JOINT FACT-FINDING MISSION TO SLOVAKIA – JANUARY 2015

HEALTH CARE SECTOR AND ITS COST-EFFICIENCY

Time and Stakeholders	Place
12 January (Monday) 9:00 – 10:00 - Health policy institute 10:15 – 11:15 - Association of doctors and hospitals	COM representation in Slovakia, Palisády 29, Bratislava

Introduction

In the area of health care, the main reason for concern is the lagging cost-effectiveness of the sector. Pending the release of the 2015 ageing report, Slovakia is expected[1] to have one of the highest increase (3 pps between 2010 and 2060) in the ratio of public health care expenditure to GDP in the EU28. At the same time, health outcomes for the Slovak population continue to lag behind the rest of the EU members. In particular, poor outcomes for selected indicators[2] are less likely to be affected by population lifestyle, which indicates the potential role of the healthcare system in delivering better health outcomes. This is confirmed by the OECD overall efficiency score for Slovakia that is much lower than the OECD average. The score suggests that there is a potential gain of 4.1 years in life expectancy to be made through greater efficiency in the health care sector compared to the OECD average of 2.3 years[3]. Given this evidence, there is a space for reduction of inefficiencies in Slovak health care, notably in terms of lower costs (savings) and improved cost-effectiveness (better health with same costs) in the health care sector.

In 2014 the Council, as a part of the #1 recommendation, encouraged SK to:

- .."Improve the long term sustainability of public finance by increasing the cost-effectiveness of the health care sector, in particular by rationalising hospital care and management and by strengthening primary care."

On top of that, the 2014 Commission staff working document highlighted that:

- Health care expenditure is expected to drive the ageing costs.
- health outcomes for the Slovak population continue to lag behind the rest of the EU.
- The problems are most visible in inpatient care. One of the main bottlenecks is the model of health care, which is centred on hospitals. Repeated debt build-up and other hospital-related indicators points to existing inefficiencies in hospitals.
- Apart from deficiencies in the inpatient segment, there are barriers in other areas as well. A lack of coordination within the fragmented outpatient health care segment and an ineffective gatekeeping role for GPs result in over-use of outpatient services.

1 *Fiscal Sustainability Report 2012*, European Commission.

2 Such as perinatal mortality, avoidable mortality.

3 OECD: Health care systems – Efficiency and institutions , 2010, p.20

- The relatively high levels of out-of-pocket payments raise concerns about the accessibility of care.

- In December 2013, the government adopted a Strategic framework for health, covering the period 2014-30. The framework sets medium and long-term objectives, including measurable targets in the areas of outpatient and inpatient care, and public health.

Implementation of Strategic framework for health for 2014-2030

In order to address the cost-efficiency issues in SK health care, on December 18th, 2013 the Government adopted the Strategic framework for health for 2014-2030 (hereafter referred to as "the Strategy"). The Strategy outlines priorities in the areas of (1) Integrated Outpatient health care (2) Inpatient health care and (3) Public health.

Integrated outpatient healthcare

The Strategy suggests the concept of an integrated model of health care focusing mainly on (a) the gatekeeping role of GPs and on (b) the concentration of activities to the centers of the integrated care. Based on the current information, the primary care services are being extended, the regular check-ups are introduced for specific diagnoses (hypertension, asthma) to save visits to second-line specialists. A residential programme is on-going with a view to attract and better retain young GPs. Plans of investment in health care include setting up integrated care centers to make the care more efficient. Clinical guidelines are being rolled out to give the GPs a clear guidance in terms of procedures. The remuneration system is being changed towards a more mixed funding model from pure capitation to half fee for service and half capitation.

1. How do you assess the governmental efforts in terms of **integrated outpatient** health care in general?

   It´s possible to determine the efforts of the Government of the Slovak Republic in the field of integrated outpatient care on the basis of a number of documents open to public, primarily

   a) Strategic framework for health for 2014-2030 (hereafter referred to as "Strategic framework")

   b) consultation procedure on the document Strategic framework for health for 2014-2030

   c) the Integrated Regional Operational Programme for the years 2014-2020 (hereafter referred to as "IROP"),

   d) the Implementation Strategy - a system of integrated health care providing: Modernisation of health infrastructure and improvement of access to quality services in primary and acute inpatient care - Implementation Strategies - integrated health care system: Modernising health care infrastructure and improving access to quality services in primary and acute health care bed and

   e) Implementation Strategy for Creation and Implementation of Medical Practice Standards and Standard Procedures for Prevention Performance prevention and from the presentations of staff members of the Institute of Health Policy of the Ministry of Health at several national-level conferences.

Strategic framework was the first document, adopted by the Government of the Slovak Republic in December 2013. Content of the comment procedure make it clear that most government ministries, departments or organizations established by the government and other commenting subjects do not understand the importance of this document, its context nor its pros and cons. In our opinion it is due to the very substance and character of the government consultation process and the manner it is in most cases organized in Slovakia. Consultations are usually limited to certain central and regional governemntal bodies and non-governmental organizations, but they lack explanatory campaign. Moreover, the commenting parties are not given sufficient time to understand the documents and respond to them. This results in a number of comments concerning irrelevant and unrelated issues. This is the case even with governmental sectors as the Ministry of Labour, Social Affairs and Family, responsible for social welfare, Ministry of Finance, Ministry of Interior or the largest state health insurance company, where more professionalism is expected. According to the internal research of the Slovak Medical Chamber even the organizations in social sector directly established by the relevant ministry, nor the Council of the Slovak Republic for the Elderly had information on the Strategic framework a year after its the adoption. The draft document of the Ministry of Labour, Family and Social Welfare of the Slovak Republic „National Priorities of Social Services Development for years 2015-2020" which was commented upon in the second half of 2014, mentions the issues of integration of health services and integration of health and social services only indirectly and very vaguely in its Priority No. 1 „To ensure availability of social services in accordance with needs of target groups and communities". It states the following:

"Requirements for achieving priority:

- To support development of existing and new social services and professional activities of community character (social counseling and social rehabilitation, preventive activities, field crisis intervention social service, home care services, monitoring and signaling of need of help, day centers, community centers, early intervention services, independent housing support, subsidized housing, etc.) with emphasis on services for families who care for family members incapable of taking care of themselves.

- To interconnect social services and health care to the long-term health-social care system at both community and residential services level. "

The document fails to mention the planned establishment of regional centers for primary health care which should include selected social services.

The Slovak Medical Chamber rightly criticizes the responsible Ministry of Health and Ministry of Labour, Social Affairs and Family of the Slovak Republic for the lack of coordination and insufficient involvement of other relevant players in preparation of these materials.

Consultation procedure of the document Integrated Regional Operational Programme, coordinated by the Ministry of Agriculture and Rural Development once again did not involve non-governmental experts in the field of health care who would comment on the objective of the Priority Axis No. 2 - Easier access to efficient and better public services, 2.2.1 Investment Priority No. 2.1: Investment in health care and social infrastructure contributing to national, regional and local development, reducing inequalities in terms of health status, promoting social inclusion by improving access to social, cultural and recreational services and transition from institutional to community-based services. Preparation of IROP was thus realized without the attention of health care professionals in Slovakia.

It is with regret that the Slovak Medical Chamber observes insufficient involvement of representatives of the medical professionals and health care providers in the preparation of these documents by the Ministry of Health so far, although recently (end of 2014) it slightly improved (see jointly organized conference on the reform of outpatient care at the Ministry of Health on December 18th, 2014), but overall we assess it as unsatisfactory. Feedback statements, comments and suggestions of the Slovak Medical Chamber have not been incorporated in the mentioned strategy and implementation documents yet and the Slovak Medical Chamber therefore considers the documents to be still unclear, inconsistent, difficult-to-implement and in some cases not only non -contributing tools to improve health indicators of the Slovak population health status and the status of existing providers of ambulatory health care in the system, but to rather bringing uncertainity in relation to functionality or accessibility of existing system of health care provision.

For example, according to the approved Integrated Regional Operational Programme for years 2014-2020 (hereinafter IROP) the professional organizations will not be able to be directly involved in the ministry-generated non-profit organizations in order to obtain funds from the European Regional Development Fund earmarked for investment in buildings - creation of non-profit organizations is surmised only in conjunction with the self-governing regions and municipalities owning property in what Slovak medical Chamber sees as a direct threat to the existing operations of health care providers in the country, who have already built their practice.

Compared to the same document (page 60) the primary goal will be to integrate the provision of primary health care – and, I quote, by "increasing the number of physicians accounted for one-place of contact". Compared to the previous version of the document it is a slight positive that the expected integration of outpatient care at one point of contact includes offices of physicians and paramedical specialist outpatient care. This could help primary care practitioners by delegating selected activities to other health care professionals and social workers. However, experiences from existing health centers in Slovakia, where is currently provided only medical and pharmaceutical health care and where the doctors of so-called primary contact and other specialists are already 'physically' integrated, have shown, that such "physical" integration of providers at one place is clearly not sufficient to improve the perfomance indicators of Slovak population health status.

Concerning the necessary adjustments of processes the document envisages a link to the Operational Programme Human Resources and support of needed so-called soft extension by means of the European Social Fund, but only in the area of clinical practice standards and standard procedures for the exercise of prevention, which is not sufficient.

From the perspective of the Slovak Medical Chamber the document lacks information on description of mechanisms of internal integration (within the centers) and external integration (medical facilities and other facilities close to the centre), professional and specialized medical activities excercised paralelly with the processes of provided health care.

While it does not say anything about possible forms of integration as such, the project revolves mainly around the construction and reconstruction of health care centers at the primary level. However, it should only not be a real estate project. We do not know the form and content of the planned three pilot projects yet, but they may not be sufficient to deal with the problems of different forms of integration at the macro- (system level), meso- (organizational and professional level) and micro- (clinical level). **Their mutual horizontal functional and normative**

interconnection with the aim to improve the health of communities and countries in addition to care of the individual, will be a challenge. Therefore we propose a gradual, more dimensional testing in individual pilot projects. It will probably need to be more than three of those and they certainly should not be tied to physical interconnection of providers. That should remain only as one of the alternatives.

For a successful implementation of the whole project of integrated health centers the Slovak Medical Chamber would welcome if the European Commission by means of its financial support from the Operational Programme Human Resources (or other sources) parallely at the same time allowed

a) defining such standard "meta" integration processes including recording the multidisciplinary dimension of provided services;

b) defining of the quality outputs criteria of of provided health care for the signing/extending of contracts between providers of outpatient care and health insurance companies (= method of increasing the certainty of existing providers in the health care system, that in the process of provision of quality health care they may continue to remain in the system and will be endangered by the establishment of integrated centers without possibility of appeal[4]);

c) defining the criteria for creation of minimum and optimum network of health care providers (ditto reason);

d) the establishment and capacity support for establishment of necessary structures responsible for their compliance and continuous updating and

e) creation of working groups and documents related to the implementation of the relevant legislative changes and their implementation.

Professional organizations in the health care sector and organizations representing health care providers in Slovakia would be very happy to become official investigators or participants in creation of these documents.

It is also necessary to state that prior to launching the pilot centers of integrated health care it would be appropriate to amend the Slovak legislation in the sense that professional bodies will have greater impact on regulation of medical professionals of relevant medical profession than currently. This could be achieved by adopting the institute of compulsory membership of doctors in the Slovak Medical Chamber. The current dual model applied in Slovakia - registration at the

[4] Note: In the current system of contracting between health care providers and health insurance companies on reimbursement of health care provided from funds from mandatory health insurance in Slovakia, the contracts are usually valid for 1 year (except health insurance company Union, from which contracts with providers are conluded for indefinitive period) with the fact that price conditions are set from 6 till 12 months. These contracts should be generally replaced by contracts of indefinite duration and should be changed only in case of shortcomings. Entering into contract is not possible in case of failure to meet predetermined conditions, for example due to absence of result quality criteria that should be applied in the system. It is not possible to appeal against not being entered into contract with, or more precisely, against not getting reimbursed for the so-called over the limit performances that were necessary and justified for the patient.
In the opinion of the Slovak Medical Chamber is the addition or support of insufficient capacity of outpatient care providers still only declaratory, it encounters in practice still existing barrier of non-reimbursement of so-called „excessive" medical services which exceed the limit set by the health insurance companies (although they are necessary for the patient and justified) without the possibility of appeal, and suchlike. The Ministry of Health has yet not demonstrated any willingness to implement changes in the payment system of provided healt care in connection with the introduction of integrated health care centers.

Chamber/membership in the Chamber - is not correct, because it allows healthcare professionals to avoid impending disciplinary proceedings conducted by the Chamber by cancelling their membership in the Chamber. It allows the system to tolerate health care professionals who incline to poor quality or unethical behavior without any recourse and should be corrected. Slovak Medical Chamber would welcome if the European Commission recommended and supported such changes in legislative before launching of pilot testing of integrated health care centers.

Overall, even with regard to the question of timing – it is indeed positive, that in the first phase of implementation of integrated health care centers in the system of health care provision in Slovakia that according to the statement of the Ministry of Health of the Slovak Republic (December 18th, 2014) a maximum of 3 pilot integrated health care centers is planned. In terms of the length of the programming period and thus de facto investment support of the centers (2020) with a target of 134 centers in 2023, it is, however, questionable whether such an important phase of pilot checking, which should last at least three years, will not be unduly reduced, or rather how will be the development of integrated centers funded in the future.

In our view the above-mentioned document is not ready for practical implementation and it shows that the authors did not understand the true meaning of integrated health care system, nor current needs of the Slovak health care sector. On the contrary, they focused their activity and attention primarily on construction of medical facilities, without previous preparation and verification of contribution and importance for Slovak patients, doctors and health professionals.

If possible comment also specifically on issues as follows:

I. Roll-out of integrated care centers
The centers are not running yet. Finalisation of the Strategy of Integrated Centers Implementation by the Ministry of Health is expected in the near future. The first calls for proposals or rather launching of pilot project centers can be in our estimation expected in september 2015 at the earliest.

II. Residential program for graduated GPs
Residential program is underway. It has not been resolved how to handle (purchase by the state or other method) the practices of those health care providers who will have to cease activity because they were "replaced" by graduates of the residential program in the new integrated centers. There is also no legislative solution ready on facilitation of transfer of patients between these health care providers, nor has been provided a secure financing of counselling, or rather consultations with older, more experienced colleagues from the existing portfolio of health care providers.

III. Reform of education with respect to promotion of GPs´ gate keeping role in the system
With regard to the limited capacity of available GPs in Slovakia (resident program is de facto in its infancy, health status o the population is alarming, we need to respond to the overall trend of population ageing, etc.) we suggest to make the role of GPs as gatekeepers more attractive and support it financially as well.

IV. transfer of competences from second-line specialists to GPs

So far (in 2014) the professional directive of the Ministry of Health granted only transfer of responsibilities to exercise pre-operative evaluation. The Slovak Medical Chamber would like to see greater involvement of professional organizations in the formulation of clinical practice standards (provision of experts, securing payment for their activities, travel costs, etc.).

V. Roll-out of Standard Clinical Guidelines

Slovak Medical Chamber noticed adoption of two new professional regulations from the Ministry of Health concerning setting-up of new clinical medical practice standards (one for the allowed competence of GPs to exercise pre-operative evaluation and one for unification process in indicating of laboratory tests) – both in 2014.

Professional organizations and representatives of health care providers have not been effectively invited in the process of creating medical practices standards. We would appreciate if professional organizations could nominate experts for particular issues whose activities would be funded from project of the Ministry of Health, or the like. One of the few representatives involved comes from the Association of Private Physicians of the Slovak Republic, but only in the monitoring committee. Ministry of Health announced (at a conference on December 18th, 2014) possible involvement in the development of procedures that will be supported by a project funded through the Operational Programme Human Resources, i.e. in our estimation, from 2016 on.

VI. payment mechanism for GPs (half per capita, half per service fee)

Slovak Medical Chamber has not yet experienced any initiative directed on changing payment mechanisms oriented on change of payments realized by the "per capita" and "per service fee".

VII. e-health readiness to support integrated outpatient healthcare

In relation to the implementation of e-health system health care providers and professional bodies were in the last year gradually obliged to provide necessary data (registers of medical professionals, registers of licences) by means of law motions, unfortunately still without being provided financial coverage (see the SMC comments on the draft law amending and supplementing the Law no. 580/2004 Coll., and some other laws – www.portalpravnychpredpisov.sk, currently the document was submitted by the Ministry of Health to the Government talks on December 22nd, 2014) necessary for software changes associated with the alignment and integration of data of professional organizations and providers of outpatient health care (state contribution , the contribution of EU funds, other form), which, taking into account the threat of fines by the state, is for some professional organizations and providers almost liquidating. We would welcome financial support for professional organisations in this area.

VIII. bill on regulating fees which the out-patient (ambulatory) doctors can charge the patients for extra services

Financing of outpatient health care is a different issue. Payments from insurance companies largely do not cover the costs of health care provided by the practice. Rent, materials, energy costs and salaries of nurses do not reflect the lack of resources in the health care sector. It does not help if the doctor has a significantly larger number of patients than there should actually be. Grave shortage of GPs, their old age and

especially an unattractive speciality in this field causes a high number of patients per physician. The amount of paid duties which are not even marginally related to provision of health care as security project, work services, project of responsibility for sensitive data and the like exacerbate the deficit of some practices. To sustain activity, staffing and at least minimal standard of the doctor, these practices have no other choice but to collect fees/additional charges not directly related to health care. We realize, however, that this is not the right way - for the patient nor the physician, but the current organization and financing of the Slovak health care has led to this. The Slovak Medical Chamber is preparing systemic actions that would change this situation.

Inpatient healthcare

The Strategy aims to re-evaluate a number and structure of acute beds and to strengthen after-care, rehabilitation, nursing beds and beds for long- term patients. The aim is to achieve balanced budgets for all state owned hospitals in 2015. To this effect, some facilities may consider extending their services provided while downsizing and closures can be expected elsewhere. The insufficient supply of service in Bratislava resulted in a plan to build up a new hospital through a PPP with public procurement for the concession. The introduction of the DRG is expected in 2016 at the earliest only after analysis on 2014 and 2015 data is carried out.

2. How do you assess the governmental efforts in terms of **inpatient** healthcare in general?

On January 7th, 2015, the Ministry of Health of the Slovak Republic launched on its website a public procurement to find a partner for the construction, financing and 30-year operation and maintenance of the new hospital in Bratislava, which will not only provide superior health care, but will also focus on education and research. In addition to approval of the intention by the Government and the feasibility study, procurement notice was preceded by a number of negotiations and gaining experiences abroad. The Slovak Medical Chamber notes with regret that there were absolutely no parallel negotiations with Slovak professional community, for example on the experience of representatives of the Slovak medical professionals with implementation of international knowledge and experience into Slovak conditions.

According to the adviser to the Ministry of Health on the subject in the Slovak Radio on January 8th, 2015, a feasibility study should have been declassified and made available to the public on the website of the Ministry of Health of the Slovak Republic on January 9th, 2015.

The prepared project of running the top medical facility in Slovakia with education of medical students by a private company expresses demonstrable failure of the state in its capacity to effectively manage public hospitals and thus to ensure the patients health care guaranteed by the Constitution of the Slovak Republic. The service concession using for hospitals providing equals their de facto privatization and the disappearance of public health care.

The Slovak Medical Chamber has unfortunately once again stated that the representatives of organizations of health professionals and health care providers were not invited to participate in creation of such project as the planned construction and operation of the new University Hospital.

If possible comment also specifically on issues as follows:

I. efforts to prevent the build-up of debt in hospitals

II. envisaged model of DRG based on German model, lessons learnt so far, delays in implementation and its impact on SK healthcare once operational

III. efforts to cut/transform acute care beds

IV. issue of long-term care and social care in SK

V. minimum network of hospital care providers

VI. efforts to start private and public partnership projects to build-up new hospitals, in particular the faculty one in Bratislava

Public health

The Strategy targets implementation of fast, affordable and effective exchange of information in the healthcare (eHealth). Based on current information, e Prescription is envisaged in spring 2015.

Further to that, the Strategy aims at implementing medical preventive programs which would have a potential to support citizens´ responsibility for their health, thus decreasing cost of a follow-up treatment and improving health prospects for patients. Slovakia reports one of the lowest rates for both cervical and breast cancer screening and almost the highest mortality of colorectal cancer from all OECD countries. More extensive screening programmes, not least for cancer, as outlined and targeted in the Strategy, may yield sizeable promotions for the quality of living and increase in life expectancy.

3. How do you assess the governmental efforts in terms of **public health** in general?

The Slovak Medical Chamber has a detailed analysis of the Strategy framework in the extent of about 20 pages, we can promptly provide it to interested parties.

Existing medical preventive health promotion programs – The National Programme of Cardiovascular Diseases for the years 2014 to 2018, The National Diabetes Programme for the years 2014 to 2018, The Screening Programs of Cancer Diseases - Colon, Breast and Cervical Cancer for the years 2014-2018, which were according to the original list of tasks of the Slovak Government to be prepared as separate prevention programs, have been subsumed and incorporated with other planned activities in the field of prevention of obesity and inactivity, smoking, alcoholism, mental illness, etc. into one existing document Update of the National Health Promotion Programme in the Slovak Republic, adopted by the Resolution of the Government of the Slovak Republic on December 10th, 2014.

Unfortunately, according to the proposal report and the impact clause to the above mentioned document[5] completely without specifying the financial coverage for each year yet. Statement that - quoting from the proposal report, "An updated National Program of Health Promotion in the Slovak Republic will be implemented within the adopted limits of the affected chapters, specific programs and their funding will be drawn up in 2015," we consider it the overall underestimation of long-term indicators of health status of the Slovak population, which clearly shows that the measures taken so far in the field of health promotion need to be further strengthened to ensure they capture a wider range of population than up to now. Furthemore, we need to improve and intensify interdisciplinary general and specialized outpatient care in health promotion (= non-pharmacological interventions)

[5] Avilable at the website of the Government Office - online quoted on January 9, 2015 http://www.rokovania.sk/Rokovanie.aspx/BodRokovaniaDetail?idMaterial=24097

as well as intersectorial cooperation which in the initial phase always requires directing the necessary amount of funds in the stated area.

Medical preventive health promotion programs were merged into one National Health Promotion Programme. Unfortunately, under the impact clause attached to said material without the necessary financial coverage of preventive activities by the state.

If possible comment also specifically on issues as follows:

I. Delays in eHealth implementation and its impact on SK healthcare once operational

In our opinion, delay of implementation of e-Health in the area of public health delays the system capabilities to support the health of inhabitants but does not exclude its implementation completely. However, modification of relevant payment mechanisms is a prerequisite. Wider prevention can be implemented earlier, without the introduction of e-Health.

II. Scope to further regulate ambulance services (unjustified used of the service)

III. Scope to cut expenditures on pharmaceuticals and medical tools

The costs have decreased, but so far it does not mean that the patient will be happier and healthier. Because of the absence of an extensive support system of public health strengthened by a wider system of non-pharmacological interventions[6], the concept of long-term care and integration of community and health care has been prepared for about 20 years but has not yet been reflected in practice. On the one hand one-sided orientation to reduce costs of health insurance companies can indeed mean success of health insurance in the form of saving money but on the other hand a burden of health care providers, for example in the form of their solidarity with health insurers as co-financiers of health care in case of failure to pay for the so-called over the limit medical performances (nadlimitné výkony), or in the form of deferred health care, failure to monitor and respond to health risk factors of the patient and ultimately strain on the patient in the form of further deterioration of his health.

IV. Efforts to roll-out prevention programmes including incentives for doctors and patients

Incentives for doctors, health professionals supporting the activities of doctors and patients to intensify prevention and systematic interventions are in general for the time being at minimal level - see above - payment mechanisms, excessive (anchored in legislation) performance orientation (= execution of as many performances as possible, duplication of performance to ensure the necessary funds etc., for example see also the project of insurance company according to which the diagnostic performances of hospitals are reimbursed with lower payments than surgeries. On the one hand hospitals are thus motivated to operate, but on the other hand they are demotivated to implement prevention, etc.; paradoxically meeting the needs of the patient then sometimes receives the second to third place among the priorities of the provider.

Concluding word

[6] Even if it is well known that in case of some lifestyle diseases the use of non-pharmacological interventions reduces mortality by as much as 80 % .

Looking at the existing reform efforts and at the system globally, do you see any pertinent weak spots and areas where efforts should be strengthened? (ig. loosening of the legal requirements and delegate doctor-specific tasks to other medical staff; regulation of demand side – out-of-pocket payments, standard/non-standard services; issue linked to waiting lists and emergency receptions; regulated minimum wages in the health-care sector; strengthening accountability of hospital managers).

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