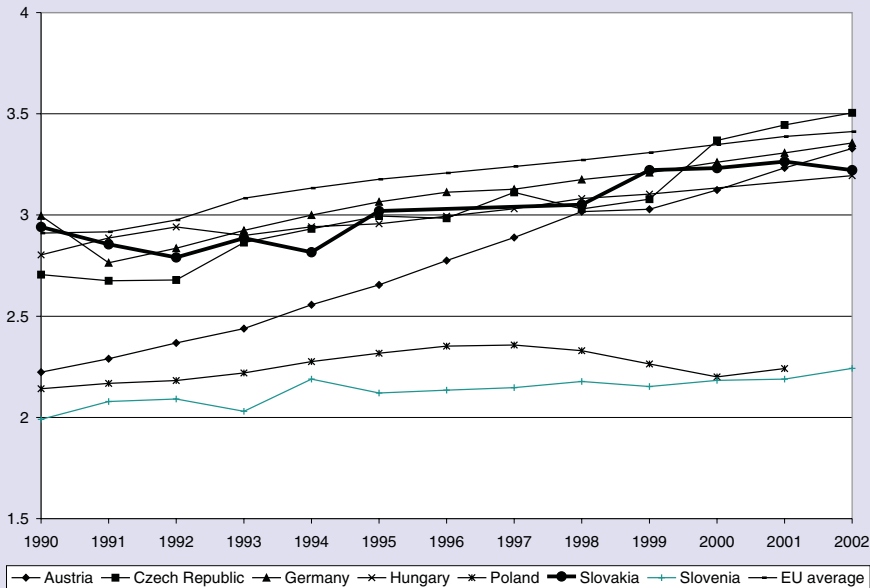
Since 2000, primary training of nurses and midwives has been based exclusively in universities. Postgraduate training of health care professionals may now be provided by all universities upon accreditation.

Pharmaceuticals

Since 1995 health insurance companies have not automatically fully reimbursed pharmaceuticals registered for the Slovakian market. Instead, drugs are classified into three categories: essential pharmaceuticals that are fully reimbursed, partially reimbursed drugs (mainly me-too drugs until 2004) and drugs on a negative list.

Expenditure on drugs has grown rapidly since 1991, although growth has slowed in recent years

Fig. 3. Physicians per 1000 population, Slovakia, selected countries and EU average, 1990–2002



Source: WHO Regional Office for Europe health for all database, June 2004.

due to stricter cost-containment measures. In 2002 Slovakia spent 34% of its total health budget on drugs in ambulatory care, the highest share of all EU countries. Four fifth of drug expenditures were paid by social health insurance and less than one fifth by private households.

To better control expenditures, fixed co-payments and spending caps for drugs and medical aids were introduced at individual provider level in 2003. Since then, health insurance companies have negotiated strict monthly or quarterly prescription limits as part of their contracts with providers. Health technology assessment is used increasingly to inform the drug classification process, the last changes being made in June 2003. Since 2004, the Ministry of Health's responsibility for drug categorization has been integrated with the functions of determining maximum prices of drugs and medical devices which used to be a task of the Ministry of Finance. The 2004 reform provides that at least one drug of

a positive list of approximately 115 ATC groups must be fully reimbursed by the publicly funded health insurance.

Financial resource allocation

Third-party budget setting and resource allocation

The system of resource allocation has been decentralized in several steps and cost-containment has become increasingly strict. Until the end of the 1990s, health care services were paid retrospectively according to invoices rendered. From 1998 prospective spending caps for individual hospitals and providers of outpatient specialist care were introduced.

Contracts between providers and social health insurance companies included both the range of services to be delivered and quantitative factors, for hospitals e.g. the amount of money and the volume of services. From June 2003, health insurance companies became obliged to negotiate structured contracts with all providers and to monitor their performance. The five health insurance companies hold a dominant position in these negotiations, especially when contracting with individual health care providers. Due to their tight financial situation, they partly delay payment to health care providers who are therefore unable to meet bills (e.g. from suppliers of drugs or electricity) and in turn evade health insurance contributions for their employees.

Payment of hospitals

Since the introduction of social health insurance and performance-related payment principles in hospital care, reimbursement methods for recurrent expenditures have been changed several times, including a retrospective reimbursement system based on fee-for-service points (1993–1994) and per-diem charges (1994–1998). From 1998 hospitals received prospective budgets according to the number of cases and services in the previous months, thus based on historical expenditures. In response to hospitals' substantial debts a case fee system based on diagnosis-related groups was introduced in 2002. The new payment system shall provide incentives to enhance transparency of services and costs, shorten the average length of stay and increase day-treatment procedures.

Payment of physicians

The reimbursement mechanisms for primary care physician services have changed several times. Since 2001 the capitation for primary care physicians has been structured by age and complemented by a fee-for-service payment for preventive services.

For dentists and private office-based specialists or for the employers of salaried specialists,

outpatient care services continue to be reimbursed by fee-for-service (on a points basis). Total reimbursement is controlled by limiting the range and volume of services negotiated with individual specialists each month.

At the start of the privatization process privately contracted doctors were given an advantage over public institutional providers as their fee-for-service points were multiplied by a co-efficient. Private physicians pay salaries to their nursing and other staff, and rent rooms and equipment mostly in polyclinics or hospitals.

State employed specialists and other personnel continue to be salaried according to a national pay scale but since January 2004 employers have been given more flexibility to align the motivation component of their pay.

Health care reforms

Since the velvet revolution in 1989, different governments have stressed differing policy priorities, but the main strategies – health care financing through social health insurance and decentralization including privatization of health service provision – did not change. However, cost-containment became increasingly stringent from 1999, and the role of complementary funding from private sources was increased from 2003.

During the legislative period 1998–2002 reforms addressed issues like defining the appropriate role of the Ministry of Health, privatizing or devolving hospitals, reducing excessive bed capacities, introducing budgets and diagnosis-related payments in hospitals, promoting day and home care services.

Since October 2002 the re-elected government has placed great emphasis on health policy and developed an encompassing reform agenda to reduce the gap between public revenues and expenditures as well as to increase the system's efficiency, accountability and responsiveness to population needs.

Stabilization measures were introduced in June 2003 in order to stop the growth of debts, especially by extending co-payments and introducing prescription limits to pharmaceuticals. The first measures seem to have decreased prescriptions and physician visits without restricting socially disadvantaged persons' access to necessary care, but their impact cannot be fully evaluated at this stage.

The major part of the government's reform agenda, a package of six reform bills, was submitted to parliament in May 2004, amended and finally enacted in October 2004.

Some of the 2004 reform measures received broad consensus, such as the increase of state insurance contributions based on average salaries (rather than minimum wages), the clarification of competencies and relations among actors, the permission for nurses and midwives to work as independent providers, the requirement of independent financial audits for all institutions above a certain annual turnover, the strengthening of prevention and reorganization of emergency services, a clear priority setting, and – generally – a greater involvement by the private sector in health care delivery or the establishment of voluntary, complementary health insurance.

Other reform measures raised considerable controversies before they were finally passed by parliament:

- The range of benefits reimbursed fully by mandatory social health insurance will be restricted to a list of priority diseases, defined by a ministry of health task force.
- Less prioritized diseases and completely excluded conditions will be paid out-of-pocket or through voluntary complementary insurance, defined by the Ministry of Health Categorization Committee, which may also add other conditions to be fully reimbursed.
- The health insurance companies, currently operating on a not-for-profit basis, will be transformed gradually into for-profit joint stock companies with the government holding shares.
- Hospitals will be transformed gradually into joint-stock companies.

Health insurance companies as well as hospitals and other health care providers will be accredited, supervised and audited by the new Office for the Supervision of Health Care according to health care specific rules. The office shall also control the content and scope of health care services purchased within the framework of the publicly financed “solidarity package”. The new insurance houses offering voluntary health insurance will be accredited and supervised by the Financial Market Authority.

Conclusions

During the last fifteen years of fundamental socioeconomic transformation, Slovakia has managed to shift from an integrated tax-based system with a state monopoly in providing care to a pluralistic and decentralized social health insurance system with a private-public mix of providers. Downsizing measures finally have achieved the reduction of excessive inpatient capacities in the capital and major cities. The new private or public owners of health facilities increasingly hold managers accountable. In the face of fiscal constraints, public health expenditures have been contained at, or even decreased to, a relatively low level compared to other EU Member States. Yet, Slovakia has succeeded in maintaining equal and universal access to a comprehensive range of benefits, although access in rural areas is more limited than in cities. Reforms seem to have been implemented without significant adverse effects on the population's health.

Despite these achievements, Slovakia is confronted with various challenges. The

widespread perception of crisis relates to aspects of good governance, accountability, responsiveness and prudent use of resources. Reforms have neither stopped the growth of debts nor increased the motivation of health professionals. While drug expenditures take a comparably large share of expenditures, health professionals' incomes have not increased satisfactorily. Acute bed capacities are very high by international standards but community-based services and day-treatment still are regarded as underdeveloped. Most notably, the goal to strengthen primary and community-based care has not been achieved fully. There is not sufficient encouragement for health care to be delivered at the most appropriate and cost-effective level of care.

The reform provides ample opportunities to meet these challenges more effectively but also holds potential risks. The outcomes will depend largely on its implementation throughout the following years. Although painful, this fundamental reform could represent a significant step forward in the history of the Slovak health care system.

The Health Care Systems in Transition profile on Slovakia was written by Svätopluk Hlavačka (Ministry of Health of the Slovak Republic), Róbert Wágner (Slovak Healthcare University Bratislava) and Annette Riesberg (European Observatory on Health Systems and Policies, Berlin). The responsible associate research director was Reinhard Busse (European Observatory on Health Systems and Policies, Berlin). The Health Care Systems in Transition profile (HiT) draws upon an earlier edition published in 2000 that was written by Svätopluk Hlavačka (Ministry of Health of the Slovak Republic) and Dagmar Skačková (WHO Liaison Office in the Slovak Republic).

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The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Systems and Policies.

The Observatory is a unique undertaking that brings together the WHO Regional Office for Europe, the governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health care systems in Europe.

The HiT reflects the state of reform and data in October 2004.