3.3 HEALTH CARE

3.1.1 Patient's Rights

The object of health care is the patient as a client of health care services.[96] In a democratic world, the relationship between the patient on one hand and the physician, health staff, and the whole system of health care, on the other one, has started to change in recent decades. No more is patient a mere passive object of health care whose role it is to follow decisions of experts and to passively accept the prescribed way of his/her treatment. Patient has increasingly become the physician's partner, a respected client of health services.

Patient's rights have been derived from basic human rights. Respecting of patient's right by health professionals is assumed to enhance the responsibility and the involvement of patients in the health care process. In addition to this, the more the public knows about their right for autonomy, about the right to make decisions and choices, the stronger is the patients' participation in the process of improvement of the quality of health care. Informed citizens also actively assume the responsibility of taking care of their own health.

Patient's rights may be subdivided into individual and social. Individual rights are based on the principle of self-determination. They usually include the principle of informed consent, right for privacy, access to own health records, confidentiality of information, and the right to complain.[97]

Informed consent – represents one of the basic rights. It means a combination of information and consent; patients must be well informed to be able to give his/her consent with a certain examination or intervention. With respect to information, pursuant to the domestic legislation, patients are entitled to receive "adequate instruction/explanation, in particular on the nature of the disease, health interventions required, on the associated risks and on health prognosis".[98] "Physicians shall be liable to instruct the patient and/or persons close to the patient in an appropriate and demonstrable way with respect to the nature of his/her disease and on health interventions required to enable him/her to actively cooperate in the provision of health care. It is up to the physician to determine the contents of the appropriate instruction/explanation case by case so as to provide it in a tactful and ethical manner and so as to avoid any disturbance of the treatment process."[99] Compared to the standards of European Union Member States, however, this formulation of informed consent is vague.[100]

Access to patient's own health records – pursuant to the domestic legislation, a patient is entitled to inspect health documentation and to make extracts of it on the spot.[101] Pursuant to the legislation of several European countries, a patient is entitled to obtain copies of his/her health documentation for a fee.

Confidentiality – pursuant to the domestic legislation, a patient has the right to have all data concerning his/her condition of health and facts connected with his/her condition of health treated as confidential.

Possibility to complain – pursuant to the domestic legislation, a patient may file complaints if assuming his/her rights for the provision of health care have been violated. Complaints may be filed with director of State health care establishment, with State District Physician, State Regional Physician, Ministry of Health, and with professional organizations.

Social rights represent accessibility and quality of health care, accessibility in geographical and financial terms, and elimination of discrimination barriers of inequality. The provision of patient's social rights is determined by the economic potential of the country.

The basic social right in the field of health, the *right for health care*, above all means the right for protection of health. The principal international documents that characterize general social rights include the European Social Charter of the Council of Europe of 1961 (amended in 1996), ratified by the Slovak Republic in 1998. Article 11 of the said Charter is entitled „Right for Health Protection," and it binds the contracting countries to provide for the elimination of reasons for morbidity, education and counseling

[96] In the following text the term patient is used in the sense *client* or *customer*.
[97] Source: De Bijl (2000).
[98] Section 6, NR SR Act No. 277/1994 coll. on Health Care
[99] Section 15, NR SR Act No. 277/1994 coll. on Health Care
[100] For instance, pursuant to the Dutch Medical Contract Act that is part of the Dutch civil code, patient must be informed about the suggested examination and therapy as well as about his/her condition of health. The information should concern the following aspects: nature and purpose of suggested examination or therapy, necessary interventions, risks and consequences for patient's health, examination and therapy alternatives, patient's condition of health, and forecasts of his/her condition of health in the future. Also, pursuant to German Patient's Charter physician must inform patient about the risks and objectives of examination or therapy, therapy alternatives, patient's condition of health, and expected outcome of therapy.
[101] Section 16, NR SR Act No. 277/1994 coll. on Health Care

establishments for health promotion, strengthening of personal responsibility in health issues, and prevention of epidemic, endemic and other diseases and accidents to the extent possible.

Legislative Regulation of Patient's Rights

In Slovakia, the patient's rights-related legislation is based on the Universal Declaration of Human Rights adopted by the UN General Assembly on December 10, 1948, and on the Constitution of the Slovak Republic of September 1, 1992.

Article 40 of the Constitution of the Slovak Republic states that "Every person shall have the right to protect his or her health. Through health insurance, citizens shall have the right to free health care and medical equipment for disabilities under the terms to be provided by law." The right for health care is preceded by the right to have one's health protected. Statutory laws regulate the method of health protection and of the provision of health care to citizens. Act of the National Council of the Slovak Republic (NR SR) No. 277/1994 coll. on Health Care, as amended, regulates the provision of health care, its organization, rights and responsibilities of physical persons and legal entities in providing for this care.

Box 3.7
Legal Awareness of the Public in Slovakia

Under the project supported by the Vienna Institute for Social Sciences, a study was conducted during the second half-year of 2000 whose aim was to measure the legal awareness of Slovakia's citizens with respect to that portion of civil and human rights that concerns individuals upon falling ill, i.e., their rights as patients. A total of 1,874 questionnaires were evaluated, covering all regions of Slovakia.

According to the survey, the basic knowledge about patient's rights is relatively unfavorable – only 66 percent of the respondents knew that such rights exist. A majority of the respondents believed that these rights are not respected. This negative attitude to some extent is also connected with the generally widespread opinion of the citizens concerning Slovakia as a State of rule of law and respecting law by the society as such.

A part of the survey concerned the option of free choice of physician and health-service institution. The responses suggest that a majority of the population is aware of the choice. The less unambiguous position on the issue of free choice of health care facility is based on practical experiences, where – contrary to the declared option of choice – some restrictions apply. It follows from the replies that physicians meet their liability to provide patients with explanation on the nature of their diseases and interventions scheduled but rather insufficiently. The confidentiality-related obligation of health professionals seems to be well known, as is the option to refuse required care. One in seven patients is not aware of this option, though. Surprising is the weak legal awareness with respect to cases when therapy may be ordered pursuant to law, not requiring patient's consent. Also surprising is that only 61 percent of the respondents knew that they have the right to refuse their participation in medical training and research.

When asked to rank the values of the individual patient's rights, half of the respondents put the quality of care to the top, ranking self-determination last. Interestingly, free provision of services did not play an important role in the replies. Absence of active interest in one's own health and ignorance of the need to cooperate in preserving one's health has been evident from the evaluation of patient's responsibilities: the interest in adhering to the principle of a healthy regimen ranked last. Prevention was assigned the not very flattering position last but one.

The study suggested that a majority of Slovak citizens are aware of the existence of some patient's rights, but the opinion prevails that such rights are not respected. Citizens have adequate knowledge of the option they have to choose their physician and health care establishment, but the responses suggested that health professionals inadequately respect patient's right to be informed about everything necessary about his/her disease, diagnosis and therapy. Citizens are not aware of their responsibility to actively take care of their health and do not attach sufficient importance to prevention. Similarly, they do not understand the association between due payments of insurance premiums and the capacity of the health system to provide state-of-the-art services. Overall, it may be stated that any activities – governmental as well as non-governmental – directed towards raising the awareness of the public about their rights as well as responsibilities in the process of health care will be welcome and needed.

NR SR Act No. 272/1994 coll. on People's Health Protection, as amended, defines the term of health and the modes of its protection. NR SR Act No. 98/1995 coll., on the Therapeutical Order, as amended, regulates the conditions of the provision of health care and medical devices based on health insurance as well as against partial or full compensation by the insured. NR SR Act No. 273/1994 coll. on Health Insurance, Financing of Health Insurance and on the Establishment of General Health Insurance Company and on the Establishment of Sectoral, Branch, Company and Civil Health Insurance Companies, as amended, regulates the responsibilities and rights of insured persons.

With respect to social rights of patients, Act No. 277 on Health Care provides as follows: "State creates conditions for the provision of health care on a professional level, continuously, and to be accessible."

In the legislation of the Slovak Republic, patient's rights are referred to in a number of laws, making a general overview uneasy. A Task Force established at the Slovak Ministry of Health drafted at the turn of 2000/2001 the Charter of Patient's Rights in the Slovak Republic. The Charter was adopted by the National Council of the Slovak Republic in September 2001. The Charter comprises two parts: the first one is general statements on the backgrounds and general human rights. Part two of the Charter is

rather specific, and directly concerns patient's rights. It contains articles on confidentiality-related rights of patients, on the right for information, on conditions of patient's consent, on the confidentiality of health-related information, on care for incurable and dying patients. The article dealing with the very treatment and care mentions the type of care the citizen may claim. The last two articles concerning complaints and damages will certainly become subject of most intense discussions and interest on the part of patients.[102]

The Charter of Patient's Rights in the Slovak Republic was drafted as a document summarizing the individual rights of patients laid down in legislation. Its purpose was to facilitate the orientation of citizens and health professionals in the field. In comparison with EU Member States, legislation on patients' rights in Slovakia is insufficient. Patient's rights laid down in Slovak laws need supplementation and extension, best by drafting a separate law.

3.3.2 Key Problems of the Slovak Health Sector and the Analysis of Their Causes

Health is perceived as a necessary prerequisite for a meaningful and free choice of individuals to freely decide about their lives.

Indicators of health in the SR fall behind highly developed countries rather markedly. As was outlined in the previous chapters, the health status is a result of numerous factors of health-care-related and particularly of non-health-care nature. The societal developments in the past decades have deeply rooted the belief that the issue of health is more connected with the curing of ill health than with the prevention

Box 3.8
Selected Data on Slovak Health Care

- The Constitution of the Slovak Republic guarantees the right of every citizen to health protection and to free health care based on health insurance, which is founded on principles of solidarity, non-profitability and plurality. This system includes practically every permanent resident in the SR. Access to health services is provided for by a network of health care providers.
- Outpatient care comprises primary outpatient care (general physician, pediatrician, gynecologist-obstetrician, dentist), specialized outpatient care (e.g., ophthalmologist, dermatologist), joint examinational and therapeutical units (e.g., biochemical laboratories, x-rays), pharmacies, policlinics, agencies of home care. Majority of physicians in primary and secondary care conduct business as private entities based on license issued by the regional state physician and a contract with health insurance agency.
- Inpatient care includes hospitals and specialized institutes (e.g., oncological, psychiatric). Hospitals are divided by range of services provided into three categories. In 2000, there 92 hospitals operating in Slovakia, out of which three were private (567 beds). Most of the public hospitals (35,557 beds) were transferred within the public administration reform to towns and municipalities.
- Community care services include long-term inpatient care, day care centers and social services for the chronically ill, the elderly and other groups with special needs such as the mentally ill, mentally handicapped, and the physically handicapped. Many of these institutes were transferred to municipalities and are under mixed ownership.
- Ministry of Health maintains a wide scope of competence, which covers development of policy and drafting of legislation on health care and health protection, health care provision in public inpatient facilities, price and wage regulation, supervision, etc.
- Underlying the competence of the Ministry is also the National Health Protection Center and a network of 37 state health institutes, which provide health and hygienic services in line with State health protection strategy.
- There are five health insurance companies operating in Slovakia at present, of which two are administered by State. As a result of uneven numbers of active and inactive insured a redistribution of collected insurance premium was introduced.
- There were 360 doctors per 100,000 inhabitants (representing 272 inhabitants per 1 doctor, estimate of the Statistical Office of the SR); the respective number for EU-15 was 353 doctors. In comparison with EU countries the number of general physicians is lower in Slovakia, whereas the number of specialists is higher than in the EU.
- In 2000, there were 6.5 hospital beds per 1,000 inhabitants, which is more than the average for OECD countries. Hospitals operate at less than 70 percent of bed capacity (OECD more than 80 percent), the average length of stay represented 8.9 days, which is more than in the Czech Republic (8.7 days), (Hungary (7.0 days) and Austria (6.8 days).
- less than 70 percent of the bed capacity compared to 80 percent and more in OECD countries. Average length of stay in acute hospitals is 8.9 days (in 2000), which is relatively high compared to other countries of the region, like Hungary (7.0), Czech Republic (8.7), and Austria (6.8).
- Total expenditures on health care (including informal payments) made up 7.3 percent of GDP in 2001. According to WHO data, public expenditures range as high as 90 percent of total expenditures, which is a substantially higher share than in most EU member and candidate countries (2000). Average per capita expenditures adjusted for purchasing power parity was US$ 690, which is less than is spent in Slovenia, the Czech Republic, and Hungary, but more than in the remaining candidate countries (except for Cyprus and Malta).

[102] Source: Sedláková, D.: The Government Adopted the Charter of Patient's Rights. In: Magazine Partnerstvo, No. 2/2001,

of this condition. The expectations associated with health care thus go beyond its real impact on public health.

Similarly, as other countries of the region, Slovakia has achieved several strides in health during the socialist era. Progress resulted from mass immunization, lowered child mortality, preventive medical checks, improved access to safe water and better sanitation, overcoming the problems of malnutrition, and efforts to control communicable diseases.[103] Most developed countries of the region reached parameters of health comparable to developed Western countries during the 1950s and 1960s. Since then, however, the gap has gradually deepened as a consequence of both health care-related and non-health-care factors. Health systems – seemingly offering free, comprehensive and universal health care – were oversized and produced debt similarly as the whole societal establishment, while remaining in isolation from the development in the West.[104]

Societal changes after 1989 have also introduced changes in public health. These stem from new trends in lifestyles, broader foodstuffs supply, improved access to information, transfer of know-how in medical science, better accessibility of high-quality medication, and demographic development. The said changes have contributed to the positive trend in the health condition of the population, which is however, according to opinions of both experts and lay public not accompanied by an adequate growth in the quality of health care provision.[105] Health care remains an area with many deformations from the past even after a decade of economic and social reforms. The current crisis of the Slovak health system originates in inherited distortions and a lack of reform measures after 1989.

Negative trends in health care crowd out positive tendencies and positive changes. Recognition of the causes of the crisis of the Slovak health care system is one of the decisive ways out to gradual solutions to the problems. Due to this fact, the following analysis focuses mainly on the problematic issues and possible positive aspects stay rather in the background.

The modern health care system should meet three essential objectives:

1. Improving health status of the population;
2. Improving customer satisfaction with health services;
3. Providing reasonable protection against financial risks associated with health care provision.

When evaluating the health system, it is appropriate to specify more detailed criteria and/or objectives of health care. These have a significant influence on the aforementioned ultimate objectives:

- Access/availability;
- Efficiency;
- Quality;
- Financial burden;
- Costs.

The specification of supporting objectives allows to define the problems faced by the Slovak health care sector (Table 3.11).

p.14

[103] Source: World Bank (2000a).

[104] Research using the concept of avoidable mortality, has suggested that about 25 percent of the mortality gap between east and west Europe for the age group 0-75 could be attributed to inadequacies in medical care in 1998. Deaths from avoidable causes declined at a slower rate in the east than in the west. (source: Study on the Social Protection Systems, 2002).

[105] Some sources (e.g. World Bank, 2000a) state that changes in health outcomes in transition countries after societal changes (and/or their worsening in the former Soviet Union countries) have not been attributed to a serious worsening of the health systems; rather it was changes in living conditions and behavior such as increased consumption of alcohol and tobacco, spreading of HIV, etc. Research undertaken in transition economies suggested that most vulnerable groups in this respect include those who have experienced the most rapid transition and had poor social contacts (men of middle age, with low levels of education and insufficient social contacts (e.g., singles).

Table 3.11
Main Problems Faced by the Slovak Health Sector

Problem	Causes	Consequences
Insufficient effective availability	1. Central management of the health sector 2. Unequal chances and soft budgetary restrictions 3. Passivity of health insurance funds 4. Passivity and lasting socialistic attitudes of patients	1. Corruption 2. Spare capacity resulting from the fact that ineffective providers are not shaken off
Low allocation efficiency and technical inefficiency	1. Health insurance system parameters are set in a way that does not induce motivation 2. Payment mechanism system applied to out-patient departments does not induce motivation 3. State ownership and lasting socialist practice in in-patient facilities 4. Inappropriately set system of risk sharing by the individual entities	1. Wasting of sources 2. Rent-seeking behavior is preferred to profit-seeking 3. Extremely high debt
Poor quality	1. A relation between what I pay and what I get in turn is not sufficiently strong 2. Competition absence 3. Poor organization of patients	1. Corruption market
What degree of solidarity is desirable and which level of revenue collection is optimal?	1. Health insurance is not sufficiently separated from the State Budget 2. A relation between what I pay and what I get in turn is not supported 3. Private sources in the health sector are not legally permitted	1. Combination of insurance and income redistribution elements 2. Default payers (delinquents) 3. Corruption
Unbearable amount and inappropriate structure of costs	1. Inadequate scope of uninsurable risk 2. Ineffective and often useless state regulation	1. High value of funds for treatment and low for prevention 2. Debt 3. Low proportion of private sources

***Source**: Pažitný – Zajac (2001).*

Problem I – Insufficient Effective Availability

The universal approach is often referred to as the key achievement and advantage of the Slovak health sector. The notion access has several dimensions. First, it is often understood in terms of the types and number of services offered within a specific region. In such case, access stands for physical availability. Second, access could be interpreted as use (hospitalization or outpatient visits measured per capita in various population groups). Access as effective availability is probably the most important understanding of this notion as it takes into consideration location, costs, travel expenses, waiting time, behavior of providers and business hours.

Among the causes of insufficient availability of health care in Slovakia are:

- *Central Management of the Health Sector.* The health sector is centrally managed by the Ministry of Health, which is exclusively responsible for strategy and management of health care, management of state-owned health facilities, state supervision, decision about financial resources, price and tariff wage setting, drug regulation. Such management is marked by poor flexibility, a high level of regulation, excessive corruption and varying rules of the game. The health care system still has a "socialist" form, in which the State strictly defines and centrally manages the network of health care facilities, distorts price mechanisms, suppresses competition, and makes effective wage differentiation impossible.
- *Unequal Chances and Soft Budgetary Restrictions.* This refers to the fact that risk is not shared equally. The State guarantees the ability to pay in respect of two health insurance funds, managed by the State, and is liable for debt generated by all state hospitals.[106] Unlike other sectors of

[106] The two state-owned health insurance funds (Všeobecná zdravotná poisťovňa, Spoločná zdravotná poisťovňa) insure about 80 percent of the insured. There are only three non-state inpatient facilities; the State is not liable for their debt.

economy, the health sector is subject to soft budgetary restrictions, which is marked by granting exceptions by the State (e.g., exceptions from distraint and bankruptcy proceedings, regular relief of debts produced by hospitals and health insurance funds, etc.).

- *Passivity of Health Insurance Companies.* Besides bearing financial risks of health insurance funds, the State guarantees the funds, an administration fund amounting to 4 percent of premium collected. Missing responsibility results in health insurance companies not performing their fundamental role, which is to actively buy effective health services. As the funds are reluctant about their financial performance (profit/loss), they are not motivated to place sufficient pressure on providers to perform more cost effectively, which would then have a positive effect on the structure of providers corresponding to the real needs of customers. Health insurance companies only have a redistribution function, which means that they allocate funds in line with the terms and conditions set by the Ministry.
- *Passivity and Lasting Socialist Attitude of the Patient.* Free medical care for all citizens guaranteed by the State directly distorts their behavior. There is no link between the incurred costs of medical services provided and the financial burden. This results in unlimited consumption and emphasis put on treatment and not on prevention. Corruption is an accompanying phenomenon, through which patients get access to "free services".

Problem Two – Poor Technical and Allocation Efficiency

Efficiency expresses the relation between costs and desirable outputs. If a health care system is not efficient in technical and allocation terms[107], it does not attain the desirable objectives. An inefficient system means that spare sources are wasted. The main causes of low efficiency of the Slovak health sector include:

- *Existing Health Care System Parameters Do Not Induce Motivation.* The financing of the Slovak health care sector is based on an insurance scheme. The existing insurance system is distorted in several ways:
  1. Despite significant differences in the amounts of health insurance contributions, the system provides every citizen with the same level of health care. The disadvantage of this understanding of solidarity is the fact that it is often misused.
  2. The five health funds finance the same level of health care to all the insured registered with them, which turns the plurality of health insurance into an empty word.
  3. The health insurance funds do not bear any financial risk and a 4 percent administration fund for each of them is guaranteed.
  4. The system inadequately combines the redistribution of funds (the State's payments for inactive insured) and the elements of social security insurance (contributions by economically active).
  5. Funds collected are distributed to the health insurance funds via a special redistribution account. This arrangement was introduced in 1995 as a result of different structures of active and inactive insured and it has been subject to many arguments and discussion. A gradual increase in the amount of re-allocated funds to 100 percent of insurance premium collected resulted in a situation where health funds with disadvantageous portfolios benefit from this subsidy mechanism.[108] Rules of redistribution substantially changed over the past 7 years, and the stability of the system has not been ensured.[109]
  6. Health insurance companies lack motivation because poor legislation does not force them to operate and manage funds in a better way. There is also a lack of real finances in the competitive environment of providers that would decrease the prices of services. The health insurance funds are not dependent on profit generation and do not bear any business risk; their operation is reduced to a mere collection of premiums and ensuing complicated redistribution. This often-changing system of health insurance funds lacking any motivation has resulted in the indebtedness of the whole health sector.

[107] Technical efficiency stands for maximization of outputs under a given level of inputs, and/or reaching a given level of outputs while decreasing inputs. Allocative efficiency relates to the decision about a set of services, which will bring highest benefits for the health condition. The notion is prevailing in the Slovak health system that increasing efficiency is an issue of raising inputs while retaining or decreasing outputs.

[108] The redistribution mechanism is based on the redistribution of premium collected from the health insurance companies with a high proportion of active population (which has a low risk index) to insurance funds with inappropriate portfolios (including mainly children up to the age of 3 and elderly people above the age of 60, who have high risk indices and high costs of medical treatment). The introduction of this cross-subsidy system triggered the emergence of "double souls" who are subject of redistribution. Over the period of 1997 to 1999, the number of the insured was by 250,000 (approximately 4.4 percent) higher than the country's population.

[109] The redistribution ratio represented 85 percent of insurance premium collected as of December 2002. In spite of disagreement of a part of the health insurance companies, the Ministry of Health is considering to increase the ratio to 100 percent.

- *Outpatient Care Payment Mechanisms Lack Motivation.* Primary care doctors in outpatient departments (e.g., pediatricians) are paid on a per capita basis. This means that a doctor receives a flat sum from the relevant health insurance fund for each contractually registered patient, irrespectively of actual performance/service delivered. Thus, the doctor is paid for "readiness" to provide health services, which also has weaknesses:
  1. Doctors are not motivated to provide health services. Despite being physically available, they often reduce the real availability of care to patients (for instance by low working hours, etc.).
  2. The quality of services provided has been falling.
  3. The efficiency of services provided has been falling as patients receive fewer outputs (doctors treat less) for the same volume of inputs (funds received by doctors on a per capita basis).
  4. Costs are shifted to other health care providers, for instance to hospitals.
  5. The per capita remuneration system (or simply the capitation) is regulated by the Ministry of Health, which specifies the capitation rate. From the point of view of doctors, the capitation is the best remuneration system (it is not dependent on performance/services delivered). What they mind is the fact that the level of capitation payments is not sufficiently indexed.

  Non-state specialists working in outpatient departments (e.g., plastic surgeon) are paid on a fee-for-service basis, whereas each service unit performed is priced by an appropriate number of points. Due to demand induced by doctors and a limited budget of the health insurance funds, an upper limit (cap) of pre-paid points is specified for specialists.[110] Although the capped fee-for-service payment system is a modern payment mechanism, it has some weaknesses and specific consequences for every player in the health sector.
  1. In line with trying to hold on costs, the Ministry of Health is not motivated to increase the value of point price. At the same time, the Ministry is aware that non-state doctors are exposed to all financial risks and will have to manage their revenues efficiently, which means that they will have to economize. It is a paradox that the Ministry of Health is not requiring the same from state-owned hospitals.
  2. Being bound by the Price Regulation of the Ministry of Finance (issued by the Finance Ministry on the basis of recommendations of the Ministry of Health), health insurance funds specify so-called upper limits for the individual non-state providers. Such upper limits are designed to minimize induced demand and prevent costs increases in this group of providers. At the same time, they show their weakest link – their lack of interest in an efficient allocation of funds.
  3. For health care providers – specialists, this system means that they have either to work for free for the some proportion of month or to reduce the number of patients treated in order to be in line with the "number of points ordered." Any points exceeding the upper limit are not accepted by the health insurance funds, which unilaterally violate the right to own claims.

  In Slovakia, state doctors receive salaries specified by the Ministry of Health in one of its decrees. This decree is binding upon every state-owned facility manager. And thus the management of a state-owned facility can hardly influence this key cost group – the labor costs. The only, limited room for maneuvering left is personal bonuses. Poorly paid doctors offset their low salaries by rent seeking taking the format of bribery and corruption.
- *State Ownership and Lasting Socialist Practices in Inpatient Facilities.* The Slovak health sector suffers from distortions from the past, which are most visible in the operation of in-patient facilities. The inappropriate structure of in-patient facilities entails an excess of acute beds and a lack of chronic beds, an inappropriate territorial distribution of hospitals with acute beds, an excess of doctors, nurses and other medical staff – notably in bigger cities (i.e., Bratislava, Košice, Banská Bystrica). The financing of hospitals and of hospital employees is non-motivating, since it follows a flat allocation of sources and/or salary tables taking into consideration age and education, but not performance.

This arrangement has ultimately resulted in a paradox situation in the Slovak health sector with an excess supply and excess demand.

Problem Three – Poor Quality

Quality of health care may be perceived in different ways. Quality is often rendered as quantity ("the more medical examinations the better quality"). Health care professionals perceive mainly the clinical aspect of quality (e.g., correct diagnosing). Patients frequently assess the quality of services by the comfort, quality of accommodation and diet, respect for them, etc. Quality is thus a multidimensional factor. The causes of insufficient quality of health care include:

[110] The price per point at SKK 0.30, set by the Ministry of Health in 1996, has not changed. However, some health insurance funds have slightly increased this rate for specialists (for instance, to SKK 0.31 – 0.34) taking into consideration "competition".

- *Insufficient Link Between What the Citizen Pays and What He/She Gets in Turn.* The current setup of contributions is virtually a scheme of compulsory taxes imposed on employees, employers and self-employed. In principle, no payments for health services[111] or voluntary health insurance exist. A large part of the public does not realize that health care is paid for and they think that it is free of charge. The awareness that quality of services depends on invested resources is insufficient. It is necessary to realize that quality is a function of resources. In principle, no marginal costs or voluntary health insurance exist. The quality of health services in Slovakia is reduced as a direct result of a broadly conceived scope of uninsurable risk (the currently applicable legislation forces providers to provide everything and such arrangement is detrimental to quality) and of poor efficiency of the system (limited resources are used to subsidize ineffective providers and not to support quality performance).
- *Absence of Competition.* Quality largely depends on the degree of competition in the sector. The absence of competition between health service providers is a result of inflexible prices (payment mechanisms) and inflexible supply (number) of providers. This is caused by the fact that the provider network is fixed by the Ministry of Health (see Table 3.12).

Table 3.12
Provider Market Distortion

Inflexible prices	Inflexible supply
1. A well-performing doctor/hospital is not adequately paid. There is rather a tendency to "equalize" all providers. 2. There is not price competition because the Ministry of Health centrally sets prices. 3. There is no equality of chances between state-owned and private providers.	1. Monopolistic nature of primary ambulatory and specialist ambulatory doctors. 2. State ownership with no effort to restructure the network. 3. Excess supply of physical capacity: doctors, beds.

***Source**: Pažitný – Zajac (2001).*

- *Poor Organization of Patients.* Poorly organized patients directly influence poor quality, among others. This is a result of a poor legal awareness of citizens and the impossibility to compare the existing system with another alternative system. At the same time, it should be noted that there is still a lack of collective responsibility prevailing in the Slovak health sector and poor law enforcement resulting from a poor institutional framework.

Problem Four – Degree of Solidarity Optimal Revenue Collection

An important aspect of assessing the financial burden is the fact that a person (or institution) paying contributions directly into the system may eventually not be the one who bears also the financial burden. An example is the position of the State as payer and that of the taxpayer as the bearer of the financial burden related to State's payments on behalf of the economically inactive insured. With respect to the allocation of the financial burden, the key issues are:

- *Health Insurance Is Not Sufficiently Separated from the State Budget.* The existing link is obvious in three areas.
  1. The State (parliament) sets requirements for the operation of health insurance funds and unilaterally specifies the amount of insurance base for "its" insured irrespectively of the real costs incurred in respect of their treatment.
  2. The health insurance funds receive approximately one-fourth of their revenues via the Ministry of Health (from the State Budget).
  3. The health insurance companies receive other funds via several channels from the State Budget, for instance from other ministries or directly by means of financial aid from the general treasury.

  The above-specified arrangement results in a complicated and non-transparent system of cash flows, which is a mix of tax revenues and an insurance system. However, the core of criticism is the fact that the parliament too often changes the conditions of health system financing and thus restricts its operation.
- *The Relation Between What the Citizen Pays and What He/She Gets in Turn is Not Strengthened.* In Europe, the financing of health systems is based on solidarity, notably the solidarity of economically active population with that proportion of the population that does not produce assets yet and a proportion of population that does not produce assets any longer. Furthermore, economically active

[111] The introduction of payments (fees and charges) is important not that much from the point of view of funds acquisition, but mainly as a tool to attenuate demand. The amount of marginal costs cannot by far cover the actual costs for the health service provided, but its symbolic value can have a significant psychological effect on the citizens-patients in terms of reducing the demand and the awareness that health care is not free of charge.

population must also show solidarity with their unemployed peers. The setup of the system is also one of the causes why the group of "paying" economically active is further reduced by those who evade paying taxes and contributions. In Slovakia, the State contributes 25 percent of the total health funds revenues, but for almost 60 percent of the population (Table 3.13).[112]

Table 3.13
Development of the Number of Insured (in thousands of persons, as of December 31 of the respective year)

Indicator	1996	1997	1998	1999	2000	2001
Total number of insured	5,372	5,638	5,613	5,563	5,546	5,526
of which:						
employed (earners)	2,093	2,216	2,321	2,211	2,265	2,286
registered unemployed [a]	80	105	128	147	142	152
State insured [b]	3,200	3,278	3,131	3,195	3,130	3,079

***Note**: a. National Labor Office pays contributions on behalf of registered unemployed who receive unemployment benefits. b. State pays insurance premium on behalf of children, pensioners, unemployed recipients of social assistance benefits due material distress, persons taking care of children and disabled, soldiers in compulsory military service, prisoners, refugees, and other economically inactive persons.*
***Source**: Statistical Office of the SR.*

The Slovak health insurance system is designed to allow all Slovak citizens to benefit from it by means of health care irrespectively of the fact whether they share any financial burden related to the delivery of such care or not. Article 40 of the Slovak Constitution clearly refers to "the right to free health care". However, free health care is only an illusion because all resources of financing come from citizens.[113]

- *The Contribution of Private Resources to the Health System Is Impossible.* An economically unstable and non-transparent financial system of the public health care is unable to attract private resources.[114] Another reason explaining the absence of private resources is insufficient legislation governing the establishment and operation of private insurance companies in the health sector, notably in respect of voluntary insurance schemes.

Problem Five – Unbearable Amount and Inappropriate Structure of Costs

In a condition of limited sources, health care costs should be viewed as opportunity costs, which could be spent on other values instead of health. The decisive criteria then is whether the benefit of utilizing increased sources in health care exceeds the potential benefit of utilizing these sources in another sector.

Health care costs may also be assessed through the adequacy of expenditures spent. The sum of health sector costs includes all governmental expenditures, health insurance funds (public as well as private) expenditures, household expenditures (formal and informal) and corporate expenditures. However, these expenditures also include opportunity costs related to the search for an optimum ratio between public and private sector expenditures, which would be most beneficial to the whole structure and amount of health sector expenditures. The causes of the current state being far from optimal include:

- *Inadequate Scope of Uninsurable Risk.* Uninsurable risk means the essential package of services, which is granted by law to each citizen regardless of premium paid. This package is currently specified by two pieces of legislation – the Constitution and the Act on the Rules of Medical Treatment.

  Article 40 of the Constitution guarantees the right to health protection and free health care. However, a wrong interpretation of the Constitution resulted in a virtually non-existent financial participation of the patient in the delivery of health services and the existence of moral hazard.

  The Act on the Rules of Medical Treatment belongs to the key laws as it specifies the scope of free health care. No government so far has been able, probably due to political reasons, to reduce the broad scope of the Rules of Medical Treatment.

- *Inefficient and Often Useless State Regulation.* State regulation comprises mainly the regulation of providers (by specifying the health facility network), control of the market in medicines through the

[112] Payments by the State on behalf of an inactive person represented SKK 378 in 2002. In 2003, the payment should amount SKK 405 per inactive individual. On the other hand, an employee receiving average wage pays jointly with his/her employer about SKK 1,800 monthly for health insurance.
[113] Economically active population contributes by health insurance payments to health funds. State budget income comes from direct taxes (income tax and profit tax) and indirect taxes (VAT, concise taxes, customs duties, etc.) as well as various property taxes.
[114] According to WHO data, private expenditures made up 10.4 percent of total expenditures on health care in Slovakia (2000).

categorization of drugs, regulation of remuneration by setting prices and payment mechanisms, and fixing of salaries through wage regulation.

The existing scope of uninsurable risk and inefficient state regulation result in an inflexible market of insurers and providers. Excess supply and demand causing an immense increase in debt is common to such market.

3.3.3 Consequences of Not-solving Problems in Health Care

The aforementioned problems of the Slovak health care system, mainly problems concerning quality and accessibility, have a direct negative effect on the health status of the population. Both domestic and foreign experiences confirm that low quality medical care leads to unnecessary deaths, invalidity, inability to work, poor outcomes of medical treatment, etc. The problems of the Slovak health system have, apart of the negative consequences upon the very object of health care services – the human health, also specific consequences. In this respect, corruption and debt are the most serious consequences, completing the critical picture of the entire system.

Consequence One – Corruption Market

According to its communist legislative legacy, the Slovak health system guarantees free health care to every citizen, based on health insurance. Such arrangement undoubtedly causes several deformations of supply as well as demand. One of the sharpest post-communist deformations is excess supply and demand without any chance to find market balance. In the existing, non-functioning system, informal payments that indirectly and unofficially condition the effective availability of health care have become "cleaning" instruments.

Informal payments are not restricted to the patient-doctor contact. They work at all the layers of the system and result in the corrupted market, which replaces non-functioning, or even non-existent market relations, as is the case of Slovakia. Corruption involving the patient and health care staff is mostly discussed, since it concerns virtually everyone. The so-called sophisticated or non-public corruption is much more dangerous; it involves significantly less people, but enormous financial means.

Motivation Behind Corruption and the Subject Matter of Corruption

Health care is an area that concerns a major portion of the population; surveys suggest that during the last two years more than 80 percent of Slovak households have visited a health care facility.[115] The health system is at the same time being perceived as a sector with the highest incidence of corruption (Table 3.14).[116]

Table 3.14
Extent of Perceived Corruption (in % of respondents' replies)

Areas where bribes are needed	1997	1998	1999	2000
Courts	22.51	23.65	26.37	26.18
Privatization	22.59	22.17	12.67	12.46
Banks	8.90	8.27	4.78	4.87
Police	14.45	16.71	14.18	17.18
Health care	*66.62*	*68.93*	*66.77*	*66.89*
Education sector	28.59	33.72	27.89	32.01
Business	17.95	18.30	16.25	15.78
Customs authorities	5.10	6.32	6.85	6.12
Tax offices	6.69	7.03	7.81	6.64
Labor offices	8.29	8.43	6.69	8.48
RO, DO, TO, MO [a]	14.37	12.57	13.55	12.83
Other	6.24	2.73	5.42	2.58

***Note**: a. Regional offices, district offices, town offices, municipal offices.*
***Source**: Statistical Office of the SR, www.government.gov.sk*

There are three key reasons behind the corruptive behavior of patients. First, the desire to obtain certain additional advantage, for instance to reduce waiting time, to select a surgeon, etc. Second, the

[115] Source: World Bank (2000b).
[116] Perception of widespread corruption in health care is confirmed also by surveys conducted by the World Bank. For details see *Corruption in Slovakia. Results of a diagnostic survey.* World Bank (2000b).

desire to get access to medical treatment that should be provided as an essential service, however, due to limited resources and the lack of motivation in respect of the payment mechanisms, such treatment is scarce. Since the regular market does not function, as it should, such treatment is offered in the corrupted market. Third, this tradition is a result of the feeling of gratitude.

The consequences of this phenomenon rather severely impact on the quality of life of the population. They reduce the accessibility of a good quality health care; the society starts to polarize into those who are able to provide for it through bribes and those unable to afford it. This evokes feelings of inequality in a sensitive area such as health.

As for health care staff, notably in state-owned facilities, corruption is a result of, among others, their poor financial conditions. Doctors as well as other medical staff improve their financial conditions by means of additional informal income. In hospitals, the salaries of medical staff are based on the principle of general wages reflecting age and qualifications and not work done. Available service artificially becomes unavailable to "make" the patient stimulate the provider. This category also includes so-called "willingness or lack of willingness" of a doctor, a nurse, a laboratory worker, an ambulance driver, etc. In this specific hospital environment, the whole behavior of medical staff expects some "graft or bribe". This environment makes the patient active and willing to bribe, thinking the staff is passive and left to accept bribes. What is dangerous about this form of corruption is its scale. It is often pretended that this is not corruption, but one of Slovak tradition and habits of so-called "gratitude".

Box 3.9
Negative Effects of Corruption

Foreign surveys suggest that a large extent of corruption worsens the conditions in the health sector and enhances inequality of people:

- *Gupta, Davoodi and Alonso-Terme (1998) demonstrated based on empirical studies that increasing corruption by one unit reduced expenditure rates in health system by 0.6 to 1.7 points.*
- *Gupta, Davoodi and Tiongson (2000) reported that increasing corruption by one unit raises child mortality by 1.1 to 2.7 deaths per 1,000 liveborn children.*
- *Ghura (1998) reported that raising corruption by one unit reduced income of the poor by 2 to 10 percentage points.*
- *Gupta, Davoodi and Alonso-Terme (1998) reported that raising corruption by one unit increased inequality of income (Gini coefficient) by 0.9 to 2.1 points. (Source: Global Corruption Report, Transparency International, 2001)*

Sophisticated corruption is limited to a small group of people who are either able to use the non-functioning system to their benefit or even have power and competencies to ensure the non-functioning of the system. This category comprises informal services and payments by:

1. Primary care doctors for making contracts with a health insurance fund or for an earlier payment for their performance;
2. Pharmacies to health insurance funds for giving a priority to their invoices;
3. The suppliers of goods and services to hospitals for the deliveries of goods and subsequent payment of their invoices;
4. The producers and distributors of medicines and special medical material for incorporating their products into category I (fully paid);
5. State-owned hospitals for receiving capital transfers to purchase heavy equipment;
6. The suppliers of heavy equipment for the purchase of their products (financed from the capital transfers from the State);
7. Members of parliament for amendments to legislation;
8. Health insurance funds investing billions of SKK into buildings and IT systems.

The volume of corruption in the health sector depends on three factors: service availability, the number of contacts and urgency of a case. Taking into consideration that health care goods/services are of luxury nature (i.e., the income elasticity of demand is more than 1), it is assumed that corruption in the health sector is above the limit of 15 percent.[117] Given these facts, the scope of corruption may be estimated at SKK 12 billion. When calculated on a per capita basis, corruption stands at SKK 2,222 a year, which is SKK 186 a month.[118]

Consequence Two – Debt

The primary problem in Slovakia's health care financing is the imbalance between revenues and expenditures. In effect, revenues are fixed while expenditures are open-ended (see Graph 3.13).

On the revenues side, the health insurance contribution rate of 14 percent is relatively high, and further increases would impose an intolerable burden on employers/employees. There also exists the

[117] According to Eurostat data, the share of shadow economy in Slovakia was 15 percent in 2001.
[118] Source: Pažitný – Zajac (2001).

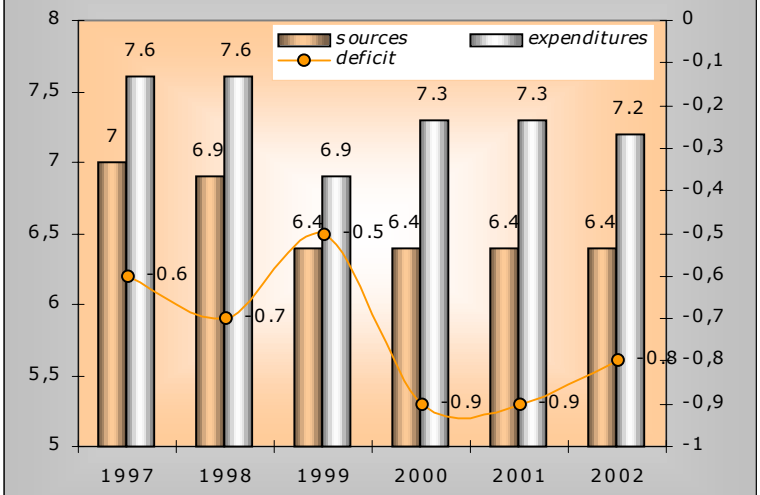
additional risk of negative effects on premium collection and formal employment, while encouraging growth of the shadow economy. The level of premium paid by the State for "its" insured is relatively low.

In fact, it is more a problem of resource utilization and allocation than resource availability. There are several factors that affect the expenditure side. Most importantly, provider payment mechanisms in both outpatient and inpatient care create incentives for rapid growth in the volume of care, which, coupled with a very generous package of health services covered by health insurance, contributes to high health care expenditures. Moreover, the network of health care facilities and providers is large and inefficiently organized, contributing to high costs of health care delivery.

The outcome of a system that provides unconstrained services with a fixed budget is a viscous circle, in which insurance companies do not receive sufficient contributions, at the same time do not pay the providers, and these in turn owe money to suppliers of goods and services.

Graph 3.13

Financial Position of the Slovak Health Care Sector (indicators as % of GDP)



***Source** : Pažitný - Zajac (2002).*

The external debt in health care reaches at present almost SKK 30 billion.[119] The debt grows by roughly SKK 780 mln monthly, of which SKK 600 mln on the part of the health care providers (e.g., hospitals) and the rest on the part of health insurance companies.[120] During the recent years, one-off sums from privatization revenues were used to reduce the growth of the debt, however not eliminating the causes of indebtedness. The causes lie in the expenditure side of the system, mainly in lasting state ownership, insufficient restructuring, inadequate network and high fixed costs of inpatient facilities, payment mechanisms lacking any motivation and inappropriate risk spreading.

The origin, causes and on-going increase in debts can be divided into two groups. First, external causes that usually cannot be influenced by the Ministry of Health. Second, internal causes that can be directly affected by the Ministry (Table 3.15).

[119] External debt expresses the indebtedness of the individual entities in the health sector towards external creditors. It mainly refers to the debt generated by inpatient facilities towards their suppliers and the debt generated by health insurance funds towards pharmacies, state budget and other health care providers.
[120] Source: http://www.ineko.sk/reformy2003/zdravotnictvo.htm

Table 3.15
Causes of the Debt

External factors	Internal factors
1. The 1993 economic recession. 2. Insufficient payment of health insurance contributions by the State. 3. Article 40 of the Constitution guaranteeing free health care.	1. Non-transparent financial relations and the failure of the control/audit system. 2. The debt itself. 3. Insufficiently restructured supply side (notably inpatient facilities and their extremely high fixed costs). 4. The application of the income/expenses principle is preferred to the revenues/cost principle and non-existing charges. 5. The organizational structures of the individual entities, the wrong system of remuneration and payment mechanisms. 6. All risk is borne by the State (for the health insurance funds as well as inpatient facilities).

Source*: Pažitný – Zajac (2001).*

Consequences of the Growing Debt

At present, the external debt amounts to approximately one third of the health sector's annual budget. Such enormous debt has been taking its toll:

1. Margin of the suppliers of drugs and special medical material increases. The margin includes the suppliers' increased costs related to the fact that their bills (invoices) are overdue for 300 and more days. Due to late payments, the suppliers are exposed to a higher foreign exchange risk. This results into increases in prices and costs related to the delivery of health services. In other words, debt generates more debt.
2. Corruption is growing. It is caused by the preferential treatment of those creditors by debtors who bribe them.
3. The debt ties financial means, motivation and efficiency decreases – this results in a decrease in quality and subsequently in the deterioration of health.
4. The internal debt continues to grow (estimates of this debt range around SKK 50 billion[121]). It reflects tear and wear and obsolescence of assets in the health sector. Since health care providers have difficulties in covering their operating costs, they can only use subsidies earmarked for capital expenditures to replace fixed assets. Subsidies amount to about SKK 2.2 billion a year, which is not enough to finance investment projects. It was already mentioned that the centrally allocated subsidies attract sophisticated corruption.
5. The high indebtedness has a negative effect on public finances and thus also on the economic stability of the country.

[121] Source: Pažitný – Zajac (2002).

Box 3.10
Expectations Versus Willingness to Pay

One of the main issues in the ongoing discussion about the health care reform in Slovakia (but also the reform of tertiary education) is the search for an optimal system of financing. In principle, there are two choices: payments by the users (charges for treatment, drugs etc.) or payments by the whole society (employed) in the form of taxes.

A representative public opinion survey (undertaken by INEKO and MVK agency in October-November 2002) examined which financing scheme is preferred by Slovak citizens. The results of the survey show that 70 percent of inhabitants are not aware of the need to decide for one option. An alternative explanation may rest on the fact that citizens understand the necessity of this compromise, but do not share a realistic notion about costs of health care and education. Another possible answer may lie in the existence of false solidarity ("health care and universities should be free of charge for everyone, however, I don't want to pay for it").

The reason for this perception may be the experience with living on debt, which refers not only to the pre-1989 period but also to the years of transition (foreign loans, budgetary spending of privatization revenues). However, all explanations lead to the same conclusion: there is discrepancy between high expectations and real operation of the health system and universities. Any reforms thus automatically run against a high degree of public resistance.

According to the survey, as many as 95 percent of respondents are of the opinion that people should pay nothing or just a smaller part of the costs of health services and medical care; but only one fourth agree that the active population should pay at least one half of total health care costs through taxes.

An extreme case occurs in 9 percent of the citizens who admit no fees for medical care and university education and at the same time refuse any taxes paid for the two sectors. This opinion is most frequently found among people with primary education, low incomes and also among old-age pensioners. Almost 15 percent of inhabitants refuse both sources of financing in the education sector (no tuition, no taxes), while the corresponding figure is 19 percent in health care (free of charge care, no taxes).

Who is in favor of charges for services? Full coverage of costs for health care through payments is supported by the "healthier" segments – young people, university students, men, people with higher income, entrepreneurs, specialists. On the other hand, in favor of coverage of costs through taxes are students, university educated people, but also manual workers. *(Source: http://www.ineko.sk/projekt_verejna_mienka.htm)*

Graph 3.14
Financing of Health Care in the View of Citizens