

HEALTH CARE REFORM

SUMMARY: MAIN PRINCIPLES AND OBJECTIVES OF THE HEALTH REFORM

The reform has been designed to achieve the following broad objectives:

- 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. A patient, as an individual owner of a health commodity, takes over higher responsibility for her or his own health status, including covering some prevention as well as treatment costs.
- Position of the state shifts from a health care services producer, a price maker, a wage setter, a distributor of finances only to the position of a price regulator and network manager.
- Providing financial protection of individuals from so-called catastrophic expenses on health care.
- Maintaining balanced financing of the health care system. 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.
- Increasing the flexibility of the health care system that would respond to the needs of citizens, changing environment, shifts in structures of diseases, and technological progress. The provider takes over higher responsibility for correct provision and quality of health care, including the possible risk of penalties.

STABILIZATION MEASURES

The main objective 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).

The second new element was the introduction of user fees for physician consultations, for issuing prescriptions, and providing related services (starting on June 1, 2003). This step was meant to increase the responsibility of patients for their own health (Table 1), and was not intended to secure massive additional resources into the system. Fees are of a symbolic nature, while certain groups of patients, like children under 1 year or 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.

Table 1: User fees introduced since June 1, 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 health insurance company |

Source: Ministry of Health, 2003

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 2000-2002 the new uncovered debt was growing by the average annual rate of SKK 7.0 - 9.0 billion (approx 0.9% of GDP), despite injecting SKK 10.5 billion during 2000-2002, in 2003 there was a SKK 4.8 billion growth and in 2004 the Ministry expects only SKK 2.4 billion.

EXPERIENCE FROM IMPLEMENTATION OF USER FEES

Having people participate in bearing the costs of health care is the first step toward a true reform of health care. Health care is now viewed as a good by more than three in five respondents (61%); a similar number also believe

that people should be primarily responsible for their own health. On the other hand, only one in eight respondents (13%) think the government should be primarily responsible for people's health.

Data supplied by health insurance companies report that in the second half of 2003, i.e. after the fees were introduced, visits to doctors providing primary outpatient care declined by 10% from the same period in 2002. A similar result was seen in first aid, where the number of visits dropped by 13%. On the other hand, specialized outpatient care doctors and hospitals saw only a slight decline in the number of visits (2% each).

Fears that medical services would become less available were not corroborated, as shown by a survey conducted in January 2004. Only one in 67 respondents (1.5%) stated that the fees had made them stop seeing their doctor altogether. On the other hand, almost three in five (58.4%) said they had not changed their habits, and that they visited their doctor just as frequently as ever. A reduction in surplus demand was recorded in almost one in five (18%) respondents, who said they saw their doctor less frequently than before.

User fees have helped Slovaks understand a simple truth: Though health care may officially be free of charge, it is not without costs. User fees have not met with a positive response, which is understandable. Nevertheless, people are gradually beginning to understand their meaning; even more importantly, they are beginning to realize the value of their own health as well as the meaning and value of solidarity.

DESIGN OF THE REFORM (SYSTEMIC MEASURES)

The six major acts of health care reform were adopted on 21-22 September, 2004. Later they were vetoed by the president and definitely accepted by the Parliament on 21st of October, 2004. The objective of systemic measures is to create a new system of providing health care, fair in distributing health care commodities and financially sustainable in the long-term.

Health Care Insurance

Public health care insurance is based on following principles:

- Universality and solidarity. Every citizen is obliged to equal treatment to equal need, and is entitled to have the need satisfied in an equal way regardless of one's social standing or income
- Financed from public sources that are collected on an obligatory principle and redistributed on the solidarity principle, while competitive social insurance is present. The Health Care Supervision Authority (HCSA) shall supervise the redistribution of the financial resource between the Health Insurance Companies. Effective rate of redistribution shall reach 85.5 % of the prescribed insurance premiums
- Every insured person is guaranteed free choice of the health care insurance company, which cannot refuse insurance to anybody
- Contributions are 14 % of wage up to a given ceiling (three times the average wage). The state pays insurance for vulnerable groups of 4 % of average wage

Individual health care insurance allows the reimbursement of treatments that are not paid from public health care insurance. Individual health care insurance is the product that shall be offered by commercial insurance companies. These will be supervised by the Financial Market Authority.

Health Insurance Companies and Supervision 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 - entities of private law. HIC are allowed to generate profits – however, if there are waiting lists in place, up to 100 % of the profits must be used for the benefit of those on the waiting list.

Solvency, i.e. the ratio of own resources to revenues from insurance after redistribution in health insurance companies, cannot fall under 3 %. If necessary, the Authority may issue fines and order a remedy plan, forced administration or liquidation of insurance companies.

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.

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 hospitals and other budgetary or state owned facilities providing health care will be transformed to joint-stock companies, with minimal 51% state ownership.

Very important is the new definition of the public network of health care providers. HIC shall sign contracts directly with providers that must observe the condition of a minimal public network as for geographic and demographic situation. The minimal public network is set by the Ministry as the minimal number of providers in given specialization in the given geographical area.

Scope of Benefits Covered from Public Health Insurance

The Scope of Benefits 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 – a flexible Benefit Package – based on the list of priorities that is in line with the fiscal capacity of the Slovak economy. Definition of priorities is calculated by three mechanisms:

- The mechanism of defining the priority list of covered diseases. The priority list is a positive list of diagnoses where there is zero co-payment of insured patients and the patient only pays the user fees (SKK 20 or 50). Other diagnoses not listed could be co-paid by patients
- Mechanism of cataloging. All diseases shall be subject to the process of cataloging where they would be assigned a list of interventions fully reimbursed from public health care insurance. Standard diagnostic and therapeutic procedures are thus created
- Mechanism of categorization. For diseases not listed on the priority list, categorization shall determine the extent of patient co-payment for interventions

CONCLUSION

Both the stabilizing and systemic measures were strongly supported by the Creditor project aimed at solving the cumulative old debts of the system until 2002. Via Creditor Company the system obtained approx. SKK 15 billion which served for bailing out the old debt of providers and Health Insurance Companies after a massive control and audit of their debts (the system claimed debts in volume SKK 26 billion at the end of the year 2002). This last bail out served also as a basic precondition for ambitious structural changes in the health sector, primarily changing the legal subjectivity of health providers, the legal subjectivity of Health Insurance Companies, imposing hard budgetary constraints and new incentives mechanisms with state remaining as a regulator of the health sector in terms of benefit package, minimal network, maximal prices and patient protection. Since 2005 the fiscal position of Health sector in Slovakia is expected to be balanced (Table 2).