HealthManagement
Promoting Management and Leadership

Volume 9, Issue 2 /2007 - Country Focus:Slovakia

Reforms of Healthcare Delivery in Slovakia and Their Impact on Performance of Hospitals

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The Slovak government in the post- Soviet era started massive reforms, focusing on maintaining the access to, and increasing the quality of healthcare systems. Other priorities were to improve outcomes, especially life expectancy, and to control the costs of healthcare systems.

The most important goals of the reforms were healthcare for everybody, a guarantee of 'essential' healthcare for everybody, cancellation of a state monopoly in healthcare, plurality of provision of healthcare, privatization, increased participation of selfgovernment in healthcare systems, the introduction of comprehensive compulsory (social) health insurance, multi-resource financing of healthcare, 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 the necessity to balance costs and resources became an increasing priority, and from 2004 additional new market type elements were incorporated.

	1996	1997	1998	1999	2000	2001	2002
Health insurance system resources	35.4	38.4	41.4	43.0	45.3	49.6	55.0
Resources from the Ministry of Health	4.6	4.9	4.7	4.4	4.5	4.9	4.8
Resources from Social Insurance Company	1.0	1.2	1.3	1.3	1.0	1.1	1.2
Direct payments from inhabitants	2.6	3.8	4.1	5.4	5.9	6.3	7.0
Total resources	**43.6**	**48.3**	**51.5**	**54.1**	**56.7**	**61.9**	**68.0**
• Primary care costs	4.3	4.5	4.2	4.4	4.7	4.9	5.1
• secondary ambulatory care costs	0.2	1.3	1.5	1.8	1.9	2.1	2.2
• In-patient care costs	21.4	24.0	25.6	25.0	26.0	28.1	29.5
• Medicaments and health aids costs	12.2	14.4	16.1	18.8	20.6	22.8	24.1
Other costs	1.1	3.4	5.0	4.1	6.9	7.7	8.0
Ministry of Health costs	4.6	4.9	4.7	4.4	4.5	4.9	4.8
Total costs	**43.8**	**52.5**	**57.1**	**58.5**	**64.6**	**70.5**	**73.7**
Balance	-0.2	-4.2	-5.6	-4.4	-7.9	-8.6	-5.7
Deficit coverage	0.2	4.2	5.6	4.4	7.9	8.6	5.7
External debt	0.2	4.2	5.6	4.4	4.4	5.2	2.1
Privatisation grants	0.0	0.0	0.0	0.0	3.5	3.4	3.6

Table 1: The Economic Performance of the Health Care System in Slovakia (in billions of SKK)
Source: Nemec, Gbuer, 2003

The 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 healthcare system started in the middle of the 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. During 2003/2004, some hospitals became non-profit, semi-independent bodies.

The privatization of specialized, ambulatory care was slower, but already by 2001 the state sector accounted only for 26 % of facilities (see Zajac, Pazitny, 2002). The semiradical shift after 2002 to limited marketization of the system was concluded in June 2004, when the health minister Zajac prepared and submitted the set of new health laws to the Parliament, expected to significantly change the system, by increasing the level of co-payments, the introduction of commercial voluntary health insurance, and changing health insurance companies into joint-stock companies. All six draft laws were approved and were valid from January 1st, 2005.

Health Reform Outcomes and the Problem of Their Measurement

One of the most difficult public policy and public finance issues 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, such as: “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 the reformation of the Slovak healthcare system from 1990 to 2002. We have to stress immediately that our view is only a short-term view. Respective reform measures were in force for relatively short periods, and their longterm consequences might differ from short-term perspectives. However, relatively radical changes from 2005 represent discontinuity, preventing long-term outcomes occurring.

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 many dimensions, preventing its unified use. In the following, we focus on two dimensions: clinical quality of care, and organizational (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 a 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, Pazitny, 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 healthcare quality problems, the Slovak Ministry of Health initiated from 2002 several actions to improve the situation, like the creation of special unit for patients´ complaints in the ministry, the promise to introduce medical standards for all levels of healthcare; and the immediate inspection of cases of mistreatment by the Ministry. In most cases the doctors responsible were suspended, and the respective hospital departments were even temporarily closed.

To document existing problems in clinical quality of care, we use two sets of indicators in our paper. One of them is the increased frequency of reporting (by media) on the misconduct of medical personnel when treating patients, and the related increase of court cases suing medical professionals for mistreatment. In 2004 alone, the media reported on four cases where the death of the patient was clearly caused by the hospital; the highest number ever. In the beginning of 2005, a patient won a case against a doctor, concerning mistreatment for the first time in Slovak history. In 2006, again for first time in Slovak history, the official statistics of the established cases when patients died in hospitals because of apparent mistakes of the medical personnel was published (23 cases – www.udzs.sk).

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 organizational aspects of quality and existing data prove that the level of dissatisfaction increases. The weakness of this indicator is connected with the problem of expectations in two directions:

• if there are no expectations, no claims would occur,

• if there are expectations that complaints would not help, the number of complaints decreases.

There is some evidence to prove 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 of a precise appointment is typical with most providers, including private ones. As mentioned, an important indicator of both clinical and organizational quality is the reactions of patients. As part of developing the governance and e-governance system in Slovakia, all patients have now the possibility to complain about healthcare-related problems to a special unit in the Ministry of Healthcare: the Unit for Protection of

Patients´ Rights. The number and structure of such appeals is telling, and shows that there are major quality problems that need to be solved.

Quality of Financial Management

Taken together, the governmental statements identify the improvement of efficiency as one of the main aims of transition. But in practice this aim has not been consistently realized, and by 2002 the hospital and insurance sectors in Slovakia were heavily in debt. 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 insufficient effectively- managed capital programs, 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 programs, and insufficient resources were devoted to preventive medicine.

Wrong Policy or Wrong Implementation?

We may conclude without much doubt, on the basis of the 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 better perhaps than under the old regime. It is too early to predict the future, after major changes in the beginning of this century. Taking this situation into account, we may ask the question: wrong policy or wrong implementation?

If the policy is already improperly formulated (or not effectively formulated at all) it is very difficult to achieve positive outcomes. When implementation fails, policymaking loses its purpose, mission, credibility and effectiveness. Evidence on the practice of policy-making shows that both stages (policy formulation and policy implementation) are extremely weak in Central and East European countries.

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

One of the crucial issues of the reform was the idea of replacing the former general taxation-based model of financing of healthcare by a 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 an idea could be the subject of objections to the general economic and health economics theory, especially for transitional periods, which are beyond the scope of this article (for detail, see for example Nemec and Lawson, 2003). The crucial issue is that basic preconditions for the functioning of the insurance market were not 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, and set maximum levels of administrative costs. Furthermore, the Slovak Parliament also deliberately decides on the level of the state contribution for economically inactive citizens, representing an important part of insurance funds. The level of equalization between insurance companies was a matter of permanent dispute between different actors in both republics, involving frequent changes in the system, but ending with 100% equalization in Slovakia from 1999. The financial and especially the reimbursement, rules changed almost every year.

Reimbursement Systems for Providers in Slovakia

The impacts of such tight regulation of freedom of insurance systems are straightforward. The change saw a proliferation of companies followed by a rapid consolidation and final domination by a single player: the Slovak General Health Insurance Fund (SVZP). By late 1995, twelve insurance companies were operating 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 healthcare 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 i.e. 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 bail-outs, by early 2002 the system had been educed 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 a path was frequently chosen by the Slovak Parliament, which has repeatedly used its powers of intervention in an unwise manner. For example, under Act No. 374/94, Parliament determines the annual payments to the insurance system for -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

healthcare system to delay payments and waste resources in lobbying politicians for their release. Under subsequent legislation, the private sector lost any real legal chance of being repaid for “compulsory crediting” of health establishments, in the form of non-paid invoices for delivery of goods and services to the health sector.

Conclusions

The Slovak healthcare system after 1989 was influenced by differing reforms. The first ten years of reforms did not deliver enough positive outcomes. To cope with increasing economic efficiency and deficiencies of the system, major market-based reform was introduced after 2000, with most of the 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 goals were not achieved. We argue that both ineffective policymaking and ineffective policy implementation processes might be one important factor lying behind this situation. It is difficult to realize effective reforms in an environment of transition from centralism to democracy and the market as there no experience of such change. However, if it is politics and not policy that is the main determinant of the reform contents, inefficiencies are inevitable.

Published on : Sat, 24 Feb 2007