Health-care Reform in Slovakia

Peter Pažitný, Rudolf Zajac and Anton Marcinčin*

The market for health-care services has been described as a place where people yearning for immortality meet the unforgiving world of finances. Although most of the reforms, ongoing in many countries, are hardly ever acceptable to the citizens, many partial steps bring forth almost immediate palpable improvements that are important for gaining and maintaining financial stability and trust of the society. This is the basic lesson from Slovakia's health-care reform.

OECD countries spend on average 8.4 percent of their GDP (OECD 2003a) on health care. In 2003, Slovak health-care expenditure amounted to 6.9 percent of GDP, which is lower than the OECD average but slightly higher than the average of the seven new EU member states (6.7 percent of their GDP, WHO 2003).

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

Reasons for the reform

The socialist health care system offered its services free at the point of delivery. However, patients were constantly under-treated and deprived of the latest advances in pharmacological technologies, diagnostics and treatment. A vast network of physically available, yet inefficient hospitals was built. Excess demand was balanced by nepotism and corruption.

At the present time, treatment in Slovakia has already become more effective. This is shown by a significant growth in the mean life expectancy: From 1990 to 2002, the annual growth was 0.18 years for females (1960–90 only 0.10 years annually) and 0.27 years for males (previously –0.04 years annually). This improvement was driven mainly by increased expenditures on new technologies and pharmaceuticals, because no significant structural changes except the privatisation of primary and secondary care on the supply side of the system took place between 1990 and 2002.

The health-care system used to pride itself in providing a high level of equality in access to care, which was, furthermore, delivered for free. In reality, neither of these points were true. Disequilibrium on the market was corrected by informal payments, which further deepened inequalities (OECD 2002b).

Thanks to the generous scope of benefit packages provided, free access to health care, inherited extensive supply, spreading of noninfectious and chronic diseases and limited solvency, demand as well as the supply exceeded available resources. The high demand for health-care services can be illustrated with the following figures: While the annual number of physician consultations in OECD countries was 5.6 (OECD 2003b), the number in Slovakia was 9.2. According to estimates by the Slovak Ministry of Health, 41 tons of prescribed and unused drugs are wasted each year.

Table 1

Revenues and expenditures of the health care system
in % of GDP

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

e = estimated; f = forecast.

Source: Ministry of Health of the Slovak Republic.

* Peter Pažitný, researcher at Health Policy Institute, Bratislava, economic advisor to the Minister of Health and co-author of the health reform (pazitny@mesa10.sk); Rudolf Zajac, Minister of Health of the Slovak Republic, initiator of the health reform; Anton Marcinčin, health policy advisor, World Bank.
The article is based on a longer paper which contains more details: Zajac, R., P. Pažitný. and A. Marcinčin, 2004.

Until 2001, this inequality resulted in continuous growth of deficits, mounting costs (Table 1) and prolonged waiting periods. The financial problems reached a peak in 2002. If public finances are not capable of covering the actual costs of health care, it is possible to react on the revenue side by increasing private financing (co-payments by patients via private insurance and cash payments), on the supply side by increasing system efficiency, and on the demand side by lowering expectations of the patients towards the publicly financed health-care system.[1]

Fundamentals of the reform

Politically, health-care system reform is a complex issue because in the short-term there are no clear winners: patients lose free health care, providers of health care are deprived of soft budget constraints and producers of technologies and pharmaceuticals lose part of their market. The reform aims to lower the expectations of citizens associated with the health care system and to strengthen their responsibility for their own health. From the public finance perspective, it means the introduction of a clearly defined system in three categories: fully covered, partially covered and non-covered health-care.

The reform is based on a critical assessment of the (mal-) functioning of the pre-reform system. The most critical characteristics have been:

- Moral hazard,
- unsustainable coverage,
- dominance of soft budget constraints,
- management by physicians, and not by enterprises,
- inability of the system to react to the changing structure of diseases.

From these functional distortions the main objectives of the reform heave been derived:

1. Creating an environment supportive to incentive mechanisms to improving the health of the population, increasing the safety of treatment and trust of patients in the health-care system. The position of the state shifts from a health-care services producer, price maker, network manager and distributor of finances to the position of a regulator. The patient takes over higher responsibility for her or his own health status, including covering some prevention as well as treatment costs. The provider takes over higher responsibility for correct provision and quality of health-care, including the possible risk of penalties. A health-care insurer takes over responsibility especially for the management of patients within the system, and solvency in purchasing health-care complying with hard budget constrains, with the risk of facing bankruptcy.
2. Maintaining balanced financing of the health-care system.
3. Increasing the flexibility of the health-care system so that it will respond to the needs of citizens, changing environment, shifts in structures of disease, and technological progress.
4. Providing financial protection of individuals from so-called catastrophic expenses for health-care.

The reform measures undertaken can be grouped into stabilizing measures and measures of systemic change[2].

Stabilizing and systemic measures

Stabilizing measures

First steps: The main goal of the stabilizing measures was to stop the accumulation of debts and limit excessive consumption of health-care services and pharmaceuticals. To start any changes it was first of all necessary to create a proper definition of the term "health-care" and differentiate health-care services proper from those services which are only related to health-care (e.g. food, lodging and transportation).

User fees: The second new element was the introduction of user fees (Table 2) for physician consultations, for issuing prescriptions and providing related services (started 1 June 2003). This step was meant to increase the responsibility of patients for their own health, and was not intended to secure massive additional resources into the system. Fees are of a symbolic nature, while certain groups of patients, such as children under 1 year or the chronically ill are exempt. Poor patients, at first, paid lower fees; however, this proved to be administratively complicated; exemptions were thus canceled and the poor receive a monthly contribution from the social system of SKK 50 per household member to compensate for health expenses.

[1] For further analysis of the Slovak health sector, see Pažitný and Zajac, 2002.

[2] Both the stabilizing and reform measures are profoundly described in Pažitný and Zajac, 2001, and then later in governmental documents in 2003 and 2004.

Table 2

User fees introduced since 1 June 2003

Type of care/provider	User Fee	Per	Who keeps it?
Primary outpatient care	SKK 20	visit	Doctor
Specialized outpatient care	SKK 20	visit	Specialist
Hospital (i.e. room and board)	SKK 50	day	Hospital
Transport	SKK 2	km	Transport
Prescription	SKK 20	Prescription	SKK 5: pharmacy; SKK 15: HIC

Source: Ministry of Health (2003).

The introduction of user fees led to a 10 percent decline in visits to general practitioners and a 13 percent decline in first aid calls (Table 3). Interestingly, the public does not complain that these fees jeopardize the access to care. According to a public poll in January 2004, only 1.5 percent of respondents (FOCUS January 2004) claimed that they stopped visiting the doctor after the introduction of user fees. This means that user fees were able to reduce artificial demand with only a negligible impact on the patients. The lower number of visits might also lead to higher quality of care, because physicians can devote more time to serious illnesses. Fees thus had the effect of reducing excessive demand, while concerns about compromised availability of care proved to be unjustified.

The introduction of fees improved cash income of physicians by SKK 7,000–9,000 per month. Payments in hospitals for food and lodging provided patients with incentives to demand higher quality of services. The significant immediate effect is that patients started to feel that health-care is not free of charge (source: similar polls as mentioned above).

Another likely impact of introducing fees was a drop in corruption. While in November 2002 as many as 32 percent of respondents associated health-care with corruption, in January 2004 it was only 10 percent. There was a drop in the frequency of providing bribes and gifts – to specialists from 18 percent in summer 2002 to 14 percent in the autumn 2003, and in hospitals from 14 percent to 11 percent respectively over the same period (source: public opinion polls in 2002 and 2004).

The general design of the new system of user fees was further developed and ended up with a complex co-payment scheme, which is part of the Reform Acts with the following main objectives[3]:

[3] The fundamental points of the general design of the system of user fees was discussed during a conference on health-care reform in Bratislava in 2004. The issues raised by Osterkamp's presentation on the subject (Osterkamp 2004) were influential in shaping the final design of the system.

Table 3

Number of visits per quarter in 2002 and 2003

Period	Number of visits to outpatient departments				Number of hospitalizations	
	General practitioners, pediatricians, gynecologists	Dentists	First aid	Specialized outpatient care	Hospitals	Other medical establishments
1 Q 2002	3,955,031	652,062	219,141	3,391,103	206,352	33,015
2 Q 2002	3,867,676	640,379	241,975	3,361,904	196,638	33,742
3 Q 2002	3,457,192	558,015	254,146	2,965,542	189,765	30,987
4 Q 2002	3,892,173	620,004	250,615	3,241,337	193,305	29,582
2002	15,172,072	2,470,460	965,877	12,959,886	786,060	127,326
1 Q 2003	4,141,886	638,254	260,616	3,371,764	196,378	31,496
2 Q 2003	3,619,596	623,961	235,854	3,302,044	199,175	34,821
3 Q 2003	3,042,471	542,567	219,884	2,867,805	185,309	32,313
4 Q 2003	3,596,287	621,555	219,419	3,216,420	189,156	32,197
2003	14,400,240	2,426,337	935,773	12,758,033	770,018	130,827
Relation of 2004 to 2003						
1 Q	1.05	0.98	1.19	0.99	0.95	0.95
2 Q	0.94	0.97	0.97	0.98	1.01	1.03
3 Q	0.88	0.97	0.87	0.97	0.98	1.04
4 Q	0.92	1.00	0.88	0.99	0.98	1.09
Year	0.95	0.98	0.97	0.98	0.98	1.03

Source: VšZP (General Health Insurance Company).

1. Separation of non-healt-care services (setting minimal flat user fees).
2. Definition of the national priority list (uninsurable risks that are costly, rare and severe diseases) with no co-payment only user fees that are approved by the parliament. Currently 6,700 diagnoses..
3. Establishing catalogization committees for defining the catalogue of procedures for every diagnosis.
4. Establishing categorization commissions that define the financial co-payment on the non-prior diagnosis (currently 4,300 diagnoses, which are cheap and privately insurable).
5. Increasing the patient's responsibility and involvement by setting rules on compliance and misuse of health-care.

Pharmaceutical policy: The third stabilizing measure has focused on pharmaceutical policy. Several measures have been taken to support the decrease of drug expenditures both as a result of price and volume decrease:

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

"Fast track" means that for a drug in question there is no requirement for a price evaluation by the reimbursement committee. The fast track procedure is granted, when a pharmaceutical company decreases the price of a product by 10 percent or more compared to the cheapest drug in the cluster (based on: active substance, route of application, pharmaceutical form and strength). Having one drug of the cluster on the "fast track" leads to price reductions for the other drugs in the cluster. Moreover, the patients benefit from using the fast track drug. Table 4 gives an example.

Table 4

Comparison of "normal" and "fast track" regime, in SKK

	Price	Reimbursement from HIC	Co-payment of the patient
Current status of drugs A, B, C	1,000	800	200
Normal price decrease of drug A before introduction of fast track	800	640	160
Fast track of drug A with 25% bonus	800	680	120
The status of drugs B and C after fast track of drug A	1,000	680	320
Result A-(B and C): Clear comparative advantage of drug A	–200	0	–200

Source: Ministry of Health, 2004.

Table 5

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

Date of publishing of positive list	Price for DDD in SKK	Price decrease in %	Comment
15 Nov. 2003	180.0		
1 Feb. 2004	160.0	–11.1	1st generic entered the market
15 March 2004	144.0	–10.0	
1 May 2004	80.0	–44.4	2nd generic entered the market
1 July 2004	68.4	–14.5	
1 October 2004	44.1	–35.5	Total decrease –75.5%

Source: Ministry of Health, 2004.

The fast track procedure led to a significant price reduction. Table 5 gives an example for a specific drug.

Decrease in prices and volumes of pharmaceuticals led to a substantial slowdown in the growth of expenditures allocated to drugs. While in previous years that growth was regularly in the double digits, in 2003 it dropped to 8.9 percent. Figures for the first half of 2004 were also encouraging, with drug expenditures falling by 11 percent year-on-year (Table 6).

Table 6

Expenditures for pharmaceuticals

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

* End year projection after the real data for first half of 2004.

Source: IMS 2004.

Restructuring of hospitals: Fourth, the decentralization of selected hospitals made their restructuring process faster. At the same time, big hospital complexes in two large cities, Bratislava and Kosice, were consolidated, resulting in the sale of several buildings. Transferring hospitals to municipalities and regions led to their better monitoring and management. It seems that the changes and expectations of further changes provide incentives for self-governing processes in hospitals. The restructuralization path has been supported by decreasing the number of beds and by a strong reduction in employment in the health sector in the last two years (Table 7).

Five main sources for cost savings can be identified (Table 8). The stabilizing measures brought an annual savings of SKK 4.0 billion in 2003 and an estimated savings of SKK 6.4 billion in 2004, especially by reducing induced excessive demand. While in 2000–02 the new uncovered debt was growing by the average annual rate of SKK 7.0–9.0 billion (approx. 0.9 percent of GDP), despite injecting SKK 10.5 billion during 2000–02, in 2003 there was a SKK 4.8 billion growth and in 2004 the Ministry expects only SKK 2.4 billion. The adopted reforms have led to stricter adherence to budget constraints. After the adoption of systemic reform and its implementation in 2005 and 2006, the Ministry expects a balanced system with zero growth of debts. Due to the reduced costs of healthcare there was a significant decline in growth of indebtedness.

Systemic measures

The central goal of the systemic measures is to create a new system for providing health-care that would be fair and financially sustainable.

The political background: The adoption of the systemic measures, known also as "The Reform Puzzle", in such a sensitive area as healthcare cannot be described as the great political success of a minority government with only 68 out of 150 members in parliament. 81–88 MPs, depending on the specific act, voted for the reforms. This also shows the necessity for the government to find a political consensus with the independent MPs on the reform.

The objective of systemic measures is to create a new system of providing health-care, fair in distributing health-care services and commodities and financially sustainable in the long-run. Unlike in other areas of public finances, there is no benchmark of best practices for health-care. Therefore, this concept has to be innovative.

Table 7

Number of beds and health-care employees

	1999	2000	2001	2002	2003	2004[e]	2005[f]
Number of beds per 1000 inhabitants*	6.6	6.2	6.1	6.0	5.8	5.6	5.2
Employees in health sector	118,473	120,773	116,938	113,734	106,523	99,900	n.a.
Nominal annual change		+2,300	–3,835	–3,204	–7,211	–6,623	n.a.
Change per year in %		+1.9	–3.2	–2.7	–6.3	–6.2	–

* without psychiatric beds; e = estimate; f = forecast of authors.

Source: Statistical Office of Slovak Republic.

Table 8

Estimated efficiency of stabilizing measures in 2003 and 2004
in SKK billion

Measure	Effective	Savings in 2003	Savings in 2004[e]
Decentralization and establishment of NGOs	January 03	1.3	1.0
New definition of health care and introducing fees for physician consultations and pharmaceuticals	June 03	2.3	3.6
Introducing amendments to contracts of hospital directors	October 03	0.1	0.5
Restructuring hospitals in Bratislava and Košice	October 03	0.1	0.4
Pharmaceutical policy	November 03	0.2	0.9
Total savings		**4.0**	**6.4**
Expenditures on Health		**82.2**	**85.8**
Total savings as a % of total expenditures		**4.9**	**7.5**

e = estimate.

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

The new system contains first of all definitions of insurance, insurance companies, providers, health-care, and the basic package of care. The hottest political debates centered on two questions. First the question of constitutional compatibility of the Act on Scope of Health-Care which reduced the part of health costs to be covered by public health insurance, and second on the transformation of the Health Insurance Companies from public funds into joint stock companies.

Health-care insurance and supervision: The basic function of health-care insurance is to generate resources based on the solidarity principle. That means specifically that also those risks must be covered which have already occurred and are, thus, not insurable under market conditions (or insurable only for a premium which is equal to the costs of treatment).

Public health-care insurance is based on the following principles:

1. Universality and solidarity. Every citizen has guaranteed access to equal treatment for an equal need regardless of one's social standing or income.
2. The necessary financial means are collected from the public on an obligatory basis and redistributed on the basis of the solidarity principle, while there is competition between providers of social insurance. The Health-Care Supervision Authority (HCSA) shall supervise the redistribution of the financial resources between the Health Insurance Companies. The effective rate of redistribution should reach 85.5 percent of the prescribed insurance premiums.
3. Every insured person is guaranteed free choice of the health-care insurance company, which cannot refuse insurance to anyone.
4. Contributions are 14 percent of wages up to a given ceiling (three times the average wage). The state pays 4 percent of average wages for vulnerable groups.

Additional individual health-care insurance is allowed. It reimburses the costs of treatments that are not paid by public health-care insurance. Individual health-care insurance is a product that is to be offered by commercial insurance companies. These will be supervised by the Financial Market Authority.

The goal is to introduce hard budget constraints, transparent financial relationships and transfer responsibility for patient management onto Health Insurance Companies (HIC). HIC must obtain a license from HCSA and are joint-stock companies, i.e. entities of private law. HIC are allowed to generate profits – however, if there are waiting lists in place, up to 100 percent of the profits must be used for the benefit of those on the waiting list. The state is the 100 percent owner of the largest HIC ($^2/_3$ of the market) and a specialized HIC for army and policemen (8 percent of the market), both are also joint stock companies. There are three other HIC on the market with approximately 26 percent market share who have private owners.

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

The act aims at stimulating competitiveness and introducing market rules for health-care insurance and provision. Currently, health-care providers claim finances from HICs for services provided, regardless of their quality, efficiency or competitiveness. In future, patient management will bring about higher competitiveness and change in payment mechanisms from service mix to case mix.

The selection of providers by HIC is allowed, while respecting the minimum network and quality standards. Together with modern payment mechanisms these shall be the principal tools of competition. HIC shall not compete in collecting contributions for public insurance, but in the efficient purchasing of health-care. We presume that managed care will appear, as well as organizations similar to HMO.

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

Health-care providers: The goal is to increase the decision-making autonomy and responsibility of providers. At the same time, the controlling and supervisory function of the state is strengthened. The new system is based on the following principles. First, artificial barriers to entry erected by professional chambers are to be eliminated. Second, new types of health-care providers, like providers of one-day care and houses of custodian care, are to be introduced. Third, the number, position and tasks of professional organizations in health-care are to be regulated. Compulsory registration and membership of health-care professionals in chambers as the condition for practice is to be abandoned. However, at the same time compulsory registration with the supervisory authority is necessary to ensure continuous retention and renewal of professional competence.

Very important is the new definition of the public network of health-care providers. HIC are allowed to sign contracts directly with providers, but must observe the condition of a minimal public network, related to the regional demographic situation. The minimal public network is set by the ministry as the minimal number of providers in a given field of specialization in a given geographical area. The supervision authority and local government authorities have to monitor whether HICs contract the predefined minimum number of health-care providers.

There will be contract-based and other providers functioning within the system. While a contract-based provider will be reimbursed directly by the HIC and the patient will pay only a user fee (SKK 20 or 50), other providers will charge costs directly to the patients. Following a prior consultation, the patient may ask HIC for reimbursement, but only up to the amount of usual reimbursement of the contracted provider. The hospitals and other budgetary or state owned facilities providing health-care will be transformed to joint-stock companies, with minimal 51 percent state ownership.

Redefining the scope of benefits covered by public health insurance: The definition of a specific scope of benefits which is covered by the public health insurance companies is derived from the principle that an insured person has the right to equal treatment in case of an equal need. Due to the infinite nature of needs it is, however, necessary to define a certain maximum extent of care – the benefit package – based on a list of priorities that is in line with the fiscal capacity of the Slovak economy. Therefore a clear policy of rationing has to be implemented.

The presently applied "silent" rationing is becoming a serious ethical problem and source of corruption. Decision making is done in a micro-level system, i.e. by physicians. The solution would be to replace it by explicit rationing, i.e. define clear and transparent rules binding for every participant in the system while respecting medical, ethical and economical criteria and maintaining the quality of health-care.

The definition of priorities is arrived at in three steps which redefine the mechanism of defining, cataloging and categorization of sicknesses and the related benefits provided.

The effects of redefining the list of priority diseases is shown in Table 9. The priority list contains approximately 6,700 diagnoses, which is almost two thirds of the total list of diagnoses (11,000) listed in ICD 10. Provided prices and demand remain constant, patients would pay in total almost SKK 3 billion for non-priority treatments. This creates a market for commercial health insurance companies. The average co-payment for the patients per diagnosis per case would reach approximately SKK 50–200.

Table 9

Break-down of diagnoses to the priority list and others

	Unit	Priority list	Non-priority list	Total
Number of diagnoses	ICD 10	6,700	4,300	11,000
Present volume of payments by insurers	SKK billion	19,999	9,989	29,979
% of total costs of treatment	%	67	33	100
% of total cases of treatment	%	41	59	100
% of new payments from public insurance	%	100	0-95	
New volume of payments by HIC	SKK billion	19,990	6,992	26,982
New volume of co-payments by patients	SKK billion	0	2,997	2,997
Average payment by patients per case (per diagnosis)	SKK		50-200[a)]	

[a)] Per diagnosis based on complexity.

Source: HIC, calculated by the Ministry of Health and authors.

Table 10

Private household expenses for health-care

	2000	2001	2002	2003	1st half of 2004	2004e
Monthly health consumption per capita in 1st half of the year, in SKK	87	95	102	135	242	
Total health in SKK million	6,354	7,856	8,440	10,209	7,694	15,500
Total consumption in SKK million	519,596	577,522	623 146	667 453	356,889	715,000
Total health as a % of total consumption	1.22	1.36	1.35	1.53	2.16	2.17

e = estimate, Ministry of Health.

Source: Family accounts, Statistical office of the Slovak Republic.

Table 11

Resources and expenditures in the health sector, SKK billion

	2002	2003	2004e	2005f
Total resources in health care sector	**75.0**	**77.4**	**83.4**	**91.1**
HIC	57.0	58.6	62.6	71.6
MOH (without payments to HIC) and other budgetary chapters	4.7	4.8	4.8	3.5
Out of pocket – legal	6.8	9.5	12.5	13.5
Out of pocket – informal payments	6.5	4.5	3.5	2.5
Total expenditures	**84.2**	**82.2**	**85.8**	**91.1**
Deficit	**9.2**	**4.8**	**2.4**	**0,0**
GDP	**1,096.0**	**1,196.0**	**1,311.0**	**1,408.0**
Nominal Debt Growth, in SKK billion	+9.2	+4.8	+2.4	+0.0
Health resources as % of GDP	6.8	6.5	6.4	6.5
Health expenditures as % of GDP	7.7	6.9	6.6	6.5

e = estimate; f = forecast.

Source: Ministry of Health, 2004, in compliance with Ministry of Finance, budget proposal for 2005–07.

Conclusion and outlook

Reforming the health-care system requires not only a clear concept but also the execution of a number of detailed steps, the description of which was beyond the scope of this article. Yet even immediate changes in management could lead to substantial savings and improved care. However, no concept can be successful without public and political support. Although the majority of changes do not have clear winners in the short term – direct expenditures by patients are increasing, while revenues of strong interest groups are declining (e.g. pharmaceutical industry) – many partial steps bring forth almost immediate palpable improvements that are important for winning and retaining public trust.

Table 10 shows that health-care costs of private households have indeed increased but remain a small part of total private consumption.

Since 2002 the fiscal position of the public health-care sector in Slovakia has improved considerably at a constant rate. It is expected that the system will reach financial stability from 2005 onwards (Table 11).

References

Evans, R. G. (1997), "Going for the Gold: Redistributive Agenda behind Market-Based Health-Care Reform", *Journal of Health, Politics, Policy and Law* 22(2), 427-65.

FOCUS (2004), Postoje verejnosti k problematike zdravotníctva [Public Opinions on Health-care Related Issues]

OECD (2002a), *Economic Surveys, Slovak Republic*, vol.1, Paris.

OECD (2002b), *Health Data 2002*, Paris.

OECD (2003a), *Health Data 2003*, Paris.

OECD (2003b), *Health at a Glance*, Paris.

Osterkamp, R. (2004), "Patient's Financial Involvement as a Prerequisite for Financial Stability of Health-Care Systems", presented at New Health-Care as a Challenge and Opportunity, Conference in Bratislava, 7 April, 2004.

Pažitný, P. and R. Zajac (2001), "Stratégia reformy zdravotnictva – reálnej reformy pre obcana" [Strategy of Health-care Reform – a True Reform for the Citizen], Bratislava, M.E.S.A. 10.

Pažitný, P. and R. Zajac (2002), "Zdravotná politika"[Health-care Policy], in A. Marcinčin, ed., Hospodárska politika na Slovensku 2000-2001 [Slovak Economic Policy, 2000–01], Bratislava.

The World Bank (2002), "Budgeting and Expenditure Management in Slovakia. Improving Coordination between Departments and the Ministry of Finance", Washington, D.C.

Štatistický úrad SR: *Štatistická ročenka SR 2003* [The Slovak Republic Statistical Yearbook, 2003], Veda, Bratislava.

World Health Organization (2003), *Health Indicators*, http:// www.who.int.

Zajac, R., P. Pažitný and A. Marcinčin (2004), "Slovak Reform of Health-Care: From Fees to Systemic Changes", *Finance a úvěr – Czech Journal of Economics and Finance* 54(9–10), 405–19.