Sustainable health sector financing - the case of SLOVAKIA

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1. Sustainability as economic concept

What does it mean from general point of view and what from health care (respectively Mental Health Care and/or Long Term Care)[1]?

- from general point of view – e.g. long-term ability to finance requirements/commitments without negative impacts relating to additional costs in that time and later (e.g. by loans);

- from health care point of view - "financially sustainable distribution of health services – if it respects give budget constraints, does not create conditions for the systematic accumulation of debt, and complies with priorities of citizens and policy makers" (*Ministry of Health of SR, www.newhealthcare.sk*).

Health Care is financially balanced if supply is equal financial resources and demand (*Evans, 2000*) or in other words if current and future sources could be able non-debt creating finance current and future entitled requirements and costs.

Challenges:

1. How to finance and from which sources (private-public mix) finance current and future expenditures?
2. How to synchronize of justified entitlements of clients with their own responsibility and limited funds available in public finance and in households? *(LTC Model in SR*)
3. How to synchronize citizens growing expectations and growing costs and economic possibilities (limited solvency) and policy possibilities?

2. Current economic and political framework (future limitations and/or possibilities)

Economic situation is still limiting factor of current financing health sector in SR, because:

- growing, but still insufficient economic performance of economic entities; on the other side real GDP growth is higher than average GDP growth in EU (thereby influence on possible rising of difference health care expenditure ratio between SR and EU from 6.9%: 8.1% of GDP in 2003);
- growing, but still low income level of households;
- limited public sources intended to health care financing, accompanied with public finance deficit and excessive and distorted public expenditure (high demands for other public expenditures: pension reform costs, subsidies to enterprises…) - "crowding out in public finance".

Political situation is have improved and health reform inter alia has lead to:

- improvement conditions for multi-source financing of health care (although still insufficient);

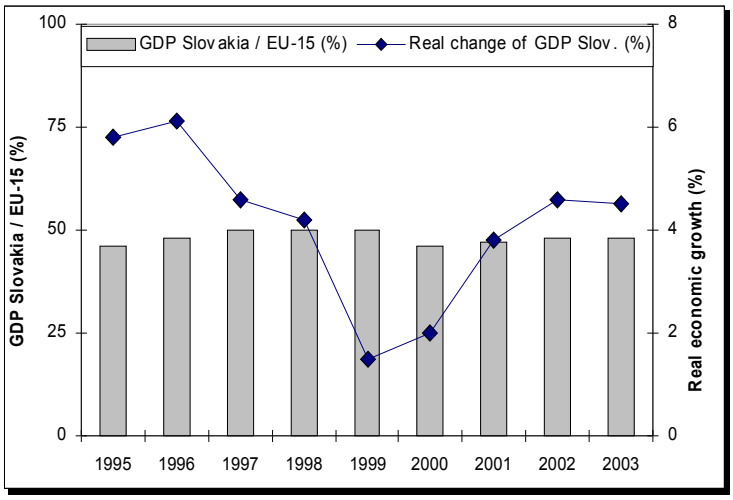
[1] Mental Health Care (MHC) and Long Term Care (LTC) are parts of several systems, at least health and social systems.

- more transparent financial flows
- higher and more clear responsibilities of stakeholders.

During the economic transformation, Slovakia has survived considerable real economic growth. However, Slovakia's economic performance and productivity still significantly lacks behind many economically advanced countries. For example, the GDP of Slovakia per capita and calculated in power purchasing parity reached circa 48% of the former EU-15 average in 2003 (see Graph 1). Domestic price (including wage) level is more behind the EU level for instance to the EU-15 average. The price level in Slovakia reaches only circa 43% of the average price level in the EU-15 (according to year 2003).

Graph 1

Level of GDP Slovakia in relation to average of EU-15 per capita and real GDP growth of Slovakia



Note: GDP per capita calculated in power purchasing parity.

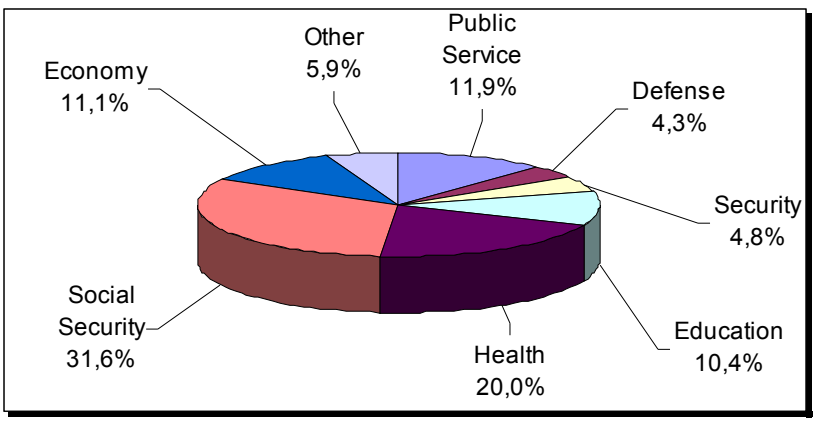
Source: Statistical Office of Slovak Republic, Eurostat

Capacity of resources for sufficient health care financing is limited by low economic performance and productivity, thereby also low income level of individuals and households. This restrains introducing significant out of pocket payments of clients in near future.

Significant present problems of financing health care follow from problems and distortions in public finance. Public finance deficits are first barriers of increasing funds towards health care, which are also in permanent deficits. Another limitation is excessive role of Slovak Government in the economy and society (since ratio of public expenditure to GDP corresponds almost to 45%) and distorted structure of public expenditures. For example, health care expenditures are partially "crowding out" by subsidies and other transfers to the economy (especially by subsidies to agriculture, but also financial supports to foreign investors). This fact confirms that government pay too attention to activities which do not belong to its main role (subsidies to economic entities) and on the other side do not pay sufficient attention to its basic functions. – see Graph 2.

Graph 2

Structure of general government expenditures by functions in Slovakia (2003)



Note: Data corresponds to IMF Methodology (Manual on Government Finance Statistic - GFSM 2001) and COFOG.

Source: Gonda (2004), Ministry of Finance of Slovak Republic.

Limited sources in public finance for health care follow also from requirement for huge money demand because of structural reforms (e.g. pension reform) and other health care costs, including payment of loans. The stated facts confirm the impossibility to keep current share of public resources in financing of increasing requirements of expenses.

3. Problematic current financing of health care

A main significant change in the Slovak health system was recorded in 1994, when the integrated general tax based system with state monopoly in providing care and insurance company was replaced by compulsory public insurance system with mix a private and public providers and insurance companies.

However, main systemic distortions have remained especially until 2003. They are relating to: excessive share of public scheme (thereby low pressure on personal responsibility), predomination of mandatory principle, soft budgetary constraints to providers and HICs (by government guarantees of their solvency) and mainly "free" provision of health care services. All insurance companies offer the same package of benefits and generally contract the same network of providers.

Thus, the key problems in health care system, mainly before adoption of first health care reforms acts in Slovakia (2004),[2] followed from too comprehensive health care benefits. The basis for determining the health care benefits covered by health insurance has laid down for long-term period in Constitution of Slovakia,[3] where health care is understood as "the right to free health care".

The health insurance system with universal principle, without cost restrictions and with "free-of-charge" access to a generous package of services led to unsustainable state in relation to sources of financing. Expenses reached 7.7% of GDP in 2002, but revenue corresponded to only 6.8% of GDP (Graph 3). The gap (deficit) between expenditures and revenues has been

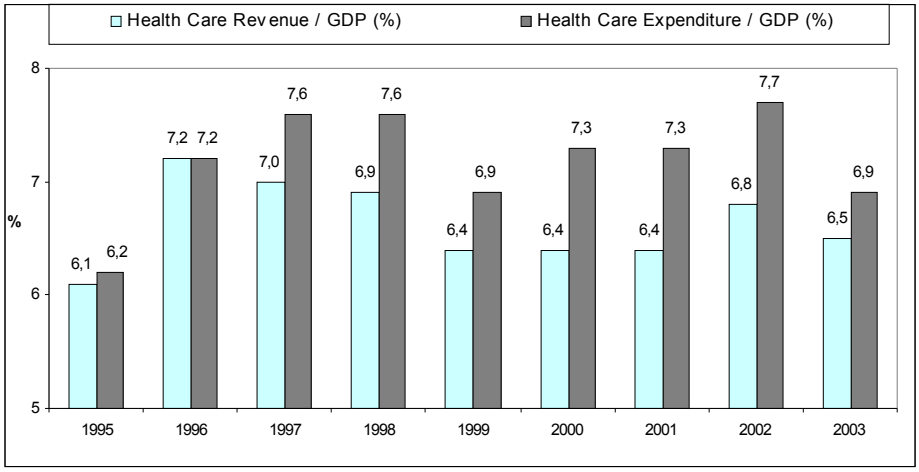
[2] From 2004, Slovak Ministry of Health has started apply a certain maximum scope of public benefits, followed from a flexible Basic Benefit Package, based on list of priorities that is in line with the fiscal capacity.

[3] The wording of Article 40 of the Constitution of Slovakia: "Everyone shall have the right to protection of his or her health. The citizens shall have the right to free health care and medical devices for disabilities on the basis of health insurance under the conditions to by specified by a law".

widening over the years giving rise to growing debt. External health care debt reached SKK 26.6 billion (2.4% of GDP) in 2002.

Graph 3

Development of health care revenues and expenditure (% of GDP)



Source: www.health.gov.sk, *Pažitný-Zajac (2002), Nemec (2004)*

Health care expenditures in Slovakia are still financed mainly by public sources, while private sources are not-significant. This persist, even there has been recorded trend of gradually and moderately decreasing public sources, significantly in 2003 (Table 1) and thereby moderate rising of significance of private sources (from 5.7% in 1996 to 10.9% in 2002, respectively to 13% in 2003)[4].

Table 1

Main sources of financing of general health care in Slovakia (%)

	1996	1997	1998	1999	2000	2001	2002	2003
Private sources (Out of pocket)[a]	**5.7**	**7.2**	**8.0**	**10.4**	**10.6**	**10.7**	**10.9**	**13.0**
Public sources	**94.3**	**92.8**	**92.0**	**89.6**	**89.4**	**89.3**	**89.1**	**87.0**
Taxes	*34.0*	*31.3*	*24.5*	*5.2*	*5.0*	*4.4*	*3.2*	
Mandatory social health insurance	*60.3*	*61.4*	*67.5*	*84.5*	*84.4*	*84.9*	*85.9*	

Note: [a] – include negligible nongovernmental organizations´ expenditures from 1999 – 2002; private health insurance are negligible.

Source: Statistical Office of the Slovak Republic, OECD (2003)

[4] These data include formal co-payments for excluded services, but not informal payments.

Current share of private sources in financing health care in Slovakia represents less weight than in most OECD, respectively EU countries,[5] even also significantly less than share of private sources in other new EU countries, e.g. Poland, Hungary and Latvia.

Formal private sources in Slovakia cover notably:

- co-payments for drugs, dental services, visual aids, medical devices;
- marginal co-payments for visits of patients at primary outpatient care, specialized outpatient care facilities and for issuing prescription (with exemptions excluded for paying these fees) – introduced in June 2003;
- marginal co-payments for provision related services in acute health care system (with exemptions excluded for paying these fees)[6] – introduced in June 2003;
- negligible insurance premium payments for voluntary health insurance are offered on a contractual basis (for higher standard, for provision of health care for other purposes than treatment…).

On the other hand, major source of public and overall health care financing is mandatory health insurance, which corresponds to circa 86% of health care financing in 2002. Social health insurance in Slovakia as dominant method for funding health care is similar as several (not most) countries in EU.[7] Health insurance contributions are income-related, set at 14% of the assessment base, and shared between employers (10%) and employees (4%).

It contributes to excessive burden of social and health contributors, and thereby cause high "tax wedge" in Slovakia. Total contribution burden of employers and employees in average is circa 47.5% of assessment base, what significantly increases non-wage labour costs of employers. This is one of the most important obstacles of creation new (productive) jobs and solution of problems relating to high (long-term) unemployment in Slovakia

Rest public source of health care financing is from tax revenue transfers on behalf of economically inactive persons are (including dependent people, elderly, soldiers and disabled).

What was result of health care policy until 2003? Persisting socialistic approach to health care with free of charge its services, soft budgetary constraints and other mentioned problems led to huge debt in health sector in Slovakia. Thanks to wide extent of "free" health care excess of demand was induced by existing capacity on the supply side, while the demand as well as the supply exceeded available resources (Evans, 2001). It is clear, that this disequlibrium was corrected by remaining corruption and nepotism, and the level of the system, no charges to patients resulted in increasing prolonging waiting periods.[8]

But this imbalance may be worsening because increasing demand, thereby costs in systems and limiting (public and private) resources in future.

4. Financial pressures on the increasing costs

[5] Except of France (with 9.8% out of pocket payments from total expenditure on health in 2002) and Netherlands (with 10.1%). On the other hand, in Portugal and Spain more than one third of all health care expenditure are out of pocket payments.

[6] It relating to board and bed during the provision of inpatient care for each day of inpatient care, for at most 21 days of the same healthcare at the same provider.

[7] It is similar as in Austria, France, Germany, Luxembourg and Netherlands.

[8] *Zajac, R. – Pažitný, P. – Marcinčin, A. 2004*.

We expect mainly:

a) ageing of population – increasing number of citizens in higher age groups (mainly after 2011 – Graph 4)

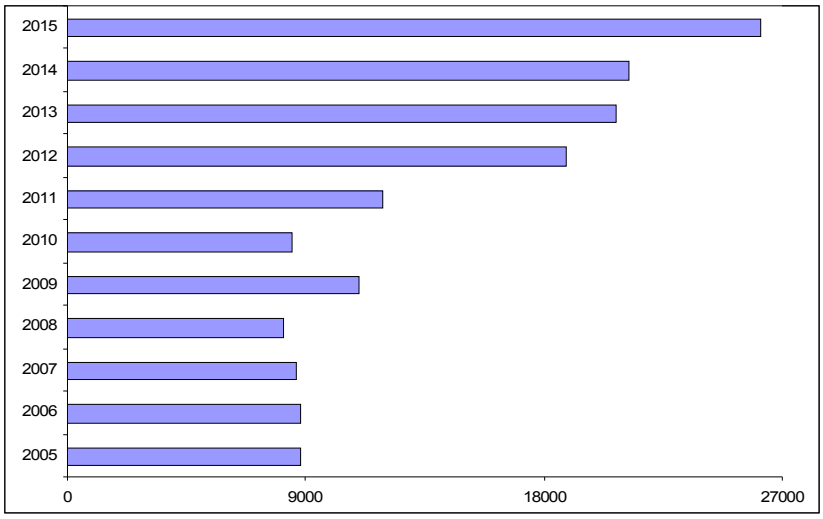
b) rising expectations and demands of patients-clients, their families and client organizations for extension of services and increasing of quality of services

c) increasing of weight of difficult diagnosis – non-infections (cardiovascular and oncological) diseases, chronic diseases, serious mental problems;

d) development of new, more expensive technologies.

Graph 4

Year on year increase of Slovak citizens over 65 years



Source: Infostat (2002), Author

5. What was/is response of Slovak Government to current problems and future risks

A/ Health care reform – from 2003 – focused mainly on solution current financial problems and partially on restraining future risks

B/ Long Term Care Reform – with planned to launch in practice during 2006, focused mainly on solving future risks, but also current problems

C/ National Program of Mental Health of the Slovak Republic, intended to start with systemic changes in Mental Health Care as basis for solving current problems and future risks

Ad A. Health reform

The reform consists of stabilizing and systemic, respectively also network measures

- STABILIZING POLICY – aimed at halting debt

AIMS: by cost contained /limited policy, focus on:

- decreasing and eliminating deficit and stop and canceling the debt;

- reducing citizen´s expectations and

- decreasing excessive consumption of services and drugs
  (while the annual number of physician consultants in OECD countries was 5.2, in SR was 9.2, and according to estimates by Ministry of Health 41 tons of prescribed and unused drugs are wasted each year).[9]

STABILIZING MEASURES

- definition of related services with health care (boarding, lodging, transportation)[10]
- introduction of marginal fees for visits of patients at primary outpatient care a specialized outpatient care facilities and for issuing prescription
- introduction of marginal fees/payments for related services
- new initiatives in pharmaceutical policy – user fees for dugs prescription, "fast track" regime in drug policy…
- pilot projects in two big hospitals in order to decrease their costs

First positive results have been already recorded in the same year. These measures led to significant decline in visits to general practitioners, decline in emergency services calls, improve cash income of physicians, and drop in corruption already during 2003. Deficit between revenue and expenditure was decreasing to 0.4 % of GDP in 2003 from almost 1% of GDP in 2002 (Graph 3). Subsequently debt fell from SKK 26.6 bill. in 2002 to SKK 14.8 bill. in 2004, repayment is assumed in 2005.

➢ SYSTEMIC POLICY

AIMS: to create a new system for providing health care that would be far and financial sustainable

MEASURES/ACTS

- clear distinction between public health care insurance and individual HCI – mutual supplementation, different supervisions…

  / principles for public HCI – universality, solidarity, obligatory, free choice of health insurance company, flat rate of contributions with ceiling, then regressive /

- higher competitiveness and market rules in HICs operations (providing of services) and their stronger supervision (by new agency – Health Care Supervision Authority

- new rules (elimination artificial barriers to entry, introducing more possibilities, setting clear rules for public network, …

- scope of benefits from public health insurance, followed from a flexible Benefit Package , based on the list of priorities that is in line with the fiscal capacity of the Slovak economy (similar as in Oregon – US, Holland, Sweden and Great Britain)

1. priority list – positive list of diagnoses, which are fully finance from public sources, with exception marginal user fees (20-50 SKK)

[9] Zajac, R. – Pažitný, P. – Marcinčin, A., 2004.

[10] Healthcare-related services are defined as lodging, boarding and transportation (more in the Act on the scope of healthcare covered by public health insurance and on settlements for healthcare-related services).

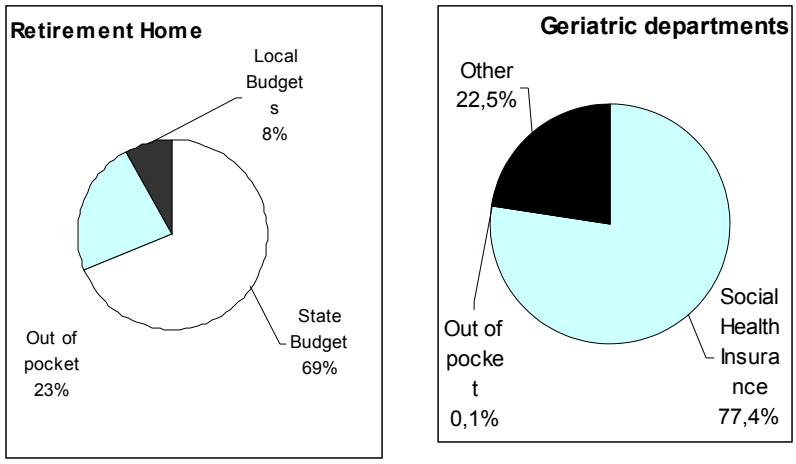
2. Other diagnosis could be co-paid by client – the categorization commission determine the extent of patient co-payment for interventions

Ad. B Long Term Care Reform, with focus on financing of LTC

Current situation:

- LTC as system does not exist, split between two different systems (social and health sphere)
- arrangements of financing LTC from any person with long term functional disabilities (frail elderly and severe disabled people) is absolutely different between social system and health care system (example on the Graph 5)
  - absolutely difference in approaches, relating to co-payments, and main public sources

Graph 5 Comparison of structure of financing social and health facility in average



AIM: to built new, integrated, LTC system, which improve quality of life of persons with long-term disabilities, improve quality, accessibility and effectiveness of LTC and it will be financial sustainable

PRINCIPLES AND MEASURES OF FINANCING

- universal entitlement of assessed individuals to care on standard level along with strictly controlled expenses limited by the budget and with requirements of means tested co-payments (very strict link between assessment team and financing)
- multi-source financing (public-private mix) with same setting of conditions for all entities
- financing according to client and type of expenses:

- health part of LTC at standard level – from public health insurance;
- social part of LTC at standard level – from taxes;
  - total costs on services related to LTC – client , regarding to his/her financial possibilities;
  - responsibility of Local Government to finance part of payment for expenses on related services for clients, who, due to financial capacity, are not able to pay for it;
- shifting to key responsibility to Local and Self-Governments and clients.