Strategic framework for health for 2014 - 2030

Commentary of the Slovak Medical Chamber

Strategický rámec starostlivosti o zdravie pre roky 2014 - 2030

(original document)

Content

Introduction

The entire framework is brief in form but also in content. In the introduction authors characterize it as „**the main document that should determine medium and long-term direction of Slovak health policy**". Unidentified authors of this text declare that: „... **the efforts of the Ministry of Health will be to apply the *principle of Health in all policies* and thus to collaborate in development and promotion of health policy with all other sectors to achieve the set objectives**." They also point out that „**the submitted Strategic framework (from now on referred to as the Strategy) will have no ambition to remain unchanged by 2030 in terms of the tools for transformations. Based on the relevant and informed arguments, it will be re-evaluated on a regular basis and individual implementation strategies may be corrected accordingly. Therefore, it is necessary to understand this document as a dynamic material that may be amended in the future on the basis of new knowledge**."

1. International context

In the first part „**International context**" the material quotes the priorities of the World Health Organization for the region of Europe summarized in document Health 2020. These priorities supposedly reflect the priorities of health care in Slovakia.

The second part deals with the analysis of the current state of health care in Slovakia in terms of its efficiency, and statements like „*A little health care for a lot of money*" from the **Ministry of Finance of the Slovak Republic Institute of Financial Policy** paper are discussed. The paper analyzes alleged ineffectiveness of the current health care in Slovakia.

The third section which analyzes the current demographic development in Slovakia by 2015 provides estimates of the impact of aging on health care. It also defines so-called „key factors" by means of which Slovakia must respond to the worsening demographic development.

After these initial three chapters which practically do not contain any original data and ideas strategic plans in three priority areas of health are discussed whose implementation should begin „**as soon as possible**".

The fifth part identifies so-called **Key areas and indicators of health and health care status and currency tools** in Slovakia, and its comparison with OECD countries and other countries in the V4 group as our reference countries. The chapter states five „core groups":

health status of population

public health promotion

general/outpatient care

inpatient care,

e-health

In this part so-called *target parameters of individual indicators* for 2030 are identified. The „basic tools

by which these target indicators can be gradually met“ are set therein as well.

The material states that when the tools for reaching the determined parameters are identified, „implementation strategies“ will be prepared for each tool to be realized and monitored under the Ministry of Health of the Slovak Republic.

The next part describes the monitoring system that will be implemented in order to monitor changes in individual indicators, fulfilment and realisation of individual strategies as well as to „update the strategic framework“ on a regular basis.

In the last part of document, various funding sources of implementation of realisation strategies are presented.

Evaluation and opinion of the Slovak Medical Chamber of this document

From the outset it should be noted that our assessment and opinion of the Strategy is carried out at a time when we already know the circumstances of its creation better, and after obtaining additional information and some other documents that the Ministry of Health of the Slovak Republic published in the meantime and which actually represent instructions for the implementation of the so-called sub-strategies, albeit in thicker gauges, and after two meetings with the *Institute for Health Policy* of the Ministry of Health of the Slovak Republic.

At the same time within the Slovak Medical Chamber, its boards and the committees there is a discussion underway mainly concerning the partial implementation strategy, already published in August 2014 under the name ***Implementation strategy - a system of integrated healthcare provision****: Modernisation of health infrastructure and improvement of access to quality services in primary and acute inpatient Integrated outpatient care* (from now on referred to only as „*the Integration of outpatient care*“). A debate also took place at the XXIX. Council of the Slovak Medical Chamber in September 2014 in Žilina, where the Assembly of the Slovak Medical Chamber in its resolutions on the subject expressed concern about some proposals for implementing the Integration strategy of outpatient care, particularly in the implementation of the physical structure of the so-called Integrated primary care centers, their ownership, methods of physical concentration of physicians in these centers, as well as concerns about the loss of existing business and contractual guarantees of general practitioners working mainly in peripheral areas. The Assembly also expressed concern over the fact that this issue tells us little about the real and practical improvements of the situation of the patient, and the first mention of efficiency, quality and alleged resources saved.

Debate also took place at the XXIX. Council of the Slovak Medical Chamber in September 2014 in Zilina, where the Council in resolutions on this subject expressed concern about some proposals for implementing the strategy of Integration of outpatient care, particularly in the implementation of the physical structure of the so-called Integrated primary care centers, their ownership, methods of physical concentration of physicians in these centers, as well as concern about the loss of existing business and contractual guarantees of general practitioners working mainly in peripheral areas. The Assembly also expressed concern over the fact that there is very little discussion about real and practical improvements of the situation from patient´s point of view, and efficiency, quality and alleged resources saved are mentioned far more often.

A year after, the retrospective look at the text of the STRATEGY document, approved by the Government of the Slovak Republic document on December 18th, 2014, is certainly different the one at the time this document went through the process of review. The Slovak reality of consultation is far from the method called „an open consultation“ of government materials as it is applied in

several countries of the European Union, or directly on the EU level. Abruptness, shortness of time and the lack of knowledge of the subjects - including government ministries, agencies, or other organizations established by law, but also addressed NGOs – certainly had a negative impact on the quality of comments and suggestions. At the time of the consultation not all the subjects identified the document as fundamental, one that should be consensually respected by political, economic and financial entities and the public and in the future consensually developed and supplemented. Such consultation procedure resulted in several unimportant, out of context, or even inexpert comments. In the present state of knowledge the document can be described as necessary, one which should have been appeared at the time of assessment of the developments in the health sector after the reform period 2002-2006. But at least in the period that coincided with the publication of publications mentioning the Slovak health care, cited in the material, written by authors working at the International Monetary Fund or the OECD (Grigoli et al., 2010 Journard et al., 2010). At the same time it should already have been supplemented with an original professional Slovak interpretation and data, so that we now - 10 years after the beginning of the last reform – do not have to rely solely on foreign point of view. Despite the existence of several "think tanks" oriented on monitoring and even research of the Slovak health care, there is little effort for disclosure, acquisition and objective analysis of relevant data from relevant sources.

Although the STRATEGY lacks a lot of the above mentioned, and even the initial three "Analytical" chapters chapters contain little own data, the Slovak Medical Chamber considers it a document which should be further developed - at least to the extent mentioned in the text of the Section 6 (Monitoring system) on the establishment of so-called Monitoring Committee with participation of enumeratively listed entities and also non-governmental entities (Paragraph 2). Unfortunately, the Strategy doesn´t mention any representatives of patient organizations (hopefully by mistake).

By informal telephone and personal enquiry the Slovak Medical Chamber found out that in course of November 2014 a number of governmental and non-governmental agencies and organizations in the health care or welfare sphere did not know of the existence of the STRATEGY and therefore did not take any stand thereon. That suggests poor information campaign and promotion of this major project among the Slovak professionals and the general public. A retrospective, even if only partially relevant research, could be done by means of media analysis in the period from August 2013 to December 2014. This would perhaps help to better plan the promotion of the ongoing project.

Let us analyze the individual chapters of the STRATEGY and also recall the state of implementation of objectives mentioned in them, realized over the past year.

1. International context

This chapter suggests and develops the goals of a common policy framework – a material of WHO Europe called Health 2020 adopted in 2012 by 53 Member States of the European region during the sixty-second session of the WHO Regional Committee for Europe (WHO Europe 2012). According to WHO, these four objectives (improving health and well-being significantly, reducing health inequalities, strengthening public health and ensuring the universality of people-centered health systems, their sustainability, fairness and high quality) should be implemented through four priority areas for policy action:

1. invest in health through a life-course approach and empower citizens,
2. tackle Europe’s major disease burdens of noncommunicable and communicable diseases;

3. strengthen people-centred health systems and public health capacity, including preparedness and response capacity for dealing with emergencies; and

4. create supportive environments and resilient communities.

The document *Health 2020* sees politically - professional solution as a combination of central management and "new forms of cooperation with the professional community, independent agencies and civil society".

The findings of the Slovak Medical Chamber (further referred to only as Findings): we conclude that we have seen little action in Slovakia in the past two years after the approval of this document. Apart from the approval of Updated of the National Health Promotion Program in December 2014 by the Government of the Slovak Republic. However, this update lacks any comprehensive critical assessment of the period since the previous update in 2011 (Government of the Slovak Republic, December 2014).

Within the Slovak realities the STRATEGY addresses four above-mentioned priority policy areas according to WHO.

1. The document generally mentions planned or continuously implemented activities of health promotion in Slovakia. But where it should be critical, it just makes theoretical statements. It does not analyze in terms of efficiency, or at least does not comment on the progress and results of the programs in public health and infrastructure that supports it, for example, in specialized areas of chronic diseases (cardiovascular diseases, diabetes, obesity, dementia), in the areas of community infrastructure, activation, or educational, or in social health programs for communities and social groups (eg, Healthy cities and communities, access to drinking water and sewer infrastructure building, support of marginalized groups and suchlike).

Findings: though probably because of its compactness and brevity the STRATEGY only mentions this priority in general, we are lacking at least an informed estimate of the Slovak reality in the document. We will see whether there are more informed descriptions in the various sub-strategies. But it is not a good sign because in our view it suggests that health care should bear all responsibility for poor indicators of population health in the future and de facto refuses the Lalonde model of conditionality of health or its modifications. The lines that deal with this priority (health promotion) do not mention any strengthening of the responsibility of the population for their own health. Unfortunately, this in accordance with the historical - albeit undeclared - public health policy stance of the politicians and the players in the health care sector, which perceives the inhabitants as passive and easily manipulated body. The population is then "repaying" the system by expecting "miracles", consuming it without self-criticism and is not active enough regarding its health and the health care system as a whole.

2. The STRATEGY also mentions the solutions to the biggest challenges in the region: communicable and non-communicable diseases only in general terms and its findings are at best, at a newspaper article level.

Findings: are contained in the above sentence.

3. The third priority area of the document WHO Europe Health 2020 which calls for strengthening

people-centered health systems as well as of the capacity of public health, is in the STRATEGY referred to only as a statement of internationally received document on the need for universal coverage, resilience of system to economic cycles, the commitment to improve primary health care and the need for the introduction of new forms of health care in this area as a team and continuing provision, on support of extending the competencies and skills of providers in this area, and on improvement of the care of people for their health.

Findings: similarly to the first two priorities, this one is also just a reproduction or a comment on the original document. Again, we lack insight into the Slovak context.

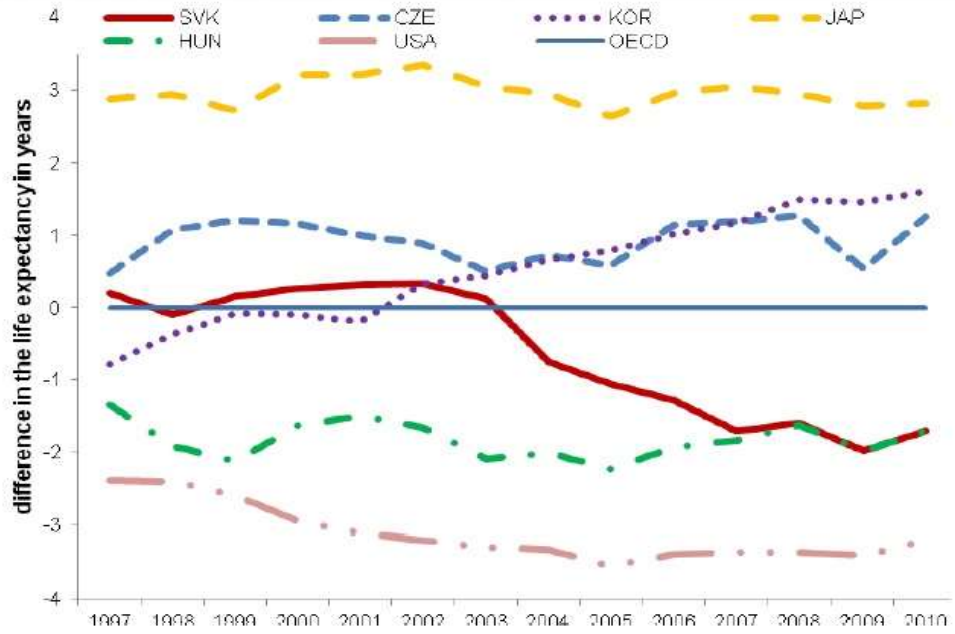
4. The fourth priority area: creating healthy communities and a supportive environment for people´s health amounts only to quoting activities and findings of WHO Europe. The Strategy also mentions environmental factors as a cause of poorer health and cause of death. It quotes support of healthy communities and promotion of health of marginalized groups.

Findings: We are missing at least a mention or a reference to Slovak realities again.

2. Performance analysis of the Slovak health care system

In this section the STRATEGY refers to three publications - unfortunately two of the three relevant ones are foreign - that should be the basis for the assessment of the Slovak health care system as inefficient compared with those of the OECD countries (Grigoli et al., 2010 Journard et al., 2010 Financial Policy Institute 2012). Comparisons with the other three countries of the so-called Visegrad Troika, which are our post-communist neighbors, are cited as partial. From the publication of the International Monetary Fund and the OECD study the STRATEGY discloses data about the relationship of modeled life expectancy, calculated on the basis of certain lifestyle factors (consumption), social-economic factors (unequality of wealth) and economic, political and social factors ("post-communist past") and their relation to expenditure on health and from subsequently made comparison with the actual, statistically ascertained test life expectancy. From Chart. 1 it is evident that when adjusting for above-mentioned factors Slovakia in spite of increasing expenditure (in relative value to GDP) recorded an increasing difference between the model and the actual life expectancy, specifically in the years 2003-2010, when the divergence from the OECD average gradually amounted to 2 years.

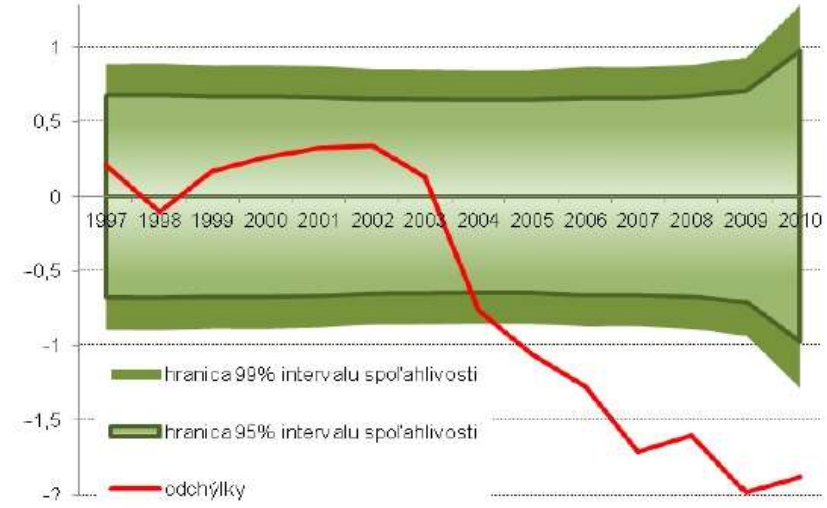
Graph 1: **Efficiency of Slovak health care**



Source: IFP from OECD data

This figure was only by 9.1 percentage points worse than the average of the observed countries. Other displays (Graph 2, Graph 3, Graph 4, Graph 5 and Graph 6) are modification of the data of source publications created by the Institute of Financial Policy of the Ministry of Finance of the Slovak Republic (Financial Policy Institute 2012). They show - not quite clearly – the dependence of variation of significance of the level of statistical deviation on the scope of the derogation of average life expectancy during the years 1997 - 2010 (Graph 2), which is interpreted as a decline in efficiency.

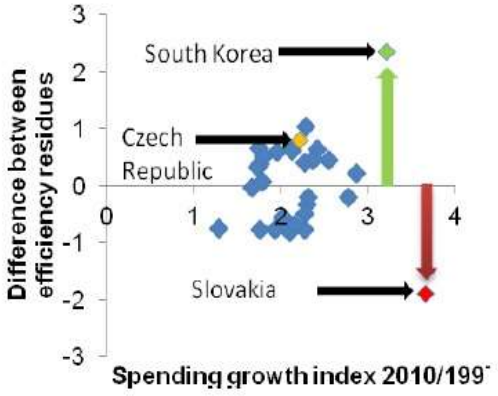
Graph 2: **Statistical significance of the deviations – drop of efficiency of Slovak healthcare**



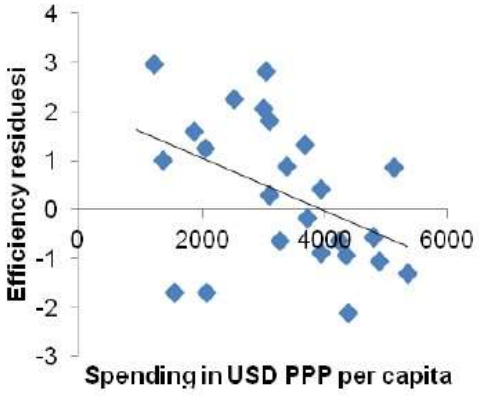
Source: IFP from OECD data

99% confidence interval level
95% confidence interval level
Deviations

Graph 3 Relation between the change of efficiency and growth of spending[7]



Graph 4 Relation between the efficiency and health care spending in 2010

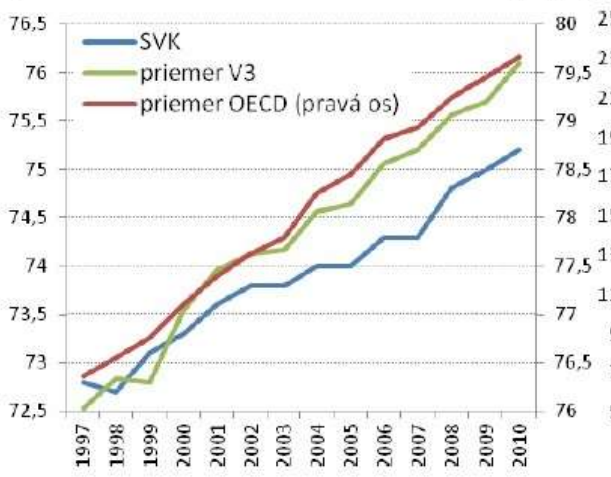


Source: IFP from OECD data

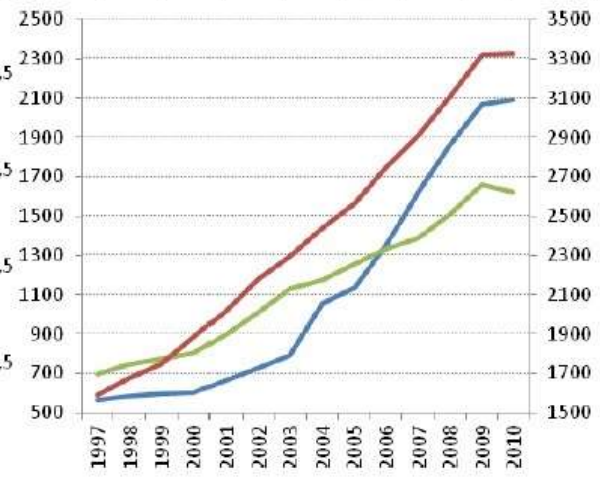
Graph 3 shows the relationship between growth of expenditure and efficiency, which, in the case of Slovakia, is the highest, but also negative. In contrast it is positive in cases of Czech Republic, where it reaches a value of about + 0.8, and South Korea, where the percentage is about + 2.5.

Dependence of efficiency on the amount of expenditure expressed by purchasing power parity (PPP) in USD, according to which the efficiencies should be – except a country unidentified on the graph - dropping from 4000 PPP dollars. There are, however, countries that have high level of efficiency at 1500 to 2000 PPP dollars. The original publication states regression coefficient r = - 30.

Graph 5 Life expectancy in years



Graph 6 Healthcare spending in USD PPP per capita



[7] Data in graph 3 and 4 from year 2010 or nearest available.

Source: IFP from OECD data

SVK – blue line
V3 average – green line
OECD average (right axis) – red line

V3 Countries – Poland, Hungary and Czechoslovakia

Graph 5 shows the development of (expected?) life expectancy from 1997 to 2010 in OECD countries, V3 and Slovakia, where the "Slovak scissors" start opening around 2003. Graph 6 shows the evolution of expenditure for health care per capita in PPP dollars from 1997 to 2010, where expenditure in Slovakia grows to the average of V3 countries around 2007 (2300 PPP dollars) and then is steeply rising for the following three years to the level of 3000 PPP dollars, which is about 200 PPP dollars below the average of OECD countries. The expenditure probably doesn´t include private "out of pocket" expenses even though the OECD has its own methodology to determine them. These charts, however, do not depict varied situations described in the original publication of the OECD (Jounard et.al 2010)[1], giving the impression that Slovakia is the only "flop" in the efficiency of spending, which is not true. There is not enough space in our commentary to quote from both original publications, which are of high quality and accurately describe the strengths and weaknesses of some of its rationale, resulting either from the input and output of data, their quality and relevance, or due to the inherent characteristics of analysis methodologies and interpretations. We can also look at yet another analysis: (Asadului L, Roman M. 2014) - The Efficiency of Healthcare Systems in Europe: A Data Envelopment Analysis Approach – 1-s2.0-S2212567114003013-main.pdf).

Simply choose not OECD countries, but states of the European Union, and with almost similar input data, the order of effectiveness of health care systems as determined by the DEA, the end (ouput) indices ALE and HALE is completely different - led by Bulgaria and Romania. Sources

[1] http://www.keepeek.com/Digital-Asset-Management/OECD/economics/health-care-systems_5kmfp51f5f9t-en #Page13

from Eurostat were used as input data.

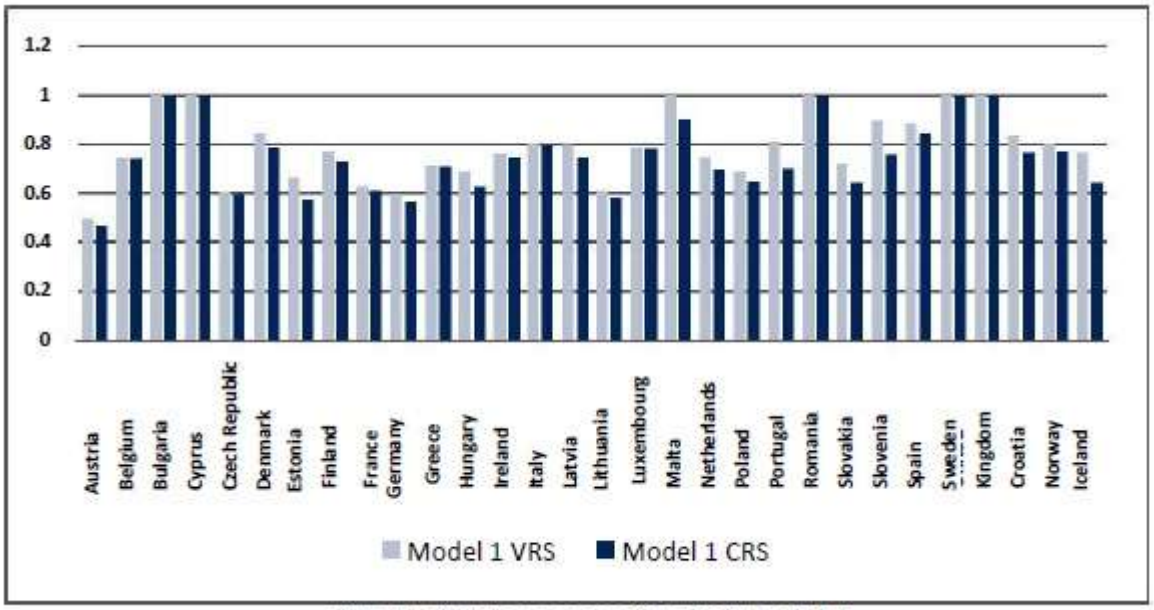
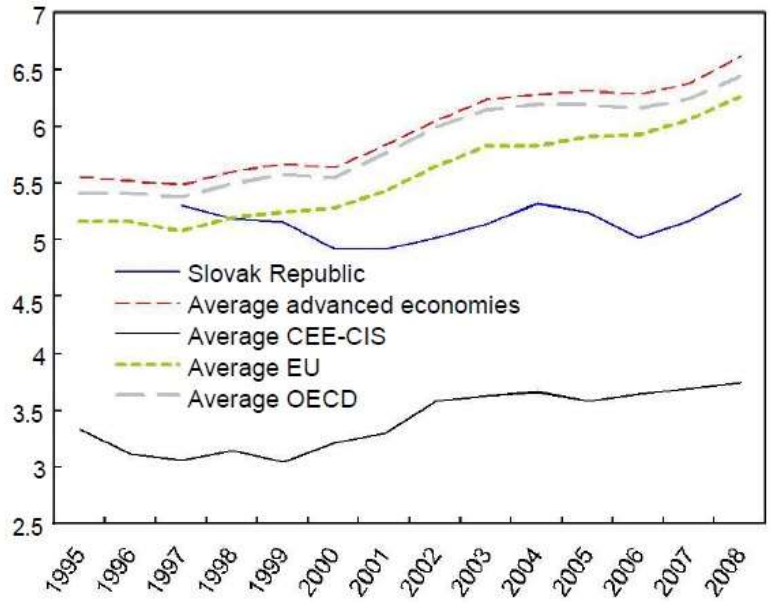


Fig. 1. Efficiency scores for DEA model 1

Findings: conclusions presented in this chapter of the STRATEGY are not quite correct, are out of the context of the original works and give the impression that it is the intention. However, the Slovak Medical Chamber does not claim that the Slovak health care is effective. A similar publication would deserve a more critical look abroad, as other specialized publications have. In this form it seems to contain more political than professional arguments. It should be noted that in terms of the ratio of health expenditure to GDP the development of expenditure in Slovakia is still relatively modest (Grigoli F. 2012).

Figure 11. Health Expenditure

(Percent of GDP)



Source: IMF Fiscal Affairs Department. Available at

http://www.imf.org/external/pubs/ft/sdn/2011/data/sdn1115.xls.

This finding doesn´t say anything about their effectivity - but it says something about the title of the publication of the Health Policy Institute (Health for little (little?) a lot of money).

3. Demographic development

This part of the publication briefly describes possible scenarios of the effects of "demographic transition" that Slovakia will experience over the next 30 years. The STRATEGY views this development in terms of health care and describes the estimates of some trends that will apply in the following years. Estimates assume:

- number of financial resources for health sector will be stable or slightly declining, (?)
- a number of acute patients will be stabilized,
- a significant increase in a number of performances in the area of medical and social care due to population ageing is expected,
- a number of people working in health sector will slightly decline.

The publication also briefly discusses how will health systems respond to these trends: they will implement integrated models of health care provision with strengthening of the primary sector, nursing, with reduction of specialist outpatient health care and acute care - we quote:

- a significant increase in efficiency of use of existing financial resources in health sector,
- a significant increase in labour productivity, especially in hospitals,
- transfer of care from acute hospital beds to outpatient healthcare, or nursing care services at home,
- reduction of number of acute beds in hospitals and reduction of hospitalisation length in these hospitals,
- creating cost-effective system of social and medical beds for long-range patients, whose acute exacerbation of chronic diseases cannot be therapeutically treated at home, requires the long-term professional integrated health care and social care provided in a community, but it does not require the use of cost-intensive beds in hospital,
- promotion of preventive programmes and activities for prevention of communicable and noncommunicable diseases and disability (regular preventive care in the outpatient units of general practitioners providing general outpatient care for adults, paediatric practitioners providing general outpatient care for children and adolescents, in centres of early diagnosis and within scope of vaccination.
- a necessary condition for functioning of integrated model of health care provision is fast, affordable and effective exchange of information - eHealth.

Findings: this section describes some of the possible responses of the health care system, among which undoubtedly reigns integrated patient care. However, this section does not answer the question, what it actually means. The concept of centers "for rapid diagnosis" also appears here, but does not appear anywhere in the publication and does not occur even in later publications that describe sub (implementation) strategies. We will have to wait to find out its meaning.

4. Strategic objectives

In this chapter, the STRATEGY begins to indicate some basic, more or less real and not declarative concepts and intentions, which after its approval became de-facto also the intentions of the current Government of the Slovak Republic. The publication is in fact quoting that part of the Programme declaration of the Government of the Slovak Republic: which says:

The mission of health sector is to significantly contribute to improvement in quality of life of population by reducing mortality, morbidity, permanent and temporary effects of diseases and injuries, by providing specialized, quality and effective health care, public health, by promoting individual and community health care.

The STRATEGY (Strategic framework) defines the followig three priorities:

Integrated outpatient health care

Its core lies in the work of general practitioners for adults, paediatric practitioners for children and adolescents, gynaecologists and dentists providing general outpatient care, together with nurses and other health professionals. General outpatient health care should be the basis of healthcare provision with links to the specialized and after-treatment health care. At present, the outpatient health care is fragmented, with different motivations and lack of coordination that causes inefficient use of resources. Fragmentation has a negative impact on quality, costs and results. Eliminating this inefficiency is key to improving quality parameters and cost reduction. The evidence shows that this is possible to achieve by higher vertical and horizontal integration of health care provision (no further explanation). Integrated model is an organized, coordinated and collaborative network (?) linking various providers to provide continuous health services (no quotation, probably Kodner et al. 2002 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1480401/).

In this area have been, for the given period, set the following priorities:

- To implement the concept of integrated model of healthcare focusing mainly on position of general practitioner for adults, paediatric practitioner for children and adolescents and gynaecologist as the first contact physicians (gatekeeping) and nursing based on the concentration of activities by creating new procedures in the field of treatment and prevention, by strengthening and expanding general outpatient and nursing care.
- To ensure health system to be renewed by general practitioners and specialists by means of residential program (financially promoted specialization study), with subsequent placement in the regions with shortage or higher average age of physicians.
- To implement medical preventive programmes focusing on prevention of communicable and noncommunicable diseases through cooperation with other components of health care provision.

Findings: thus easily described model of integration is almost no different from the Czechoslovak modification of the Semashko-model of territorial health care (Bulletinof the WHO 2013). Regardless of the fact that the so-called integrated centers should concentrate more doctors and first contact staff at less space, compared to the original model of territorial health district. If this should be the"improvement" in the 21st century, it´s so much worse. And if a network of health care providers should be the principal integration model for the next 15 years, we might think that this publication and government, which approved it, do not get a sense of integration on the background of demographic challenges and the rising prevalence of chronic conditions. A slight excuse is that

similar fumbling takes place for example in neighboring Austria[2] [3].

After all, such a model of integration would be convenient for primary care physicians, especially if it was more in the virtual than physical form. But like this we won´t manage primary sector practices of shared funding in 15 years, let alone integration (organizational and normative) in services, particularly in social care. And community level itself won´t have possession of the resources that could finance this integration... This position may be influenced by the current health and social care divergence also in case of populations that would urgently need their closer integration, including financing from a single source, such as some and still growing groups of seniors. Perhaps it is also be influenced by some WHO recommendations, which put relatively little emphasis on this type of integration and mention coordination more, which by far doesn´t have to work, even when the services are under one (physical or virtual) roof.[4]

All this requires a professional. but also civic debate as soon as possible, which would sufficiently analyze the possible organizational and financing models and their application in the context of previous traditions, or against them. One of the reasons for failure of the local health care system in the past was not only a lack of competence of the community and its regulatory subordination to the health care component – to regional and district Institutes of National Health - but also the complete absence of an integration of social care into community social - health care. Well, it was socialism, the population was much younger and did not feel such needs...

The Slovak Medical Chamber is thus a bit skeptical concerning such view of integration of health care. Already now we can say that it will be - at least in relation to elderly population for which it´s being created - less effective and possibly malfunctioning.

5. Key indicators of the state of health care and tools for change

The STRATEGY states that on the basis of defined priority areas in the previous chapter it identified key parameters describing the status of health and health care in different European countries. When analyzing the parameters of Slovakia, the following sources were used:

1. OECD Health Data
2. European Community health indicators (ECHI)
3. WHO Global Health Observatory
4. National Health Information Center (NHIC)
5. Statistical Office of the Slovak Republic.

According to the STRATEGY, the aim of the Ministry of Health was to identify key performance indicators in the fields of outpatient care, inpatient healthcare and public health, to set a current value of the indicator in Slovakia, average for the OECD countries and for the top 5 countries of the OECD or the EU. Subsequently, a target value of the indicator for 2030 in Slovakia was identified.

The Strategy presents are several tables with these indicators including their target values for

[2] Bundesgesund Ministerium, Juni 2014, „Bundeszielsteuerungskommission am 30. Juni 2014 http://www.bmg.gv.at/home/Schwerpunkte/Gesundheitsreform/Die_Gesundheitsreform_2013

[3] Konzepts zur multiprofessionellen und interdisziplinären Primärversorgung in Österreich – Das Team rund um den Hausarzt http://www.bmg.gv.at/cms/home/attachments/1/2/6/CH1443/CMS1404305722379/primaerversorgung.pdf

[4] WHO Europe Health Services Delivery Programme, Division of Health Systems and PublicHealth 2013

Slovakia. The indicators are divided into five areas called "priority health areas". In addition to the three aforementioned priority areas (Integrated outpatient care, Inpatient care and Public health), the indicators of health status of population and eHealth should be assessed as tools for achieving accessibility, quality and efficiency in all three priority areas.

These public health indicators were chosen:

a. For the health status of the population: healthy life years at birth, life expectancy, potential years of life lost (for all causes), all these indicators will be presented for females and males. Potential years of life lost will be presented per 100 000 inhabitants. Target values of indicators in 2030 should reach or surpass the OECD average.

Among other indicators are the causes of mortality expressed in relative ratio per 100 000 inhabitants and on an annual basis. For any of the causes it is not stated whether it be a gross or standardized measure. These rates will apply to all causes, avoidable causes and diagnostically specific causes (cardiovascular diseases and malignancies).

Among non-medical determinants of ill health yearly consumption of tobacco, alcohol and obesity rate will be monitored - probably for females and males together, and for age groups over 15 years (smoking, alcohol).

Among prevention indicators should bemonitored immunization programs, not only "classic" ones, but also against hepatitis B and influenza. Also the number of women aged 50-69 involved in mammography screening and the number of women participating in screening for cervical cancer should be monitored.

b. The following indicators of primary health care should be observed:

- the average age of general practisioners for adults
- number of patients transferred to higher levels of care (not monitored by OECD)
- number of general practitioner consultations (per person and year)
- number of clinical guidelines implemented in the primary care (% of patients in ambulatory (?) care in every practice (?) treated according to clinical guidelines (not monitored by OECD)
- total expenditure on pharmaceuticals and other medical non-durables
- consumption of drugs - namely antibiotics (in DDD)
- access to health care - so called financial approach hampered by out of pocket expenditure. It is expressed as a share of total spending on health (OECD methodology)
- prevention (in the ambulatory care? in total?) as a percentage of patients who underwent preventive check-ups and prevention programmes examinations (not monitored by OECD)

In-patient health care

Indicators to be monitored:

- Number of discharges (all diagnoses, diseases of the circulatory system separately) in ratio per 100.000 population
- Number of available hospital beds (total number of hospital beds, curative (acute) care beds) in ratio per 1.000 population

- In-patient utilisation expressed by so-called occupancy rate. Acute care beds occupancy rate will be monitored. It is expressed as a percentage of available hospital beds occupied by patients
- Obsolescent hospital infrastructure: average age of hospital buildings in years should be monitored (not monitored by OECD)
- Average length of stay (for all causes, for acute care)
- Standardized clinical processes (number of implemented clinical guidelines expressed as a percentage of patients in hospital care treated according to clinical guidelines)

It can be said that indicators of health status of population are a part of indicators of public health care.

3. Research and development expressed as a number of teaching hospitals operating in research programs with universities, Slovak Academy of Science, foreign teaching hospitals and private companies (not monitored by OECD)

4. Health care system financial stability expressed as operational profit of hospitals (not monitored by OECD)

5. eHealth

- The area to be monitored is electronic health documentation, indicated by number of providers of health services involved in the National health information system, expressed as a number of eHealth accounts as a percentage of the potential maximum and number of entries into eHealth record (the last one not monitored by OECD).
- Another area to be monitored is electronic medication, indicated as a number of items on eRecipes (not monitored by OECD).

6. Health promotion

The area to be monitored is the number of visits of National health portal, indicated by number of visits per month (year?) (not monitored by OECD).

Within the scope of aforementioned priorities, the detailed implementation strategies should be gradually created during the period 2014 – 2030, which will describe the methods for achieving the defined target indicators in detail. The realisation strategies will include specification of objectives, structural decomposition of activities, time-schedules, responsibility and rights matrices of the project implementers, the plan of resources, costs planning, risks and restrictions analysis and project inspection plan.

On grounds of predefined indicators, the tools for individual (six) areas have been identified, by implementation of which the target values of indicators will be achieved. Expected impact of the strategy/tools on the accessibility (A), quality (Q), efficiency (E) of health services provision was also identified. Every strategy has set a starting time of realisation (between 2013 – 2016).

It is declared:

1. **Area of public health and population health status**

- indicators: healthy life years, life expectancy, potential years of life lost
- Strategies/tools for transformation: improvement of the health determinants (Q, A, E), prevention, development of programs to encourage regular physical activity in all age groups, improvement of the healthcare quality, higher safety of the patient, lower disparity, implementation of the unitary public health insurance system (?!) (Q,A,E) (2015)
- Area of indicators: causes of mortality
- Strategies/tools for transformation: diseases prevention programmes, support for the cooperation among the general practitioners, specialists and specialised medical centres, national monitoring programme (Q) (2015).

Oncology prevention programmes, workable National Health Care Registers, support for the cooperation among the general practitioners, specialists, and specialised medical centres, a national monitoring programme, functional screening programme, the care of patients in remission, a national action plan (hereafter only NAP) for solving the problems with alcohol and NAP for tobacco control (Q) (2015).

2. Public health – public health promotion

- Area of indicators: non-medical determinants of health
- Strategies/tools for transformation: monitoring of alcohol consumption spotreby alkoholu, public education in critical segments (Q) (2015), monitoring of tobacco consumption, public education in critical segments (Q) (2015), monitoring of obesity, prevention programs, healthier food and nutrition, legislative changes (Q) (2015).
- Area of indicators: prevention
- Strategies/tools for transformation: implementation of standardised practices of medical prevention into law (Q, A, E) (2015).
- Indicator: prevention, immunisátion
- Strategies/tools for transformation: carry on the vaccination programme (A, Q) (2013), diversification of the immunisation programme (Q, A) (2015).

3. Primary / Outpatient Care

- Area of indicators: general practitioners (GPs), GPs acting as gatekeepers, consultations
- Strategies/tools for transformation: residential programme, redefine the scope of competence of general practitioners in legislation, building centers of integrated health care (A, Q, E), (2014)
- Area of indicators: standardized clinical processes
- Strategies/tools for transformation: implementation of the standardised clinical processes into the legislation Q, E, A) (2016)
- Area of indicators: Pharmaceuticals and health aids
- Strategies/tools for transformation: implementation project of the standardised clinical processes (Q, E, A) (2015)
- Area of indicators: access to health care

- Strategies/tools for transformation: programme for reducing of private sources in medical care by means of adjusting the fees of medical services (A) (2014)

4. In-patient health care

- Area of indicators: discharges, hospital beds, in-patient utilisation, obsolescent hospital infrastructure, average length of stay
- Strategies/tools for transformation: better cooperation among general practitioners, specialists and social sector, effectivity in sharing the information among hospitals (e-Health), new programme of hospitals infrastructure (A, Q, E) (2016)
- Area of indicators: standardized clinical processes
- Strategies/tools for transformation: implementation project of the standardized clinical processes (E), (2016)
- Area of indicators: research and development
- Strategies/tools for transformation: biomedicine strategy implementation (Q) (2015)
- Area of indicators: Health system financial stability
- Strategies/tools for transformation: implementation of controlling mechanisms in management of faculty and university hospitals, DRG implementation (E) (2013)

5. eHealth

- Area of indicators: electronic health documentation
- Strategies/tools for transformation: electronic health books for all policy holders of health insurance companies, data basis of National Health Information System (NHIS) (A, Q, E) (2016)
- establishing the National Health Information System, connecting the NHIS to the Paneuropean system of the exchange within the scope of epSOS project (D,K,E) (2016)
- electronic support for vaccination, management of laboratory tests, reminders for patients (A, Q, E) (2016)
- Area of indicators: electronic documentation
- Strategies/tools for transformation: electronic prescription, electronic support (Q, E) (2016)
- Area of indicators: Health promotion
- Strategies/tools for transformation: National Health Portal (NHP), information centres of NHP on social networks, mobile support (A) (2014)
-

Findings: From a methodological point of view we have no objections to dividing areas of indicators according to selected priorities, especially if they are methodologically related, the so-called triple aim (Berwick et al.2008)[5].

The question is whether it is necessary to integrate directly into the strategy the indicator areas or

indicators that are not compared internationally, or we would suggest that - for methodological reasons - these areas and indicators are no longer part of other indicators - whether they are of any

[5] The Triple Aim: Care, Health, And Cost Health Aff May 2008 vol. 27 no. 3 pp. 759-769

priority area. Moreover, it is precisely these indicators that are sometimes not very relevant and sometimes they are controversial – suitable only for a sample survey and not for national statistics and testimony.

For example:

General - outpatient medical care: the average age of general practitioners, general practitioners functioning as gatekeepers, or numbers of implemented clinical guidelines expressed as a percentage of ambulatory care patients treated according to clinical guidelines.

In-patient health care: again the number of implemented clinical guidelines.

Science and research: reporting of number of university hospitals involved in research programs together with universities, the Slovak Academy of Sciences, foreign teaching hospitals and private entities. For even the target value is modest (3) and it is not worth the statistics.

Financial stability of the health system: reporting an operating profit / loss of hospitals

eHealth: the number of entries in the electronic health books, the number of items on e- recipes.

Health promotion: the number of visits of the National Health Portal - in terms of the offer of internet coverage it is not a priority indicator.

On the other hand, we propose, for example, that the implementation of the STRATEGY should search for indicators characterizing a certain dimension of the integrated health care (Policy Research Innovation Unit – PIRU) or (IEMAC-ARCHO 2012).[6]

Similar indicators will show progress in the implementation of integrated health care reform sooner and more significantly than the standard "triple aim" approach. The alternative is that these indicators should be monitored in context of the implementation strategy.

[6] www.piru.ac.uk/.../IC%20and%20support%20Pione, http://www.piru.ac.uk/publications/piru-publications.html *or http://www.iemac.es/data/docs/Formulario_IEMAC_english_version.pdf*

6. Monitoring system

According to the STRATEGY the task of the monitoring system is: "to observe and meet the requirements related to the strategic framework itself, the preparation and implementation of partial strategy policies focused specifically on meeting the strategic objectives defined in single strategy priorities, as well as reaching the target values of the selected indicators".

Monitoring should be carried out on two levels as follows:

1. the Ministry of Health of the Slovak Republic (MH SR)

The Ministry of Health of the Slovak Republic will elaborate **"Action plan for specifying the partial strategies"** (or **Action plan for specifying the partial strategies/tools for transformation** according to the new version), which will define in details:

- a time-schedule for specifying the partial strategies and the commencement of their implementation,
- the subjects responsible for designing of partial strategies, as the case may be, other relevant subjects participating in designing such strategies.

Performing the Action plan – devising the partial strategies – will be monitored on grounds of beforehand fixed deadlines, resulting from the directives of the Ministry of Health of the Slovak Republic.

2. The monitoring panel

The Ministry of Health of the Slovak Republic will found the monitoring panel that will consist of the representatives of the Ministry of Health, Ministry of Education, Ministry of Labour, Social Affairs and Family, Ministry of Finance, Public Health Authority of the Slovak Republic, patients associations, professional associations of healthcare employees, non-governmental non-profit organisations, the representatives of health insurance companies, health care providers, higher territorial units, the Association of Towns and Communities of Slovakia and of the representatives of universities.

This panel will regularly monitor the progress within the STRATEGY, propose possible amendments to the framework, and supervise whether the single strategies are followed. The work of the monitoring panel will reportedly not affect the budget of the Ministry of Health of the Slovak Republic.

The Ministry of Health of the Slovak Republic in cooperation with their partners will compile the reports on achieved progress within the strategic framework on a yearly basis, particularly by means of updating the values of the selected indicators and submitting the information on the status of pursuing the strategies/applying the tools with regard to undertaking the transformations. The reports will be publicly available on the Ministry of Health of the Slovak Republic website.

Findings: Every project with an extent of the Strategy, especially if it is approved by the Government, requires some form of monitoring. The first level is the level of the Ministry (not the Government), the second level is the level of the Monitoring Committee.

As for the Ministry of Health, a year after the approval of the Strategy there has not yet been published the announced "Action Plan for the Preparation of Sub-strategies", although two action (implementation) strategies were already published in 2014.

A Monitoring Panel has been set up on March 1st, 2014, via publication of its Statute in the Ministry of Health Bulletin, Volume 62, Item 11-20 of February 26th, 2014.

According to Article I, paragraph (1) The establishment and tasks the Panel is established by the Minister of Health as its supervisory and advisory body.

According to paragraph (2) letter a) key areas that the Panel will deal with include: monitoring of the progress of the indicators of population health status and health care system, set out in the SRATEGY.

According to subparagraph b) it is proposed modifications and update of the strategy.

According to letter c), the Panel will work on identification of tools and strategies for fulfilling the strategies set out in the STRATEGIC framework.

And finally, under point d), the Panel will deal with the development of annual reports on the achievement of progress towards set of indicators.

We mentioned the composition of the Panel of 18 members earlier. Its members and the Chairman and Deputy Chairman of the Panel are appointed by the Minister (Article II, paragraph (2).

Membership in the Panel is honorary and lasts three years and can be extended by the Minister for another three years, paragraphs (4) and (5).

According to Article III. Negotiations of the Panel, paragraph (1) Panel meetings shall be convened and chaired by the President of the Panel at least once a year, according to paragraph (5) sessions of the Panel are non-public. The meeting, the minutes and all materials related to the activities of the Panel are confidential.

According to paragraph (11) resolutions of the Panel are only recommendatory for the Minister.

According to paragraph (15) members and Secretary of the Panel are obliged to keep all facts which they learn in the performance of their duties or in connection with it confidential. The Minister may absolve persons under the previous sentence from the obligation of confidentiality.

According to paragraph (16) the obligation of confidentiality binds also the persons invited to the session of the commission.

Article IV. talks about securing the activities of the Panel. Financial support and space is provided by the Ministry of Health.

Funding includes costs of reasonable refreshments for the Panel members, a reasonable amount of office supplies for the session of the Panel, payment of travel expenses to the place of negotiations of the Panel and back within Slovakia, with the exception of air fare.

Findings: Despite the fact that the Statute of the Panel has been in force for over a year, representatives of health care professional associations including the Slovak Medical Chamber have not been invited to participate at its activites. At the time of writing of this document the Panel has met once, which is in our opinion very insufficient. According to the publication of the minutes to this meeting it adopted one relevant favorable resolution concerning material The Implementation Strategy for Creation and Implementation of Standard Clinical Practice and Standard Procedures for the Exercise of Prevention, there was no relevant resolution adopted concerning the second material the Implementation Strategy - an Integrated System of Health Care Provision: Modernisation of Health Infrastructure and Improvevement of Access to Quality Services in Primary and Acute Inpatient Health Care[7].

Since then, the Monitoring Panel had not met physically. And that is very little. At the time of writing of this document one more activity of the Monitoring Panel took place: in days 28.11.-

[7] Available online: http://www.health.gov.sk/?strategia-v-zdravotnictve.

*09.12.2014 it voted for the document "**Description of Monitoring and Control of the Fulfillment of Tasks of the Strategic Framework for Health Care for Years 2013 – 2030“** - EN SK per roles. Eleven from a total of eighteen members of the Monitoring Panel for Supervising the Implementation of the Strategic Framework for Health Care for the Years 2014 – 2030 sent a opinion favorable to its wording.*

When assessing the factual existence of the Monitoring Panel, the Slovak Medical Chamber has come to a conclusion that this type of monitoring is merely symbolic due the absence of any obligatory character of the Panel´s recommendations, as well as of other limitations to its competences and due to absence of possibilities of monitoring of preparations of partial strategies, the obligation of silence clause and the absence of any meaningful funding of the work of the Panel.

***The Statute curtails the competences of the Panel very consistently and turns it into a mere extra to the STRATEGY and its implementation.** Slovak Medical Chamber does not like that the partial strategies have been published and possibly implemented without comments on prepared actions. It is typical for the material **Implementation Strategy - an Integrated System of Health Care Provision: Modernisation of Health Infrastructure and Improvevement of Access to Quality Services in Primary and Acute Inpatient Health Care.** It was published, while there was no platform where any comments could have been added, except the Monitoring Panel, whose incomplete composition, the only meeting and no adopted resolutions on the theme (with no powers to correct the proposed actions) we already described. We can also mention the document **„Description of Monitoring and Control of the Fulfillment of Tasks of the Strategic Framework for Health Care for Years 2013 – 2030“,** which acquaints us only with a characteristic of the so-called Managing Committee of the Ministry of Health. The Statute of this commission was published in the Journal of the Ministry of Health on April 14, 2014 (Journal of the Ministry of Health, Year 62, figure 21-22[8]). The Commission is composed of representatives of the Ministry of Health: State Secretary of the Ministry of Health, two members as representatives of the Health Policy Institute, one member as a representative Section of financing, one member as a representative of the Health section and one member as a representative of the Section of European programs and projects. In regular intervals, at least once a month, this Commission is supposed to monitor progress in the implementation of implementation strategies and to monitor implementation of programs and projects following from the implementation strategies.*

Among key actions which the Commission should address are in particular:

a) assignment of tasks associated with the preparation and review of implementation strategies,

b) approval of proposals and changes to implementation strategies,

c) assignment of tasks associated with the preparation and review of programs and projects following from the implementation strategies,

d) approval of proposals and changes to project ideas,

e) approval of proposals and changes to program and project plans,

f) approval of reports on the progress of programs and projects developed by the Health Policy Institute of the Ministry of Health,

g) monitoring the implementation of the objectives of implementation strategies, programs and projects.

This according to the Slovak Medical Chamber definitively configured the inequality in the design,

[8]Available online: *http://www.health.gov.sk/?vestniky-mz-sr*

monitoring and correcting of the STRATEGY and its partial implementations between the professional and civic society on the one hand, and the executive power represented by the Ministry of Health on the other. The whole thing is supported by the planned execution of the so-called Integrated Operational Programme (IROP) - Priority Axis 2: easier access to efficient and better services - Investment priority 2.1. Investments in health and social infrastructure which contribute to regional and local development, reducing inequalities in terms of health status, and promote social inclusion through better access to social, cultural and recreational services and transition from institutional to community-based services. Under this investment priority there are recorded also the costs of building or reconstruction of dozens of the so-called points of the first contact in which first contact doctors along with nurses and other medical personnel, as well as some selected social services are to be physically concentrated. Professional public was not invited to participare in the consultation process on this part of the Integrated Regional Operational Programme, nor did it have any information about it.

However, this is a matter of assessment of this part of IROP and on its basis already implemented Implementation Strategy of Integrated Health Care System.

7. Source of finance

According to the text of this chapter funding is required to implement the STRATEGY. It is possible to obtain it through several sources.

1. The public health insurance which should be used to finance a proportion of realisation strategies. A so-called „better form of redistribution of resources between providers“ should be used. This process should only be aplied in cases when higher efficiency is expected. However, it will not lead to a reduction of financial needs but to better availability and a higher productivity and quality of health care delivery.

2. State Budget Funds

The Ministry of Health allocates a certain part of the state budget funds on the so-called allowance for state insured, operation of institutions under the Ministry, implementation of prevention programs and investments in modernization of health care facilities infrastructure. Estimated amount of funding of activities in the field of public health and prevention programs is at this time 7,000,000 €.

3. Structural Funds for programming period 2007 - 2013

Financial resources within the framework of the Operational Programme Health care have been already exhausted. The activities for healthcare human resources development may be supported within the Measure 2.2 of the Operational Programme Education. In this field, the funds of 5 million EUR are withheld for the implementation of residency programmes. The possibilities, instantaneous availability of funds and the suitability of such funds use will be assessed in the course of implementation of the priorities within the scope of the STRATEGY, and these funds from the Structural Funds have to be spent by 31st December 2015. Funding of the so-called residency program from these sources will end after a year with this.

4. Third EU Action Programme of Health care for 2014 – 2020

5. Within the scope of the programme, it is possible to finance the activities on an international level, the objectives of which are to complement and support the state policies of the member states with the aim to improve the health of the EU citizens and to reduce the disparities in the field of healthcare by means of promoting a healthy lifestyle, by motivating the innovations in the field of health care, by enhancing the sustainability of the health care systems and through protection of the EU population against serious health threats. The programme initiates and supports the collaboration among the member states in areas, where such collaboration on the European level is more suitable, as the case may be, inevitable, and functions as a complement to national policies of the member states as for the common solving priorities and objectives. The contribution to attaining the objectives of the STRATEGY is expected through the participation of the Slovak Republic in the relevant common activities of the programme, which can supplement and support the national strategies and initiatives. In case of this source of finance, it is not possible to identify the subject and volume of disposable funds for a single member state in advance; since the projects within the programme are implemented on a multinational level and calls for proposal are announced according to annual work plans[9].

Findings: The Slovak Medical Chamber is particularly interested in the future, or rather, financial sustainability of the resident program not outlined by the STRATEGY. It also has strong reservations on the proposed implementation of available resources, structural EU funds in the investment priorities of the Integrated Regional Operational Programme (IRO) in Priority Axis 2, investment priorities 2.1 planned for construction or reconstruction of the so-called Integrated

[9] Regulation (EU) No 282/2014) Regulation (EU) No 282/2014 of the European Parliament and of the Council of 11 March 2014 on the establishment of a third Programme for the Union's action in the field of health (2014-2020) and repealing Decision No 1350/2007/EC Text with EEA relevance http://eurlex.europa.eu/legal-content/SK/TXT/HTML/?uri=CELEX:32014R0282&from=EN

health care centers. These concerns are mentioned in a different document (Mission Questionnaire - January 2015).

A table attached to the document provides an overview of key priority measures and instruments of change from chapter 5 and their primary sources of funding. It is actually an overview of financial sources of partial implementation strategies. Potential impacts of priority actions/tools of change on the availability (D) and efficiency (E) of public health sector and on health care are provided.

Findings: Slovak Medical Chamber is disappointed that the STRATEGY doesn´t mention the National Health Promotion Programme at all. It is a multi-department and society-wide program, which should include the STRATEGY and in our opinion it should be superior to the STRATEGY and therefore its implementation should be mentioned in the STRATEGY more often. The Slovak Medical Chamber is considering it a fundamental error of the STRATEGY. At the same time it is a mistake of the existing state policy - in this case, health policy - that all the political suites in the history of the Slovak Republic always regarded it only in declarative form and implemented it only formally.

Health - whether public or health care won´t not handle the challenges of the next few years alone[10].

It also follows that the Strategy should be, in our view, coordinated by the Slovak Government and not the Ministry of Health, and should be part of the National Health Promotion Programme.

Among the measures of the STRATEGY, for example, these inherently multi-departental programs are mentioned:

Program of Health Promotion of Disadvantaged Communities

The National Monitoring Program

The National Action Plan for Problems with Alcohol

The National Action Plan for Tobacco Control

We can also to include The Program for prevention of Obesity, Healthier Food and Nutrition. According to the Slovak Medical Chamber the Department of Health may be entrusted with their operational management but the Slovak Government should be responsible for making all the policy decisions. It did so when it endorsed the STRATEGY in December 2013 but it forgot that it had to give the STRATEGY an explicit and binding multidimensional character and it should have interconnected it more with the National Health Promotion Programme. It is typical that the Government did not set any deadline after which it wants to control the advancement of the STRATEGY[11] and the deadline for information on the National Health Promotion Programme is in 2020[12]. That is a real difference for example compared to the United States of America where this responsibility lies with the Health Department which has to inform the Congress once a year.[13]

As a curiosity we can mention that among key priority areas of public health is also a measure (sub-strategy/tool of change) - Introduction of a unitary system of public health insurance. Primarily it is supposed to be financed from the state budget and it promises an impact (improvement?) of the efficiency and quality of public health (?). We do not understand what is this politically dead project doing in the STRATEGY.

[10] (WHO Euro Health in All Policies – HiAP) http://www.euro.who.int/en/health-topics/health-determinants/socialdeterminants/policy/entry-points-for-addressing-socially-determined-healthinequities/health-in-all-policies-hiap

[11] *http://www.rokovania.sk/File.aspx/ViewDocumentHtml/Uznesenie-13850?listName=Uznesenia&prefixFile=m_*

[12] *http://www.rokovania.sk/File.aspx/ViewDocumentHtml/Uznesenie-14539?listName=Uznesenia&prefixFile=m_*

[13] http://www.ahrq.gov/workingforquality/nqs/nqs2013annlrpt.htm

Findings: Even in this case it is primarily the agenda of the whole government while the Ministry of Health performs only subtasks. The assumption that funding from one source has a positive impact on availability and efficiency of public health is somewhat questionable – but several studies and comparisons - in addition to the previously mentioned - testify in favour of it (WHO Euro Health for All Database, Papanicolai et al. 2013, Kai SCHNACKENBERG 2011, Bloomberg Sept. 2014, A.Behm. et al. 2014, ECHI 2013, The Economist,Aug. 2013).

However, generally it is true that countries with more fragmented politically – correct layout and more fragmented health care systems have multiple actors and these actors are more heterogeneous, and have more diverse interests. We will not look for arguments only from the public health area, but a typical example of health care in number of countries has been introducing procedural codes linked to 10, the International Classification of Diseases. Their implementation was more successful in countries with centralized administrative as well as financial mechanisms of health care management, including its financing, as in systems with decentralized health care (even with universal coverage), plus with decentralized political organization. And not only in case of prospective financing (acute institutional care) but also for other purposes (planning).[14] *However, despite the fragmentation of payers, providers and political arrangement, the German version of procedural codes*[15] *was introduced in Germany rather quickly. We'll see what problems we will encounter in Slovakia. Although the amounts of financial contributions are not mentioned, the Slovak Medical Chamber is confident that a review of their distribution and a significant strengthening of public Health will be necessary.*

However, the measures that are perhaps the most discussed by the Slovak Medical Chamber are the instruments of change and sources in financing of general outpatient care. The STRATEGY presents here an ambitious plan of building the so-called "Integrated care centers" funded from structural and investment EU funds plus "packaging", or rather „padding“ comprising the creation/innovation of standardized clinical procedures, their implementation in legislation adaptation (?) and the same for the creation and implementation of procedures for the performance of medical prevention, modification of the payment mechanism in the primary sector, the new concept of development of general medicine and resident program, of eHealth and program of reduction of supplements and fees in health care.

[14] *http://en.wikipedia.org/wiki/ICD-10_Procedure_Coding_System, http://www.cms.gov/Medicare/Coding/ICD10/downloads/pcs_final_report2010.pdf*
[15] *https://www.dimdi.de/static/en/klassi/icd-10-who/index.htm*

Tab.: No.3: Sub-strategies / tools for transformation sources of financing

Key priority areas	Measures (sub-strategies / tools for transformation)	Primary sources of financing	Impact on the accessibility (A), efficiency (E) of health care / public health
Public health	Health Promotion Programme for disadvantaged communities in Slovakia	Structural and investment funds, state budget	A
	Implementation of prevention programs, non-medical (cardiovascular and oncological diseases)	State budget	A
	National Monitoring Programme	State budget	E
	National Action Plan for solving the problems with Alcohol	State budget	A
	National Action Plan for Tobacco Control	State budget	A
	Program of restraining alcohol consumption, further education in critical segments	State budget	E
	Program of restraining tobacco consumption, further education in critical segments	State budget	E
	Minimizing the obesity prevalence	State budget	E
	Implementation of the unitary public health insurance system	State budget	A, E
	Implementation of obesity prevention programes, healthier food and nutrition	State budget	A
	Carry on the vaccination programme	Public health insurance	A

Key priority areas	Measures (sub-strategies / tools for transformation)	Primary sources of financing	Impact on the accessibility (A), efficiency (E) of health care / public health
Primary / Outpatient Care	Concept of general practice development	state budget	A, E
	Program of planning human resources in healthcare	EU programs for health, structural and investment funds, state budget	D, E
	Implementation project of the standardised clinical processes	Structural and investment funds	A, E
	Implementation of the standardised clinical processes into the law	public health insurance	A, E
	Designing and introducing the standardised practices of medical prevention	Structural and investment funds	A, E
	Implementation of standardised practises of medical prevention in to the law	public health insurance	A, E
	Building the integrated health care centers	Structural and investment funds	E
	Adjusting payment mechanism of general outpatient health care	Public health insurance	E
	eHealth	Public health insurance, Structural and investment funds	E
	Programme for reducing the private sources in medical care by means of adjusting the fees of medical services	State budget	A
	Resident programme	Structural and investment funds	A
Inpatient Care	New programme of the hospital infrastructure	PPP	E
	DRG	Public health insurance, structural and investment funds	E

Key priority areas	Measures (sub-strategies / tools for transformation)	Primary sources of financing	Impact on the accessibility (A), efficiency (E) of health care / public health
	Program of planning human resources in healthcare	EU programs for health, structural and investment funds, state budget	D, E
	eHealth	Structural and investment funds, public health insurance	E
	Implementation project of the standardised clinical processes	Structural and investment funds	A, E
	Implementation of standardised clinical processes into the law	public health insurance	A, E
	Implementation of the controlling mechanisms in the management of faculty and university hospitals	state budget	E
	Biomedicine strategy implementation	Structural and investment funds, state budget, Third EU Action Programme of Healthcare for 2014 – 2020	E

Conclusion

The study of integrated care has contributed significantly to the understanding of how to create components of such care, and how to put them into action in order to successfully spread the integrated care. The problem is not in listing the components of integrated care, however, the problem lies in our understanding of how the integration of different components should be combined together in order to ensure that the integration of these components will not only make sense in the meaning of "how" things should be done, but also „what“ should be done. Moreover, all this has to be done in environment of the Slovak health care system which after reforms of 2004-2006 gave way to fragmentation or even disintegration at places. We must realize that even in the European context the area of integrated care within the meaning of the applicable theory is still fragile, that there are still problems with implementation of research results into practice and that we still lack sufficient critical mass of "evidence based" knowledge. One of the reasons for that is, that the objectives of integrated care are often vaguely defined and there is still lacking a view of the facts that would contribute to the observation that there have always been integration programs successful in achieving these objectives and the extent of failure of these programs remains high.

A key challenge faced by researchers, health professionals as well as politicians dealing with integrated care is that it is a highly complex service innovation. Understanding the development and impact of integrated care is often described as solving simultaneous multiple equations, requiring understanding and assessment of combination factors that occur at multiple levels at different times and in different contexts. Often it is found that a single model is not for everyone. I tis fittingly described (Crramm et al. 2013) in a study on the development and application of eight cardiovascular disease management programs in the Netherlands, describes as "a process with huge differences manifested in costs, characteristics and applications, extremely time-consuming".

This complexity should force us to be cautious in introducing similar models and multi-level frameworks and methodologies with realistic assessments and not wishes. Only in this way we can obtain lessons for practical application of acquired knowledge in various relationships and circumstances. It is typical for various potential frameworks of coordinated health care. Two problems arise right at this point. The first one concerns the fact that theories which help us understand the interconnectedness of components of integrated care are still underdeveloped. And secondly, the complexity of interactions and difficulties in obtaining sectional sectoral or even cross-sectoral data constitutes a major obstacle to the uncritical claims of causality. However, this makes comparison of different models and control files extremely difficult.

Wheter one or the other program will be successful in supporting the implementation in practice it´s not important now, what it is important is that health care managers and leaders will continue to develop knowledge based on their own experiences or experiences of others. Experimental learning from those who were the first and have the most experience has always been at the forefront when implementing strategies for integrated care.

However, now that we are familiar with the content and form of the first implementation strategy – the System of integrated delivery of health care subtitled Modernising Health Care Infrastructure and Improving Access to Quality Services for Primary and Acute Health Care, we can rightfully ask: on what theoretical and practical basis should this model be developed? On experience of what practical programs is it based? Is this program adapted to the local context? One could ask many such questions. But the worst is not the lack of similar information for the public.

There is, however, something else we consider wrong and it is the almost exclusive implementation of the top/down principle as a major tool for change, and downright primitive social engineering methodology of planning infrastructure projects or of monitoring changes, the so-called endpoints (targets) that are not based on the principles of integrated care. Perhaps it would help to be more focused on the chronic care model theory (The Chronic Care Model), studies dedicated to the functioning of the medical practices of primary care (eg CHOIR) or integrated health care reforms in some European countries and tools of their monitoring (Bengoa R., 2015, Nuria Toro Polanco 2012 Annand K.Parekh et al 2011).

Despite its criticism for its shortcomings, the Slovak Medical Chamber considers the document Strategic Framework for Health Care for the years 2014-2030 (Strategy) beneficial. Our fundamental objections can be formulated as follows:

1. The Chamber is under the impression that the document wasn´t created as a response to major problems of the Slovak health care but was made-to-order to obtain funds from the European Structural funds. Strategy (and its first partial implementation concerning integrated health care) delivers too little software - assessment, analysis, guidelines and lacks mobilization potential.

2. When working with sources, the STRATEGY is unilateral and its resources are astonishingly poor, there are almost no quotes. When there are any, they are not used entirely correctly.

3. The STRATEGY works almost exclusively with the health care sector and we believe this to be its fundamental error. It does not mention any link to the National Program of Health Promotion.

4. The STRATEGY does not mention other setbacks of health care as its integration (eg. corruption, adapted and new legislation, public administration reform supporting the integration).

5. The STRATEGY and its first partial implementation regarding the integration of health care unduly prefer solely physical association of providers of outpatient care without any alternatives, as well as without instructions how to teach them to cooperate.

In Bratislava 26. January 2015

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