1. INTRODUCTION

Slovakia is a relatively small country with 5.5 million inhabitants located in the center of Europe. The Gross Domestic Product (GDP) per capita is approximately 50% below the EU average but, in certain areas, the standard of living is relatively very high. In the Bratislava region, the GDP per capita is above the EU average and, when taking into account local purchasing power, significantly above the EU average.

The health care system in the country is based on the principle of free access at the point of delivery for most services, with costs financed predominantly from a compulsory social health insurance. The performance of the health care system in Slovakia was recently evaluated by the World Health Organization (WHO) and shown to be similar to other Central and Eastern European (CEE) accession countries (Table 1).

<table>
<thead>
<tr>
<th>Country</th>
<th>Overall</th>
<th>Health</th>
<th>Fairness</th>
<th>Cost**</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>1</td>
<td>4</td>
<td>26</td>
<td>4</td>
</tr>
<tr>
<td>UK</td>
<td>18</td>
<td>24</td>
<td>8</td>
<td>26</td>
</tr>
<tr>
<td>Germany</td>
<td>25</td>
<td>41</td>
<td>6</td>
<td>3</td>
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<tr>
<td>US</td>
<td>37</td>
<td>72</td>
<td>54</td>
<td>1</td>
</tr>
<tr>
<td>Slovenia</td>
<td>38</td>
<td>62</td>
<td>82</td>
<td>29</td>
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<tr>
<td>Czech Repub.</td>
<td>48</td>
<td>81</td>
<td>71</td>
<td>40</td>
</tr>
<tr>
<td>Poland</td>
<td>50</td>
<td>89</td>
<td>150</td>
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</tr>
<tr>
<td>Slovakia</td>
<td>62</td>
<td>88</td>
<td>96</td>
<td>45</td>
</tr>
<tr>
<td>Hungary</td>
<td>66</td>
<td>105</td>
<td>105</td>
<td>59</td>
</tr>
<tr>
<td>Estonia</td>
<td>77</td>
<td>115</td>
<td>145</td>
<td>60</td>
</tr>
<tr>
<td>Russia</td>
<td>130</td>
<td>127</td>
<td>185</td>
<td>75</td>
</tr>
</tbody>
</table>

* Based on 1997 data for 191 countries (highest = 1).
** Based on total spending per capita in international dollars.

The process of reforming the Slovak health care system started immediately after the “Velvet Revolution” in 1989. Key elements included privatization and a change from general taxation to a social health insurance system of financing care, but the reforms are far from being finished. Policy making and implementation failures during the reform have created additional large-scale problems; many of them today are connected with finance. No consistent central health policy in Slovakia yet exists. However, as a result of development trends - both in society and in the

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health care sector, the need to create real health making policy implementation and analysis capacities in the country is becoming more urgent.

To support these changes, a system of academic education and training for health management was created and/or updated relatively quickly, but its current quality and capacities are still not sufficient. There are two main approaches to the preparing and/or training of health managers. The first, represented by the Faculty of Economics of Matej Bel University, is a more generalist approach with the graduates being given a comprehensive base of economics, management and health care courses. However, the number of such graduates is very small and there is only a limited effort to increase enrollment. The second, represented by the Faculty of Health Care and Social Work of the University of Trnava and the School of Public Health of the Slovak Health Care University, is predominantly based in medical disciplines and health management courses represent only a marginal part of the curriculum. This type of education and training, coordinated mainly by medical doctors, also has very limited chances of producing new, effective health managers.

Under these circumstances, the capacity of education/training institutions to influence the quality of management of health care establishments is very limited and there will be significant problems in attempting to change this situation (which perhaps can only be brought about by introducing more private funds into the system and creating real conditions for a public-private mix in the delivery of health management training).

Health policy does not exist as a specific curriculum or system of study and only a few hours on this subject are taught at Banska Bystrica or Trnava. There is a specialized health policy center at Banska Bystrica, but there is no permanent staff, and the capacities of this center are mobilized only on a case-by-case basis. As independent health policy research is unlikely to be financed from private resources, and public finance capacity will be limited for some period, this area should be considered as one of the important fields of future foreign aid.

2. COUNTRY PROFILE

In early medieval times (after the defeat of the Moravian state by Hungarian troops), Slovakia was a part of the Hungarian Empire. The system of public administration in Slovakia was an integrated part of Hungarian public administration, characterized by the relatively strong position of municipalities. Many of the basic features of Austro-Hungarian public service became the basis for the public administration system of the first Czechoslovak state, which was established on 28th October, 1918.

The period 1918-1939 was characterized by the development of a democratic civil service in a market economy environment. In spite of the relatively centralized management of public administration from Prague (the capital of Czechoslovakia), the public service system of the country showed many features of modern public administration (including a well-developed civil service law and the strong status of municipalities) which led to the development of an impartial and professional civil service system.
In 1945, after the Second World War, Czechoslovakia was re-established as a unitary state. The Communist Party of Czechoslovakia won the democratic elections of 1947 and then, in February 1948, took over all powers of the state. The period between 1948 and 1989 may be characterized as the period of so-called “socialist democracy” and a planned economy. The public administration system was re-organized to serve the interests of the Communist Party and became fully dependent on its political masters.

After the Velvet Revolution in 1989, the process of a gradual transition to a pluralistic, democratic public administration system started in Czechoslovakia. Most tasks of formal restructuring according to western standards were realized in the early stages of the transition period. The first public administration reform in Czechoslovakia was defined according to the most important tasks of revitalizing democracy (Nemec, Berčík and Kukliš, 2000):

- to create real self-government institutions;
- to divide executive and legislative power on all levels;
- to create a new organization of the civil service with two levels of administration;
- to change the territorial structure of Czechoslovakia; and
- to restructure the central government and the system of control of the civil service.

The first democratic elections were held in June 1990 and became the basis for most of the changes in the public administration system in Czechoslovakia. The self-government of municipalities with high levels of independence was re-established. The system of National Committees (a socialist form of local government, combining in one office both local state administration and self-administration functions) was abolished and replaced by 38 district general state administration offices and 121 sub-district general state administration offices. Local self-government, with representatives elected directly by the local population, was constituted through municipalities which were established as territorial and legal entities. Within limits set by the law, local governments have their own budgets and assets. Local governments may issue ordinances which are binding on all individual or corporate bodies within their jurisdiction. These ordinances may be superseded or invalidated only by parliamentary acts. In some cases, local governments may be delegated additional powers necessary for the administration of the state and financed by state funds. Interference with the powers of local self-government is possible only by legislation passed by the Parliament.

On January 1st 1991, Slovakia became an independent country after the friendly and smooth splitting of the former Czechoslovakia. Later, in 1996, a second wave of public administration reform began. It was characterized by the parallel imposition of a radical change in the territorial and administrative structure of the state, and by the establishment of the uniform two-tier (regions and districts) system of offices of general state administration with a broad range of tasks and responsibilities. The reform had the goal of increasing the effectiveness and quality of public administration and creating a customer-friendly and responsive system to serve the citizens. The costs of the reform were much higher than planned and the results have been very limited (Audit ústrednej štátnej správy, 2000).

After the 1998 general elections, the new Slovak government reaffirmed public administration reform as one of its main goals. The primary rationale for the reform was that decentralization would solve all inefficiencies (Stratégia decentralizácie a reformy verejnej správy 1999). The
start of the reform was postponed several times because of a lack of political consensus between the political parties. Only the massive interventions of Prime Minister Dzurinda at the beginning of 2001 pushed the process forward; he called the achievement of public administration reform the main government priority.

Subsequently, but perhaps too quickly, the Parliament approved all proposed basic legislation. The following laws were among the most important ones enacted in 2001:

- Civil Service Code (July)
- Public Service Code (July)
- Law on Creation of Territorial Self-Government – Regions (July)
- Law on Elections of Territorial Self-Government Bodies (July)
- Law on Transfer of Competencies of the State to Regional and Local Self-Administration (September)
- Amendment of the Law on Municipalities (October)
- Amendment of the Law on Municipal Property (October)
- Law on the Property of Territorial Self-Government (October)
- Amendment of the Law on Budgetary Rules (October)
- Law on Remuneration and other Aspects of Performing the Position of the Head of Territorial Self-Government (October)
- Law on Financial Control and Audit (October)
- Law on Ombudsman (December)

The important Law on Transfer of Competencies defined the very large set of responsibilities to be transferred to regional and local self-government in 2002-2003. Municipalities received new responsibilities in the areas of road communications, water management, evidence of citizenship, social care, environmental protection, education (elementary schools and similar establishments), physical culture, theatres, health care (primary and specialized ambulatory care), regional development, and tourism. Regional self-government became responsible for areas of road communications, railways, road transportation, civil protection, social care, territorial planning, education (secondary education), physical culture, theatres, museums, galleries, local culture, libraries, health care (polyclinics and local and regional hospitals), pharmacies, regional development, and tourism. Many of these competencies previously had been the direct responsibility of the ministries (e.g., hospitals, education).

The elections in autumn 2002 gave political power again to the Dzurinda cabinet, and the reforms plans were not changed. The EU enlargement decision, effective May 2004 (when Slovakia is included in the group of countries to become new EU members), created additional pressures to incorporate the main principles of European public administration – openness, participation, accountability, effectiveness and coherence – and the principles of subsidiarity and flexibility into daily administrative practice.

Important steps in this direction have already been taken, but many problems remain or may appear. The main problem with the current reform measures has been an overestimation of the potential for decentralization, which has evolved from a reform tool to a reform goal (as apparent from the reform document and its “strategy of decentralization and reform”), together with a current territorial structure that is too fragmented. The number of municipalities is extremely
high (2,875 municipalities), and many municipalities are too small (68.4% of municipalities have fewer than 1,000 inhabitants). Such fragmentation increases the transaction costs of the system and does not create an environment for effective realization of self-government functions on the local level.

3. HEALTH CARE SYSTEM

The objective of the pre-1989 health care system in the former Czechoslovakia was to provide a comprehensive system of health care for all members of society. Decisions about medical care provisions were made by the federal government and by the national Czech and Slovak Ministries of Health – and generally were made on political or administrative grounds. The only accountability in the old system was to the Communist Party.

Under that system, both services and medicines were free to the patient; however, until 1987 there was no individual choice of practitioner. The supply of services was constrained by the plan, and the purchaser and provider were one. Economic resource allocation played no part in determining services; the level and distribution of these services, although influenced by social, medical and administrative considerations, were determined by political decisions. No cost-benefit calculations were undertaken. There were no economic incentives, either for individuals or for the system, to improve performance, and there was chronic and sometimes acute excess demand for services.

Yet, when the transition began, the Czechoslovak system was far from being in the crisis state of the Polish and Soviet systems (Davis 2001). When necessary, everybody was able to get appropriate health care consistent with a relatively high international medical standard. Most equity considerations were achieved (although there also were special medical institutions that provided higher quality care for high-ranking officials). The old system is often described as obsolete and inefficient, but with approximately 5% of GDP allocated for health care expenditures most demand was covered without significant waiting lists. Relatively high-quality care was a characteristic of the health care system, in spite of insufficient quantity and quality of equipment.

General trends in health policy in Slovakia after 1989 (health care was the responsibility of the national Slovak government and not the federal Czechoslovak state as it had been since 1968) were defined by programmatic statements of government and the main reform document (first published in 1990). The most important goals of the reform were as follows:

• create a system of “health care for everybody” (i.e., a system of public health), as described by the document “National Public Health Program”;
• provide universal access to a defined scope of health services and benefits;
• make the free decisions of citizens the basis for the creation, implementation, and control of health policy;
• eliminate the state monopoly in health care and encourage many providers of health care, privatization, and increased participation of self-government in the health care system;
• establish public health as a dominant part of a health care system;
• ensure that primary care has the dominant position in the health care system;
• ensure that a citizen has the right to choose a provider;
establish compulsory health insurance;
• promote citizens’ participation in the protection and improvement of their own health;
• develop multi-resource financing of health care;
• improve economic and financial management in health care establishments; and
• end the impairment of the health status of citizens.

**BASIC FRAMEWORK FOR HEALTH CARE SYSTEM**

New legislation was soon adopted to achieve the proclaimed goals. Of the many legal documents adopted, the most important for providing a basic framework for the health care system in Slovakia include:

- the Constitution of the Slovak Republic;
- the package of laws related to the creation of an insurance scheme;
- the Law on Treatment Order;
- the Law on Health Care; and
- the Law on Health Protection of People.

**The Constitution of the Slovak Republic**

The Constitution of the Slovak Republic is the highest institutional guarantee of human rights in Slovakia. Since 1 September 1992, the Constitution is in principle a modern one that provides for a standard system of human rights within a democratic society. In the area of economic, social and cultural rights, it provides for a universal right to the protection of health. On the basis of an insurance system, citizens have a right to free medical care and related medical benefits according to the provisions of complementary law.

**The Law on Treatment Order**

This law establishes the most important principles with regard to qualifying conditions for services, scope of cash and in-kind benefits and the organization of health care. It regulates the extent of the health care to be provided under a compulsory health insurance plan, the conditions under which it is to be provided, the reimbursement schedule, the categorization of drugs (for different levels of co-payment) and the rules on health insurance coverage of medical aids. It also defines the nature of reimbursement of spa treatments.

The most important parts of this law are:

- With health insurance, health services, medicines and medical aids are provided as indicated on the basis of health needs. This is to be based on current achievements in the medical and biomedical sciences and effective treatment following therapeutic and pharmaco-therapeutic rules is guaranteed. Health services provided according to this law are listed in its annex 1. The list and categorization of medicaments are provided by annex 2. The medical aids list is in annex 3 of the law.
- Insurance companies reimburse contractual health care establishments for the costs of health care provided according to the list of treatments, medicines and medical aids and the prices of service, medicines, and medical aids are to be defined by price regulations (issued by the Ministry of Finance).
• Specialized health care is provided to a patient only on the basis of referral by a general practitioner or by referral by another specialist.
• On the basis of their health insurance, patients shall get only defined daily doses of medicines.

The Law on Health Protection of People

This Law defines the rights and obligations of the state administration, municipalities and other personnel, as well as the responsibility of the state administration and of state supervision in the field of protection of the health of the people.

The Law on Health Care

This law deals with the provision of health services, organization and management of health service and defines the rights and obligations of personnel in connection with health care. It also delegates the main regulatory, planning and managerial tasks to the Ministry of Health. It declares:

• “Everybody has the right to receive health care, including medicines and medical aids. Health care is provided by state health establishments, municipal health establishments, medical establishments run by legal or territorial entities, and is provided on the basis of the existing accessible know-how of the medical and other biomedical sciences.”
• “Health care is provided for citizens:
  a. free, on the basis of compulsory health insurance
  b. on the basis of additional insurance contracts
  c. from state budget resources
  d. on the basis of the financial resources of charities, legal or physical entities
  e. based on the co-payment or full participation of the health care receiver.”
• “A citizen has the right to care according to the kind and level of the health problem. She/he has the right to choose the doctor or health establishment. In the case of an emergency, she/he has the right to get medical care in the nearest medical establishment available to provide the appropriate health care.”

The Set of Laws on Health Insurance

Slovakia, similarly to most of the other CEE countries, introduced the so-called “Bismarck” system of social health insurance to replace the old general taxation system of financing health care. The main set of laws regulating health insurance was passed in 1994 creating the basis for the establishment of 13 health insurance companies, most of which disappeared from the “market,” thus leaving five still existing in 2002. The change in the health insurance system was supported by the typical arguments on behalf of plurality, independence and competition. However, the Constitution and consecutive sets of laws guarantee the citizen universal and free access to health care. Thus, this package must be delivered by all insurance companies for a price that is regulated by the Ministry of Finance. Consequently, some level of system plurality and competition was visible only in the starting phase of the insurance system, when the services to the insured were, to some extent, different.
CURRENT SITUATION OF THE HEALTH CARE SYSTEM

Health Status in Slovakia

Health status in Slovakia, as measured by the most important indicators during the 1989-2000 period, was similar to other more developed CEE countries (Czech Republic, Hungary, etc.). There is not adequate data to assess what the main factors behind this positive trend were or to what extent this was caused by an increased quality of health care or other factors such as changes in lifestyle, improving environment, etc.

Table 2 provides the most important indicators of health status development. It shows that life expectancy has significantly improved but is still below EU levels (WHO 2002). The difference in life expectancy between men and women is still relatively large, but has decreased from 1990. The quality adjusted life expectancy in Slovakia was 66.6 years, significantly lower than the lowest level in the EU – Portugal, with 68.9 years (Slovensko 2001, p. 499). Mortality is very slowly going down, but is much higher compared to the EU, especially for cerebrovascular mortality (26.6 % of deaths in Slovakia).

Table 2. Main Indicators of Health Status in Slovakia

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy (years)</td>
<td>Men</td>
<td>66.9</td>
<td>66.6</td>
<td>68.4</td>
</tr>
<tr>
<td></td>
<td>Women</td>
<td>74.7</td>
<td>75.4</td>
<td>76.3</td>
</tr>
<tr>
<td>Death/1,000 Inhabitants</td>
<td>All</td>
<td>10.2</td>
<td>10.2</td>
<td>9.8</td>
</tr>
<tr>
<td>New-born mortality</td>
<td>All</td>
<td>11.1</td>
<td>8.4</td>
<td>7.9</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>All</td>
<td>16.3</td>
<td>12.0</td>
<td>11.0</td>
</tr>
</tbody>
</table>

Source: UZIS, different tables; see [http://www.uzis.sk](http://www.uzis.sk).

An emerging problem since 1990 is the declining natural increase in number of inhabitants. The natural increase in 2000 was only 2,427 persons, compared to 4,821 in 1999, 72.2% less than in 1995 and 90.4% less than in 1990. There are only a few regions where the number of live births exceeds the number of deceased (Zdravotnicka rocenka SR, 2000).

The health status indicators show that negative factors connected with transformation (stress, decreasing standard of living for a large proportion of inhabitants, increased consumption of drugs) were outweighed by other positive factors. The medical quality of health services might be one of them, due especially to significant improvements in the equipment of providers and the medicines available.

Access to Care: Universality and Equality

As already mentioned, according to the legislation, access to most services is free at the point of delivery. Overall, there is no evidence of any group or citizen being denied access to any free service which they have a right to receive. General practitioners, dentists and opticians cannot refuse to treat patients but where waiting lists exist for specialists, unequal treatment may occur.
because there are no formal and effective rules of access. With hospital care it is common to make additional illegal or non-legal payments for extra services; for example, for a separate room. A systematization of these practices through additional co-insurance is likely to be introduced.

On the other hand, because of corruption and other factors, access is not equal. There are no Patients' Charters, and complaints generally find no responsive addressee. This is important because more than two-thirds of Slovaks claim that they have had to pay a bribe to ensure good care (Miller, Grodeland and Koschechkina, 1998, estimate an 89% likelihood that bribes must be offered to medical doctors in Slovakia). Bribes have been estimated to amount to a tenth of health costs (a recent unpublished study financed by the World Bank estimates this amount to be 3 mld. Sk).

The question of access to health services in Slovakia represents a two-dimensional issue. On one hand, there is the widespread and popular commitment to universal access to health care, free at the point of use. The 1998 Slovak Government Programmatic Statement (www.government.gov.sk), prepared at the time of the increasing financial crisis of the system, reflects this:

“The government will guarantee generally accessible and high quality health care for all citizens. Within the framework of the basic health insurance, any citizen is assured equal access to and equal quality of basic health services”.

On the other hand, real inequality in access is increasing; to a large extent as the result of the deepening financial crisis and the unofficial shift of financial burden to citizens. The increasing inequality of access to health services in Slovakia has already been recognized by most important international organizations, such as the World Bank and the OECD.

Quality of Care

It is very difficult to assess developments in quality of care after 1989, as there are not any good indicators available. Yet, as mentioned in the evaluation of health status developments, there are significant quality improvements on the supply side, mainly in:

- the structure and quality of equipment available in health establishments; and
- the structure 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. Contradictory outcomes resulted – on one hand, there were improvements in the technical aspects of the quality of services; on the other hand, there was a relative oversupply of technologies and expensive drugs, which caused one of the financial problems of the system.

Compared to the positive technical developments, the trends in other aspects of health care quality are both more controversial and difficult to prove. In spite of many promises, no Slovak government was able to introduce a systematic medical and organizational audit of health providers which would tell more about how the care is delivered by doctors and the conditions
by which it is delivered to patients. A well known case of mis-treatment of the Slovak President in 2000 (Slovensko, 2000) clearly showed the basic weaknesses in the daily delivery of care - but it was not used as an impetus for change.

The organizational quality of patient’s care is improving, but very slowly. Compared to the old system, there is now a choice in provider, but the patient is still very far from becoming the central subject of the system. The document “Patient Rights” was prepared and published only in 2000 and some establishments still have not developed it to local conditions. Queuing in front of a clinic, without the opportunity for an exact appointment, is still typical for a large proportion of providers, including private providers.

**Economic Performance of Health Care System**

The main problems of the system after 1989 are connected with finance. The under-financing of the system at the start of the reforms after 1989 and the decrease of the economic performance of the country as the result of transition are critical factors. However, there are significant design and implementation factors that have brought the system close to collapse.

Table 3 describes the overall financial performance of the health care system in Slovakia after 1995, when the financial problems started to be apparent.

**Table 3. Economic Performance of the Health Care System in Slovakia (mld. Sk)**

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total health insurance system resources</td>
<td>26.3</td>
<td>35.4</td>
<td>38.4</td>
<td>41.4</td>
<td>43.0</td>
<td>45.3</td>
<td>49.6</td>
<td>55.0</td>
</tr>
<tr>
<td>Resources from the Ministry of Health</td>
<td>4.1</td>
<td>4.6</td>
<td>4.9</td>
<td>4.7</td>
<td>4.4</td>
<td>4.5</td>
<td>4.9</td>
<td>4.8</td>
</tr>
<tr>
<td>Resources from Social Insurance Company</td>
<td>0.9</td>
<td>1.0</td>
<td>1.2</td>
<td>1.3</td>
<td>1.3</td>
<td>1.0</td>
<td>1.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Direct payments from inhabitants</td>
<td>1.8</td>
<td>2.6</td>
<td>3.8</td>
<td>4.1</td>
<td>5.4</td>
<td>5.9</td>
<td>6.3</td>
<td>7.0</td>
</tr>
<tr>
<td><strong>Total resources</strong></td>
<td><strong>33.1</strong></td>
<td><strong>43.6</strong></td>
<td><strong>48.3</strong></td>
<td><strong>51.5</strong></td>
<td><strong>54.1</strong></td>
<td><strong>56.7</strong></td>
<td><strong>61.9</strong></td>
<td><strong>68.0</strong></td>
</tr>
<tr>
<td>Primary care costs</td>
<td>1.3</td>
<td>4.3</td>
<td>4.5</td>
<td>4.2</td>
<td>4.4</td>
<td>4.7</td>
<td>4.9</td>
<td>5.1</td>
</tr>
<tr>
<td>Secondary ambulatory care costs</td>
<td>0.0</td>
<td>0.2</td>
<td>1.3</td>
<td>1.5</td>
<td>1.8</td>
<td>1.9</td>
<td>2.1</td>
<td>2.2</td>
</tr>
<tr>
<td>In-patient care costs</td>
<td>25.3</td>
<td>21.4</td>
<td>24.0</td>
<td>25.6</td>
<td>25.0</td>
<td>26.0</td>
<td>28.1</td>
<td>30.1</td>
</tr>
<tr>
<td>Medicines and health aids costs</td>
<td>2.0</td>
<td>12.2</td>
<td>14.5</td>
<td>16.1</td>
<td>18.8</td>
<td>20.6</td>
<td>22.8</td>
<td>24.1</td>
</tr>
<tr>
<td>Other costs</td>
<td>0.9</td>
<td>1.1</td>
<td>3.4</td>
<td>5.0</td>
<td>4.1</td>
<td>6.9</td>
<td>7.7</td>
<td>8.3</td>
</tr>
<tr>
<td>Ministry of Health costs</td>
<td>4.1</td>
<td>4.6</td>
<td>4.9</td>
<td>4.7</td>
<td>4.4</td>
<td>4.5</td>
<td>4.9</td>
<td>4.8</td>
</tr>
<tr>
<td><strong>Total costs</strong></td>
<td><strong>33.6</strong></td>
<td><strong>43.8</strong></td>
<td><strong>52.5</strong></td>
<td><strong>57.1</strong></td>
<td><strong>58.5</strong></td>
<td><strong>64.6</strong></td>
<td><strong>70.5</strong></td>
<td><strong>74.6</strong></td>
</tr>
<tr>
<td>Balance</td>
<td>-0.5</td>
<td>-0.2</td>
<td>-4.2</td>
<td>-5.6</td>
<td>-4.4</td>
<td>-7.9</td>
<td>-8.6</td>
<td>-6.6</td>
</tr>
<tr>
<td>Deficit coverage</td>
<td>0.5</td>
<td>0.2</td>
<td>4.2</td>
<td>5.6</td>
<td>4.4</td>
<td>7.9</td>
<td>8.6</td>
<td>6.6</td>
</tr>
<tr>
<td>By external debt</td>
<td>0.5</td>
<td>0.2</td>
<td>4.2</td>
<td>5.6</td>
<td>4.4</td>
<td>4.4</td>
<td>5.2</td>
<td>3.0</td>
</tr>
<tr>
<td>By privatization grants</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>3.5</td>
<td>3.4</td>
<td>3.6</td>
</tr>
</tbody>
</table>

*Source: Zajac and Pažitny (2002) (2002 data are estimated).*

The data show that, in spite of the economic performance of the system and the fact that the system’s improvement was on the agenda of all Slovak governments, the actual results are unsatisfactory. From 1997 on, the system systematically has consumed 10-15% more resources than have been available and this trend has not changed in spite of the implementation of many measures. The main sources of this imbalance in the system are analyzed in the sections that follow.
Resources of health care system in Slovakia. As is apparent from Table 4 below, the system depends heavily on public resources – in part from the health insurance system and in part 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. Compounding this, the total amount of resources has been directly limited by the performance of the national economy which has been much below the EU average (also in purchasing parity terms), and only recently reached the level of the pre-transition period.

**Table 4. Resources of Health Care System in Slovakia**

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>20.1</td>
<td>11.2</td>
<td>1.8</td>
<td>33.1</td>
</tr>
<tr>
<td>1996</td>
<td>26.1</td>
<td>14.9</td>
<td>2.6</td>
<td>43.6</td>
</tr>
<tr>
<td>1997</td>
<td>29.2</td>
<td>15.3</td>
<td>3.8</td>
<td>48.3</td>
</tr>
<tr>
<td>1998</td>
<td>32.2</td>
<td>15.2</td>
<td>4.1</td>
<td>51.5</td>
</tr>
<tr>
<td>1999</td>
<td>33.2</td>
<td>15.5</td>
<td>5.4</td>
<td>54.1</td>
</tr>
<tr>
<td>2000</td>
<td>35.1</td>
<td>15.7</td>
<td>5.9</td>
<td>56.7</td>
</tr>
<tr>
<td>2001</td>
<td>37.7</td>
<td>17.9</td>
<td>6.3</td>
<td>61.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Health Insurance (in %)</th>
<th>General Taxation (in %)</th>
<th>Direct Payments (in %)</th>
<th>Total (in %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>60.6</td>
<td>33.9</td>
<td>5.4</td>
<td>100.0</td>
</tr>
<tr>
<td>1996</td>
<td>59.8</td>
<td>34.2</td>
<td>6.0</td>
<td>100.0</td>
</tr>
<tr>
<td>1997</td>
<td>60.5</td>
<td>31.6</td>
<td>7.9</td>
<td>100.0</td>
</tr>
<tr>
<td>1998</td>
<td>62.4</td>
<td>29.6</td>
<td>8.0</td>
<td>100.0</td>
</tr>
<tr>
<td>1999</td>
<td>61.4</td>
<td>28.6</td>
<td>10.0</td>
<td>100.0</td>
</tr>
<tr>
<td>2000</td>
<td>61.9</td>
<td>27.7</td>
<td>10.4</td>
<td>100.0</td>
</tr>
<tr>
<td>2001</td>
<td>60.8</td>
<td>29.0</td>
<td>10.2</td>
<td>100.0</td>
</tr>
</tbody>
</table>


The insurance premium is currently set at a 14% of income-related base (14% from 2002), but the state is expected to pay for large groups of persons without regular income (children, pensioners, etc.), representing about 3.5 million of a total of 5.5 million inhabitants. As indicated by Table 5 below, for this group of citizens the state contributes on a very low level. The amount to be paid is set on a yearly basis in the Parliament when voting on the state budget. As a result, the rules of the game fare differently for the main participants: the private sector has to pay a fixed rate, while the state has not contributed the minimum full amount (at least 13.7% from the minimum wage) for any of the evaluated years. As a result, the system is not provided with the expected amount of resources.

**Table 5. Contributions of the State into the Health Insurance System**

<table>
<thead>
<tr>
<th>Year</th>
<th>Contribution per Insured Person, Sk</th>
<th>Total Contribution, mld. Sk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>181</td>
<td>7.1</td>
</tr>
<tr>
<td>1996</td>
<td>269</td>
<td>10.3</td>
</tr>
<tr>
<td>1997</td>
<td>269</td>
<td>10.4</td>
</tr>
<tr>
<td>1998</td>
<td>270</td>
<td>10.5</td>
</tr>
<tr>
<td>1999</td>
<td>283</td>
<td>11.1</td>
</tr>
<tr>
<td>2000</td>
<td>283</td>
<td>11.2</td>
</tr>
<tr>
<td>2001</td>
<td>336</td>
<td>13.0</td>
</tr>
</tbody>
</table>


Costs of health care system in Slovakia. As there is limited space to increase revenues for the health care system in Slovakia, the focus should be on cost-containment measures, efficiency and economy of the system in order to balance the demand, supply and resources available. However, very little has been done in this respect since 1989. The most important health sector inefficiencies include excessive employment, the low economic performance of hospitals and ineffective drug regulation policies.

The problem of employment is highlighted in Table 6, which shows that the total number of health personnel is similar to the pre-reform period, despite the fact that “over-employment” was accepted as the main problem of the system from the beginning of the post-1989 changes. [The decrease in 1995-97 is not real because the methodology did not react to privatization in time.]
Table 6. Employment in Health Care (number of persons)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>State sector</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>86,450</td>
<td>86,033</td>
<td>83,188</td>
<td>86,023</td>
<td></td>
</tr>
<tr>
<td>Non-state sector</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>19,919</td>
<td>32,702</td>
<td>32,971</td>
<td>34,750</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>129,468</td>
<td>125,581</td>
<td>127,414</td>
<td>121,464</td>
<td>96,935</td>
<td>106,369</td>
<td>118,735</td>
<td>116,159</td>
<td>120,773</td>
<td></td>
</tr>
</tbody>
</table>

Source: Statisticka rocenka SR (2002).

As was apparent from Table 3, the costs for drugs rose by 100% between 1996 and 2002 (the data for 1995 do not include the costs of drugs consumed in hospitals). The increase can, in part, be explained by the changing structure of the drugs used (the importation of more effective, but also more expensive, medicines at international market prices). However, it is also caused by the ineffective regulation system for prescription drugs. The tools of evidence-based medicine are still not used for setting the rules for which medicines are to be prescribed, and to whom and under what circumstances -- thus leaving space open for lobbying by pharmaceutical firms, as well as bribing doctors to prescribe more expensive and larger amounts of drugs than necessary. Insurance companies have lists of doctors who prescribe 10-20 times more than average costs, but there is no mechanism to handle this. In this non-effectively regulated environment, the cost for drugs has almost reached the costs of the hospital system.

The most costly part of the health care system in Slovakia is in-patient care which did not change very much during the entire period from 1991 to 2000. Data showing the main performance problems of hospitals are provided in Tables 7-10. Table 7 shows the problem the deficit and the lack of capacity/will to manage fixed costs of hospitals.

Table 7. Performance of Hospitals

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Number of patients</td>
<td>1,055,757</td>
<td>1,090,672</td>
<td>1,109,210</td>
<td>1,059,533</td>
<td>1,063,611</td>
<td>n/a</td>
</tr>
<tr>
<td>Change (%)</td>
<td>2.6</td>
<td>3.3</td>
<td>1.7</td>
<td>-4.5</td>
<td>0.4</td>
<td>n/a</td>
</tr>
<tr>
<td>Costs (mld. Sk)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed costs</td>
<td>15.4</td>
<td>17.7</td>
<td>19.3</td>
<td>19.3</td>
<td>19.7</td>
<td>21.6</td>
</tr>
<tr>
<td>Variable costs</td>
<td>6.1</td>
<td>6.4</td>
<td>6.3</td>
<td>5.7</td>
<td>6.3</td>
<td>6.5</td>
</tr>
<tr>
<td>Total costs</td>
<td>21.5</td>
<td>24.1</td>
<td>25.6</td>
<td>25.0</td>
<td>26.0</td>
<td>28.1</td>
</tr>
<tr>
<td>Total costs – change (%)</td>
<td>12.1</td>
<td>6.2</td>
<td>-2.3</td>
<td>4.0</td>
<td>8.1</td>
<td></td>
</tr>
<tr>
<td>Revenues (mld. Sk)</td>
<td>19.8</td>
<td>22.9</td>
<td>22.3</td>
<td>20.2</td>
<td>22.5</td>
<td>24.9</td>
</tr>
<tr>
<td>Balance (mld. Sk)</td>
<td>-1.7</td>
<td>-1.2</td>
<td>-3.3</td>
<td>-4.8</td>
<td>-3.5</td>
<td>-3.2</td>
</tr>
</tbody>
</table>


Table 8 shows that there are minimal changes in bed capacity and use during the period 1991-2000, indicating that the trends in in-patient care continue.
Table 8. Management of Bed Capacity in In-Patient Care

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Average length of treatment (days)</td>
<td>12.9</td>
<td>13.4</td>
<td>12.7</td>
<td>11.2</td>
<td>11.5</td>
<td>11.3</td>
<td>11.2</td>
<td>10.1</td>
<td>9.1</td>
<td>8.9</td>
</tr>
<tr>
<td>Use of beds (days)</td>
<td>276</td>
<td>274</td>
<td>268</td>
<td>280</td>
<td>289</td>
<td>290</td>
<td>286</td>
<td>284</td>
<td>254</td>
<td>258</td>
</tr>
<tr>
<td>Beds/number of doctors</td>
<td>8.4</td>
<td>8.1</td>
<td>8.6</td>
<td>7.9</td>
<td>7.9</td>
<td>7.5</td>
<td>7.5</td>
<td>7.3</td>
<td>6.7</td>
<td>6.6</td>
</tr>
<tr>
<td>Beds/1,000 inhabitants</td>
<td>7.6</td>
<td>7.6</td>
<td>7.9</td>
<td>7.1</td>
<td>7.5</td>
<td>7.5</td>
<td>7.3</td>
<td>6.7</td>
<td>6.6</td>
<td>6.5</td>
</tr>
<tr>
<td>Use of bed capacity (%)</td>
<td>75.6</td>
<td>75.0</td>
<td>73.4</td>
<td>76.6</td>
<td>79.3</td>
<td>79.5</td>
<td>78.4</td>
<td>77.9</td>
<td>69.5</td>
<td>70.7</td>
</tr>
</tbody>
</table>

*Source: Zdravotnicka rocenka SR (multiple volumes).*

Table 9 indicates that the numbers of staff were not reduced during the period of large deficits, and over-employment persists. Wages are calculated as part of the fixed costs of hospitals and with increased rates for employees, wages account to a larger and larger proportion of the total costs.

Table 9. Structure of Employment in Hospitals

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>10,567</td>
<td>8,000</td>
<td>9,243</td>
<td>9,416</td>
<td>9,323</td>
<td>9,761</td>
</tr>
<tr>
<td>Nurses</td>
<td>30,334</td>
<td>24,546</td>
<td>28,738</td>
<td>28,846</td>
<td>27,497</td>
<td>28,037</td>
</tr>
<tr>
<td>Other medical staff</td>
<td>13,036</td>
<td>11,208</td>
<td>13,194</td>
<td>13,396</td>
<td>13,468</td>
<td>12,644</td>
</tr>
<tr>
<td>Administrative staff</td>
<td>21,329</td>
<td>17,158</td>
<td>19,193</td>
<td>18,644</td>
<td>17,712</td>
<td>19,982</td>
</tr>
<tr>
<td>Others</td>
<td>1,871</td>
<td>1,593</td>
<td>1,810</td>
<td>1,805</td>
<td>1,790</td>
<td>1,181</td>
</tr>
<tr>
<td>Total</td>
<td>77,137</td>
<td>62,506</td>
<td>72,178</td>
<td>72,107</td>
<td>69,789</td>
<td>71,605</td>
</tr>
</tbody>
</table>

*Source: Zajac and Pazitny (2002).*

Table 10 presents detailed data on costs and revenues for selected categories of employees; these data suggest that the more efficient use of manpower has not had significant impacts.

Table 10. Individual Performance of Staff in Hospitals

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of diagnoses/employee</td>
<td>1,064</td>
<td>862</td>
<td>844</td>
<td>839</td>
<td>823</td>
<td>835</td>
</tr>
<tr>
<td>Number of diagnoses/doctor</td>
<td>8,311</td>
<td>6,729</td>
<td>6,462</td>
<td>6,278</td>
<td>6,041</td>
<td>6,110</td>
</tr>
<tr>
<td>Revenues/doctor (Sk)</td>
<td>2,478,107</td>
<td>2,473,468</td>
<td>2,366,756</td>
<td>2,166,794</td>
<td>2,309,061</td>
<td>2,541,271</td>
</tr>
<tr>
<td>Revenues/nurse (Sk)</td>
<td>807,704</td>
<td>795,539</td>
<td>772,538</td>
<td>734,652</td>
<td>803,901</td>
<td>889,445</td>
</tr>
<tr>
<td>Revenues/employee (Sk)</td>
<td>317,186</td>
<td>316,748</td>
<td>309,053</td>
<td>289,451</td>
<td>314,767</td>
<td>347,342</td>
</tr>
<tr>
<td>Costs/employee (Sk)</td>
<td>342,973</td>
<td>332,994</td>
<td>355,175</td>
<td>358,614</td>
<td>363,248</td>
<td>392,534</td>
</tr>
</tbody>
</table>

*Source: Zajac and Pazitny (2002).*

_Coping with deficits: shifting the burden to the private sector._ None of several reform measures has been able to significantly influence the negative economic performance of the health care system in Slovakia -- which has been producing large debts every year. Instead of stronger pressures for higher efficiency within the system, the system worked in favor of those creating debts and penalized private sector payees for problems caused mainly within the system by health professionals and health establishments. This solution of shifting the debt burden out of the health care sector clearly shows that the level of development of relations between the state and other sectors is still far from international standards -- thus leaving too much room for the state to move its own problems (an imbalance between the resources available and the scale of “free” services promised to citizens) on to be the costs of others -- in this case mainly to the
private sector and to patients who are pushed to bribery to get appropriate services. Table 11 shows how the deficit is developing and how it is covered.

Table 11. Scale and Structure of External Debt of Health Care System (mld. Sk)

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-paid drugs delivered by pharmacies</td>
<td>0.9</td>
<td>0.8</td>
<td>2.1</td>
<td>3.8</td>
<td>3.6</td>
<td>4.0</td>
<td>4.7</td>
<td>5.9</td>
<td>6.6</td>
</tr>
<tr>
<td>Credits and other similar resources</td>
<td>0.6</td>
<td>0.7</td>
<td>1.7</td>
<td>1.9</td>
<td>4.4</td>
<td>4.0</td>
<td>4.4</td>
<td>4.4</td>
<td>5.8</td>
</tr>
<tr>
<td>Non-paid social contributions</td>
<td>0.4</td>
<td>0.4</td>
<td>0.7</td>
<td>1.8</td>
<td>3.0</td>
<td>4.5</td>
<td>4.4</td>
<td>3.1</td>
<td>4.2</td>
</tr>
<tr>
<td>Non-paid drugs from other suppliers</td>
<td>1.2</td>
<td>1.2</td>
<td>2.3</td>
<td>3.6</td>
<td>3.7</td>
<td>3.8</td>
<td>3.8</td>
<td>3.9</td>
<td>3.8</td>
</tr>
<tr>
<td>Non-paid food and other material supplies</td>
<td>0.6</td>
<td>0.7</td>
<td>1.0</td>
<td>1.9</td>
<td>2.6</td>
<td>2.7</td>
<td>2.2</td>
<td>3.5</td>
<td>3.7</td>
</tr>
<tr>
<td>Non-paid energies</td>
<td>0.4</td>
<td>0.4</td>
<td>0.6</td>
<td>1.0</td>
<td>1.1</td>
<td>1.5</td>
<td>1.7</td>
<td>2.0</td>
<td>2.5</td>
</tr>
<tr>
<td>Total</td>
<td>4.0</td>
<td>4.2</td>
<td>8.4</td>
<td>14.0</td>
<td>18.4</td>
<td>20.5</td>
<td>21.1</td>
<td>22.7</td>
<td>26.6</td>
</tr>
</tbody>
</table>


Clearly, the data on economic performance shows that health care reform measures have not had a significant positive impact on the economics of the health care system. The main problems causing inefficiencies include:

- oversupply of medical personnel, mainly doctors;
- oversupply of facilities, mainly hospital beds;
- lack of capacities to manage demand (rationing);
- ineffective management of hospitals;
- ineffective drug management; and
- limited prevention and lack of incentives to protect the health status of the patient.

These problems persist and are solved largely by imposing costs on the private sector and consumers of health care.

Such development trends indicate important gaps in the area of health policy. The problems of the health system are real, well-known, and still grow; but no government has been able to solve any of them during the entire period since changing to an insurance-based health care system of financing in 1993. The state health policy was, from the beginning, not in an active forward-pushing position; on the contrary, it was not even able to predict potential negative outcomes of the changing environment.

After 1989, pressure groups quickly developed as doctors, hospitals, pharmaceutical companies, health insurance companies, but not citizens, vied for power and resources. The more conservative nature of Slovak public opinion helped the bureaucracy to retain their policy and operational powers. The choice of insurance-based health funding had been made without public discussion, before the division of Czechoslovakia into two independent republics. Most of the key problems that then emerged were the direct consequences of the funding switch, as the logic of the insurance solution worked itself out through market segmentation, the collapse of pooling solutions, fewer providers, state enforced premium redistribution and less competition.
The lack of capacity in policy making and policy implementation is obvious, and has many negative impacts, paid, in the final phase, by the most important player – the patient, in monetary and non-monetary (decreasing quality and access) form. Some changes seem to have occurred under the most recent (2002-3) Slovak government, but they are very slow. The health policy area was not developed and supported, but was neglected during the whole 1990-2002 period and such capacities cannot be created overnight.

4. PUBLIC ADMINISTRATION/MANAGEMENT EDUCATION

Public administration was not recognised as an independent academic field of study in Slovakia prior to the 1980s. Top public servants received their education outside of Slovakia (mostly in Moscow), or in special “Universities of Politics” established by the Communist Party in Prague and Bratislava. Middle and low level public servants did not receive specialised public administration education, which had a negative impact on the quality of the civil service. This situation also influences the current structure of public servants as most of them still do not have a university degree in public administration (PA).

The necessity to change the country’s “materialistic” approach to education (in which, according to economic theory, only employees in “material sectors” of the economy – industrial branches, agriculture, forestry, mining, building industries, etc. – created national income) and to start to promote, in addition, the services sector was not recognized until the 1970s. This led to the emergence of public administration/public management (PA/PM) programs.

ACADEMIC PA/PM PROGRAMS

In 1977, the first faculty preparing university graduates for all branches of the service sector was established as the part of the University of Economics, Bratislava in Banska Bystrica. From the early beginnings of this faculty’s existence, increasing attention was given to the development of study programs preparing specialists for so-called “non-productive” branches of the economy, including public administration. As a result of these developments, the first study program in “Economics of Non-productive Services and State Administration” was established in this faculty in 1986. At the same time, similar programs were also established in the Czech Republic (Prague, Ostrava and Brno).

In addition, the faculty of Economics of Tourism and Services was a unique university-level institution with a PA program until 1989. However, many subjects from the PA/PM field were also included into the curricula in various faculties of the University of Economics in Bratislava, mainly in the Faculty of the National Economy (high quality courses on public finance, for example).

After 1989, new PA and similar programs were established in Slovakia, as a result of two important factors:

- the society started to feel the need for academically-trained professional public administrators prepared to realise effective public administration and public management roles
• a liberalisation of the system of academic studies in Slovakia - each university gained the right to decide on the structure of its faculties and study programs

On this basis, the current structure of public administration academic programs was established. According to recent legislation (2002 University Law), three levels of public administration/public management (PA/PM) studies are available to students:

• Bachelor’s degree studies in PA/PM (3 years); students receive the bakalar degree.
• Master’s degree studies in PA/PM (2-3 years); students receive the inzíner (Ing.) or magister (Mgr.) degree.
• Postgraduate degree studies in PA/PM (3-5 years); graduates receive the Ph.D. degree.

The following are academic institutions in Slovakia where specialised PA/PM degree programs are taught:

1. Matej Bel University Banska Bystrica, Faculty of Economics. In this faculty (which is more a business school than a school of economics), PA/PM education is delivered through coordination with the Department of Public Economics and the Institute for Local and Regional Development, within the framework of the program “Public Economics and Public Administration”; four specializations are offered.

2. University of Economics Bratislava, Faculty of the National Economy. This faculty is between that of a typical school of economics and a typical business faculty. PA/PM studies represent one specialization within the study branch National Economy.

3.

4. University of P. J. Safarik Kosice, Faculty of Public Administration. This specialized faculty was established in November 1998; prior to that time, PA studies were realized in this university within the framework of the Faculty of Law by the Institute for Public Administration.

5. University Trencin, Faculty of Socioeconomic Relations. This university created its PA academic program as a specialization within the broad study program on human resources.

6. University of Cyril and Metod Trnava, Faculty of Philosophy. In 1998, this faculty started two study programs related to PA/PM: Law in the Public Services, and Management and Economics of Public Services. Neither program was accredited (and probably will not be accredited soon) and had to be closed.

There are also other university programs with some features of a PA/PM degree program. These include:

1. Matej Bel University, Banska Bystrica, Faculty of Political Sciences and International Relations
2. Matej Bel University, Banska Bystrica, Faculty of Law
3. Comenius University, Bratislava, Faculty of Philosophy, Department of Politology
4. Comenius University, Bratislava, Faculty of Management
5. Comenius University, Bratislava, Faculty of Law
6. University Presov, Faculty of Philosophy

As regards the structure of PA/PM programs in Slovakia, one must stress that the system of university degree programs (branches and specialisations) is, as the result of a new university law, under heavy reconstruction today. Consequently, the current names and structures of extant programs might be changed in a short time.

Most of the PA/PM academic degree programs in Slovakia are developed on the basis of economic studies and are more (Bratislava) or less (Banska Bystrica, Trencin) dominated by the economic and management disciplines. Only the PA degree in Kosice has a more diverse character involving economics, management, legal and other studies.

IN-SERVICE PA/PM TRAINING

In-service training in public administration in Slovakia is highly decentralized as a result of a system of personnel management in the public sector that was highly decentralized before 2002 when the new Civil Service Code and Public Service Code were adopted. There are many institutions participating in some form of in-service training. Probably the most important of them (at least according to the number of trained civil servants) is the Institute for Public Administration in Bratislava (an organization of the Ministry of Interior of the Slovak Republic), with branches in Kosice and Banska Bystrica.

This Institute is responsible for the compulsory training of local state administration employees, as per governmental ordinance Nr. 157/1997 on the specific qualification assumptions needed for executing certain activities in regional and district offices. Additional main training courses of this Institute are as follows:

- three-year training in public administration, focusing on legal issues;
- three-year training in public administration, focused on socio-legal issues;
- two-year training in archives;
- training for city managers;
- training in basic principles of auditing; and
- many short courses.

As a result of the decentralised personnel management in Slovak public administration, there are many state-owned training centres, mostly related to various ministries. They include:

1. Institute for Training and Services, Ministry of Building and Public Works (five-day courses on public procurement, housing, regional development, etc.);
2. Institute for Foreign Trade and Education, Ministry of Economy (organizes a 12-day training course for managers in public administration);
3. Secondary School of Fire Brigades, Ministry of Interior;
4. Institute for Education and Technique, Department of Training in Civil Protection, Civil Protection Branch;
5. Agroinstitute, Ministry of Agriculture;
6. Institute for Education and Training in Forestry and Water Economy, Ministry of Agriculture;
7. Institute for Education and Training of Veterinary Doctors, Ministry of Agriculture;
8. Slovak Agency for Environment, Ministry of Environment;
9. Training Center of the Ministry of Labor, Social Issues and Family;
10. Center for Education of the National Labor Office;
11. Training Center for Employees of the Ministry of Finance;
12. Institute for Further Education of Health Care Employees, Ministry of Health;
13. Slovak Institute for Technical Norms;
14. Institute for Further Education of Employees of Justice Branch, Ministry of Justice;
15. Research Institute of Geodesy, Cartography and Cataster; and

There are also private and semi-private, for profit and not-for profit bodies providing training courses for many specific groups, including public servants. Among the many, especially notable is the Foundation for Self-government Training, founded by the Association of Towns and Municipalities of Slovakia.

**HEALTH CARE ADMINISTRATION, MANAGEMENT AND POLICY DIMENSION OF PA/PM EDUCATION**

Of all the aforementioned institutions, there is only one where PA/PM education is closely combined with health care administration management and policy education and training. As will be noted below, the Faculty of Economics at Matej Bel University in Slovakia has, as part of its PA/PM program, the specialization “Economics and Management of Health Services.”

**5. CURRENT EDUCATION AND TRAINING PRACTICES IN THE AREA OF HEALTH CARE ADMINISTRATION, MANAGEMENT AND POLICY**

The need to educate health administrators was recognized by the old regime. The first activities in this area were carried out by the training institute of the Ministry of Health of the Slovak Republic (IPVLF) [As indicated earlier, health care was the responsibility of the national states after the federalization of Czechoslovakia in 1968.] Post-graduate training in health administration/management was a pre-requisite to be appointed to the position of director of a hospital or polyclinic or to other health care managerial posts. The requirement of “second attestation” in health administration was incorporated in a binding regulative document – Health Care Job Description. However, the training in health administration/management by IPVLF was predominantly focused on aspects of health care organization and included very few management science courses (not surprising, as the hospital directors were not expected to be independent managers in the old centralized system) and was delivered by medical doctors.

The creation of the Faculty of Economics of Services and Tourism (FECSR) of the School of Economics, Bratislava in Banska Bystrica in 1977 represents an important step in the development of health administration/management studies in Slovakia. The important role of services in the national economy was, for the first time, really recognized in academic studies, and the Faculty became responsible for the education (at the master’s degree level) of managers for all service branches, including health care services. This way, in the eighties, health care economics was incorporated into the curricula of the study branch “Economics of Non-
productive Services and Public Administration” and a new channel for preparing administrators/managers of health establishments was created. However, as the non-written rule (valid also today) provided that hospital directors are to be medical doctors, the graduates of these studies were usually not able to get hired for any position higher than that of economic vice-directors of health organizations.

Thus, prior to 1989, some system of preparation of health administrators/managers (but not health policy experts, as health policy was the sole responsibility of the Communist Party) existed in Czechoslovakia. However, the content of both types of studies (at the IPVLF and at the FESCR) was based on “socialist ideology” and the rules of a centrally planned and managed economy.

The massive health care reform after 1989 created the need for the education and training of new managers for health care establishments. The reaction of the existing bodies (IPVLF and FESCR) differed in that IPVLF reacted to the changes very slowly and this pushed a small progressive group of medical doctors to establish (while still maintaining their positions in the School of Public Health created by IPVLF on July, 1st, 1991) an independent, private, non-profit organization, the Health Management School (HMS), to deliver management training for medical doctors. FESCR (converted in 1992 to the Faculty of Economics of the Matej Bel University [EF UMB]) reacted very quickly and changed the curricula and the content of studies over a two-year period (in 1992, the curricula were similar to western master’s programs).

The processes of establishing HMS and changing the system of studies in EF UMB were supported by the EU program TEMPUS, and the main partner in supporting the necessary developments was the Academic Hospital in Groningen, Netherlands. Very soon after the TEMPUS health management program finished, a new foreign partner came to Slovakia to help to continue the process of change. The US Agency for International Development (USAID) financed a program establishing health management studies in Central Europe and allocated responsibilities to manage this program to AIHA. AIHA selected, through competition, US universities to execute the program in selected CEE countries, and the University of Scranton, PA was chosen to serve in Slovakia.

The AIHA health management program started in the late nineties with four institutions involved, the University of Scranton, as the donor’s representative, two already existing bodies, HMS and EF UMB, and the newly established Trnava University, with its Faculty of Nursing and Social Work (later, the Faculty of Health Care and Social Work).

The AIHA program was very comprehensive and its main phase lasted three years, producing many important outcomes. Among the tools developed to update the system of health management (but still not health policy) education and training in Slovakia were the creation of the Journal of Health Management and Public Health, the organization of a yearly Health Management Symposia, the exchange of teachers and students, the support of the participation of Slovak experts in international conferences and the writing of core textbooks, among many others. By the program’s end in 1998, all three Slovak partners had become well functioning health management centers and sustainability was achieved.
By the late 1990s, other institutions (new and existing) had also recognized the importance of academic education and training in health care. The current structure of the field is noted below.

**ECONOMICS AND MANAGEMENT OF HEALTH CARE STUDIES IN BANSKA BYSTRICA (EF UMB)**

Today, EF UMB is the only institution in Slovakia that delivers health management (and, to some extent, health policy also) education as a part of public administration/management studies. The study branch “Public Economics and Administration” (the name may change and accreditation is to be extended also to the Ph.D. degree level in the near future as the result of a new university law in Slovakia) still represents a unique academic program in the country, fully compatible (from the point of view of curricula) with similar leading programs in more developed countries.

The EF UMB studies include three main phases. The first phase (first three years) includes primarily business administration and economics subjects (e.g., Microeconomics, Macroeconomics, Economic Policy, Quantitative Methods, Management, Marketing, Business), plus a few core PA/PM subjects (e.g., Public Economics, Public Administration, Social Policy, Non-profit Management). In the second phase (fourth year), PA/PM knowledge is further developed through courses like Public Finance, Public Services, Non-profit Sector, and others. The last (specialization) phase (fourth and fifth years) overlaps to some extent with the second phase and provides students with specific knowledge in a selected area of public sector management, namely, “Economics and Management of Health Care,” through health care economics, management and policy courses.

Most courses are delivered by PA/PM and health economics experts, but some part of them are also delivered by medical doctors working part time for the Faculty (in areas such as Clinical Management and Public Health). Thus, the graduates receive comprehensive knowledge and are able to adapt to different positions in the health care sector and in other public sector organizations, as well as in the private for-profit sector.

EF UMB is also involved in the on-the-job training of health care managers. In past years, it has delivered a one-year training course “Economics and Management of Health Insurance Company”. Recently, it conducted a two-year training program for managers of non-profit organizations; some health care managers also participated in this course, since the number of applicants for training in health management was not sufficient to open a specialized course only for this group.

**OTHER EDUCATION AND TRAINING PRACTICES IN HEALTH CARE ADMINISTRATION, MANAGEMENT AND POLICY**

Of the other two USAID/AIHA health management programs, only one exists today – the Faculty of Health Care and Social Work of Trnava University (FHCSW). As it became more and more difficult for HMS to survive as a private body in the health management training system (due to increasing competition and the decreasing influx of foreign aid), the main representatives of HMS decided to turn back and to incorporate their activities within the framework of the
training institute of the Ministry of Health (at that time called SPAM) that was converted in 2002 to the Slovak Health University. As a result, the existing School of Public Health (SPH) of the Slovak Health University became the new (real) actor in the field of health management training in Slovakia, and thus the circle IPVLF – HMS – SPH was concluded.

In addition to the dominant actors in the field of health management education and training that already have been discussed, there have been recent attempts to introduce this type of education and training into the activities of the Medical Faculties in Bratislava, Martin and Kosice and also the Faculty of Health in Presov; however, such activities do not go beyond including some specific courses in the curricula of academic education or training courses.

Faculty of Health Care and Social Work, Trnava University

This Faculty has accreditation for the study branch “Public Health”, providing it with the right to deliver a master’s degree in this area (again, this name may change, and the accreditation would be extended also to PhD studies in the field, as the result of recent reform). Within this study branch, the students can choose, in the last (5th) year, the specialization Health Management. The responsibility for this specialization lays with the Department of Health Management, consisting of 50% medical doctors and 50% other specialists.

The curricula of the branch and the specialization are dominated by medical courses, supported by the extensive language preparation of students. The first four years include only two courses related to our topic – Health Policy (12 hours) and Health Management (36 hours). In the specialization phase (one semester), the students take the following courses – Health Policy in Public Health, Health Financing, Organization of Health Care, Public Health Advising, Biostatistics, Ethics in Management, and Insurance.

School of Public Health of the Slovak Health University

As already indicated, the history of this school is an interesting story. It was created in 1991, but with a limited scale of activities in health management training in the beginning and some of its teachers created the private non-profit HMS (while simultaneously continuing in the School) for a certain period to deliver this type of training. Significantly interconnected with Trnava (FHCSW), the same names appeared on the list of members of the Department of Health Management in Trnava and in Bratislava (Dr. Hlavacka also served simultaneously as the top civil servant – director – in the Ministry of Health and as the medical doctor in the hospital).

The most unusual issue connected with the school is the process of the creation of the Slovak Health University. The university was created by the specific law voted in by the Slovak Parliament in 2002 as the result of the lobbying of medical doctors focused on increasing the status of SPAM (the training institute of the Ministry of Health). It is not accredited for any degree yet, in spite of the fact that no academic education institution can be created without preliminary accreditation. It is not part of the standard university system in Slovakia, but is linked directly to the Ministry of Health.
The School delivers (more or less illegally) a master’s degree program in Public Health (three years of studies) and training courses for medical employees. The Public Health program also includes topics on health economics and management. The Department of Management organizes short term training courses, such as Management of Spas, Health Management and Finance, Management of Health Establishment, Health Management, Salaries in Health, for medical employees every year.

Thanks to its direct link to the Ministry of Health, the School of Public Health has a more or less monopolistic position in the training of health professionals, including those in management positions. Other training courses are generally not recognized by the Ministry, and thus are not officially valid for qualification assessments. Because of its character and program, for health management education and training analysis purposes this School is listed in Appendix B as a training institution.

6. CONCLUSIONS AND RECOMMENDATIONS FOR NEW INITIATIVES

As described earlier in this chapter, the Slovak health care system is currently in a deep crisis, especially from the point of view of finance. There are many reasons for this situation, some of them objective (like the level of performance of the national economy, limiting the amount of resources to be able to allocate to health care), but many could also be solved in the short term - limited quality of managers of health care establishments and lack of capacity in health policy making among them.

QUALITY OF HEALTH MANAGEMENT/MANAGERS AND HEALTH MANAGEMENT EDUCATION

The low economic performance of health care establishments, especially hospitals, represents one of the important reasons for the financial crisis of Slovak health care, as already shown. The hospital system is, year by year, in “red figures”, as they are not able to balance costs and revenues. There is no doubt that this negative trend is connected to the quality of hospital management and hospital managers. What is the relation between this problem and the system of health management education/training?

To answer this question, we have to focus, at a minimum, on two dimensions. The first dimension is the quality and scale of health management education and training and the second is the capacity of the system to accept well-educated and trained managers.

The earlier analysis shows that the system of education and training of health care managers in Slovakia still has some significant limitations in content and in scale, too. The number of graduates from Banska Bystrica is very small; on average, five to ten per year. The graduates are very good generalists, but need some additional experience from health care system practice. The education and training in Trnava and Bratislava are very much based on medical courses, and the graduates are really not provided with a sufficient knowledge of management and related disciplines.
However, the main problem is (at least today) outside of the education/training system. The tradition that the health establishment’s directors are medical doctors, and that the role of economic managers is limited, still persists in the Slovak health system. Doctors and their interests dominate the system, and space for effective managers is very limited. Because the state was not able to react to the bad economic performance of hospitals, and simply covered the debts of the public health care system (see Table 2), there have been no real incentives to manage health providers’ organizations in an effective way. Under these circumstances, the system is not ready to accept well-educated and trained managers, and the best managers try to find other opportunities in different branches of the national economy. [This is one of the reasons EF UMB and FHCSW did not decide to increase the number of graduates in the field.]

The situation in the sector may change very soon, however. The current Slovak government has decided to privatize most of the health care establishments (the hospital sector remained in the hands of the state until 2002) or to transfer them to local and regional self-governments. It also has promised not to cover any additional debts. If this were to occur, the external environment would change, there would be pressure to change the system of management of hospitals, and the need for effective managers should increase. In this event, the system of health management education and training would need to improve to be able to respond to these developments.

HEALTH POLICY DIMENSION

Many individuals have argued that there is no consistent health policy in Slovakia (Zajac and Pazitny 2001; Zajac and Pazitny 2002). The main causes underlying the problems of the health care system are well-known, often described, and publicly discussed (e.g., the imbalance between the resources available and the scale of care provided free at the point of delivery), but no Slovak government before 2002 was able to respond to them.

The reasons for such a situation can be found by investigating the interests of the main “players” – none of them has promoted the necessary changes. The inaction also is the result of the limited policy making and policy implementation capacity of the public administration system.

Health care policy-making, policy implementation, and policy analysis issues are taught only in a few courses, and there is neither the capacity, nor the demand to improve the situation. There are still few experts on these issues in Slovakia, and this situation is not likely to change quickly. The government demands health policy advice only infrequently; most decisions are not discussed with academic and scientific circles.

There is only one health policy think-tank formally established in Slovakia – The Center for Health Policy and Strategy in Banska Bystrica, a non-profit organization based on voluntary memberships (there is no permanent staff). Because of its structure and territorial location outside of the capital, the capacity of the Center to influence health policy in Slovakia is somewhat limited (the Center provided certain expert studies, mainly on health financing, funded via Phare or The World Bank).
CONCLUSIONS AND RECOMMENDATIONS

The analysis in this chapter confirms that a basic system of health management education exists in Slovakia, and that its current performance is in accordance with the real demand from the health sector. However, recent changes in the health care system may significantly increase demand for well-educated and well-trained health management professionals; in this event, the current education/training system will face significant difficulties in responding effectively. All existing education/training institutes are public sector bodies, and it is likely that they would not be sufficiently adaptable to increase both their capacity and their quality. [A primary barrier might be the low level of salaries, limiting the chance to hire additional high-quality staff.] The private sector is not yet involved in the area because a mixed public-private system to deliver certificate training is not supported by the Ministry of Health, which still protects the monopolistic position of its training institute in the field.

Taking into account the current situation and possible future perspectives, the recommendation for the area of health management education/training is straightforward – the capacities to deliver health management education/training have to be increased, and a pluralistic delivery system must be created. The main source of financing capacity growth would probably be private finance or external resources as the public finance system cannot be expected to support such processes in a significant way. Much more co-operation between existing institutions is needed.

A system of health policy-making, implementation and analysis has not really been created. Pressure for it may arise very soon as the health care system is closer and closer to collapse and there will be no additional resources to recover its debt from privatization or similar non-regular incomes. Systematic and effective measures to prevent these trends will be needed by any government (as the collapse of the health care system could cause large political changes in a very short period). To react to such a demand will not be simple, and many new young people have to be attracted to contribute (as changing the heritage of a “command society” is not simple), and an additional transfer of knowledge from developed countries might be needed, too. Additional public or external resources have to be found to finance the system, as the private sector is not likely to be able to do so (vested interests are some of the reasons). Finally, given limited local public finance capacity for the area of health policy, the financial assistance of foreign donors/borrowers - either directly by providing funds, or indirectly by providing expertise and know-how – may be required.
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APPENDIX A.
ACADEMIC PROGRAMS IN HEALTH MANAGEMENT IN SLOVAKIA

Faculty of Economics, Matej Bel University, Banska Bystrica

1. **Name of the program**: Verejna ekonomika a sprava (Public economics and administration), specialization: Ekonomika a management zdravotnictva (Health economics and management).

2. **Accreditation**: full accreditation for bachelor’s, master’s and doctoral studies.

3. **Contact address**: Helena Kuvikova, EF UMB, Tajovskeho 10, 974 01, Banska Bystrica, Slovakia, kuvikova@ef.umb.sk, www.econ.umb.sk

4. **Established**: 1987

5. **Number of students**: students are regularly admitted for five-year combined bachelor’s and master’s program, full-time. The average number of full-time students is 10-15 per year. The part-time studies and doctoral studies are not regular and depend on demand.

6. **Degree**: Ing. (Master of Public Management)

7. **Main partners**: University of Scranton (USA); Masaryk University Brno (Czech Republic).

8. **Curricula**:

   **Main (compulsory) courses, bachelor’s level**: Microeconomics, Macroeconomics, Mathematics, Statistics, Management, Marketing, Informatics, Public Economics, Public Administration, Economics of Municipalities and Regions, Foreign Languages (2), World Economy, Accounting, Enterprise Management, Human Resources Management, Public Services, Non-profit Organizations, Demography, Public Sector Control/Audit.


9. **Impact in the country**: The program started with high expectations, as there was clear potential for demand. However, the actual acceptance of graduates in the health care system was very limited; as a result, the willingness of students to apply for the program decreased. The program staff represents the core of the Center for Health Policy and Strategy in Banska Bystrica, an independent, non-profit “think tank” in the health policy area. This center is irregularly, from time to time, invited to participate in health policy analysis activities. The primary examples of these activities were the award of one part of a PHARE-financed hospitals program in 1996 and a World Bank-financed program in 2002 that analyzed hospital versus outpatient treatment of minor diseases. Its name and representatives are well-known in the country, but its real impact on health policy making is still very limited, since the government is not very proactive in cooperating with other sectors when preparing the main policy documents.
Faculty of Nursing and Social Work, Trnava

1. **Name of the program:** Verejne zdravotnictvo (Public Health), specialization Zdravotnicky management (Health Care Management)
2. **Accreditation:** full accreditation for bachelor’s, master’s and doctoral studies.
3. **Contact address:** Bohumil Chmelik, FOSP TU, Univerzitne namestie 1, 917 00 Trnava, [www.truni.sk](http://www.truni.sk)
4. **Established:** 1994
5. **Number of students:** students are regularly admitted for five-year combined bachelor’s and master’s program, full-time. The average number of full-time students is about 10 per year. The part-time studies and doctoral studies are not regular and depend on demand.
6. **Degree:** Mgr. (Master of Health Management)
7. **Main partners:** University of Scranton (USA).
8. **Curricula:**

*Main (compulsory) courses, years 1-5 (except for specialization):* Anatomy, Biophysics, Biology, Biochemistry, Physiology, Nursing, Health Law, Biostatistics, IT, Philosophy, Psychology, Foreign Languages (3), Hygiene, Microbiology, Anatomy, Internal Medicine, Surgery, Pediatrics, Primary Care, Epidemiology, Pharmacology and Pharmacoeconomics, Oncology, Health Policy, Radiology, Infectious Diseases, Health Management, Gynecology, Social Medicine, Social Work, Risk Calculations, Health Programs, Health Ethics, Public Relations.

*Main (compulsory) courses for specialization (year 5):* Health Financing, Managed Care, Insurance, Management Ethics, Advising in Public Health, Public Health Policy.

9. **Impact in the country:** The program started as a result of AIHA activities in Slovakia. Similar to the EF UMB program, the graduates have only a limited chance for “fast track” employment in the health management system. Students’ interest in applying is limited. Internal staff members involved in the implementation of the program are not significantly involved in health policy making and analysis in the country.
APPENDIX B.
TRAINING PROGRAMS IN HEALTH MANAGEMENT IN SLOVAKIA

As described in the main text, the primary, essentially “monopolistic,” provider (as a result of Ministry of Health policies) of health management training programs today is the School of Public Health of the Slovak Health University.

School of Public Health of the Slovak Health University

2. Training programs:

   Master of Public Health (for university graduates – “executive” master’s program)

   Training for Head Nurses of Spas – 3 days
   Contents: managerial tasks, motivation, managerial psychology, conflict management, change management, management of quality, strategic management.

   Health Management and Finance – 12 days
   Contents: health management and financial management.

   Management of Spas – 4 days
   Contents: management and marketing of spa organization, balneotherapy, managerial skills of head nurse.

   Management of Health Establishment – 3 days
   Contents: strategic management, change management, health policy.

   Health Management – 3 days
   Contents: strategic management, managerial psychology, change management, conflict resolution.

   Remuneration in Health Care – 1 day
   Contents: remuneration system for public health organizations, financial management, labor relations, performance management and appraisal.