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Healthcare sector and its cost-efficiency

14th. November 2016

Position of the Slovak Medical Chamber

Fiscal sustainability and cost-efficiency of healthcare:

Introduction

On November 16th, 2016 at 14:45 p.m., delegation of the Slovak Medical Chamber, together with representatives of the Association of Hospitals of Slovakia and representatives of general practitioners in the European Union council headquarters met with a team of experts who came to visit during their trip ("Fact-finding Mission") between 14th and 16th November 2016, held in the framework of the European Semester. Experts came to monitor any area in which recommendations of the 2015 Country Report identified certain weaknesses, and were interested in how some of the specific recommendations for our country (country specific recommendations) were implemented. In healthcare, interest of the delegation focused on several areas, primarily on the project of integration of healthcare and the progress that has been made in improving the "gate-keeping" function of general practitioners, enhancing their competencies or rationalization of institutional care of the sick and the role of the planned integrated care centres. They were also interested in approach to the publication of the Institute of Financial Policy "Review of Healthcare Spending - Final Report, October 2014 (Value for Money, Final Report – Healthcare , October 2016). Unfortunately, another questionnaire with 31 questions concerning our views on some other areas of healthcare - many of which are discussed in the above-mentioned publication - we only acquired on Friday, November 11th, 2016 at 5 p.m., so it was impossible to prepare a more exhaustive

answer. That is one of the reasons why we arranged with Mr. Vladimír Solanič, that we will send our answers in writing later, with an expected date of November 30, 2016. Due to unfortunate circumstances, however, we managed to complete this document later, one of the reasons being the need for their approval by the Council of the Slovak Medical Chamber. The following sections therefore offer our observations on these issues.

Marian Kollár

President of the Slovak Medical Chamber

1. **What is your assessment of the main conclusions of the review "Value for money in the health sector"?**

Publication of the Ministry of Finance „*Revision of Health Expenditure - Final Report, October 2016*" (1) presents the following statements in its introduction:

a. Revision of health expenditure in the amount of 5.6% of GDP (€ 4.443 mil.) annually has set as an **expenditure target** to **identify possible savings, primarily in spending on healthcare** and to use them for subsequent efficient and necessary investments in patient facilities as well as dampening of spending growth to the level of price growth pace in the economy.

b. **The result goal of the revision is to reduce the number of amenable deaths** to an average level of Czech Republic, Poland and Hungary (V3 countries).

c. Achieving the result goal requires effective **redistribution** of resources, transfer from areas where resources are spent inefficiently to areas where they will contribute to reducing amenable mortality.

d. **Slovakia spends on healthcare more compared to the neighbouring countries, however, it lags in results**. The Czech Republic, Poland and Hungary achieve amenable mortality lower by 18% in average. **One of the causes of lagging behind is low efficiency of the Slovak healthcare.**

e. If the efficiency rose to the OECD average level, life expectancy in Slovakia would be extended by three months or Slovakia could achieve the same life expectancy with expenditures lower by 8%[1]. (2)

Position of the Slovak Medical Chamber on these findings:

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[1] Methodology of the study – A Little Health for a lot of Money: Effectiveness Analysis of the Slovak Healthcare http://www.finance.gov.sk/Default.aspx?CatID=8789. Variations may be caused by inconsistent reporting of statistics.

a. The Slovak Medical Chamber supports effective redistribution of healthcare budget. However, we are concerned that the redistribution will be affected by impending lack of funds to cover the legitimate needs of the population of the Slovak Republic and the claims of providers to fulfil them. We consider the indebtedness of inpatient facilities, mainly the state ones (currently in debt around € 600 million) and the net loss of the General Health Insurance Company caused by insufficient technical reserves to be extremely dangerous.

The largest health insurance company with 3.2 million insured persons in August achieved a record loss of € 137 million, by the end of the year the loss should amount up to € 280 million, according to an independent audit by Deloitte Advisory. The analysis shows that the General Health Insurance Company (VšZP) is facing a net loss of € 283 million this year. The General Health Insurance Company has shown balanced economy for several years. Suddenly it plummeted into a loss of € 37 million in July, in August the downfall increased by €100 million. Adverse development of administration is also recognized by the management of the General Health Insurance Company which ordered this analysis at the beginning of its term in August 2016. According to the director of the insurance company the downfall is caused by a historic rise in healthcare costs since 2015. That includes increasing of salaries of doctors´ of and health professionals, but also payments for services of doctors as a compensation for abolished fees increased. Director Kočan said that costs of the insurance company increased more than € 190 million compared to 2015. The chief of state insurance company added that the situation was complicated by **technical reserve** which the insurance company is obliged to create, but VšZP does not **get as much money** as it should. The insurance company is supposed to cover already carried out examinations and operations from the reserve. „We only made the creation of technical reserves more realistic now," said Kočan. (3)

Table: VšZP financial management (in millions €) (4)

2015	2014	2013	2012	2011	2010
17.6	12.1	15.6	26.3	5.7	-120.2

Source: TREND[2]

2. Are you aware of any legislative proposals regarding on-going/planned cost-effectiveness analysis in healthcare leading to more balanced budgets?

Position of the Slovak Medical Chamber:

[2] http://www.etrend.sk/ekonomika/vseobecna-zdravotna-poistovna-je-v-rekordnej-strate.html

a. Publication „*Review of Health Expenditures*“ provides only a few proposals for legislation. In the measures chapter „Saving“ it foresees legislative regulation for introduction of rules on reimbursement for drug exemptions. Legislation concerning prescription of medications on en prescriptions with name of generic substance is presented in the chapter „Value“. Legislative regulation of exchange of information on export of drugs between the State Institute for Drugs Control, the Financial Administration of the Slovak Republic and the Statistical Office of the Slovak Republic is also mentioned there. This section also mentions the preparation of legislative standard for transparent rules on patient charges. Also the chapter „Management“ provides measures that will require legislative regulation. This includes rules for improving the independence and professionalism of categorization bodies and increasing of their transparency. Introduction of a legislative scheme for extended monitoring of health insurance companies to the area of healthcare spending is presented In the chapter „*Data and methodology*“.

In the Manifesto of the Government of the Slovak Republic adopted at its meeting on April 13, 2016, it is stated, among other things, on healthcare: The Government will prepare a strategy and legislative and technical framework to specify the scope and rules for the use of public funds built around the principles of efficiency, effectiveness and solidarity in distribution of public funds. The Government wants to achieve an optimum accessibility of health care according to approved diagnostic and treatment procedures through guaranteed categorised interventions. The Government will prepare the rules for effective spending of public funds which will also include ***limitations on profit of health insurance companies***, in compliance with EU and Slovak laws.[3] (5)

3. Is there any evidence that the implementation of past/current policy measures is helping contain cost-growth in the healthcare sector?

Position of the Slovak Medical Chamber:

For the time being we did not notice such measures/policies that would effectively mitigate or rather maintained the cost growth, not regarding the previous government, nor in the case of the current government.

On the contrary, some of actions of the Slovak Government resulted in hundreds of millions in revenue shortfall of health insurance companies. For example introduction of deductible component of health insurance for low-income employees will cause a shortfall of approximately € 150 million in 2016. Also, salaries of doctors connected to the average wage in the national economy, as well as the salaries of other health professionals increased. For 2017 this shortfall should be covered by cancelling social contribution ceilings for high earners, increased economic performance and employment, thereby increasing revenues from health insurance contributions. For the last two months of 2016 health insurance state

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[3] http://www.rokovania.sk/Rokovanie.aspx/BodRokovaniaDetail?idMaterial=2547

contributions for the state insured persons are being increased as an exception. Stakeholders argue in unison that the solution is stable and all-year increase of state payments to the health insurance system. They point out that revenues, mainly of hospitals, barely suffice to cover operating costs and essential maintenance of buildings and equipment, or a relatively modest technology innovations.

4. Are you aware of any assessments of effectiveness of use of the medical equipment for example by inquiring to what extent is its capacity used? If such equipment is not fully used, what are main reasons for its under-use?

Position of the Slovak Medical Chamber:

To begin with, it is necessary to mention that source information of the National Health Information Center (hereinafter NCZI) obtained so-called through the so-called annual statements in its structure do not allow qualified assessment of use of of the use of healthcare technology (see for example Annual report on the activities of radiology KO4 (K-MZ SR 4-01) (6).

It is not possible to learn much about utilization of radiological departments for example from the form Annual report on the economy of organizations in healthcare E02 E (MZ SR) 2-01 (7). The publication "Review of Expenditures in Healthcare" is dealing primarily with lowering the unit price performance and limits for imaging (CT, MRI) examinations (planned savings of €10 million) and a reduction in prescribing radio-diagnostic and laboratory examinations through imposing limits on outpatient providers (saving of € 3 million per year) in chapter „Savings ". Source data comes from The Health Care Surveillance Authority (hereinafter "HCSA") and health insurance companies. When justifying the imposition of limits on reimbursement price and number of examinations, the authors refer to the international price comparison of CT and MR examinations, data on the rate of growth of numbers of these examinations and regional disparities in Slovakia, where the growth is more pronounced in territories with CT and MRI ambulances compared to the other regions, suggesting a growth induced consumption. Thus, instead of making these tests available to a wider population, they are going to be limited for that where they are available.

In connection with this it is necessary to say the following:

Utilisation of the potential capacity of medical equipment is only a rough indicator of their efficiency, or rather cost-effectiveness. Of course, it can be expressed in financial units, as a utility. If we focus for example on medical devices (medical devices, medical equipment), we will see that their influence on public health is by far not dependent only on their utilisation. Firstly, it is important whether our country has provided the basic framework for development of essential health technologies that will have impact on alleviating the burden of diseases on residents and ensure efficient use of resources, and secondly, whether the country supports

business, scientific and technical communities to identify, adapt and implement innovative technologies that can have a positive impact on public health.[4] (8)

Partial solution to this problem is the Act No. 363/2011 Coll. on Scope and Conditions of Payment for Drugs, Medical Devices and Dietary Food via Public Health Insurance and on

Amendment and Supplementing of Certain Acts) of September 13, 2011 in the current version of 1/11 2015 (9), and associated regulations of the Ministry of Health No. 423/2011 and 424/2011 (10).

Proposed benchmarking of prices of special healthcare materials and medical devices to strengthening revisions of health insurance companies, as mentioned in the document of the Ministry of Finance of the Slovak Republic *"Revision of Expenditure in the Health Sector"* is only a small part of this process.

Medical technology instrumentations are evaluated only occasionally in Slovakia - the first one evaluated was the purchase of a robotic surgical system da Vinci for the F. D. Roosevelt Hospital in Banská Bystrica. The analysis was performed in 2011. We do not find the area of HTA in program priorities of the Ministry of Health (***PVV 3- efficiency and effectiveness***). But we do not have a legislative provision, the above-mentioned framework for evaluation of health technologies and their impact on health and the public health of the population (Health Technology Assessment - HTA) in Slovakia.

Suggestion of the Slovak Medical Chamber: Building of professional capacities for HTA in Slovakia, at the beginning, for example with establishment of an official commission for HTA with one of the appropriate bodies (State Institute for Drug Control, Ministry of Health or NHIC), which shall prepare official materials for HTA in Slovakia. Later, maybe establishing a special agency for HTA in Slovakia.

Healthcare structural problems

Hospital finances

5. What is your assessment of the hospitals' debt levels and arrears and reasons behind their repetitive build up?

6. What is your assessment of the results of 2015 hospital budget plans and outcomes of financial audits in the 14 public hospitals and ensuing policy measures (e.g. progress of (pilot) use of the new information system with economic and clinical data - see further below under information systems)?

Position of the Slovak Medical Chamber (on questions 5 and 6):

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[4] WHO Medical device technical series Preface p.3. - http://apps.who.int/iris/bitstream/10665/44564/1/9789241501361_eng.pdf

Health insurance companies sent almost € 1.5 billion to hospitals in 2015. It was more than in 2014. It was still not enough to stop hospitals - especially the state-run ones – from generating debt. At the end of 2015 overdue financial liabilities of hospitals amounted to more than € 442 million. It was already far beyond the sum at which these hospitals previously eliminated the debts. There were only two hospitals that did not generate debts - Teaching Hospital Nitra and Children´s Teaching Hospital in Košice. Debt structure has been the same for years – constituted by debts to suppliers of medicines and special medical material, social insurance debts, tax debts and debts to health insurance companies. The main reason for constant indebtedness are continuing operating losses, since these hospitals are performing procedures which are financially the most challenging. Meanwhile, labour costs and costs of medicines and medical supplies are constantly growing - in relation to medical procedures. However, patients that take medicines prescribed in standard outpatient care, have to bring them to hospitals with them. The ratio of costs and benefits of these hospitals is constantly negative. At the same time, health insurance companies increased their payments. However, many hospitals are lacking performance operations with better ratio of payments to performances. This situation results from changes in 2002-2004, when services such as emergency health service, dialysis, imaging techniques (e.g.: computerized tomography, nuclear magnetic resonance), laboratory services, etc. were privatised (in order to attract private capital investments in healthcare). These segments preferentially gained higher remuneration. On the one hand, it led to quick improvement of such services, on the other hand to their excessive and often unjustifiable utilisation through ordering from hospitals and outpatient sector. Moreover, contractual relations with similar services of private nature among them and the health insurance companies were often set up so that they did not allow flexible reduction of payments with increasing competition. A typical example of "economic" behavior of public hospitals is lasting hesitation to introduce the so-called one day surgery services. Payment for these performances were and are lower than hospitalization for an extended period, which in turn ensured occupancy of hospitals to some extent. This approach is often paired with ineffective management of hospitals, lack of benchmarking, joint purchasing and many other managerial misconducts arising from local circumstances, but also from poor regulation of hospitals by segment management at the Ministry of Health. And let us not forget downright management fouls where one cannot help but suspect criminal activity (e.g. rigged tenders and other purchases). All this also applies to hospitals managed by self-governing regions or cities, which have completely failed in their management and as a workaround they used privatization of their operations. Thus happened that the regions lost their influence on planning and decision-making in regional healthcare, while they also lacked the appropriate legislation and competences for similar activities. **Slovakia has virtually no regional planning of healthcare services according to the needs of the population and is served by private plans of providers of acute hospital services, over which the state or self-governing regions have zero influence. This is a unique and dangerous situation that has no precedent in the EU.**

7. What is your assessment of the use of the following finance management tools in hospital care?

- structural audits
- identification of sources for operational savings
- budget constraints and incentives
- performance-based (PB) remuneration of managers
- public procurement in hospital care (see further below)
- monitoring and benchmarking (see further below)

Position of the Slovak Medical Chamber:

Slovak Medical Chamber does not have the information on tools of financial management in hospitals at its disposal. Currently our positions are based solely on the so-called disclosed information from hospitals, which are obliged to publish it, and these are hospitals under direct or indirect management of the Ministry of Health. These are the so-called subsidized hospitals controlled by the Ministry, or non-profit hospital organizations established with participation of the state. This also includes hospitals belonging to self-governing regions and municipalities. According to Act. no. 211/2000 Coll. on Free Access to Information there is a possibility for organizations, but also individual persons to requests information - for example on management of hospitals or in writing for specific cases, which are not published obligatorily. However, this Act does not impose any obligation to privately owned hospitals to disclose or provide information. There are more than 20 such hospitals in Slovakia. Most of them, however, do not shy away from providing certain selective information on their financial management. Unlike public hospitals it is to be regarded as a trade secret. For example, they do not disclose or provide information on contracts and purchases from third parties. Some hospitals do not publish nor provide final reports on management and auditing. The Slovak Medical Chamber believes that where such information is relevant to management of public funds health insurance (not only state subsidies), private hospitals should disclose them just as the public ones. This fact may is applicable to all private commercial organizations that are managing public funds - and there is many of those. We consider this to be a fault of the above mentioned Free Access to Information Act.

From the above mentioned instruments, audit is used and also published in public hospitals by default - mostly just financial, less focused on quality. Almost all public hospitals begun to use standard tools to identify savings in their operations, information is available (although not always) on demand, even with some results. One of the tools of procurement of special medical supplies is benchmarking of prices – which, for example, the state-controlled network of hospitals started to use recently. It is possible to organize a joint procurement within the project. Public eProcurement of similar but also other commodities is being used increasingly,

although it suffers from "childhood illnesses" and is not always effective. We assume that remuneration of top managers, including CEOs is based on achievement of performance criteria. However, details are not published and it can be difficult to obtain them on request, with reference to protection of personal data. Slovak Medical Chamber believes that these data should be published.

8. How would you assess the current system of reimbursement of hospitals' activities by insurance companies?

Position of the Slovak Medical Chamber:

The current system of flat-rate payments associated with reimbursement stratification of hospitals by estimated costs has been in place since the year 2000. Flat-rate payments apply not only for hospitalization cases, but also for outpatient procedures performed in hospitals. However, some items are paid separately - for example, financially extremely demanding performances, one-day surgeries and the like. Differentiated payments per day of hospitalization were made until then. Payments were differentiated according to categorization of hospitals based on expected difficulty of their activities. Recent system was supposed to stabilize funding of inpatient care. Most of hospitals, except for rare exceptions, at that time belonged to the state, the self-governing regions or cities. The share of average personnel costs of hospitals was significantly lower. However, typical disadvantages of particular uncertainty in how much a case of hospitalization really costs, were reflected very soon as well. Unfortunately, the final political decision to introduce payments to hospitals through DRG system was made only in 2011. The German system (German DRG) was chosen as the basis. The Health Care Surveillance Authority (HCSA) was supposed to implement the project. The HCSA concluded a cooperation agreement with the company InEK (Insitute for Entgeltsystem im Krankenhaus) established by the Association of German Hospitals (das Deutsche Krankenhausgesellschaft), the Federation of German Health Insurance Companies (die Spitzenverbände der Krankenkassen) and the Association of Private Health Insurance Providers (Verband der Privaten Krankenversicherung, e. V.)[5] (11). After various mishaps and delays, related mainly to unclear list of items of the performance catalogue, definition manual, monitoring of economic costs of selected hospitals and stratified hospitals, assembling of procedures of all hospitals, personnel training, or to the use of grouper, the actual operation of DRG is approaching. Unlike the selected hospitals that watched their costs, other hospitals sent the HCSA a demand for a so-called annual levy.

The so-called “real operation” of DRG is supposed to start on 1. January 2017. However, the system of stratification of hospitals (to 5 groups) will remain in place, with its planned gradual convergence - but without a defined date. To begin with, the problem is also the selection of grouper. The only, reportedly certified one, is currently owned by the Health Care Surveillance Authority. There are, however, other communication problems, because communication with the grouper is currently possible only via the Internet. Hospitals, along

[5] http://www.g-drg.de/cms/Das_Institut, file: /// C: / Joseph / Downloads / Contract% 20o% 20spolupr% C3% A1cii% 20pro% 20zav% C3% A1dzan% C3% AD% 20syst% C3% A9mu% 20DRG% 20v% 20Slovenskej% 20republike% 20-% 20text.pdf

with health insurance companies, will kick-start the DRG with a different one, “Slovak-made” grouper (12). In the first phase, health insurance companies will pay only for part of the case mix cases through DRG payments. Heretofore, however, it is not known whether capital costs of hospitals and the costs of specialized tests (such as CT, MRI, laboratory tests) will also be a part of payments through the DRG. Their inclusion would mean that hospitals would have to cover also examinations and investments through DRG payments, which would increase pressure on their effective financial management. We don´t know the further development. In any case, the next year will be also be kind of "training". Full functionality of DRG and gradual convergence of the case mix will mean a breakthrough for the Slovak healthcare.

Proposals of the Slovak Medical Chamber: We welcome the new payment system, which should, inter alia, ensure fair financing of hospitals and greater transparency. Procrastination related to the convergence of funding would not yield benefit. However, considering the current sum of funding in healthcare and in the hospital sector in particular, we believe that payments for DRG will be barely enough to cover running costs and small investment infrastructure maintenance or its development. The real solution of investment debt of hospitals (13) does not consist only of planned cuts of running costs of hospitals and reducing the hospital network, nor in using the last European funds from the IROP (Integrated regional operational Programme) (14) intended for hospitals. This gap can be covered only by resources from state or regional budget, or by private resources, and it has been already happening in Slovakia by means of transition of a significant number of hospitals into private ownership. **We have strong reservations against that**, however, we do not articulate them in this text.

A warning before fall-out of financing for hospitals´ infrastructure was the debt of hospitals in Germany after the federal states stopped their resources ("Ländern") in recent years. Disruption of statutory dual financing resulted in investment gap amounting to € 50 billion (15,16,17).

Suggestion of the Slovak Medical Chamber: given the low level of hospital funding through existing payment mechanisms we suggest to start preparing for the dual system of funding immediately. However, we are concerned that capital funding to alleviate the investment debt of hospitals will not be nearly enough for public hospitals. In case of financing only of public hospitals it will create an unequal system of financing with discriminatory character. However, it is possible that such funding will be allowed by agreements on transfer of previously public hospitals to private investors. The problem is that the last € 150 million in the form of the second IROP Priority Axis will be for a long time the last resources Slovakia may gain for its healthcare.

Public procurement

9. Have you registered any advances on the plans announced in 2015 for public procurement of medical technology and services (especially in hospital care) with regards to the following:

- price-benchmarking system or mapping

- procurement of special medical equipment (CBA-based)
- centralized procurement (e.g. energy contracts)
- guidance and supervision
- Health Technology Assessment (HTA) systems/body
- non-clinical inputs (services?)

Position of the Slovak Medical Association: plans of the Ministry of Health in 2015 practically failed to be effectively implemented in these areas. It is only up to the new minister of health to start realising some of these areas in the context of priorities of the Program management the health sector (**18**).

DRG-based reimbursement system

10. Are you aware of the current status and updated timeline for implementation of DRG?

Position of the Slovak Medical Chamber:

Slovak Medical Chamber has some (although not detailed) information on the update of schedule for introducing DRG. Originally, we had a representative in the so-called Steering Committee of the Centre for Classification System, currently its composition is as follows: the Steering Committee has seven members. Members of the Steering Committee are the chair of the Healthcare Centre Surveillance Authority (HCSA), representatives of the Ministry of Health, the Association of Hospitals of Slovakia, the Association of Teaching Hospitals of the Slovak Republic and a representative of each of the three health insurance companies. The chair of the HCSA is chairing the Steering Committee. That is why we are going to communicate with the HSCA before the end of the calendar year and gradually visit several hospitals and obtain information about their readiness for introduction of DRG.

11. Do you have any comments with respect to the currently planned set up of the DRG?

Position of the Slovak Medical Chamber: We more or less answered this question already in the answer to question no. 8. We could answer it more specifically, if we were familiar with readiness of hospitals for the launch on January 1, 2017. Meanwhile we are concerned about the situation, which suggests that hospitals are not yet prepared sufficiently.

Care management

12. Have there been any measures to rationalize hospital capacities to address high number of hospitalizations and excessive number of acute care beds?

Position of the Slovak Medical Chamber: Efforts to reduce the number of beds in hospitals started around the year 2000 with introduction of a flat reimbursement rate for hospitalization, stratified by hospital class (19). Number of beds in acute hospitals fell more spontaneously, due to the improvement of their operational efficiency. Privatization of hospitals also contributed to decline in bed capacity. Adoption of Decree of the Slovak Republic Government No. 751/2004 Coll. on Public Minimum Network of Health Care Providers which entered into force on 1. January 2005 (20), was an impulse to reduce the number of beds, even with its faults. The Ministry of Health then submitted an analysis of bed capacities of hospitals in the public network and calculated the possible reduction of beds to 6,193 beds. Health Policy Institute estimates it at 7,766 beds in public minimum network of healthcare providers. However, these estimated reductions were not applied due to legal, procedural, substantive and political reasons. A significant reduction of beds was made by the Government of the Slovak Republic through the state-owned General Health Insurance Company (Všeobecná zdravotná poisťovňa – hereinafter VšZP) in 2011-2012. This reduction was justified by system needs but also by the menacing long debt of public health insurance company, and it consisted not only of acute bed capacities but also of approx. 3000 beds for patients with chronic conditions. All previously realized changes in bed systems lacked sufficient basis in analysis of the environment in which they were supposed to be performed. The Slovak Medical Chamber considers reduction of acute hospital bed stock fund without this analysis hazardous. We do not consider analysis of environment to be only calculations of internal environment of hospitals as indicators of the average stay, bed fund, number of patients per doctor, number of patients per nurse, number of discharged patients per doctor and such, number of readmission agreements, but also an analysis of external environment in its aspects important for health. Yet we must emphasize here that external environment of hospitals is not in the least able to cope with demands that would arise due to sudden and massive reduction of their bed capacity is not the first nor the only one, missteps have been made in some other European countries. Our external environment (of healthcare) does not serve as a buffer (buffer) for inappropriate hospitalizations, nor even as a medium which would continue in quality health - social care until complete cure or safe stabilization of health of discharged patients in an integrated way. It just does not have the capacity. This is also one of the reasons for delaying transition of patients through outpatient-hospital interface, thereby lengthening time of hospitalization. Demographic development will highlight this situation even more, moreover, it will more urgently raise the issue of linking health and social services which do not work on desired level even now. Moreover, the government or anybody else does not deal with it, nor is it addressed in the Manifesto of the Government of the Slovak Republic. **Slovak Medical Chamber therefore considers launching a campaign for reform of health and social care together with considering of its integrated financing, including search for options of introduction of mandatory public long-term care (LTC) insurance.**

Suggestion of the Slovak Medical Chamber: reduction of beds in acute hospitals must go hand in hand with improvement of infrastructural, management, health - social capacity of ambulatory sector.

13. Are there any plans on transformation of these beds into the system of long-term care (LTC, elderly care), for example in terms of level, timeline, expected outcome or costs?

Position of the Slovak Medical Chamber: The plans are more hypothetical, just as they were 15 years ago, when the reduction of hospital beds fund started. In 2004, the government instructed the Ministry of Health to prepare long-term care legislation, however, it did not even make it to consultation process and was terminated by early elections in 2006. For another nine years, the governing powers have barely thought about this issue (**21**). Nevertheless, a range of materials and analyses relating to long-term care, financing, and transition from institutional to community-based healthcare was published (**22**).

So far there is no official or unofficial document on LTC, which would be published by a healthcare authority and publicly available. Existing inpatient facilities for long-term patients do not provide typical continuous long-term care. Community form of this type of care is still in its infancy. The current setup does not integrate health and social care.

Suggestion of the Slovak Medical Chamber: **It is necessary to adopt legislation regulating long-term care (LTC), including its financing. The Slovak Medical Chamber is looking for stakeholders to discuss LTC funding issues with them, including the possibility of compulsory insurance of this care, by which Slovakia would follow Germany, Japan and South Korea. We believe that expected dramatic demographic change with a growing number of people in retirement age already in 25 years , as well as the likelihood of problems with public finances raise the question of whether to invite the population to financially cover this trans-generational solidarity.**

14. Are you expecting a review of the network of "strategic public healthcare providers" (37 hospitals, no primary care providers)?

Position of the Slovak Medical Chamber: We are not counting with such alternative. Although both ambulatory and hospital sector are in need of reform, we do not think that the Ministry of Health and the government will manage it in this fashion. We still think that it is necessary to reform both components. In the ambulatory sector, it is particularly necessary to strengthen the primary sector personally, technically, procedurally and infrastructurally. Theoretically, some aspects for the strengthening are available, but others are severely delayed. Possible introduction of integrated healthcare system in the ambulatory sector is a lengthy and costly process. And its comprehensive preparation has not progressed at all. No wonder that it raises fear resistance among doctors. Again, we declare that it is not possible to reform inpatient facilities including reduction of hospital capacities and to transform some of the hospitals to long-term care facilities without a comprehensive reform of outpatient sector and community services sector. It is there where most of integrated social and healthcare activities shall take place, and not in institutional care. There are many factors that stand against transformation of hospitals and ambulatory sector, but it seems the health sector does not take them into account at all. For example, no one thinks of the current status and

financial situation of municipalities and towns. There are about 2,891 independent municipalities in Slovakia, with more than 800 of them with less than 500 permanent residents. More than 69% of all municipalities in Slovakia has a population of less than a 1000 inhabitants, but only 16% of the population are living in them. This fragmentation will severely impede the integration of healthcare services, it may even stop it completely.

15. In your opinion, what measures should be taken to maintain consumption and spending on complementary services such as diagnostic imaging, laboratories, transportation and medical rescue services?

Position of the Slovak Medical Chamber: If we assess proposals of the Ministry of Finance in the publication *Review of Health Expenditure. Final Report, October 2016*, the demonstrated analysis and proposal to save finances are quite acceptable. In our opinion, measures such as benchmarking of prices of specific health materials with creation of a database of foreign prices (with expected savings of € 35 mil. in 2017 and € 45 mil. in 2018 and 2019), benchmarking of prices and strengthening of review activities of insurance companies in cases of purchases of medical activities (with estimated savings of € 15 mil.), optimization of purchasing medicines and special medical material in hospitals managed by the Ministry of Health (with expected savings of € 8 million), cost-effective procurement of medical equipment (with expected savings of € 3 mil.), reduction of unit prices of performances and limits for imaging (CT and MRI) examinations (with expected savings of € 10 mil. in the first year and € 16 and 22 mils. in 2018 and 2019) are reasonable. All planned savings relate only to the largest – state-owned health insurance company.

Planned measures related to reduction of prescription radio-diagnostic and laboratory examinations, as well as imposing limits on ambulatory providers (with expected savings of € 3 mil. in 2017-2019) are raising our doubts. For such measure these indicators should be monitored (1):

- the average number of radio-diagnostic examinations requested by physician per patient per year

- the average cost of laboratory tests requested by ambulatory doctors

- total costs for radio-diagnostic examinations

In 2014, there were 7.43 MRI machines per million inhabitants in the Czech Republic, 6.65 in Slovakia, 6.42 in Poland, 3.08 in Hungary, but 11.49 in the Netherlands, and 11.69 in Germany.

The number of CT machines in Slovakia is 15.33, 15.08 in the Czech Republic, there were 7.88 in Hungary and 17.17 in Poland. The Netherlands had 11.52 CT machines per million people and Germany 18.72 CT machines per million inhabitants in 2016.

The number of CT examinations per 1,000 inhabitants in Slovakia is 122.8, the OECD average is 119.8, the number of examinations in the Czech Republic is 98.5, 55.2 in Poland, 92.0 in Hungary, 70.8 in the Netherlands and 61.5 in Germany. The USA are the first with 241.4 examinations per 1 000 inhabitants.

In case of CT machines it means 83 units for the whole Slovakia in 2014. There were approximately 663.000 examinations performed, which means 8.000 examinations per CT unit per year. One day estimate is 22 tests of various kind, including emergency at night and through the weekend. That makes 0.9 examinations per hour (23).

Price reduction of number of examinations, together with change of behaviour of hospitals with full application of DRG reimbursements - including financial transfers to realizers of

MRI and CT by hospitals which use these services as "outsourcing" - could lead to a significant reduction in outpatient and hospital orders. Hospital would probably shift ordering of imaging services to ambulatory sector. All this in a situation when a part of orders can actually be caused by "defensive medicine", but also lack of diagnostic and treatment guidelines describing situations where a similar examination is actually indicated. Reduction of orders of CT and MR examinations of non-hospital doctors exceeding 90 percentile of average would, according to estimates, reduce CT scans orders by 11.7% and MR examinations by 6.4% per year. With expected reduction of prices in 2017 the alleged savings would amount to € 6.7 million in case of CT, and € 3 million in case of MR.

The multiple pressures on outpatient physicians (reduction of number of orders while transferring orders from hospitals to outpatient sector) may, however, in our view, compromise the patient and the risks it creates are not worth the saved funds.

Recommendation of the Slovak Medical Chamber: quickly start working on guidelines that describe the need for CT, MRI, PET and other examinations and will provide the benchmark against the pressure of defensive medicine.

16. What is your assessment of the efforts to introduce integrated healthcare in some of the 300 centres? Are there any implementation issues?

SUBJECT: Permanent Representation of the European Commission in Bratislava - Invitation for a meeting - fact-finding mission to Bratislava of the EU Commission: Healthcare Issues – Monday, 14 Nov. 2016, 14:45

- Proposal for the position of the Slovak Medical Chamber

The aim of the meeting is to analyse the recommendations of the European Commission in Slovakia identified for Slovakia in evaluation "Country Report" in 2015 for healthcare with a special focus on specific topics of interest regarding integrated healthcare, in order to best formulate recommendations of the European Commission for 2017. In particular, the European Commission is currently interested in progress of the Slovak Republic in healthcare issues identified in the project "Value for Money":

- integrated outpatient healthcare and strengthening the role of the general practitioner as gatekeeper (the first experience with ongoing efforts) and
- rationalisation of (inpatient) hospital care and the role of healthcare (outpatient) centres (the first experience with ongoing efforts).

Position of the Slovak Medical Chamber:

Integrated (outpatient) health care

The Slovak Medical Chamber did not reject the project, but has taken a restrained approach in context of conditions that the Chamber asked to explain, expand and accept, for doctors or other healthcare professionals to be are adequately protected against tampering with their private practices from the state power without involving them in dialogue, creation of documents and so on. The Slovak Medical Chamber repeatedly said in various forums that it does not reject integration of healthcare, but that it rejects physical centralization of doctors to the centres at arbitrariness of state officials without participation of doctors in question in the process of integration, at a time when it is just as good and maybe better for benefit of patients to consider also virtual integration, or rather, to combine virtual and physical integration there, where doctors would be interested.

However, it is true that the problem is currently the unclear position of the Ministry of Health of the Slovak Republic on the project. The project was rejected by the Ministry of Health itself by its ex-minister Viliam Čislák, MPH, MBA. The information went public approximately two months after the end of roundtable negotiations at the Ministry of Health on the issue of integration of healthcare and integrated healthcare centres in June 2015. To this day, the new leadership of the Ministry of Health of the Slovak Republic did not disprove this opinion in bilateral negotiations or publicly. Although we have an inside information that they currently, approximately in October 2016, the Ministry established and filled a position of Consultant - specialist for development of integrated healthcare. Thus, there has been no official activity from the Ministry of Health concerning this issue for about a year.

There have been no activities, or professionally very poor ones, from which may be inferred interest of the Ministry of Health in development of the problem in other ways, such as by adjusting the legislation and standard diagnostic and therapeutic procedures to achieve true integration. Unfortunately, the Slovak Medical Chamber must again conclude, similarly to the last meeting with the European Commission earlier this year, that apart from roundtable meetings in 2015, we do not experience any involvement of the professional public in creation

of documents relating to integrated healthcare, or rather, we experienced total disregard of professional organisations.

The Slovak Medical Chamber (SLK) in cooperation with the Slovak Medical Association (SLS) recently had to write a letter to the Ministry of Health, stating, that the Methodology of creation of standard diagnostic and therapeutic procedures published by the Ministry in the Journal of the Ministry of Health without any consultation with the Chamber or the Association, cannot be professionally accepted, just as the process in which it was adopted. Unfortunately, no other procedural tools were available. The Slovak Medical Chamber or the Slovak Medical Association did not have any possibility of making even a note that it would be appropriate to pay special attention to integration of healthcare in the process of creation of standards in order to eliminate risk for patient in the process of healthcare provision.

Likewise we have to state with regret that the Ministry of Health of the Slovak Republic, either deliberately or out of ignorance, has long been blocking adoption of important legislative changes that would contribute to development of integrated healthcare - such as definition of primary healthcare as multidisciplinary teamwork in the range of EXPH (Expert Panel on Effective ways of Investing in Health) recommendations, Report on Definition of a frame of reference in relation to primary care with a special emphasis on financing systems and referral systems, 10 July 2014[6]. Definition of secondary and tertiary care including long-term care is also still lacking in the legislation, and therefore their elaboration in the implementing legislation.

Definition of properly provided healthcare is lacking not only as care leading to detection of illness, but as well as care leading to identification of risk factors and causes of the disease, which would create more room for respecting the International Classification for Patient Safety.

There is lack of pressure on health insurance companies to comply with valid law and order and purchase real healthcare and not financial volumes as until now. There is also lack of definition of really basic healthcare and related regulation of payment mechanisms, that would better reflect sorting of medical services to those that a) must be performed and in any case, and always must be a fully paid from public health insurance; further b) such medical performances that may not be performed to save life, but it would be better for the quality of life of the patients if they were carried out and thus can be reimbursed through combination of public health insurance and private sources (mandatory/optional supplementary insurance, direct payments); and c) such medical interventions that not indicated in the specific case, and therefore, if they are carried out, they may be fully reimbursed through direct payment by the patient. The Chamber (SLK) and the Association (SLS) brought all these factors to attention of the new leadership of the Ministry of Health in a joint letter and theses to address public health problems, which were sent to the Ministry but also to all of the winning parliamentary political parties in March 2016.

[6] Available online: http://www.vpl.sk/files/file/uvodna/004_definitionprimarycare_sk.pdf

And finally – during roundtable discussions at the Ministry of Health on the issue of integrated healthcare, which took place in 2015, the Ministry of Health of the Slovak Republic pledged to adjust the implementation strategy, as well as the actual integrated program in sections related to non-profit organizations. These organisations could be beneficiaries of financial assistance in the sense that a broader definition of non-profit organizations, which is more common in Europe, i.e. not to the concrete Slovak "specific" Act (Act No. 213/1997 Coll. On Non-profit Organisations Providing Generally Beneficial Services) will be used, which in fact does not include all forms of non-profit organizations existing also under other laws (e.g. on citizens' associations, on foundations and the like), but contains only one form of non-profit organization, moreover, absolutely unsatisfactory in the process of creation of integrated centres. We provided the Ministry of Health with detailed explanation, both orally and in writing, during the proceedings of the discussions. We still perceive this as existentially threatening to individual private providers, but also to the centres themselves. So far, the adjustment has not been made, what further reduced credibility and transparency of the whole process relating to centres and therefore the Chamber prefers only regulation of the topic of integrated healthcare, but without the integrated centres.

Physician as gatekeeper

Due to above-mentioned reasons, the role of doctor as a gatekeeper is not evident in the system at all, nor the idea how the Ministry of Health plans to fulfil this obligation.

Rationalization of inpatient care and the role of integrated healthcare centres

The Slovak Medical Chamber has not seen any effort to optimize the network of inpatient or outpatient care so far. In addition to the regulation on minimal network of providers, the Chamber repeatedly proposed adoption of a regulation on the optimal network, including rules for its creation, which are still lacking, thus enabling arbitrary contracting of poor-quality providers of healthcare by health insurance companies, based on personal relationships and patronage at the expense of the high-quality ones, which are in demand by patients, but conclusion of contract on compensation of provided healthcare from public health insurance funds is not transparently enforceable. The optimal network should be compiled so that it will not only take into account the real needs of patients (population health) and available capacity of healthcare workers, as well as other professionally acceptable criteria to eliminate the risk for patients. While optimizing the network, it shall be established: criteria for creation of hierarchy of hospitals to teaching, provincial and municipal; introduction of methods for shortening hidden waiting times for patients to be examined in outpatient care; definition of statute of rights of the worker of the University/Teaching Hospital; development of network of long-term care providers and the like.

The Slovak Medical Chamber has been also trying to introduce concertation procedure into the system of reimbursement of provided healthcare, so that the level of prices used in the reimbursement system reflect quality, access to health care in the territory and needs of

patients more and not the lowest price and margin payments. Payments for the state-insured must be based on expenditures on their health care. Unfortunately, according to our experience, so far, it has almost always been to the detriment of quality and patient in Slovakia. Corruption cases and transfers of funds from public health insurance outside the healthcare system and the Slovak Republic (the case of € 400 mil. of public money of the Slovak citizens payed to shareholders of health insurance company Dôvera [7]) remain open and therefore to the detriment of citizens of Slovakia, who "collected" the funds in solidarity for the purpose of providing healthcare. Due to faulty use of these funds medical care is now becoming unavailable to them in the Slovak Republic. Due to health restrictions and without adequate healthcare they are not able to fully perform their work duties and therefore they are becoming poorer.

As with outpatient healthcare, inpatient care is also lacking standard diagnostic and therapeutic procedures that would prevent hospitals from inducing patients to the hospital through its own centres or misusing of networked centres owned by the same owner extrapolated outside the hospital. It is true that it is not possible to identify the role of centres because of lack of transparent legislative instruments (definition of care, definition of correctly provided care, etc.) and communication, and as described above, it is not possible to identify the role of physician as gatekeeper at the centres.

In general

Furthermore, the communication by the Ministry of Health was also blocked, for example, by establishing of a new portal for legislation process, but mandatory commentators such as professional organizations, which under applicable law includes the Chamber, have no opportunity for consultation and participation in creation of regulations before they are posted on the portal. Although the Ministry of Health still declares the effort to communicate, in clauses to the legislation concerning the consultation process for its creation work it does not hesitate to say that before a document is posted on the portal there has been no professional discussion or even participatory document creation with involvement of public.

Thus, we can only say that results of the first efforts are not visible, because there is no evident effort, but rather lax, amateur or no approach, absence of real professional communication, and "sweeping" real problems of patients and professional public under the rug, which has been, unfortunately, to the detriment of all concerned currently, but also in the long term. Unfortunately, despite several meetings with the Minister of Health we do not record in any progress on the issue in practice.

Pharma expenditure

17. What is your assessment of the progress of external reference pricing system for medicines, with its different phases since 2011? Has the growth in pharmaceuticals expenditures been sufficiently contained or does it remain high?

[7] http://spravy.pravda.sk/ekonomika/clanok/323776-stat-sa-prizera-na-odlev-penazi-zo-zdravotnictva/, http://ekonomika.sme.sk/c/6454111/penta-a-prefto-zalozili-doveru-a-vyplatili-si-miliony-eur.html, http://dolezite.sk/old/dovera_za_Doveru_dalsi_megapodvod_na_obcanoch_230.html

Position of the Slovak Medical Chamber:

While reducing the average price of medicines, the method of referencing the prices of medicines by comparing the three lowest prices for medicines in the European Union induced a massive re-export of medicines abroad. One can assume that this re-exports will tend to rise, especially in relation to the amendment of Act No. the Act No. 363/2011 Coll. on the Scope and Conditions of Reimbursement of Drugs, Medical Devices and Dietary Foods covered by Public Health Insurance and on amending certain laws, which will come into effect soon. The amendment of this Act with measures against re-export shall take effect from 1. January 2017 and it should hinder re-exports significantly by transferring its responsibilities to marketing authorization holders and importers. Distributors along with a few pharmacies who currently dominate this business, can get penalized for breaching the law. In connection with re-export of medicines the number of distribution companies increased, although the vast majority of them even do not supply medicines to pharmacies. Recently they even stopped reporting the re-export to the State Institute for Drug Control. The scope of their business is estimated between € 300-500 million. At the same time, there has been a supply gap of medicines in pharmacies, including generics, which are worth exporting.

The Slovak Medical Chamber is concerned that even the amendment of the above-mentioned Act will not be able to hamper the re-export significantly. One option is to return to the original benchmarking, while comparing more countries than the three cheapest ones, medicine-wises. However, this would probably increase demands for reimbursement of medicines by health insurance companies and patients.

Paradoxically, in spite of cheaper medicines thanks to current referencing, household expenses on medicines increased to the (relative) level of households in Switzerland. Returning of co-payments for medicines to selected underprivileged and vulnerable groups after exceeding co-payment limits did not help. While the Czech Republic, Poland and Hungary reported spending on medical goods including medicines of around $ 483, in Slovakia it amounts to $ 669. It is a fact that some countries report “distribution” rates (the Czech Republic), others report rates after "purchase" (Slovakia, for example).

According to analysts from the Ministry of Finance this may be a result of high consumption of medicines and an inefficient system of reimbursement from health insurance, as well as methodological differences in reporting of individual countries. High consumption is induced by the offer of over-the-counter/out -of-pocket medicines in pharmacies. The reasons of high level of prescription is also the dysfunctional state information system (e.g. electronic prescription), which some insurance companies already started to replace with their own systems and practices improving the motivation of doctors to save. The amount of funds for medicines, however, is being pulled up mainly by expensive - for example, but not limited to - oncological medicines. Any such drugs should be covered by health insurance only after the so-called categorization, by which the importer or rather the permit holder must sufficiently demonstrate that the medicine improves quality of life for a period of one year, with the threshold amount for the payment for this life when covered by health insurance companies accounts for 24-times the average wage in the national economy.

In conclusion, we can state that the growth of payments, expenditures on medicines has not yet been curbed.

Suggestion of the Slovak Medical Chamber: rather than punitive tool against doctors in general with regard to prescribing, motivational and behavioural interventions could help, along with established guidelines (standard treatment guidelines), reducing the number of physician visits associated with induced prescription, introduction of electronic insurance card, e-prescription, electronic systems actively drawing attention to possible interactions of prescribed medicines and medicines that the patient is already taking, and so on. However, when prescribing expensive oncological medicines, for example, the situation of doctors is often delicate and sometimes critical – they are moving in the area of impact of the Occam's razor. The classical deliberation of Occam's razor says: *If there are several explanations of an an event, it is better to favour the least complicated one*. In case of doctors and expensive categorized medications they do not think about the definition and price of quality of life, and methods for their determination, but often about improving the condition of critically ill patients and giving them a chance to prolong their life. A standard medical procedure - although we have fundamental objections against this title and its legislative basis in our country – may - or may not - help overcome it.

18. Are there plans to centralise procurement of (expensive) pharmaceuticals?

Position of the Slovak Medical Chamber: Centralized purchasing of medications has been carried out by health insurance companies for years. However - according to our information - - it is an ad hoc basis system where insurance companies are trying to buy expensive medications cheaper than it´s determined by the maximum prices of medicines fixed within the current categorization. Often, they manage to negotiate prices that are lower than those of the categorization. This points to the fact that the Categorization Committee or Council should significantly improve their performance. Preliminary analysis actually highlighted the need to review cost-effectiveness of 147 medications with payment of € 283 million in 2015. We support improved practice of the Categorization Committee, but we also want a public debate on methodology for determining the "price of living a year of quality life" to take place in Slovakia. **At the same time, we do not want the results of work of the Categorization Commission to become a tool for extortion of doctors and of obstructing patients' access to the most modern medicines.**

Recommendation of the Slovak Medical Chamber: see above.

19. What is the current status of the use of generics?

Position of the Slovak Medical Chamber: According to our information, the share of generic drugs on consumption of medicines was among the highest in Europe. Neither the United Kingdom, where exists an obligation to prescribe only active substance, has not yet reached the level of generic prescribing in Slovakia. It is true that generic prescription of medicines in Slovakia has fallen by 10 per cent during the last six years, but introduction of

the obligation for doctors to prescribe only the active ingredient is means moving the decision-making powers to the pharmacists and may be partly affected by the current level of their margin.

The compulsory disclosure of financial and non-financial performance of physicians by pharmaceutical companies partially reduces the risk of possibility of their improper motivation. We do not know, however, about existence of the same obligation for pharmacists, or rather for pharmacies.

Recommendation of the Slovak Medical Chamber: to maintain the current system of prescribing supported by fair motivation of doctors by health insurance companies and protection of patients.

E-health system and data collection

20. What is your opinion on the current efforts to introduce the e-Health system which should include electronic health records, e-prescriptions and e-referrals and e-health portal? What are further plans in this area?

Position of the Slovak Medical Chamber: In our opinion, history of approving of the e-Health project, its creation and its implementation in practice is a history of stalling, of political abuse of a professional issue, corruption and incompetence. We have been waiting for the system for more than 10 years. Currently, there are only three hospitals and laboratories belonging to the group that owns one of them, in test practice. Meanwhile, the company Svet zdravia (Health World), currently associating 15 hospitals, introduced an information system that can communicate with ambulatory physicians to share real information about their patients who were hospitalized in hospitals of the company. We do not have more information about the system. For example, we do not know as who will pay for the system maintenance or for its changes due to legislation. **We do not know who will pay for input of basic information on insured persons onto the electronic medical records platform.** We know nothing about evaluation of the pilot phase of the project, nor about the date of the official start.

We do not know how the system is secured against data leakage. We are waiting whether legislation will change in the context of e-Health in terms of extension of security standards and the client's – patient´s power of attorney, for example (**24, 25**). Communication with stakeholders, but especially with the public is failing. After bad experiences from the past and international experience, we believe that the process of introducing eHealth - particularly of the electronic health card will take years.

Recommendation of the Slovak Medical Chamber: it is necessary to improve communication with experts and representatives of patients but also with the general public.

21. Do you see any gaps in information systems and collection of data monitoring of healthcare services use and performance assessment of the healthcare system?

Position of the Slovak Medical Chamber: In this case, we see several weak points.

Collection of information is in competence of the National Health Information Center (NCZI). On its website, it states: *"National Health Information Centre (NHIC) collects and processes selected data on health status of a population, on network and activities of health care providers and other organisations, on health workforce, medical equipment as well as on economy of health service including health care funding provided on the basis of health insurance, etc. NHIC performs tasks and activities related to the administration, updating and processing of national health registries data. The obtained and processed data are subsequently provided in the required form, extent and structure to the Ministry of Health of the Slovak Republic (MH SR), the Statistical Office of the Slovak Republic, chief experts of MH SR as well as foreign data users, namely WHO, OECD and Eurostat. NHIC regularly edits some data in statistical reports that are publicly available."*

Another source of information are the health insurance companies, particularly the public health insurance company. All private health insurance companies are also obliged to collect and publish some of the data, the scope of disclosure, however, is smaller than that of the state insurance company. Information is also collected by the Health Care Surveillance Authority.

For years, the sum of data has been accumulated without any meaningful use. Neither the Ministry of Health, nor the Health Care Surveillance Authority later did not have actionable analytical units, or rather centres which would analyse the data and provide assessments and recommendations. Until now we don´t have a framework to evaluate performance and quality of our healthcare system. The first evaluation of the performance but also of the efficiency of the healthcare system in Slovakia was prepared years later by the Ministry of Finance in December 2012 (2). The authors of evaluation complained about incompleteness and qualitative inadequacy of the data obtained. Later, foreign publications from the OECD, IMF and ultimately from the European Commission appeared. While performance of the Slovak healthcare system is impressive, there are still doubts about its quality and effectiveness. The reason for this is partly the reporting of incorrect data. One example is the data on mortality of diagnoses of so-called amenable mortality. High numbers of cardiovascular deaths were the cause of their review within the project of National Healthcare Information Centre (NHIC) and WHO, for the first time in 2011 (National Seminar within the Two-year agreement between the Ministry of Health and WHO in 2014/2015: Prevention and control of chronic non-communicable diseases in Slovakia, 02.04.2015, the Ministry of Health of the Slovak Republic (26).

The project evaluated the diagnoses of cardiovascular causes of death. Revising the causes of death was not only limited to patients in hospitals where findings found in death certificates were discussed with the physicians, but all deaths were revised. In 2011, 3,683 people (out of a total of 51,903 deaths) "travelled" from cardiovascular disease to other groups of causes of death. In 2012 it was 4,177 people out of a total of 52,437 deaths. The number of deaths in the chapter of cardiovascular causes decreased in category of men and women in the range between 12-14%. All death certificates in the following years were allegedly subjected to revision. Also in another study, the authors from the NHIC evaluated 7,000 deaths with a

group of diagnoses of acute coronary syndrome as the primary cause of death based on the set death certificates from years 2007-2008. The study found that at the biggest risk of lack of objectivity when defining the diagnoses of the cause of death were cases of death at home, without dissection and without previous hospitalization for chronic heart disease. As many as 40.9% (!) of cases of death, officially considered due to ACS in 2007 and 2008 were disputable. In the Czech Republic, it was approximately 27% of such cases at the time (27).

Similar figures undermine the credibility of diagnosing the causes of cases of amenable death. Problems with determining the primary cause of death were also found in cases of fracture of the femur (death within three months of the event), chronic obstructive pulmonary disease, dementia and cancer. While the frequency of some of these deaths is lower than deaths from cardiovascular disease, they are increasing. In case of cancer there were no such differences in the summary between 2011 and 2012. However, there were significant transfers among oncological diagnoses within their group. NHIC will reportedly continue reviewing these diagnoses in the following years (Anna Baráková, MD, NHIC, personal statement). The fact is that there are several thousand doctors in Slovakia who are certified to carry out post-mortem examinations. Most of them are only occasional coroners. Although the administrator of this activity (Health Care Surveillance Authority) performs almost continuous trainings, it is likely to improve the quality of post-mortem examinations sufficiently.

Summary: the system needs more accurate information on performance, quality and efficiency. It needs to create a functional framework for these assessments.

Recommendation of the Slovak Medical Chamber:

1. It is necessary to create a convenient framework for evaluating the performance of Slovak healthcare system (HSPA).

2. It is necessary to create a better system for data collection on diagnoses that cause deaths, together with the establishment of electronic form of death certificate that would meet the WHO standards with software, indicating any inconsistency of registered diagnoses (for example WHO-IRIS).

3. It is necessary to consider at least partial professionalization of "coroner" activities, initially in those localities where it is possible. In this case, however, it would not be "real" coroners performing also autopsies. It would be people much better educated for professional post-mortem examination of dead body and filling out death certificates. The coroner may not just be pathologists, but as until now also other medical specialties. Their remuneration should therefore be increased.

22. Are there any plans to implement any type of Health Systems Performance Assessment (HSPA)?

Position of the Slovak Medical Chamber: We are not aware of any specific plans. We believe a convenient framework is necessary. There is plenty of international knowledge

which has already been used as a source. According to our information we are represented in the Expert Group on Health Systems Performance Assessment (HSPA) (28), established in 2014 at the European Commission level, with an aim to:

• Provide participating Member States with a forum for exchange of experience on the use of HSPA at national level.

• Support national policy-makers by identifying tools and methodologies for developing HSPA.

• Define criteria and procedures for selecting priority areas for HSPA at national level, as well as for selecting priority areas that could be assessed EU-wide in order to illustrate and better understand variations in the performance of national health systems

• Intensify EU cooperation with international organisations, in particular the OECD and the WHO (Health systems performance assessment (HSPA) - Terms of reference for an expert group) (29)

The rules of procedure adopted at the beginning of activity of this expert group states in Article I - Introductory provisions, Paragraph 3), that:

The Expert Group shall focus its activities on strategic issues relevant to EU cooperation on HSPA with the following specific objectives of:

• Provide participating Member States with a forum for exchange of experience on the use of HSPA at national level.

• Support national policy-makers by identifying tools and methodologies for developing HSPA.

• Define criteria and procedures for selecting priority areas for HSPA at national level, as well as for selecting priority areas that could be Assessed EU-wide in order to illustrate and better understand variations in the performance of national health systems.

• Intensify EU cooperation with international organizations, in particular the OECD and the WHO (30).

Unfortunately, Slovakia did not benefit from work and possible outcomes of the commission so far not and we did not observe any interest in its activities. Except the assessment of the situation of health system of Belgium and principles of selection or creation of relevant indicators for assessment we haven´t learned much from publicly available data. Therefore, the Slovak Medical Chamber will approach the Ministry of Health, whose representative should be a member of this committee, to make more materials about its activities available to us, or we will contact the European Commission directly. We believe that current system of indicators, their creation, processing and evaluation still and by far does not allow for international comparisons, in which it is necessary to take into account historical development of healthcare systems. We also have reservations about some tools (used in assessing the effectiveness of healthcare systems) regarding their use - for example, in this

publication (31). Our reservations relate to validity of used indicators obtained for the OECD via questionnaire (32), as well as the subsequent use of DEA analysis. It should be noted that, for example, while in some countries, the indicator of life expectancy grew almost continuously, positive changes in its development in our country happened only after the year 2000. We don´t want to state that the healthcare system in our country has been effective in the past decade and now, however, it is necessary to obtain data on how (too much spending on bad decisions), in what (amenable mortality) and where (significant regional and probably already ethnic disparities, too).

The need for changes in method of obtaining primary data is revealed also in a story of indicator connected to years spent in good health in Slovakia (33), where a small change in the Slovak translation of the original question formulated in English caused a decrease in number of years of life health by two years in Slovakia despite the fact life expectancy in Slovakia between years 2004-2012 grew by more than two years and five European Union countries still lagged behind us. Even Hungary, which lagged by one year behind Slovakia in the length of survival "enjoyed" seven years of living longer in good health than us, and the Czechs, with whom we were at the same level, even eight years (34).

These numbers were then analysed at international level. Slovak statistics also failed in case of diagnoses of basic causes of death, although after 2010 these numbers have been "fixed", not on the primary level, but only at the level of the National Healthcare Information Centre. However, previous data were also not a basis for international analyses and comparisons.

Suggestion of the Slovak Medical Chamber: It is necessary to quickly prepare an improved internationally comparable framework (system) of performance assessment (and effectiveness) of healthcare, to identify vulnerabilities of primary data collection and its processing including collection of qualitative information (35, 36, 37, 38).

More is mentioned above.

Healthcare workforce

23. What is the status quo of the residential programme for general practitioners? Have there been any changes to the training of GPs?

Position of the Slovak Medical Chamber: The residency program will continue in 2017 and there will be € 5 million allocated for it from the state budget. The conditions for admission to the residency program did not change either (39). In years 2015 - 2016 it has been attended by approximately 200 future general practitioners, but this number is not validated by the authority of the Ministry of Health. In the opinion of the Slovak Medical Chamber, the Residency program can barely make up for the decrease of general practitioners due to aging. In any case there will be no increase in the number of general practitioners, which is much smaller compared to countries where primary healthcare system works. Skills that would move general practitioner closer to a family doctor typology, should be gained within the program, although we have rejected this type of care during the communist era.

24. Are there any new plans to make the GP profession more attractive, including performance based incentives?

Position of the Slovak Medical Chamber: Slovak Medical Chamber currently isn´t aware of any direct performance incentives of general practitioners. However, health insurance companies have introduced some indirect motivation concerning qualitative and quantitative level of prescribing, or performing some preventive examinations and testing. Several of these "incentives" are sometimes rather ruthless pressuring of doctors and to the detriment of patients. In order to reduce the number of examinations performed by outpatient specialists, for years, the insurance companies have been making deals with outpatient specialists on the volume of financing which they are willing to pay to them individually, instead of ordering specific volumes of performances. This process doesn´t have a legal foundation, but it prevailed in daily practice. In some cases, insurers not only do not order performances, but they rather determine which performances may be carried out by a doctor (?!). Legally, as well as market position-wise, the insurer is in a far-stronger position than an individual doctor. For patients, however, it has a number of adverse effects. One of them is that medical specialists typically stop taking appointments from patients after exhausting financial limits. That prolongs waiting time of patients for a specialist appointment. In case of acute patients who doctors must examine even after exceeding their "financial threshold" – they don´t have to get paid for the performance by the insurance company, despite the fact that the insurance company will record the performances as recognized (but not reimbursed). To our knowledge, legal claim of a doctor has not been addressed in court yet, except in one case in which the Constitutional Court agreed with the plaintiff doctor. There is no control authority which would monitor contractual relationships, the Health Care Surveillance Authority allegedly does not have the competence to assess and review these contracts. Very similar and basically legally uncovered contracting mechanism is working between health insurance companies and hospitals. Health insurance companies determine the volume of admissions and hospitalizations and they won´t pay for hospitalizations over the limit. The most effective weapon of outpatient doctors is a threat that in the next round of negotiations they will start providing their services for direct payments (cash) with requirement that clients of health insurance companies collect the money paid for them. Hospitals can terminate their contracts with health insurance companies and then negotiate. Collective bargaining through professional organizations is thus more efficient.

Suggestion of the Slovak Medical Chamber: To establish a **generally applicable regulation on negotiation and resolution of disputes when concluding contracts on provision of healthcare. Another option is to legally embed the organization of outpatient sector doctors negotiating contracts for healthcare, or an intermediary reimbursing individual practitioners. In this case, the proposal (Slovak Medical Chamber - unpublished) is in its details partially similar to the German model of organization of doctors contracted to health insurance companies (KBV).**

25 Are the GPs using their competences to act as gatekeepers sufficiently? Are there any plans to further broaden scope of their competences?

Position of the Slovak Medical Chamber:
The publication *"Review of Healthcare Expenditure*" states on page 45: In a long-term, Slovakia has substantially higher number of consultations with a doctor than the average of V3, the EU and the OECD. Fees are one of the possible causes of change of number of visits to the doctor. In 2013, Slovakia had an average of 11 consultations per capita, in V3 it was 10, in OECD and EU-28 it was only 7. Between 2002-2006 the number of doctor visits in Slovakia decreased by 20%, during the same period a fee for seeing a doctor in the amount of 20 SKK (€ 0,66) has been in force. After 2006, after cancellation of this charge, the number of doctor visits increased by 7.7% year on year. The issue of visits to the doctor is addressed in a separate project of the Ministry of Health called **Payments and Surcharges**. The number of doctors´ visits may affected also by introduction of referrals, but the impact is ambiguous. On the one hand, they enhance the role of the general practitioner with regard to patient management (gatekeeping), leading to fewer visits to specialists, on the other hand, the patient needs to pick up a referral ticket with the GP, which increases number of visits. Referral tickets were repeatedly introduced and abolished in Slovakia. Impact on the number of visits is not visible, with possible exception of years 2008-2011, when the number of visits decreased by an average of one visit. However, the above-mentioned text indicates that introduction of fees in 2002-2006 affected the decrease in visits to the doctor - not just general practitioners. It disrupted the then practice, that specialist referred a patient to another specialist without consulting his general practitioner. That meant multiple payments for the patient. Theoretically, this condition could be partly met by a fee and a visit to the specialist without a referral from a general practitioner. The system of referrals is not effective in the current situation because it does not reduce the number of visits to specialists. We can probably expect that the first extended competences would reduce the number of visits, but not nearly to the level of the OECD average. The fact that we still have approximately the same frequency of visits to doctors with the Czech Republic suggests rather the same erroneous (different) method of reporting visits to the doctor. than similar behaviour of patients. Although the OECD has an operational definition of physician visits (see. below), this may be different from the reality in individual countries. For example, a visit only for the purpose of prescribing medications may not be construed as consultation. It would, however, be necessary to explore operational characteristics of the indicator of physician consultations in these countries. Another reason for high numbers is the low number of general practitioners, which is for example 2.5x lower than in Germany and also lower than in other countries. The so-called. patient tribe in capitation of a general practitioner is then much higher, increasing the probability of consultation.

We believe that the statistical number of visits would be reduced through re - definition of the indicator. Further enlargement of competences and the use of them by general practitioners and their progress towards the competencies of a so-called family doctor is a long and difficult process. However, it would decrease the number of visits to specialists. Also, integration of activities of general practitioners and transfer of some competencies to outpatient nurses might have some effect. And these competencies might not be small. They

are being transferred in many countries and greatly reduced the burden of physician with often administrative tasks and activities. The significant increase of number of general practitioners is utopia and we are concerned that the so-called Residency Program will not replace their natural decline.

Suggestion of the Slovak Medical Chamber: In addition to other responsibilities of general practitioners, which will require improvement of their professional level and skills, it will be necessary to extend the competence of nurses in primary level as well. Especially in case of building integration of healthcare services, in addition to practical performance of healthcare services extended responsibilities they will also perform management operations on leading management level (senior level).

26. Are there any plans to provide for new clinical guidelines?

Position of the Slovak Medical Chamber: Barely two months ago, we got a document entitled "Odborné usmernenie Ministerstva zdravotníctva Slovenskej republiky, ktorým sa určuje metodika pre tvorbu a implementáciu štandardných diagnostických postupov a terapeutických postupov." In English it´s about: *„Vocational guidance Slovak Ministry of Health on establishing the methodology for the creation and implementation of standard diagnostic and therapeutic procedures.*" This material has been approved by the Ministry of Health without comments from the professional public, which we consider outrageous. Not least because the legal regulation of the Act No. 576/2004 on healthcare and on services related to healthcare and amending certain laws of 21. October 2004, as amended, in the seventh section entitled Performance of State Administration under section 7, §46, Article 1) for the Ministry of Health determines - among other things - that according to letter

a) *drafts principal directions and priorities for development of public health policy, under subparagraph b) drafts principal directions and priorities for development of public health policy, and according to c)* ***issues standard diagnostic procedures and therapeutic standard procedures*****, thus not determining even the methodology of their creation, nor their content**. It is a flagrant breach of the law, but also of the generally accepted principle that this area is domain of professional organisations. The fact that this sub-statutory (lower) code is in contradiction with the law on healthcare is likely caused by at least two reasons. The first is that the Ministry is "rushing" and the second is that this speed and the rules on confidentiality stem from the fact that drafting of standard diagnostic and therapeutic procedures is financed from the Operational Programme Human Resources.

In the program of the 111. sessions of the Government of the Slovak Republic on 17. September 2008 the Minister of Health presented a draft concept for creation of standard diagnostic and therapeutic procedures. The Government adopted it by Resolution No. 628/2008.

During stakeholder consultation, only the first comment of the Slovak Medical Chamber was reviewed:

1. *The document does not clearly state the relationship between standard diagnostic and therapeutic procedures and the "single clinical protocol approved be the Ministry of Health of the Slovak Republic"*

However, the key comment, which was directed to the Ministry of Health of the Slovak Republic as the submitter, by the then President of the Slovak Medical Chamber, Prof. Milan Dragula, Ph.D., is not a part of the material. **It concerned the fact that the Slovak Medical Chamber objects to the competency of the Ministry of Health to issue standard diagnostic and therapeutic procedures and requests returning this competency to the hands of physicians**.

The other stakeholder – the Slovak Medical Society – did not comment at all at the time **(40,41,42)**..

The document *Implementation strategy for the development of standard clinical procedures and standard procedures for the exercise of the prevention* of August 2014, on the page 6 states that ***Slovak generally binding legal regulations do not contain a more detailed definition, description of the purpose and content of the standard diagnostic and therapeutic procedures.*** *However, if we compare the above mentioned, it is obvious that the approach of Slovak legislators is narrower and the purpose of standard diagnostic and therapeutic procedures under the Act on healthcare is more on the normative side than just a recommendation.* While the Slovak Healthcare Act (Act č.576 / 2004 Coll) works with the term "standard" as a legislative term directly in this Act, NICE reflects that clinical recommendations "can be used" (and therefore they do not have to be) to prepare standards only as one of the possibilities of their use **(43.44).** On page 12 - after analysing the advantages and disadvantages of issuing standard diagnostic and therapeutic procedures as binding legislation or as (professional) guidelines, it states that: "*We consider it necessary to add a legal definition of SDTP to the Act."*

For STDP, issued under the authority of the Ministry of Health, to maintain the necessary professional seriousness and formal level, we propose to create a detailed methodology of their creation and this methodology was released as a generally binding regulation."

Eventually, however, this material was issued as professional guidance - which is not a generally binding regulation. Unfortunately, it was not consulted - as noted above, with the professional community. We could say that the authority of the Ministry of Health did not become legally binding. Even so, however, the methodology of creating diagnostic and therapeutic process is out of the purview of professional medical organisations, or rather, the suggestion of the Slovak Medical Chamber did not become reality – an independent centre for creation, verification, implementation and monitoring of professional regulations - guidelines

for diagnosis and treatment of clinical and preventive area and, in case of evidence based data and evidence also for health promotion, was not established.

The current model of participation in formulation and implementation: Ministry of Health -> the main experts -> experts/specialists is uncommon in Europe.

Suggestion of the Slovak Medical Chamber: Planned EU funding will require **establishment of an organizational unit** - professional background of the project, which will be coordinating the project professionally (selection of topics, organization of their processing), as well as operationally (financial uptake and reporting costs). This institution should be - in the professional part - maintained even after termination of EU funding in order to preserve the continuity of creation and innovation of these recommendations (Implementation Strategy for Development of Standard Clinical Procedures and Standard Procedures for Performance of Prevention of August 2014). Rather than the Ministry of Health we suggest an independent public institution. **We also recommend permanent scientific monitoring of areas that do not have evidence based data of sufficient force for diagnosis or treatment. There are it will still many more of them than evidence based ones and they are of nature of options, dependent inter alia on preferences of doctors as well as patients, and are often fragile to finance. These areas also require independent professional guidance supported by adequate financial background.** (**45, 46, 47**)

27. Are there any indications of difficulties that Slovakia might experience currently or in the future with regard to ensuring the sufficient number of medical professionals?

Position of the Slovak Medical Chamber: There are indications already in stage of obvious facts. The examples include: a lower the number of **licensed** physicians per capita than the OECD average, that is, practicing doctors. The share of general practitioners in the total number of licensed physicians is declining – currently they amount to14%, which is more than in neighbouring Hungary. In Poland, the portion is 12%, in the Czech Republic 15%. By contrast, there are only 5% in Greece, while the OECD average is 29%. Countries such as Sweden, Denmark, Norway and Switzerland also have a lower average than the OECD. We think the share of these doctors will not increase in Slovakia, rather the opposite. Specialists will prevail in the outpatient sector. This will require certain precautions as specialist medicine is more expensive than that of general practitioners. And healthcare systems of these countries are relatively expensive as well. For example, the share of general practitioners is also only 12 % in the United States. The highest share of general practitioners is in Ireland (60%). In Slovakia, the number of all doctors per 1,000 inhabitants - irrespective of whether they are licensed or not - was the same in 2012 as in 2000, i.e. 3.4. The actual number of practicing physicians is approximately 5-10% lower, which contributed to overestimation, for example of Portugal. Thus, the number of doctors was stable. What is worse is the growing number of doctors who are nearing retirement. The OECD average in 2002 was 19%, in 2013 it was 33%, similar as with licensed nurses. The youngest doctors were in the United Kingdom in 2013, there is still approximately 13% doctors over the age of 55. There was 36%

of doctors over 55 years in 2013 in Slovakia, 37% in the Czech Republic and 40% in Hungary (**48**).

28. Is there any danger of disrupting the work of hospitals/healthcare centres?

Position of the Slovak Medical Chamber: There is, in the period when the state budget is being approved and financial contribution of the state for the so-called state insures is being apportioned. The Healthcare Surveillance Centre Authority issues a lot of information in its annual report on performance of health insurance, but an indicator that informs about how much "costs" health insurance for state insured, is lacking. Since these are persons with many health risks, it is not a small sum and it is estimated that the level of the costs of health insurance for them is much higher than is covered by the state (50 percent or more). This creates a system of twofold solidarity when contributors are paying for healthcare not only for the other contributors but also for those who do not contribute. Thus, figuratively speaking, they are "in solidarity with the state". On the contrary, various reductions in the system of mandatory insurance payments, associated with reduction of the state subsidy and other factors create a situation of potentially impending lack of funds in the system. We already experienced similar situations when the state had to increase its contribution to health insurance in the last months of the year. Without this contribution, hospitals would have to reduce the scope of healthcare significantly at the end of the year.

In addition to finances, there is also a factor of healthcare workforce. Their increased income is a potential threat to the functioning of outpatient and inpatient healthcare, especially if there is also limited ordering of outpatient and inpatient performances, thus reducing the income of providers. The third factor is growth of debts of state hospitals, limited cash flow, threats of execution. The Ministry of Finance forecast for 2017 is favourable so far, increased employment, along with some other measures on the revenue (and expenditure) side should ensure stable funding for 2017.

Accessibility and Health outcomes

29. To what extent does the high level of private and out-of-pocket (including informal) payments affect the accessibility of healthcare?

Position the Slovak Medical Chamber: The publication of the Ministry of Finance and the Ministry of Health *Review of Health Expenditure. Final report, October 2016* states on page 22: Thanks to referencing/benchmarking, Slovakia has some of the lowest prices of medicines and medical devices in the EU-13, but in per capita it spends more on medical goods including medicines compared to the surrounding countries. While the Czech Republic, Poland and Hungary spent 483 USD per capita on medical products including medicines in 2014, this expenditure reached 669 USD (public and private) in Slovakia (1). According to analysts from the Ministry of Finance of the Slovak Republic the cause may be high

consumption and inefficient system of reimbursement from health insurance, as well as methodological differences in reporting of individual countries. For a more precise answer we, just like them, need to know the structure of out-of-pocket payments. We have only assumptions that we will not write about - in any case, what also plays a role here is advertising and susceptibility of population to tackle musculoskeletal problems by buying medicines of the ATC group out of pocket. Possible orientation of pharmacies in profit, or rather margin improvements can also affect that. *"More education is more,than more bussiness,"* is probably also true for pharmacies

30. What has been progress with the health status/outcomes? Have there been satisfactory improvements?

Position of the Slovak Medical Chamber: We show the evolution of only one of the monitored health indicators and its comparison with the country with whose population we lived in a common political arrangement for several decades.

In 1960, the life expectancy at birth in Slovakia was 70.3 years. In 1990, 71.2 years; in 2000 it was 73.4 years; in 2013, 76.5 years. In 2014 it was 76.9 years.

In the Czech Republic, it was in 70.2 years; 71.6 years in 1990; 75.1 years in 2000; 78.3 years in 2013 and 78.5 years in 2014.

In 1960 the difference was only 0.1 years in favour of the Czech Republic, in 1990 it was 0.4 years, in 2000 the difference was 1.4 years and in 2014 the difference increased to 1.6 years.

After the change of political regime - that is, during 24 years the average life expectancy of Czechs increased in 2014 by 1.5 years compared to Slovaks. This and several other indicators - despite weaknesses in their collection in Slovakia - indicate a high probability of a weaker impact of healthcare on the health status of population compared to some other European Union countries. Identification of internal causes of this phenomenon and removing them is crucial. However, studies indicate that the inhabitants of Slovakia are lagging behind on the scale and pace of lifestyle changes. Despite the prolonged period of its effect, a lifestyle change should be considered as important a factor of public policy as healthcare. And this is not happening yet.

Investments

31. How do you assess plans for a new university hospital in Bratislava?

Position of the Slovak Medical Chamber:

After the meeting of Minister of Health with representatives of the Slovak Medical Chamber and the Slovak Medical Association we issued a joint statement of the two organizations, in which we prefer termination of the initial process of public - private partnership regarding construction of a new hospital in the area, which in our opinion did not suit in terms of space,

traffic and urbanization or logistically. We supported the construction of a new hospital in another, in our opinion – more promising area, with financial backing of the state, relying on the financial analysis of the Institute of Financial Policy of the Ministry of Finance.

The project has many issues to overcome, including delayed start of construction, but we hope that a wise decision will be will made shortly, which we consider, in our opinion, the joint construction of a top facility guaranteed by the state. We have already heard about intentions of private investors to build also a larger hospital in Bratislava, but this should rather hasten than shut down the construction of the above-mentioned hospital, already because the infrastructure of Bratislava's hospitals is obsolete and it is very likely that in 10 years it will be possible to close at least one of these older facilities.

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