Reforms of health care delivery in Slovakia and their impact on performance of hospitals: quality of services and quality of financial management

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1. Introduction

Our paper consists of introductory and main parts, plus conclusions, drawn on macro and microanalysis of selected aspects of the given problem. Its two starting parts create the basis for further explanation, describing general trends of the Slovak health policy and ways how these policies were incorporated into reform documents, and implemented.

Three core parts focus on important public policy and public management issues. First of them tries to assess outcomes of health reforms in Slovakia in two selected fields (quality of hospital services and quality of hospital financial management), searching for appropriate methods and techniques for monitoring the outcomes of reform implementation, including indicators that are or could be used. The second core chapter tries to find answer, why outcomes are not very much positive, at least in short term point of view. It seems that both policy formulation and policy implementation failed. Our findings support the evidence from the practice of policy making, showing that the stage of implementation is extremely weak in Central and East European countries, but adding, policy formulation is not always of proper quality, too. The last core part tries to identify some major factors, retarding the successful implementation of reform policies.

2. Health policies in Slovakia: main reform goals

The aim of the old system was to provide a comprehensive system of health care for all members of the society. All decisions on medical provision were made by the Federal Government and the national Slovak Ministry of Health. They were generally made on political or administrative grounds, and the only accountability was to the communist party. The important reason for the relatively low priority of health was a legacy of Marxist-Leninist political economy. Drawing on Marx's distinction between productive and unproductive labor, the official ideology placed health in the second and less prestigious ideological category. This reinforced its position as a non-key sector, and made its problems less urgent for policymakers. It also accounted for its relatively low wages, and its overwhelmingly female labor force.

A second aspect of the planned economy that was to shape the structural aspects of post-revolutionary Czechoslovak health care was the supply-constrained nature of the system. This had a damaging effect on quality, raising the importance of quantity above quality in plans, and led to producers being insensitive to consumers' wishes. Neither demand nor supply influences necessarily affected the output plans of institutions, nor where exchange occurred it was the suppliers who dominated.

Concerning health, the services were free at point of use, but only after 1987 did patients have the right to choose their primary care providers, opticians and dentists. There were no economic incentives to improve systemic performance, and in general excess demand
prevailed. There were no attempts to reduce excess supplies or demands through either coordinated treatment scheduling, or pooling the resources of the different sectors of the health care system. Resources for health continued to grow, though at very modest rates, and in 1989 stood at roughly 5% of GDP, against an OECD average of about 8%.

In this starting situation, in many aspects better than in other post-soviet countries, the Slovak government started massive reforms, focusing on maintaining the access, increasing the quality, improving outcomes, especially life expectancy, and controlling the costs of health care systems. The 1992 Slovak government statement might be used as representative expression of main goals (see Programme Declaration of the Government of the Slovak Republic, 1992):

"Government activities in the field of health care shall be based on the urgent requirements to stop the impairment of the state of health of the population. Based on the "health for all" principle, the essential element in our policy of public health is to afford health care for every citizen of our republic as required by his state of health, financially based on the principle of mandatory health insurance, with the state providing this obligation in the case of economically inactive citizens. The insurance system shall result in radical changes not only in the health care financing field but will positively influence the physician - patient relationship."

Trends to slight redirection of Slovak health policies after 2002 (for example towards higher participation of patient) were envisaged by the Prime Minister Dzurinda’s coalition government proclamation as follows (Sme, 5.11.2002, p. 2):

"The government focuses to stop increasing the debt of the system, and balance its economy, on the basis of equal financial contribution (in real terms) from the state budget as in 2002. The access and flexibility of services delivered shall increase; the priority for the state will be expensive treatments that cannot be paid individually by the patient. The preventive aspects of the system, a shift to ambulatory care, home care, and same day surgery shall be priorities. The law on health care shall define the scope of services financed via compulsory insurance; all other services shall be paid from voluntary insurance system."

3. Health reform implementation processes

General trends of health policy in Slovakia were defined by Programme Declaration of Government and main reform documents (first of them published in 1990). The most important goals of the reform were health care for everybody, guarantee of "needed" scope of health care to everybody cancellation of a state monopoly in health care, plurality of provision of health care, privatization, increased participation of self-government in health care system, introducing of comprehensive compulsory (social) health insurance, multi-resource financing of health care, and to stop an impairment of health status of citizens. These goals did not change during the entire period, but in the later phase after 1995, health finance and necessity to balance costs and resources became an increasing priority, and from 2004 additional new elements were incorporated.

Two most important reform dimensions were the development of the insurance system and privatization. Slovakia introduced a system of social health insurance, to replace the old general taxation system of finance. The main laws regulating health insurance were passed in 1994, laying the foundation for establishing thirteen health insurance companies. Most of these disappeared from the “market” leaving only five by 2002.
The privatization of the Slovak health care system started in the middle of 1990’s mainly in outpatient care and pharmacies. The objective of privatizing in-patient care was proclaimed several times, but by 2001 there were only three non-state hospitals in the whole country. In 2002 the management of hospitals was decentralized, and some hospitals were given self-governing status. Only in 2003 - 2004 period some hospitals became non-profit semi-independent bodies.

In primary care, in 1995 the state system accounted for 58 % of expenditures, in 1996 only for 8 %, and by 2001, 5 %. For pharmacies, the development was similar – the proportion in the state sector decreased from 97 % in 1995 to 5 % in 1996 and 3 % in 2001. The privatization of specialized ambulatory care was slower, but already by 2001 the state sector accounted only for 26 % of facilities (see Zajac, Pažitný, 2002).

The semi-radical shift after 2002 to limited marketization of the system was concluded in Jun 2004, when the health minister Zajac prepared and submitted to the Parliament the set of new health laws, expected significantly to change the system, by increasing the level of co-payments, introducing of commercial voluntary health insurance, and changing health insurance companies into joint-stock companies. All these six draft laws were approved and are valid from January, 1st, 2005. Their impact on the health system in Slovakia will not be immediate, and are difficult to predict. In following text we just highlight their main principles (and do not discuss plus and cons of new legislation, because of the focus of our paper).

The Law on emergency service

This law is the less complicated new legal norm. It stipulates that every citizen has the right to fast emergency service, available, as maximum, in 15 minutes. The emergency service will be produced by any form legal person with the license (respecting the public-private-civil sector mix principle).

The Law on health care and other health related services and the Law on the scope and scale of health care financed by compulsory social health insurance and on financing of health related services

These two laws have to be evaluated together. The first one is the basic law, the second sets the rules of implementation. This new legislation incorporates into the health care system the principle of rationing: distinguished between what shall be available free at the point of use to everybody and what not, by setting following structure of health services:

A: Emergency health care – delivered to all threatened, independently of individual ability to pay.
B: Health care services, divided into two groups, as follows:
   B1: Basic package of health services, fully covered from compulsory social health insurance
   B2: Other health services, subject to co-payment from the patient
C: Heath related services (accommodation and catering in hospitals, etc.), delivered for fee.

The second law sets the rules for reimbursement of respective health services in detailed way.

The Law on health insurance
This law sets new rules for health insurance system. For the first time two layers of health insurance are created:

A: Compulsory social health insurance, providing insurance services according to specific health care legislation (above mentioned laws).
B: Individual (private) health insurance, providing insurance services according to general business law (Business Code).

The social health insurance system is still defined in broad way to maintain guaranteed access of citizen to basic package of health services. It is based on fixed rate contributions from employers, employees and from the state for the economic inactive citizen (new, see bellow), and includes redistribution mechanisms according to risk (to prevent cream-skimming).

The Law on health insurance companies

According to this law, all health insurance companies shall be transformed to shareholders companies, with 100 % share of the state in two of them (General Health Insurance Company a Joint Health Insurance Company). The set of rights and responsibilities of insurance companies significantly increases, to allow them to function as real regulators of the health care system: as most important, insurance companies are responsible for securing the minimum network of health facilities in their region and for contracting health providers.

The Law on health providers, health professionals and their professional bodies

This law enlarges the list of types of health providers (for example by including home care, one day care), sets the principles of minimum network and provides for transformation of all health providers to non-profit or shareholders companies (no state health care providers are expected to exist after 2006).

4. Health reform outcomes and problem of their measurement

One of the most difficult public policy and public finance issue is the assessment of the level of success of any reform measure. The NISPAcee Working group II (www.nispa.sk) indicated in its call for papers several crucial questions concerning this aspect, like:

“*What methods and techniques are available for monitoring the process and outcomes of implementation? Are there viable systems of indicators that are or could be useful in monitoring and evaluating implementation?***

In our paper we try to provide partial answers to this challenge, using two dimensions as the base: quality of hospital services and quality of hospital financial management in Slovakia and their trends, as two potential dimensions to evaluate what was achieved during reforming the Slovak health care 1990 – 2002 (real impacts of “marketization” cannot be visible as of today).

We have to stress immediately that our view is only short-term view. Respective reform measures were in force for relatively short period, and their long term consequences might differ from short-time perspective. However, relatively radical changes from 2005 represent discontinuity, preventing long term outcomes to occur.
Experts, but mainly politicians always want to show reform outcomes from their political (professional) point of view. Frequently their opinion on the same problem dramatically differs. There is no chance to find the same voice, as values differ, but some objective indicators might provide certain space for comparisons. We will try to rely on such indicators in our following analysis.

Quality of hospital services

It is very difficult to assess developments in the quality of care in Slovakia after 1989, as there are no available effective indicators. Even, the term quality has really many dimensions, preventing its unified use. In following text we focus on two dimensions – clinical quality of care and organization (patient’s) quality of care.

Concerning clinical quality of care, there have been significant and measurable quality improvements on the supply side. These have been mainly in the structure and quality of equipment available in health establishments, and in the range of medicines available and used for treatment. After 1989 several barriers limiting the possibility of importing top “Western” technologies were dismantled, and the regulations concerning what can be purchased and prescribed were weakened. Such trends delivered contradictory outcomes – on the one hand, there were improvements in the technical aspects of quality of services, on the other hand, there was a relative “oversupply” of technologies and expensive drugs, which was one of the causes of financial problems in the system.

Compared to positive technical developments, the trends in other aspects of clinical quality are more controversial, however difficult to prove. In spite of many promises the Slovak government was not able to introduce systematic medical and organizational audit of health providers, which would tell us more about how the care is delivered. Only in October 2002, with the appointment of a new health minister, has the government been willing to accept that problems with the clinical quality of care exist and probably increase year by year, as the consequence of the persistence of many unsolved internal problems in the system (for example not only low, demotivating wages for personnel, but also the non-existence of required technical clinical standards). The case of the mistreatment of the Slovak President in 2000 (see Zajac, Pažitný, 2000) clearly showed basic weaknesses in the daily delivery of care, but it was not used as an impetus for changes.

Trying to limit some health care quality problems the Slovak Ministry of Health initiated from 2002 several actions to improve the situation, like creation of special unit for patients´ complaints in the ministry, promise to introduce medical standards for all levels of health care; also known cases of mistreatment are immediately inspected by the Ministry. In most such cases responsible doctors were suspended, even respective hospital department temporarily closed.

To document existing problems in clinical quality of care, two sets of indicators are used in our paper. One of them is the increased frequency of reporting (by media) on misconduct of medical personnel when treating patients, and related increase of court cases suiting medical professionals for mistreatment. Only in 2004 media reported on 4 cases where the death of the patient was clearly caused by the hospital: highest number ever. In beginning of 2005 the patient won for the first times in the Slovak history his case against the doctor, concerning mistreatment. However, these indicators do not directly prove that clinical quality is decreasing; they just indicate increased awareness about the problem (moreover official longer sets of data are not available to define trends).

The second suggested indicator: frequency and structure of patient’s complaints, is common for clinical and organization aspects of quality – existing data prove that the level of
dissatisfaction increases (for more detailed info on structure of complaints see later text). The weakness of this indicator is connected with the problem of expectations in two directions:
- of there are no expectations, no claims would occur,
- if there is expectations that complaints would not help, number of complaints decreases.

There is some evidence proving that the organizational (patient’s) quality of care improves, but very slowly. Compared to the old system, there is a choice of provider, but the patient is still very far from becoming the central subject of the system. In Slovakia the document “Patient Rights” was prepared and published in 2000, and some establishments have not yet adapted it fully to local conditions. Queuing for treatment without the option for a precisely appointment is typical with most providers, including private ones.

As mentioned, important indicator of both clinical (see above) and organizational quality are the reactions from patients. As the part of developing governance and e-governance system in Slovakia, all patients have now the possibility to complain for health care related problems to the special unit in the Ministry of Health Care – the Unit for Protection of Patients’ Rights. The number and structure of such appeals is warning, and tells that there are major quality problems that need to be solved. We select some of negative messages, related to hospital care:
- complaints concerning the quality of care delivered
- lack of communication between medical personnel and patient
- non-professional behavior of medical personnel
- lack of information provided to the patient
- "demotivating" to complain by medical personnel
- illegal payments – to doctors and for certain services (labs, transport …)
- doctors ask directly for sponsorships
- foreign patient was not allowed to check the price list and to consult methods of treatments, etc.

Quality of financial management in hospitals: case of public procurement

Taken together the governmental statements identify as one of the main aims of transition as improving efficiency. But in practice such aim has not been consistently realized; and by 2002 the hospital and insurance sectors in Slovakia were heavily indebted. In addition several crucial and chronic weaknesses remained. Specifically: low economic efficiency; a lack of evidence-based decisions; low relative pay and the attendant labor retention problems; over large drugs bills and insufficiently effectively managed capital programmes, and a general underdevelopment of preventive medicine. Shortage of funds led hospitals to proliferate the range of services, and to pay low wages. Drug bills exploded, and the lack of overall control of the system led to inefficient capital investment programmes, and insufficient resources were devoted to preventive medicine.

The Table 1 provides basic data characterizing the financial situation of health care systems in Slovakia. Data from this Table, especially development trends of hospital
expenditures might be important indicator of quality of financial management at micro and macro level.

Table 1
The Economic Performance of the Health Care System in Slovakia (in billions of SKK)

<table>
<thead>
<tr>
<th>Year</th>
<th>Health insurance system resources</th>
<th>Resources from the Ministry of Health</th>
<th>Resources from Social Insurance Company</th>
<th>Direct payments from inhabitants</th>
<th>Total resources</th>
<th>Primary care costs</th>
<th>Secondary ambulatory care costs</th>
<th>In-patient care costs</th>
<th>Medicaments and health aids costs</th>
<th>Other costs</th>
<th>Balance</th>
<th>Deficit coverage</th>
<th>External debt</th>
<th>Privatization grants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>35.4</td>
<td>4.6</td>
<td>1.0</td>
<td>2.6</td>
<td><strong>43.6</strong></td>
<td>4.3</td>
<td>0.2</td>
<td>21.4</td>
<td>12.2</td>
<td>1.1</td>
<td>-0.2</td>
<td>0.2</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>1997</td>
<td>38.4</td>
<td>4.9</td>
<td>1.2</td>
<td>3.8</td>
<td><strong>48.3</strong></td>
<td>4.5</td>
<td>1.3</td>
<td>24.0</td>
<td>14.5</td>
<td>3.4</td>
<td>-4.2</td>
<td>4.2</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>1998</td>
<td>41.4</td>
<td>4.7</td>
<td>1.3</td>
<td>4.1</td>
<td><strong>51.5</strong></td>
<td>4.4</td>
<td>1.5</td>
<td>25.6</td>
<td>16.1</td>
<td>4.0</td>
<td>-5.6</td>
<td>5.6</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>1999</td>
<td>43.0</td>
<td>4.4</td>
<td>1.3</td>
<td>4.4</td>
<td><strong>54.1</strong></td>
<td>4.7</td>
<td>1.8</td>
<td>25.0</td>
<td>18.8</td>
<td>4.1</td>
<td>-4.4</td>
<td>7.9</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>2000</td>
<td>45.3</td>
<td>4.5</td>
<td>1.0</td>
<td>4.7</td>
<td><strong>56.7</strong></td>
<td>4.9</td>
<td>1.9</td>
<td>26.0</td>
<td>20.6</td>
<td>6.9</td>
<td>-7.9</td>
<td>8.6</td>
<td>3.5</td>
<td>0.0</td>
</tr>
<tr>
<td>2001</td>
<td>49.6</td>
<td>4.9</td>
<td>1.1</td>
<td>5.4</td>
<td><strong>61.9</strong></td>
<td>5.9</td>
<td>2.1</td>
<td>28.1</td>
<td>22.8</td>
<td>7.7</td>
<td>-8.6</td>
<td>5.7</td>
<td>5.2</td>
<td>0.0</td>
</tr>
<tr>
<td>2002</td>
<td>55.0</td>
<td>4.8</td>
<td>1.2</td>
<td>5.9</td>
<td><strong>68.0</strong></td>
<td>7.0</td>
<td>2.2</td>
<td>29.5</td>
<td>24.1</td>
<td>8.0</td>
<td>-5.7</td>
<td>5.7</td>
<td>2.1</td>
<td>0.0</td>
</tr>
</tbody>
</table>


The data show that in spite of the economic performance of the system and that the necessity to improve is on the agenda of the Slovak government, the real results are unsatisfactory. In Slovakia from 1997 the system systematically consumed 10-15% more than the available resources and this trend did not change in spite of many attempts to rectify it. Minor improvements in 2004, like decrease of total amount of drug expenditures may represent signal of “future good times”, but it is too early to assess real trends resulting from new reforms.

Reform team expected that new legislation and regulations issued after 2000 would have major positive impacts on incentives of hospitals to function effectively and efficiently, also by the mean of improved quality of financial management in hospitals. To check the reality, our team, supported by the Transparency International Slovakia, realized in 2004 field research focusing on one dimension of financial management – public procurement. The results of it are significant indicator of the real situation.

To analyze the situation 15 medium size hospitals (Malacky, Galanta, Dunajská Streda, Levice, Komárno, Myjava, Považská Bystrica, Čadca, Dolný Kubín, Lučenec, Rimavská Sobota, Humenné, Levoča, Michalovce, Trebišov) were selected and following indicators/areas used:
- organization of public procurement
- structure of public procurement
- in depth analysis of procurement in specified areas
- price benchmarking.

Concerning the organization of public procurement one hospital did not have qualified – certified staff responsible for public procurement (rule prescribed by the law). No hospital prepared and used public procurement plan and audit of public procurement outcomes was not realized. Public procurement processes in hospitals are not supported by effective software, and the evidence of data is of very low quality. Majority of hospitals has own web page, but
procurement data and information are usually not displayed. Joint procurement and frame contracts are not regularly used. On the base of these indirect indicators we can conclude that the quality of the organizational system for public procurement in Slovak hospitals is very low.

The second important set of indicators to evaluate quality of financial management in hospitals via public procurement processes are outcomes. To evaluate them we used simple benchmarking of final prices of goods and services procured compared to standard market prices. Such approach to evaluate public procurement was used in Slovakia for the first time.

Data obtained by benchmarking clearly indicate major differences between unit prices under which hospitals procure medicaments, medical equipment, daily goods and services. The Table 2 indicated the scale of differences.

Table 2

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Number of extreme differences</th>
<th>Average difference in %</th>
<th>Sum of rankings for all selected items procured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Čadca</td>
<td>2</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Dolný Kubín</td>
<td>7</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Levoča</td>
<td>5</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Považská Bystrica</td>
<td>12</td>
<td>1</td>
<td>21</td>
</tr>
<tr>
<td>Michalovce</td>
<td>6</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>Rimavská Sobota</td>
<td>3</td>
<td>9</td>
<td>24</td>
</tr>
<tr>
<td>Dunajská Streda</td>
<td>1</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>Humenné</td>
<td>10</td>
<td>5</td>
<td>29</td>
</tr>
<tr>
<td>Lučenec</td>
<td>4</td>
<td>8</td>
<td>29</td>
</tr>
<tr>
<td>Levice</td>
<td>9</td>
<td>11</td>
<td>40</td>
</tr>
<tr>
<td>Myjava</td>
<td>11</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Trebišov</td>
<td>8</td>
<td>12</td>
<td>44</td>
</tr>
</tbody>
</table>

All data were obtained from accounting books from hospitals and because of this are almost reliable. Results clearly show that the quality of public procurement in hospitals measured by outcomes is very low. One concrete example might be used to document current situation – the prices of pork meat for catering services (not out-sourced in any case) were in some hospitals as follows (price paid by hospital versus price in nearby supermarket): 170,32 versus 151,00 Sk, 163,31 versus 130,00 Sk, 173,85 versus 159,00 Sk, 162,80 versus 139,90 Sk, 173,44 versus 149,00 Sk, 180,54 versus 145,00 Sk.

All information obtained by our team clearly indicates that hospitals procure in non-transparent and ineffective way. This is mainly not because of just lack of skills, but very much more general problem, as clearly visible from the statement of the director of last performing hospital (according to our evidence) in Trebisov: “The life of the patient is much more important than the Public Procurement Law. Our only concern is to provide the patient with maximum care”. The patient does not care about the procurement of medicaments; he just wants his/her drug” (Správy STV, 3. 11. 2004). However, without efficiency available resources cannot allow to provide enough proper drugs to all.

5. Wrong policy or wrong implementation?
Without too much doubts, we may conclude on the base of indicators used that the first decade of health reforms in Slovakia did not bring enough positive outcomes. The quality increased only in certain aspects, mainly because of more resources, the financial management is may be even worthier than in old regime. It is too early to predict future after major changes in beginning of this century.

Taking this situation into the account we may put in front of us the question from the title of this part. If the policy is already improperly formulated (or not effectively formulated at all) it is very difficult to achieve positive outcomes. When implementation fails, policy-making looses its purpose, mission, credibility and effectiveness. Evidence on the practice of policy making shows that the both stages: policy formulation and policy implementation, are extremely weak in Central and East European countries.

Concerning our case of the Slovak health care reform, we are able to provide some evidence showing that the original problem is connected already with policy formulation phase and that the implementation was not able to cope with original starting failures, but it just increased the scale and scope of problems.

One of crucial issues of the reform was the idea of replacing former general taxation based model of financing of health care by new social health insurance model. This change was supported by typical arguments about plurality, independence and competition as main factors stimulating positive changes in the system. Such idea could be subject of many objections by the general economic and health economics theory, especially for transitional period, we won’t to discuss now (for detail see for example Nemec and Lawson, 2003). The crucial issue is that basic preconditions for insurance market to work weren’t created, either by the reform contents, or by its implementation.

**Plurality and Competition**

In Slovakia the Parliament lays down the level of insurance payments in relation to wages. The influence of the state on insurance companies does not stop at parliamentary finance votes. The Ministries of Finance and of Health determine most aspects of companies' payments, from the structure of the reimbursement system to the point values of all medical services, set maximum level of administrative costs. Furthermore, the Slovak Parliament also deliberately decides on the level of the state contribution for economic inactive citizen, representing important part of insurance funds.

The level of equalization between insurance companies was a matter of permanent fight between different actors in both republics, involving frequent changes of the system, but ending with 100 % equalization in Slovakia already from 1999. The financial, especially reimbursement rules changed almost every year (Table 3).
<table>
<thead>
<tr>
<th>Date</th>
<th>Primary ambulatory care</th>
<th>Secondary ambulatory care</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1993</td>
<td>Capitation</td>
<td>Fee for service</td>
<td>Differentiated price per treatment day</td>
</tr>
<tr>
<td>1.4.1993</td>
<td>Point system</td>
<td>Point system</td>
<td>Point system</td>
</tr>
<tr>
<td>1.5.1994</td>
<td></td>
<td></td>
<td>Lump sum</td>
</tr>
<tr>
<td>1.7.1994</td>
<td></td>
<td></td>
<td>Differentiated price per treatment day</td>
</tr>
<tr>
<td>1.9.1994</td>
<td>Capitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4.1995</td>
<td>Combined system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4.1997</td>
<td></td>
<td></td>
<td>Differentiated price per treatment day, change of basis</td>
</tr>
<tr>
<td>1.12.1998</td>
<td>Capitation</td>
<td></td>
<td>Budget</td>
</tr>
<tr>
<td>1.1.1999</td>
<td></td>
<td>Fee for service with upper limit</td>
<td></td>
</tr>
<tr>
<td>1.5.1999</td>
<td></td>
<td></td>
<td>Prospective budget</td>
</tr>
<tr>
<td>1.6.2000</td>
<td>Capitation based on age</td>
<td></td>
<td>Maximum price</td>
</tr>
<tr>
<td>1.1.2002</td>
<td>Capitation combined with fee for service</td>
<td></td>
<td>Service contracts</td>
</tr>
</tbody>
</table>


The impacts of such tight regulation of freedom of insurance system are straightforward. The change saw a proliferation of companies followed by rapid consolidation and final domination by single player the Slovak General Health Insurance Fund (SVZP). By late 1995 twelve insurance companies were operational in Slovakia, including the SVZP and separate companies covering the Ministry of Internal Affairs, the railways and the armed services, corresponding to their previously noted separate health care systems. However, the situation changed rapidly. In Slovakia both government and economic pressures led to a fall in the number of competing companies. Basically the eleven non-general companies were cherry picking that is, segmenting the market. The SVZP ended up with 75% of the patients, but with the least attractive ones from a medical and hence profitability viewpoint. After several bailouts, by early 2002 the system had been reduced to only five companies. To remove the impact of cherry picking, once the companies have collected their contributions all of the funds are pooled and redistributed according to the company clients’ age and sex profile. In effect competition has been removed.

**Independence**

Depending on the legislation covering the regulation of the companies, the insurance-based system multiplied politicians’ possibilities for intervention. Such path was frequently chosen by the Slovak Parliament, which has repeatedly used its powers of intervention in an unwise manner. For example, under the Act No. 374/94 Parliament determines the annual payments to the insurance system for the two-thirds of the population who are either civil servants or are inactive. From 1995 Parliament withheld significant amounts of those payments for no discernable good reasons, forcing the health care system to delay payments and waste resources in lobbying politicians for their release. By subsequent legislation the private sector lost any real legal chance to be repaid for “compulsory crediting” of health...
establishments, in the form of non-paid invoices for delivery of goods and services to health sector.

6. Main factors retarding achievement of reform goals

More factors might be found in Slovakia, limiting the chance for successful policy formulation and successful policy implementation in the area of health care reform. We mention two of them (others, like lack of general and specific expertise of persons responsible for the reform, might be added).

From political point of view, certain important factors limited the chance for successful reforms. Since 1989 till 1998 Slovak governments have been mainly unstable and generally short-lived coalitions. And in a world of drastic economic and political change it is unsurprising that only a minority of the Slovak electorate has shown some taste for significant social change. In late 1994 the Focus polling agency recorded that at the point of independence in late 1992, while 41 percent of respondents thought that "radical changes of society" were necessary, 46 % thought that only "small changes" would suffice (see SPACE, 1995). Radičová and Potůček (1997) go as far as arguing that health care professionals have in effect "captured" the Health Ministry to promote their interests.

From economic point of view, as more times mentioned, Slovakia has to cope with important problem – problem of discrepancy between “needs” and resources. The health care system heavily depends on public finance based resources, part of them coming via the health insurance system, and part of them directly from the state budget. The participation of patients in the form of direct payments/co-payment is still rather limited and much lower than in most developed countries. The total amount of resources is more or less directly limited by the performance of the national economy, which is much below the EU average (whether in nominal or purchasing power parity terms), and in terms of total output has only recently reached the level of the pre-transition period. On the other hand, all actors (doctors, politicians, patients, pharmaceutical companies), except of insurance companies (not able to control the market), are interested in the increase of scope and scale of health services delivered.

7. Conclusions

The Slovak health care system after 1989 was influenced by set of reform steps of different character. The first ten years of reforming did not deliver enough positive outcomes – certain selected indicators were discussed in our paper. To cope with pertaining or even increasing (economic efficiency) deficiencies of the system, major market based reform was introduced after 2000, with most important reform laws passed by the Parliament in 2004, effective from 2005.

The brief analysis of processes and outcomes of past health reforms clearly indicates that several expected – proclaimed goals were not achieved. We argue that both ineffective policy making and ineffective policy implementation processes might be one important factor laying behind this situation. It is really difficult to realize effective reforms in specific environment of transition from centralism to democracy and the market (as there was no experience from such change). However, if it is rather politics and not policy that is the main determinant of the reform contents, inefficiencies are inevitable.
References

17. SPACE (1995), For People and about People (in Slovakian). Bratislava: SPACE.