



**ASSOCIATION EUROPÉENNE DES MÉDECINS DES HÔPITAUX
EUROPEAN ASSOCIATION OF SENIOR HOSPITAL PHYSICIANS
EUROPÄISCHE VEREINIGUNG DER LEITENDEN KRANKENHAUSÄRZTE
EUROPESE VERENIGING VAN STAFARTSEN
DEN EUROPÆISKE OVERLÆGEFORENING
ΕΥΡΩΠΑΪΚΟΣ ΣΥΛΛΟΓΟΣ ΝΟΣΟΚΟΜΕΙΑΚΩΝ ΙΑΤΡΩΝ ΔΙΕΥΘΥΝΤΩΝ
ASSOCIAZIONE EUROPEA DEI MEDICI OSPEDALIERI
DEN EUROPEISKE OVERLEGEFORENING
ASSOCIAÇÃO EUROPEIA DOS MÉDICOS HOSPITALARES
ASOCIACIÓN EUROPEA DE MÉDICOS DE HOSPITALES
EUROPEISKA ÖVERLÄKARFÖRENINGEN
EVROPSKO ZDRŽENJE BOLNIŠNIČNIH ZDRAVINIKOV
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ΕΒΡΟΠΕΪΣΚΑ ΑΣΟΪΑΪΑΪΑ ΗΑ ΣΤΑΡΨΗΤΕ ΒΟΛΗΝΗΧΝΗ ΛΕΚΑΡΗ
ASOCIATIA EUROPEANĂ A MEDICILOR DIN SPITALE**

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Themes

- inpatient health care (e.g. rationalisation of inpatient care)
- spending on pharmaceutical (e. g over-prescriptions)
- Implementation of eHealth and DRG
- (integrated) outpatient healthcare (e. g extension of GPs' powers)
- staffing in the healthcare sector

The main objective of this report is to monitor the health policy areas identified by Slovak Medical Chamber through the year 2017 and first quarter of the year 2018. The findings will feed into the upcoming country report of Slovak Medical Chamber and a new set of its recommendations in 2018. Some meetings were held with a variety of stakeholders including think tanks, professional organizations and government. The main topics to be covered, was healthcare. We would like to discuss the following issues, taking into account the measures that will be presented in the final part of the review of healthcare in the context of the campaign *Value for Money* healthcare:

In the following we present the views of the Slovak Medical Chamber on the topics raised in discussion with stakeholders-

Discussion

1. • Institutional health care (e.g. rationalization of bed care)

In the opinion of the Slovak Medical Chamber, the network of healthcare facilities, including acute hospitals, has been subjected to a complicated period of more than 15 years. In the period 1998-2006, part of this network was gradually separated from the originally unified network of state health facilities. For example, acute hospitals of varying sizes have been managed by newly constructed self governing regions, some have even become urban hospitals. Another part of general or specialized medical facilities was transformed through a special law into non-profit organizations. Largest - tertiary hospitals - remained the property of the state. Reasons were strategic, because they included a professional leader in intellect, health and technology in Slovakia. The main sources of funding for these hospitals were income from health insurance, other sources were minimal. In general, all actual and potential revenues for functioning and recovery, already damaged and high investment debt burdened by hospital infrastructure, were inadequate long before the beginning of this millennium.

Lack of equity has been an impetus for private equity admissions into some health care areas that have been considered key. We included, for example, operations of so-called joint investigative and therapeutic components such as laboratories, radiological workplaces, dialysis, or even in disastrous conditions mobile rescue and emerging workplaces of so-called rapid medical assistance. These have been set in exclusive public procurement at the beginning of the millennium set by the exclusive prices for performance, which often exceeded the usual rates in Western European countries ... Private capital was also opened to public hospitals with this wide open door. They were only three to four years old (2002-2006), and virtually all the financially advantageous operations of most hospitals were privatized and equipped technically and personally at an unprecedented level. Mobile private emerging services, with their density of land

cover and technical equipment, have also begun to approach the standard international level. However, they have come to their clients and are often brought to the desperately neglected revenue departments of acute hospitals whose construction, technical and personal equipment has so far had problems and unnecessarily delayed a rapid solution to acutely delivered conditions. It is true that several hospital managements have managed to solve this problem by investing in their own, but now this problem has begun to be solved by the large-scale investment made by the European Regional Operational Program (IROP).

Although health insurance sources were generally considered low, many private companies providing various services to hospitals but also to the outpatient sector have, until recently, made fairly profitable profitability as failure to regulate prices in the health sector. This was and still is the role of the Ministry of Health. There was also a high rate of corruption, a lack of rules for the use of these services, which - widely available - contributed to the inefficient use of existing resources, but also to the lack of political will after any correction or, on the other hand, to the deepening of the healthcare reforms started in 2002- 2006.

The hospitals themselves stuck in cumulative debt that their top management could not, did not now, or did not want manage.

This created a situation in which hospitals began to be privatized in the regions. Local governments resigned from the concept of regional health care as there was neither a functioning state. Although Baumol's model of unbalanced growth has been revised by multiple economists (1,2), and it is true that the healthcare sector - even in connection with the unfavourable demographic population - will need relatively more workforce and resources to meet future demands made by both residents and politicians. This is evidenced by the behaviour of the governments of the European Union in the crisis years 2007-2011 (3). Private investors have long understood correctly that the healthcare sector provides investment opportunities almost everywhere, including hospital care. In the space of ten years, most regional hospitals in Slovakia have been privatized, even those that should no longer exist but have no political will to abolish them. Some investors from these hospitals - after their mass privatization - have begun to create networks and clusters to improve the economy of these facilities but also to create conditions for sustainable profit. The common ownership of hospitals, polyclinics, laboratories, pharmacies, drug distribution companies, medical devices and medical supplies has become common. The European uniqueness is an investment company owning not only of the aforementioned types and other types of the business entities, but also as non-negligible, the second largest portfolio of clients in Slovakia in its own health insurance company. This constellation offers opportunities on the one hand to improve healthcare in an economically profitable environment, on the other, the danger that similar chains will rather monitor their business plans than regional and national needs expressed by state health policy. And unfortunately, limited to the program statements of governments at the beginning of their mandate, the fulfillment of their own and pan-European goals has so far failed in the whole line. Slovakia does not have a continuous national or regional

health policy, despite a whole range of programming documents, laws, government regulations, and policy statements.

Only one self governing region in Slovakia remained, which would be able - in the case of legislative support - to implement an autonomous regional health policy. Only one of eight.

The powerlessness of the state has fully manifested itself in the indebtedness of its own hospitals. Whatever the causes of the recurrence of these debts, alternated by periods of their repayment through state assets, they point to the fundamental and long-term inability of the state to manage health. Typical is the state's inability to realize a state-of-the-art central hospital, operating for up-to-date medical clinics and departments, and securing university for under graduate and postgraduate medical education at the same high level. It will have to do, by all means, a private financial initiative.

Opinion of the Slovak Medical Chamber

As in the opinion of the Slovak Medical Chamber, there is no real and feasible continuous political vision of state health policy - there is also no vision of the transformation and development of state healthcare facilities as top-class centres of excellence and perhaps even of a European centre of excellence. That is why we have been talking about one another for the past twenty years, and now the third period of debt settlement, with their senescent infrastructure in front of us.

1. Baumol, W.J., 1967. Macroeconomics of unbalanced growth: the anatomy of urban crisis. *American Economic Review* 57 (3), 415–426]
2. What drives health care expenditure?—Baumol's model of 'unbalanced growth' revisited [Jochen Hartwig](#) *Journal of Health Economics* [Volume 27, Issue 3](#), May 2008, Pages 603-623
3. *The political economy of austerity and healthcare: Cross-national analysis of expenditure changes in 27 European nations 1995–2011* Aaron Reeves, Martin McKee, Sanjay Basu, David Stuckler *Health Policy* Volume 115, Issue 1, Pages 1-8 (March 2014) DOI: 10.1016/j.healthpol.2013.11.008 [http://www.healthpolicyjournal.com/article/S0168-8510\(13\)00305-9/fulltext](http://www.healthpolicyjournal.com/article/S0168-8510(13)00305-9/fulltext)

2. • Expenditure on medicines (eg excessive prescribing)

Legislation on reference prices for medicines, the entry of innovative medicines into the pharmaceutical market, including sharing the risks and costs of the distributor and the health insurance company, or the emerging system for individual drug care is improving. We also see a significant shift in the creation of legislative barriers to reexporting medicines, certain medicinal products on the Slovak market. Reexporting - like a good deal - was realized not only through the rapidly growing number of distribution companies so oriented, but also through some pharmacies, the owners of which, through a multiple of their original turnover, gained a very decent profit. This unpleasant episode also arose from the failure of the state, which has received an appealing price cut in medicines by changing the methodology of its price reference, but at the same time it has opened the wide-ranging reexportation, despite warnings from the professional public. The legislative increase in the "cost of human life", which in individual cases allows for access to medicines that have not been passed through the so-called categorization but have proved effectiveness, can also be positively evaluated. We also highly value the intention of the Ministry of Health to tighten the criteria for the operation of private

pharmacies, especially the position of managers with whom pharmaceutical pharmacists will have to be.

The unregulated access of the private sector to the pharmacy segment did not paradoxically lead to a market-consistent reduction in prices, but turned the pharmacy into stores where the range of drugs is often minor and the business with other commodities prevails, which pulls out - often totally unnecessary - medicines and medical devices. Expenditure for individuals has risen (after having been converted to a share of purchasing power) to one of the highest levels not only among OECD countries. In Slovakia, there is almost no private pharmacy to prepare individual medicines, even if legislation requires it. It also lacks a mechanism that would provide people with access to prescription drugs in the afternoon and night.

From other negative aspects of pharmaceutical and pharmacological policy implementation, we would point out the lack of clinical pharmacologist services, even online, which cannot be replaced by software evaluating clinical drug interactions. Certainly there will be problems with the work of hospital facilities in the so-called rational drug commissions or antibiotic commissions. State policy still fails to ensure rational prescribing of antibiotics in doctors' surgeries (which is not only a problem for Slovakia). The share of generic medicines on the market still has reservations, as well as the possibility of prescribing larger packages of certain medicines in certain patient groups, a measure that reduces visits to outpatient clinics. Electronic prescription of prescription drugs by some health insurers and its indexing to a quality parameter can bring savings only to a certain extent as it can turn against a patient for which their availability is reduced. Questions will affect the use of e-prescription. It will certainly represent an increase rather than a reduction in the administrative burden, as has happened in other countries. However, in some, there was a demonstrable effect on the reduction of prescription drugs.

Efforts to educate patients about reducing the consumption of unnecessary medications and, on the other hand, increasing adherence and compliance in pharmacotherapy lack sufficient incentive mechanisms. These, on the other hand, have been reduced by the adoption of legislation affecting the ways of contacting pharmaceutical company delegates with prescriptive medicines, measures relating to training activities and benefits, where the setting of the current lower limits for the so-called non-financial transactions for tax authorities can be considered as a measure appears to be "in no way diminishing the so-called prescribing habits of doctors" (4). However, from the same country (USA), the opposite arguments (5). There is a group of doctors in each country whose excessive prescriptions can be reduced by various mechanisms. The reasons are different and in part can be really utilitarian.

Opinion of the Slovak Medical Chamber

We agree with the view that the relative share of medicaments, as well as medical devices and medical supplies (27%) is still relatively high (6), and it is necessary to take fundamental measures to reduce it and transfer most of the money thus obtained to the

out-patient sector. The range of actions and possible measures is wide. The Slovak Medical Chamber prefers rather motivational types of measures, both for doctors and patients. In the case of prescriptive or access-limiting measures, experience from other countries needs to be gathered in order to create and sustain their reliable mix.

4. The Relationship of Industry Payments to Prescribing Behavior: A Study of Degarelix and Denosumab
Urol Pract. 2017 Jan; 4(1): 14–20. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5279985/>

5. <https://www.statnews.com/pharmalot/2016/06/20/drug-makers-free-meals-prescribed-pills/>

6. Členenie výdavkov Všeobecnej zdravotnej poisťovne na zdravotnú starostlivosť. Záverečná správa: revízia výdavkov na zdravotníctvo Ministerstvo financií Slovenskej republiky, Ministerstvo zdravotníctva Slovenskej republiky a Úrad pre dohľad nad zdravotnou starostlivosťou <http://www.finance.gov.sk/Default.aspx?CatID=11158>

4. • Implementation of eHealth and DRG

The eHealth project is a 10-year story, with millions of euros invested, still waiting for real launch. He is worried that the fate of a similar project in the UK will be fulfilled in his case (7). He spent 10 years after consuming 12.7 billion pounds. Even though we have passed a much smaller amount of reputation for the project after so many years, nothing is low, the technical problems enormous and the beginning - with primitive features in all, will be difficult. All previously considered functionalities have been dropped and, for example, the e-recipe will be the current product of one of the health insurers. The server base is outdated, migration to government servers is problematic. Peripherals were forgotten, pre-testing included a minimum number of outpatients. Patient identification does not need to (on the periphery) meet safety standards (it will go through so-called birth codes). Electronically, a doctor will be identified by means of a card and, in addition, an ambulance nurse will be happier. Patients do not yet have electronic registration cards. According to the published information, ePrescription - prescription and expense of the medicine, e-Investigation - recording of the examination record and subsequently the possibility of its presentation by other doctors, e - Lab - recording of laboratory results in the eHealth system, or the National Health Portal and the Citizen's health record with basic data .

At the same time as eHealth, the DRG system should be fully deployed. For the history of the project, what we have in eHealth is typical. Late start of the project. We are one of the last countries in Europe to introduce the system. Furthermore, there are problems in the development of the project - according to us, we have been entrusted with an institution that does not fit it (the Health Care Surveillance Authority). The project took a long time to get into the real-life testing phase. At the same time, this testing was done with a different software solution than was anticipated and should have been developed and implemented by the aforementioned office.

The Office for Year 2018 has already published the Case Lumpbooks, the Software Compliance Verification Instructions (always for a specific version of DR-DRG), and the

System Guidebook with the SK-DRG 2018 ranking algorithm. The issue of DRG's share of prospective health insurance payments in in 2018

Opinion of the Slovak Medical Chamber

Doctors in Slovakia have not taken an explicit negative attitude towards the first phase of eHealth. Much will depend on how user-friendly the first functionality will work. We appreciate the statement of the Ministry of Health that the penetration of the first functionalities will be gradual. One must realize that although a large majority of both outpatients and hospitals are adequately equipped with basic hardware, the problems stem from the compatibility of software solutions that are often installed at the last minute and at the cost of healthcare providers. The problem may be some software fragmentation. It is also unpleasant that off-record information has been obtained that several hospital information systems have not yet been certified for this project

In DRG, according to the Slovak Medical Chamber, the flat-rate payment still remains different for different types of hospitals. Calculated for 2017 would not be sufficient to refinance their costs when fully deployed. It is important that the basic rates for many subjects change for the better. Unfortunately, different payments will take some years.

7. The Electronic Health Records System in the UK <https://www.centreforpublicimpact.org/case-study/electronic-health-records-system-uk/>

5. • (Integrated) outpatient healthcare (eg widening the powers of doctors)

Another example of delays - though not as large as the e-Health and SK-DRG projects, is an ambulatory health care project. The Government of the Slovak Republic approved the Strategic Healthcare Framework for the years 2013-2030 (8) has passed four years. Follow-up implementation documents such as the Implementation Strategy - an integrated healthcare delivery system from 2014 and an update of the same name from September 2017 (9), were then followed. However, the Regional Analysis, including the methodology for the implementation and functioning of the Integrated Health Care Centres with attachments. This material was published online at this time. It describes the methodology of selecting suitable sites for the construction of centres of integrated health care, confronting this selection with individual materials of so-called Master Plans of individual self-governing regions. It also describes the use of the Geographical Information System (ESRI) and the maximum coverage methodology to identify potential centres for the realisation of project . As part of the next steps and data, they added to the Geographic Information System only after the last version published for the professional public in September 2017. This material was not already mentioned. The comments of the Slovak Medical Chamber from July 2017 can be found at: https://lekom.sk/files/Staly_vybor_pre_legislativu/LWk_Pripomienky_k_CIZS and the comments of the independent expert group at: http://centrazdravia.sk/dokumenty/pk_pripomienky1-met_jk.pdf

Unfortunately, we do not recognize the comments of other subjects. There were several shortcomings in the material, but the Ministry of Health must acknowledge that the time is running fast and the euro has not even gone.

The programming period runs until 2020. The material and associated documents deal mainly with technical issues of future centers. In the first phase, which has been earmarked for about EUR 8 million, these should be built in areas where the investment would only have a local reach. In the next phase, the project should hit areas with a developed healthcare marketplace and will - supposedly happen - convince the European Union that state aid rules will not apply to building centers. According to Art. 107 section (1) of the Treaty on the Functioning of the European Union, unless otherwise provided for in the Treaties, aid granted by a Member State or by any means from State resources which distorts or threatens to distort competition by favouring certain undertakings or the production of certain goods is incompatible with the internal market in so far as it affects trade between Member States.

Exceptions to the general notification obligation are minimal assistance,

- group exceptions,
- individual aid granted under valid and effective State aid schemes,
- individual aid provided under valid and effective minimum aid schemes.

If exemptions can be applied then much of the money is spent in the economically developed areas of Slovakia, with the aforementioned developed healthcare market, which can harm undeveloped areas that may or may not have the capacity to submit a similar project.

Opinion of the Slovak Medical Chamber

Although we can all be heard about the technical solution of the present phase before the first call (april 2018), our biggest reproach is a little different.

It concerns the fact that only technical issues take over all the time since the "Strategic Plan" approval. At this event, the author of this commentary commented on the insufficient status of the legislation and the lack of the "ideology" of integrated health care in Slovakia at a special seminar (incidentally with the participation of the professional public) held and organized on 16 December 2014. As a Slovak clinic, we pronounced the slogan: "First software, then hardware!"

All this is true so far. From the Ministry of Health's material, basically, the so-called Integrated Health Care Center will create scope for eventually integrated activities and not, on the contrary, that on the basis of integrated activities projects in localities such as communities, municipalities, associations of municipalities, larger or smaller regions, including self-governing , tailor-made centres will be created. The lack of integrated national ideology and the emphasis not only on health, but also on social and human health care, is obvious. The state does not ask people what the needs of this care are, it knows communities and health workers and social workers in them. But the state does not even think about what the future health care paradigm will be, even though we have it before us. This paradigm, according to the Slovak Medical Chamber, is based on expert assessments of national and international institutions, population aging and an increasing problem of so-called chronicity. Of course there will be other target groups that integrated

care can be provided. From physically, functionally or mentally handicapped people, over segregated populations with poor access to health and social services to, for example, drug users and carriers associated with them.

If the Ministry of Health claims in its materials that integrated health care will be provided in the environment of the current legislation, so in the opinion of the Slovak Medical Chamber it is wrong. When the UK audit agency National Audit Office commented on the decade of effort and integration of care, it said that it would need to go through a long and difficult path to its effective delivery, with legislative instruments playing a very important role. (10).

For example, health insurance legislation, long-term care (Pflegeversicherung) legislation and, in our opinion, special funding according to the German model. A good piece of help would be a new Community reform act. Today has Slovakia 3 000 municipalities. It is the same number as in Sweden, Norway, Finland and Denmark together.

Opinions of Slovak Medical Chamber in discussion with the European Commission experts during their Fact Finding Mission November 2017

Context

In the context of the 2017 European Semester, Slovakia was recommended to take measures to improve the cost-effectiveness of the healthcare system. This was also in view of the projected increase in public expenditure on health care by 2.0 pp. of GDP by 2060 (The 2015 Commission Ageing Report), much above the average increase of 0.9 pp. for the EU. When taking into account the impact of non-demographic drivers on future spending growth (the so-called risk scenario presented in the Ageing report), healthcare expenditure is expected to increase by 3.3 pp. of GDP between now and 2060, compared to the EU average of 1.6 pp. These increases impede the long-term sustainability of public finances.

In autumn 2016, the government identified in the context of the Value for Money projects several areas where efficiency gains could be achieved. Measurable indicators were identified to assess the progress in those areas. The mission's aim is to gather the latest information concerning the spending review's proposed measures, and in how far these have translated into concrete actions and realised efficiency savings.

Fiscal sustainability and cost-effectiveness of healthcare:

- 1. Have the measures envisaged in the spending review *Value for Money* in the health sector been implemented?**

Opinion of Slovak Medical Chamber: *As part of the Ministry of Finance's analysts' recommendations in the Value for Money publication (1), the Ministry of Health has carried out a number of measures in the area of public procurement of medicines, medical supplies and measures for the procurement of medical devices. However, it should be noted that the measures concerned organizations directly managed by the Ministry of Health, mainly large hospitals, as well as hospitals in which the Ministry of Health represented, as the representative of the state, the majority, for example, in the boards of directors of joint-stock*

companies or non-profit organizations providing health services. For the largest hospitals in Bratislava, the Ministry of Health introduced the so-called "central procurement." The private sector was purchasing according to its own rules and data from this area are not available to the Slovak Medical Chamber. The evaluation of some grills was also done by the chief analyst of the Ministry of Health, who stated, inter alia: "Following the centralized procurement experience, we define the specifications and publish them on the web. Hospitals want it because they are at least less concerned. "According to chief analyst Martin Smatana, the problem with purchases by hospitals run by the Ministry of Health was also the fact that they purchased separately and often expensive, often having to equip one company with no claim for this trade discount. The prices in the surrounding countries were incompletely compared, for example, with the purchase prices in the Czech Republic. Centralizing these procedures at the ministry therefore brought savings. The informational asymmetry of the hospital itself could not cope. According to Martin Smatana, the meeting of people from the Ministry of Health with foreign parent companies helped. "When we look at the cost of public hospitals, we buy 290 million dollars a year for the purchase of medicines, materials and all things. Drugs are priced as the average of the three lowest in Europe. Prices of special medical supplies also dropped by 30-40%". According to Martin Smatana, the room for further reduction of prices for these hospitals is almost exhausted. One way to reduce this, is to shorten the repayment schedule and to comply with the repayment dates. According to Smatana, purchasing specifications and negotiation with companies and not distributors should be specified. Especially in the case of electronic procurement, it is important that a wide range of company offers be obtained and therefore it is possible to dispose of so-called intermediaries, persons or firms that promise hospitals to meet their requests. It is important to enter so-called non-discriminatory specifications that would prefer only one bidder. This has often been the case in the past (2).

However, drug spending remains high despite the reference procedure in Slovakia. The forthcoming amendment to the Medicines Law proposed by the Ministry of Health should contribute to their reduction (3). It defines, inter alia, the limit of additional costs for expensive medicines, including medicines which at the time give so-called import exemptions. This is individual for each drug. The height limit, the so-called additional cost of the drug, is increased and is referenced to the so-called unit of health improvement when using the drug. This limit, however, must not exceed the so-called threshold value of the medicinal product under consideration for one year of 'standardized' quality of life. These thresholds for different medicines vary and result from a comprehensive assessment of the benefits of the drug. Thus, the willingness of the state to reap the health insurance more because of the higher benefit of the drug is expressed here. It is also important to introduce "cost sharing" and "risk sharing" systems in which the paying health insurance company and the holder of the drug registration agree on the conditions under which they will bear the costs of medicines, dietetic products and medical devices. the compensatory amount paid by the holder of the registration of the medicinal product of the health insurance company will be decided by the new rules. - The conditions of the so-called conditional classification in the group of categorized drugs are specified by law, whereas an important factor for inclusion is the defined annual amount of health insurance reimbursements for the given drug, or better to assess the efficacy and safety of the drug. The level of consumption of generic substances is still high, according to experts and the Ministry of Health. Therefore, new measures are introduced to reduce the price of the entry of the first generic or biologically similar product on the market, with the introduction of a mandatory price reduction mechanism when entering the next order. Payments for medical supplies and special medical supplies that are not officially valued

in at least two Member States of the European Union account for only 20 percent of the payment of public health insurance. The regulation of prices, reimbursements and terms of reimbursement for individually tailored medical devices, which have been carried out so far under the so-called price measure of the Ministry of Health, should also be abolished. The possibility of a regular quarterly adjustment of the prices and the extent of the reimbursement in terms of payment for a piece of tailored medical device, prescription and indication limitation, financial and quantitative limit, and limitation of the reimbursement of the health insurance company to its prior consent is ensured. These latter measures were certainly under the impression of the last scandal with falsification of payments when patients were given standard serial devices and insurance companies were charged with their individual variants, which were, of course, much more expensive. The draft law cancels the reimbursement ratio from public health insurance and surcharges, which in the established rules will allow a reduction of the individual premium on expensive medicines through the cost sharing mechanism between the insurance company and the holder of the registration. This mechanism should also apply to financially demanding medical devices and dietetic foods. The supplementary allowance for patients with severe disabilities is also reduced, for a period of three months, from € 25 to € 12.

From the ongoing implementation report of the Value for Money department of the Ministry of Finance, which maps the period January to June 2017, there are several facts. Of the measures proposed by the department's analysts, only some are in the "operating temperature". Therefore, the initially calculated savings of € 87 million was met to around 32%. The Ministry of Health has been able to reduce and shift the take-up of some public health insurance items to an estimated € 32 million, but the continuing cost growth in hospitals run by the Ministry has caused the real decline to be estimated at 27 million euros. The highest savings of 27 million was achieved through measures to over-spill medicines (€ 12 million), reference prices for special medical supplies (€ 12 million), and healthcare procurement for state hospitals (€ 4 million). The challenge, according to analysts, of the Ministry of Finance's Value for Money Department is to raise funds to reduce the consumption of potentially ineffective medicines and expensive drugs as well as optimize hospital processes not only in state hospitals (4). The Slovak Medical Chamber adds that process optimization is also needed outside hospitals. The problem is the unstandardized paths of the patient towards the upstream and downstream (up and down) across the healthcare pyramid, but also outpatient, community care, or family care. The Slovak Medical Chamber is of the opinion that even if hospital processes are set, hospitals, together with medicines, the most expensive part of the healthcare system, the overall savings and efficiency will not be enough. In a fragile and poorly managed and interconnected social and health extramural environment, the system does not save enough money, which is reflected, for example, in repeated hospitalizations of elderly patients in particular. The Slovak Medical Chamber regrets that the implementation of the establishment of so-called Integrated Health Care Centres takes into account the

construction and repair of infrastructure and not the processes and their integration, along with some social care services. The slogan, "Software After Hardware", was first spoken in December 2014 when we criticized the approach of the former Ministry of Health. Slovakia has so far lacked the idea of integrated health care, although the Government has approved a document in December 2013 (5), which was dealt with in the general diagrams. The Slovak Medical Chamber adds that the optimization of hospital operations must not be at the expense of reducing the number of medical personnel. This applies to almost all types of professions, with some hospitals moving to the edge of personal security for their operations, thus undermining also the legislatively defined minimum states, which are only a little closer to the point of view, are far from the standard required (see, for example(6)(7)(8),(9):

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- (1) [file:///C:/Users/Jozef%20Weber/Downloads/Finalna_%20sprava_revizia_ZDRAVOTNICTVO%20\(1\).pdf](file:///C:/Users/Jozef%20Weber/Downloads/Finalna_%20sprava_revizia_ZDRAVOTNICTVO%20(1).pdf)
 - (2) MÁRIA POLETOVA Odomkli sme - Má 27 rokov a šéfuje analytikom u Druckera: Unavuje ma, ako to stále skúšajú rôzni vybavovači Denník N STREDA 4. OKTÓBRA 2017 13:30 (MÁRIA POLETOVA We've unlocked - He's 27 years old and heads up with Drucker's analyst: I'm tired of how they're still testing different players Denník Wednesday 4. OCTOBER 2017 13:30) <https://dennikn.sk/895800/martin-smatana-institut-zdravotnej-politiky-rozhovor>
 - (3) Zákon č. 363/2011 Z. z. o rozsahu a podmienkach úhrady liekov, zdravotníckych pomôcok a dietetických potravín na základe verejného zdravotného poistenia a o zmene a doplnení niektorých zákonov v znení zákona č. 460/2012 Z. z., zákona č. 265/2015 Z. z., zákona č. 306/2016 Z. z. a zákona č. .../2017 Z. z. (tlač 706)
[Act no. 363/2011 Coll. on the scope and terms of payment of medicinal products, medical aids and dietetic foods on the basis of public health insurance and on the amendment and supplementation of some laws, as amended by Act No. 460/2012 Coll., Act no. 265/2015 Coll., Act no. 306/2016 Z. z. and Act no. ... / 2017 Coll. (printing 706)]
<https://www.nrsr.sk/web/Default.aspx?sid=zakony/cpt&ZakZborID=13&CisObdobia=7&ID=706>
 - (4) Príloha č. 8:Priebežná implementačná správa: Zdravotníctvo, doprava, informatizácia, 1.1.2017 – 30.6.2017(Annex No8:INTERMEDIATE IMPLEMENTATION REPORT Health, transport),
<http://www.finance.gov.sk/LoadDocument.aspx?categoryId=11154&documentId=15873>
 - (5) [Strategický rámec starostlivosti o zdravie pre roky 2013 - 2030](file:///C:/Users/Jozef%20Weber/Downloads/strategicky-ramec-starostlivosti-o-zdravie-2013-2030%20(1).pdf) (Strategic health care framework for 2013 – 2030)
[file:///C:/Users/Jozef%20Weber/Downloads/strategicky-ramec-starostlivosti-o-zdravie-2013-2030%20\(1\).pdf](file:///C:/Users/Jozef%20Weber/Downloads/strategicky-ramec-starostlivosti-o-zdravie-2013-2030%20(1).pdf)
 - (6) WHO Workload Indicators of Staffing Need (WISN) tool WHO Workload Indicators of Staffing Need (WISN) tool http://who.int/hrh/resources/wisn_software_manual/en/ <http://who.int/hrh/governance/en/>
 - (7) Health Workforce Planning Models, Tools and Processes in Five Countries Health Research Board An Evidence Review Stephen Kinsella Rachel A Kiersey Dublin 2016
http://www.hrb.ie/uploads/tx_hrbpublications/Health_Workforce_Planning_Models_2016.pdf
 - (8) Strategic Workforce Planning Tool Gov-UK Monitor 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365275/Strategy_development_to_olkit_Strategic_workforce_planning_tool_20102014.pdf
 - (9) HANDBOOK ON Health Workforce PLANNING METHODOLOGIES ACROSS EU COUNTRIES Edited by Annalisa Malgieri, Paolo Michelutti, Michel Van Hoegaerden RELEASE 1 Published by the Ministry of Health of the Slovak Republic Bratislava 2015 Joint Action Health Workforce Programming & Forecasting Funded By the Health Programme of the European Union http://healthworkforce.eu/wp-content/uploads/2015/11/150306_WP5_D052-Handbook-on-HWF-Planning-Methodologies-across-EU-Countries_Release-1_Final-version.pdf
2. **Are you aware of any legislative proposals on-going/planned to address cost-effectiveness in healthcare leading to more balanced budgets?**

Opinion of Slovak Medical Chamber: *Yes - for example, mentioned below in connection with the innovation of some of the provisions of Act 306/2016 on the Collection of Laws on Medicines and Medical Devices and on Amendments to Certain Acts as amended and amending Act No. 363/2011 Coll. on the scope and terms of payment of medicinal*

products, medical devices and dietetic foodstuffs on the basis of public health insurance and on amendments and supplements to certain laws as amended, as well as amendments to this Act, which is in preparation and which was also commented upon by the Slovak Medical Chamber.

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

Opinion of Slovak Medical Chamber:

Yes - Describes their ongoing analysts' report Value for money 13/10 2017 Integrative implementation report Healthcare, Transport, Informatization. A summary of their recommendations is as follows

- *Accelerate the implementation of financial measures in order to bring the target set in the general government budget by the end of the year.*
- *Make a more effective controlling the purchase and consumption of medicines - for hospitals (medicines in hospitals vs. sold in public pharmacies) and for health insurance companies at PNNL (central purchasing versus prescription medicines).*
- *Repeatedly analyze the review activity of the General Health Insurance Company - Determine the new value of the savings.*
- *Initiate the second section of the Health Expenditure Review aimed at achieving a more effective healthcare for the citizen.*

Measures proposed by government analysts were expected to save € 87 million this year from January to June 2017. The target for the first half was to reach 31 percent, as stated in the ongoing implementation report on health, transport and computerization spending reviews.

"In this period, the Ministry of Health of the Slovak Republic reduced spending on selected items of public health insurance by EUR 34 million, but the cost increase in hospitals has reduced the total savings by EUR 7 million, saving 27 million euros," the paper writes. The most significant savings were in the area of over-consumption of medicines (EUR 12 million), reference of special medical supplies (EUR 12 million) and procurement of medical equipment (EUR 4 million). The biggest challenges include the so-called implementation unit, which monitors the implementation of measures prepared by the Unit for value for money, optimizing hospital processes, and addressing potential cost-ineffective medicines. As noted in the Implementation Report, consumption of these 147 drugs is on the rise and their central purchasing lags behind. Centrally only 26 species were purchased. The Implementing Unit has recommended that the Ministry of Health should

accelerate the implementation of financial measures by the end of the year. He advises him / her to more effectively control the purchase and consumption of drugs or to analyze repeatedly the review activity of the General Health Insurance Company. They also want to initiate a further review of health spending that would focus on more effective healthcare for the citizen. "With regard to savings, the Ministry of Health (MZ) of the Slovak Republic is convinced that the changes adopted are effective and have significant benefits in individual segments. However, the amount saved is not a realistic picture because most of the measures implemented by the Ministry of Health were implemented in the first half of 2017, which means that the biggest savings will be felt during the second half of the year, "Zuzana Eliášová, spokeswoman, responded. She reminded that it should be taken into account that some measures cannot be implemented without changing the legislation. "The amendments to the law do not yet have a definitive form, some of them are currently submitted to the National Council of the Slovak Republic." It follows from the conclusions of the review that a revision of expenditure number 2 is needed, reflecting the situation and the changes", added Eliášová. The expected term is the end of the first half of 2018.

As the government's latest revision of expenditures has shown, Slovakia gives more health care (in proportion to GDP) than the neighbouring countries of the so-called Visegrad Four, but the results are lagging behind. One reason for the lag is the low efficiency of Slovak health care. If it would rise to the OECD average, the expected life expectancy in Slovakia would be prolonged by three months. The Slovak Medical Chamber repeatedly draws attention to the shortcomings in the so-called avoidable deaths and the method of measuring the health-experienced life, where the results deteriorated inter alia by changing the questions asked. This has made this parameter considerably worse in comparison with the Czech Republic, from which we have had it comparable, without a real objective substrate. Value for money analysts' findings accompanied in their publication by an interactive map, where it was possible to see that, according to the indicator of years of healthy life, that people in the Czech Republic expect ten years of healthier life than in our country. The average life expectancy in the Czech Republic is higher in less than two years. And for that, there will be health in Poland for almost eight years longer, and in Hungary, where the average life expectancy is one year lower than in our country, they will still enjoy more than seven healthy years more (10). Problems with this "key indicator (OECD)" are in EUROSTAT well known, but the nonsense numbers are still repeated (10),(11) (12).

(10) MILOSLAV BLAHA PONDELK 23. MARCA 2015 16:49 DENNÍK (DAILY) N Slovensko: zdravé roky stratené v preklade(Slovakia: healthy years lost in translation)

(11) Healthy Life Years Expectancy disability-free life expectancy – DFLE Method

http://ec.europa.eu/eurostat/cache/metadata/Annexes/hlth_hlye_esms_an1.pdf

(12.)BrendanCollinsM.Sc. Using a Survey to Estimate Health Expectancy and Quality-Adjusted Life Expectancy to Assess Inequalities in Health and Quality of Life Health Policy Value in Health

Volume 16, Issue 4, June 2013, Pages 599-603

<http://www.sciencedirect.com/science/article/pii/S1098301513000144>

4. Has the Ministry of Health taken sufficient measures to limit spending on imagery equipment, laboratory examination and medical materials?

Opinion of Slovak Medical Chamber - Answer: *In part, the measures have already been implemented and a correction according to the Slovak Medical Chamber will have to wait for further analysis after the end of 2017. At*

the same time, we would urgently recommend monitoring the monitoring of the impact of these measures on patients. It is mainly about monitoring their needs, the level of personal spending on different aspects of health care, or the level of their satisfaction with different aspects of health care. At the same time, we recall the need to prepare the monitoring of the implementation of so-called standard diagnostic and mainly therapeutic procedures in bed and outpatient facilities in connection with their gradual publication and practical validation. For all these suggestions, we need to set the baseline reference, initial levels. Without these measures, quality measurement of regulatory impacts or other measures on the population will not be possible. We do not consider sufficient monitoring of so-called "hard" indicators (morbidity, mortality, survival, etc.), especially in terms of the need for corrections in shorter time periods. We would not want to experience a situation that was characterized in the UK as a postcode lottery (13) and which, in reality, in Slovakia, due to the lack of rules of this time, probably exists not only but there is a bloom.

(13) THE NORTH-SOUTH NHS DIVIDE: HOW WHERE YOU ARE NOT WHAT YOU NEED DICTATES YOUR CARE Medical Technology Group 2017

<http://www.mtg.org.uk/wp-content/uploads/2017/08/The-North-South-NHS-divide-how-where-you-are-not-what-you-need-dictates-your-care-FINAL-low-res.pdf>

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

Opinion - Answer: The Slovak Medical Chamber does not know about a similar type of study at the time.

Healthcare structural issues

Hospital finances

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

Opinion of Slovak Medical Chamber:

The Slovak Medical Chamber agrees with a number of described justifications for the causes of indebtedness of mainly large public hospitals, of which there is a whole range of advice. Not from all, as it is stated. We are convinced that even the existing legal form of so-called budgetary modes of financing some of them may not be the underlying cause of indebtedness because they act in an environment of the so-called soft economic environment. Even for this method of dealing with the means obtained, the state could set up economically hard and effective rules, but it never made it even when the debt of state hospitals grew tremendously. We still disagree with the transformation of key hospitals managed by the Ministry of Health into business organizations, as suggested by several economic experts. - Give examples from abroad ... We think that - despite the reported increase in health care spending relative to the growing gross domestic product - that these facilities were and often are - both operationally and investment underestimated (underfunded). It is well known that Slovakia has neglected investments in hospital infrastructure for a long time, with badly mentioned state hospitals. When the investment debt of Slovak hospitals, according to various estimates and comparisons with other countries, is estimated to be far more than one billion euros, most of this debt is just spent in the largest state hospitals. Searching for funds for its gradual removal is also difficult in today's better times of economic conjunction.

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

Opinion of Slovak Medical Chamber:

In response to this question, we can basically reiterate the opinion of the Slovak Medical Chamber in our response to the European Commission's experts at the meeting in December 2016

Health Structured Issues Hospital Finances

5. What is your assessment of the level of debts and arrears of hospitals and the causes of their recurrence?

6. What is your assessment of 2015 hospital budget plans and the results of financial audits in 14 public hospitals and the resulting policy measures (for example, as part of the progress of a pilot study on the use of the new information system, with economic and clinical data - see below, information systems)?

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

Last year, health insurance companies sent around € 1.5 billion to hospitals. It was more than in 2014. It was still too little for hospitals - mainly state - to stop indebted. By the end of 2015, over € 442 million in hospital liabilities overdue. It was far beyond the boundaries when these hospitals had been detained before. Only two hospitals did not make debts - the Nitra University Hospital and the Children's Faculty Hospital in Košice. The structure of the debt has been the same for years - they are debts to the suppliers of medicines and special medical supplies, Social Insurance, debts to tax authorities and health insurance companies. The main reason for continuing indebtedness is continued operating losses, as the most demanding financial performances are made in these hospitals. Increasingly - in relation to health outcomes - labour costs as well as expenditure on medicines and medical supplies. In this way, medicines that patients are normally using outpatients are worn for use by hospitals. The share of costs and income of these hospitals is constantly negative. Health insurance companies have increased their payments. Many hospitals, however, lack the performance of operations with a better ratio of performance rewards. The roots of this situation are in the 2002-2004 changes when privatization of services such as rescue services, dialysis, imaging techniques (such as computer tomography, nuclear magnetic resonance), laboratory services and the like (to attract private capital investment to health care). These segments received preferential higher remuneration. This, on the one hand, has led to a rapid improvement in similar services, on the other hand, their disproportionate and often unjustified use of orders from the hospital and outpatient sectors. In addition, contractual relationships with similar services of a private nature between them and health insurance companies have often been set up in such a way that they did not allow flexible reductions in remittances as competition rises. A typical example of "economic" behaviour of state hospitals has so far been a hesitant hesitation in the implementation of so-called day surgery surgery. The reimbursements for her performances were and are lower than hospitalization for a longer period, which, on the contrary, provided for such a occupancy of the pension fund. This is often the case for ineffective hospital management, the absence of benchmarking, joint purchasing, and many other management mistakes resulting from local circumstances, as well as the poor regulation of hospitals by the Ministry of Health. But it can not be forgotten also the managerial foul, which can not be suppressed by criminal activity (eg manipulated tenders and other purchases). All this applies to hospitals that were administrated by self-governing regions or cities and who have completely failed to manage and manage them, and have used the privatization of their operations as a substitute solution. This has resulted in regions having lost their influence on planning and deciding on regional health. For similar activities, they also lacked appropriate legislation and competencies. Slovakia practically does not have regional health service planning according to the needs of the population and is served by private plans of providers of acute hospital services, for which neither state nor local government has any influence. This is a unique and dangerous situation that is not the same in the EU.

7. What is your estimation of the use of these financial management tools in hospital care?

• structural audits • resource identification for operational savings • budget constraints and incentives • performance based (PB) • public procurement in hospital care (see below) • monitoring and benchmarking (see below)

Position of the Slovak Medical Chamber: *Information on financial management tools in hospitals is not available to the Slovak Medical Chamber. At that time, we rely only on the so-published information by hospitals that are required to disclose and are hospitals under direct or indirect administration of the Ministry of Health. This is the so-contributory hospitals run by the ministry, or non-profit organizations of hospitals that were established with state participation. It also includes hospitals belonging to regions and municipalities. According to Act no. 211/2000 on the Collection of Information on Freedom of Information Act, there is a possibility for organizations but also individuals to ask for information - for example, on the management of hospitals also in writing for specific cases, which are not*

necessarily published. However, this law does not impose an obligation to publish or provide information to hospitals in private hands. Such hospitals are more than 20 in Slovakia. Most of them, however, do not hesitate to provide some selective information about their management. Unlike public hospitals, however, it considers business secrets. For example, it does not disclose or provide information about third-party contracts or purchases. Some hospitals do not publish or provide final reports on management and audits. The Slovak Medical Chamber considers that if this information relates to the management of public health insurance funds (not only state subsidies), their private hospitals should be published as publicly owned. This can be attributed to all private business organizations that manage both the public and the resources - and there is little. We consider this a lack of the aforementioned law on free access to information. From the aforementioned tools, public hospitals are normally used and published auditing - mostly financial, less quality-oriented. Almost all public hospitals have begun using standard tools to identify savings in their operations, information can be obtained (although not always) with some results on demand. One of the tools for the procurement of special medical material is benchmarking of prices - for example, in the network of state-run hospitals - which has recently begun to be used. Within this framework, joint procurement can also be carried out. Public electronic procurement of similar but also other commodities, which suffers from "childhood" illnesses, is increasingly used, and is not always effective. We assume that the remuneration of top executives, including CEOs, is already on the basis of meeting performance criteria. However, details are not disclosed and are also difficult to obtain on request, with reference to the protection of personal data. The Slovak Medical Chamber thinks these data should be published. Much of the inefficiency in the given period is also reported later in October 2017 by the Supreme Audit Office (14)(15) (16) 17) (18).

(14) NAJVYŠŠÍ KONTROLNÝ ÚRAD SLOVENSKEJ REPUBLIKY Čiastková správa o výsledku kontroly „Verejné financie a majetok zdravotníckych zariadení“ (2011 – 2015) Bratislava, október 2017 (The Supreme Audit Office of Slovak republic Subsidiary audit report "Public finances and assets of healthcare facilities" (2011 - 2015) Bratislava, October 2017)

<file:///E:/EC%20Fact%20finding%20mission%202017/Finančné%20plánovanie%20nemocníc/NKÚ%20nemocnice/NKÚ%20Čiastková%20správa%203%20-%20Verejné%20financie%20a%20majetok%20zdravotníckych%20zariadení,%203.%20etapa.pdf>

(15) Čiastková správa Verejné financie a majetok zdravotníckych zariadení (2011 – 2015) 2017

<file:///E:/EC%20Fact%20finding%20mission%202017/Finančné%20plánovanie%20nemocníc/NKÚ%20Čiastková%20správa%203%20-%20Verejné%20financie%20a%20majetok%20zdravotníckych%20zariadení,%203.%20etapa.pdf>

(16) Kontrola potvrdzuje, že zdravotníctvo potrebuje systémové zmeny NAJVYŠŠÍ KONTROLNÝ ÚRAD SLOVENSKEJ REPUBLIKY

<https://www.nku.gov.sk/documents/10157/749295/Kontrola+potvrdzuje%2C+%C5%BEe+zdravotn%C3%ADctvo+potrebuje+syst%C3%A9mov%C3%A9+zmeny/7490bf35-7e59-4c9a-9dc4-a7ba40eff458>

(17) Štátne i samosprávne nemocnice rozpočtujú formálne, bez zodpovednosti za udržateľnosť <file:///E:/EC%20Fact%20finding%20mission%202017/Finančné%20plánovanie%20nemocníc/NKÚ%20Štátne%20i%20samosprávne%20nemocnice%20rozpočtujú%20formálne,%20bez%20zodpovednosti%20za%20udržateľnosť.pdf>

(18) [file:///E:/EC%20Fact%20finding%20mission%202017/Finančné%20plánovanie%20nemocníc/Finančný%20manažment%20nemocníc%20%20Ineko%20analýza%20-%20Zdravotnícky%20systém%20v%20SR%20%20\(2012-2013\)](file:///E:/EC%20Fact%20finding%20mission%202017/Finančné%20plánovanie%20nemocníc/Finančný%20manažment%20nemocníc%20%20Ineko%20analýza%20-%20Zdravotnícky%20systém%20v%20SR%20%20(2012-2013))

8. Of which finance management tools in hospital care are you aware of?

Opinion of Slovak Medical Chamber - Answer:

The Slovak Medical Chamber agrees with a number of described justifications for the causes of indebtedness of mainly large public hospitals, of which there is a whole range of advice. Not from all, as it is stated. We are convinced that even the existing legal form of so-called budgetary modes of financing some of them may not be the underlying cause of indebtedness because they act in an environment of the so-called soft economic environment. Even for this method of dealing with the means obtained, the state could set up economically hard and effective rules, but it never made it even when the debt of state hospitals grew tremendously. We still disagree with the transformation of key hospitals managed by the Ministry of Health into business organizations, as suggested by several economic experts. Hospitals should also not forget their passive and active social responsibility... (19). We think that - despite the reported increase in health care spending relative to the growing

gross domestic product - that these facilities were and often are - both operationally and investment underestimated (underfunded). It is well known that Slovakia has neglected investments in hospital infrastructure for a long time, with badly mentioned state hospitals. When the investment debt of Slovak hospitals, according to various estimates and comparisons with other countries, is estimated to be far more than one billion euros, most of this debt is just spent in the largest state hospitals. Searching for funds for its gradual removal is also difficult in today's better times of economic conjunction.

(15) Cristina Brandão • Guilhermina Rego • Ivone Duarte • Rui Nunes, Social Responsibility: A New Paradigm of Hospital Governance Health Care Anal (2013) 21:390–402

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3825491/table/Tab1/>

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3825491/pdf/10728_2012_Article_206.pdf

9. How to you assess the planned debt assumption of hospitals' debts?

Opinion of Slovak Medical Chamber:

The healthcare financial situation has been addressed by more institutions over the past years. One of them was INEKO in publication written for the European Commission ASISP (Analytical Support on the Socio-Economic Impact of Social Protection Reforms) - Country Document 2013: Pensions, Health and Long-Term Care in Slovakia The results of the project "Monitoring and Commenting on Structural Reforms" who has financially supported the Endowment Fund of the Slovak Savings Fund at Pontis Foundation, as well as the project i-Health.sk, which financially supports the Health Insurance Company Dôvera. In the part of this publication on public hospitals, they list a number of factors that caused their debts: data on long-term hospitals could not be relied on because hospitals, so called contributory organizations, did not conduct transparent accounting according to international standards, their accounting closures were opaque and lacked independence audit (19).

State hospitals failed to meet their obligations because they lacked the right incentives. The reasons were also the politically motivated nominations of hospital directors who worked there frequently, lacking tough budget rules for hospital management, uneconomic shopping, and the vision of final debt settlement from the country's financial assets. But it was also legislation that forced these hospitals to perform healthcare even without their financial cover, or the sources of uncovered increases in the salaries of doctors and other healthcare personnel. An INEKO analyst believed that the reason for this was to identify most of these hospitals into the so-called "fixed network of hospitals" that had to get contracts from health insurance companies (note: on the other hand, lacking financial cover) (20).

Declared measures of the then showed up in the real world only as a fiction: eHealth still does not work, controlling in hospitals with a paraglider in the Ministry of Health was not functional, internal hospital reserves have been under-utilized, including making changes in the cost structure of expenditures, the DRG system is only starting to run into real-life operations (2018), performance, or purchases are not decentralized, and the like. Similar actions began to happen in 2017. We have information improvised in the personnel field, human resource planning still has a low priority over the economic rehabilitation of the critical condition. Systematic programs such for the health workforce planning are not used in state hospitals according to our information, even though these facilities are the main place for acquiring knowledge and skills not only for their employees but also many others. These facts are confirmed by the later findings of the National Audit Office (17)

(19) Zdravotnícky systém v SR (2012-2013)1 Autor: Dušan Zachar, INEKO November 2013 (Healthcare System in Slovakia (2012-2013) Author: Dušan Zachar, INEKO November 2013 [file:///C:/Users/Jozeff%20Weber/Downloads/Zdravotnícky%20systém%20v%20SR%20%20\(2012-2013\)%20\(1\).pdfpage6-9](file:///C:/Users/Jozeff%20Weber/Downloads/Zdravotnícky%20systém%20v%20SR%20%20(2012-2013)%20(1).pdfpage6-9)).

(20) Ministerstvo zdravotníctva Slovenskej republiky (2013b): Informácie o vývoji dlhu v sektore zdravotníctva na rok 2012; MoH SR, April 2013 (Ministry of Health of the Slovak Republic (2013b): Information on the development of the debt in the health sector for 2012; MoH of the SR, April 2013) <http://www.rokovanie.sk/Rokovanie.aspx/BodRokovanieDetail?idMaterial=22350>

What measures has the Ministry of Health implemented since 2016?

The government is quoting some of the establishment of a so-called Subordinate Organization Management Office (directly managed as a network of healthcare facilities). It evaluates both financial and operational reports, public procurement, supports the implementation of various projects to limit the growth of the debts of these hospitals (we do not know exactly what projects IDE). It also introduced a so-called Board of Directors in each of these facilities with three members and, at the same time, regulators with regular scheduling sessions. The Office and some other departments of the Ministry of Health analyze supplier contracts, cost of medicines, or the issue of so-called over-limitations, that is to say, health care performances performed beyond that agreed with health insurance companies. It covers the central purchase of so-called "big medical equipment". Allocative efficiency is sought in co-operation with the Department of Finance's "Value for Money" department. Performance parameters for this savings area are mentioned elsewhere in this material. The Ministry of Health of the Slovak Republic will release this year an additional 31 mil. EUR. The review identified measures totaling EUR 174 million. EUR 2017. Of the total amount, EUR 143 mil. EUR for public health expenditure. On the basis of the identified measures, internal restructuring of public health expenditure will be carried out without examination of the extent or volume of healthcare provided. Effective operation and cost-effective procurement in hospitals subordinated to the Ministry of Health of the Slovak Republic will release an additional CZK 31 million. EUR. The revision of expenditures identified a theoretical savings of up to 84 million. EUR 1 per year in operation in faculty and university hospitals [2] achieved through measures to optimize the number of staff and the number of doctors and nurses, as well as the above-mentioned energy and service procurement. Making operation and procurement more efficient and resources identified in this way help to slow down and gradually stop the indebtedness of hospitals. The Office also analyzes the identified measures and implements them gradually.

It should be added that the realization of the de-institutionalization of mainly state hospitals, in the fourth order, is an interference with the equality of conditions for the implementation of health care and can justify it perhaps by the public interest. Even many regional hospitals were badly managed by their founders in debt - but they were not de-committed, the regions sold them to private investors. Slovakia, however, in the opinion of the Slovak Medical Chamber, is not prepared to take such a step in the case of large state hospitals, many of which have the status of university hospitals and not just that, we think that this step is also unworkable. State-managed "controlled competition", which is practically only a privately owned hospital and outpatient sector, does not have practical political support in Slovakia besides private investors and some economists, and we believe that right-wing political parties will also avoid them.

So-called de-stretching has more stages. The whole process will be published on the Ministry of Health website. By signing into the system, the creditor surrenders tax secrecy to the ministry. The Ministry may, without giving any reason, exclude any claim from the system. Hospitals can only join the system if they meet the following conditions:

They will prove the outstanding obligation after the maturity date of 21.12. 2016, the hospital expresses the willingness to accept the terms of the financial mechanism, the hospital shows EBIDTA's negative balance, but it does not have to record the liabilities after the maturity date of 31.12. 2016, committing that in the following years the negative balance of EBIDTA will not be the same as for past due liabilities. the hospital is shown to be in a recovery plan. Part of the plan will also be a cost-benefit projection over the next five years. It also undertakes to set up a supervisory body with precisely defined (and extensive) competencies. If the hospital fails to complete a recovery plan, including an EBIDTA negative balance or a post-maturity liability, a financial claim from the Ministry of Health will be incurred against it for the amount that has been provided for the de-commitment.

The recovery plan itself should contain relevant measures to achieve a positive EBITDA and zero commitment over the next two years: if this plan does not recognize the Ministry of Health, the hospital will not participate in that stage of de-commitment. Further parameters will be the so-called surgery, reoperation, rehospitalisation, hospital mortality, scaffolding, and other indices that should evaluate the quality level and the impact of the measures on it.

Failure to comply with the recovery plan will trigger sanctioning mechanisms, including in particular: freezing of wages above the statutory minimum, non-utilization of funds for unbundling, change of statutory and fines.

The Ministry of Health proposed two forms of unbundling, namely electronic action and a fixed discount method. As with previous deferrals, creditors have to surrender all so-called accessories to receivables, in particular interest on late payments. The first creditors are satisfied with those who agree to the fixed discount method, the others will be included in the electronic auction. However, it does so only afterwards. Depending on the age of receivables, several periods of deferral (tranche) are expected from the oldest debts to the most recent. I. from 1.1.2016 to 31.12.2016, II. from 1.1.2015 to 31.12.2015, III. from 1.1.2014 to 31.12.2014, IV. from 1.1.2013, V. other. The auctions for a given

set of released funds will then proceed from the oldest receivables, with the creditor's entry into the auction requiring a discounted rate of 2.5%. The auction will be based on a high number of creditors (about 3,000) and a number of receivables (approximately 250,000) realized on a multi-day basis with a closing date after each competition day.

The identified need for redevelopment resources based on the aforementioned impacts (state of commitments, ongoing indebtedness, as well as an estimate of savings to be made in the course of de-baling) is up to 600 million. EUR.

It is also worth considering that the indebtedness of hospitals will continue in the coming years. If the income of indebted hospitals does not increase, their debt is expected to increase after maturity in year 2017 81 million. EUR, year 2018 67 mil. EUR, year 2019 55 mil. EUR, year 2020 43 mil. EUR

This is why the de-balancing is divided into three stages, the individual stages of de-bridging being divided as follows: In the first stage (realization in 2017) all receivables of creditors overdue over 31 December 2016 will be deferred over 2 years. In the second stage (realization in 2017/2018), the receivables over the maturity period will be deferred from zero to two years as of December 31, 2016, while the hospitals with which the Ministry of Health approved their recovery plans will be included in the decommissioning. In the third stage (implementation in 2018/2019), receivables from creditors arising after January 1, 2017 will be deferred; but only to those hospitals that will adhere to the conditions defined by the recovery plan. Debts to the Social Insurance Company should be transferred to a newly established state organization presumably under the authority of the Ministry of Labour, Social Affairs and Family. This may (but need not) write off these debts. Income tax receivable is exempt from income tax in the case of contributory and non-profit organizations according to the Ministry of Finance, so that these do not incur any tax liability. Social Insurance claims will not be part of the electronic auction system (EAS). They will proceed on the basis of a separate assignment agreement independently of an electronic auction. Between hospitals and the Ministry of Health, a mandate agreement will be concluded, in which their ministry will not only represent the detachment, but hospitals will be committed to complying with the abovementioned conditions for entry into the de-escrow mechanism. Other legal documents are the Agreement on the new commitment between hospitals represented by the Ministry of Health of the Slovak Republic and individual hospital creditors, which will result in the original with the accessories being changed to the percentage of the principal without accessories with a new maturity. It will be closed by the creditor of the hospital and by the Ministry of Health as the plenipotentiary of the hospital. Other legal documents are an agreement to accede to the commitment by the Ministry of Health to proceed to the new Obligations of a duty Hospital arising from an agreement to initiate a commitment between the creditor and the hospital (represented by the Ministry of Health), which will become the so-called solitary debtor of the creditors, it will pay the creditor the amount owed to the creditors for the regression. Then it is still a debt relief agreement or a secondary agreement for a new commitment between the Ministry of Health and the Hospital, whereby the ministry will subsequently enter into a debt relief agreement or an agreement on the private reclamation of a liability arising from a regressive claim of the Ministry of Health to the debtor's obligation and then to the creditor's payment of the obligation. The purpose of this agreement is also to determine the specific conditions for debt relief (fulfillment of the conditions of the recovery plan). Well and the end should be two more agreements. One will concern the assignment of the debts of the hospitals represented by the Ministry of Health towards Social insurance company to a third party to be newly created a state company. It should then forgive the hospital's mandate (the Ministry of Health) all debts that have been

10. **How do you assess the current system of reimbursement of hospitals' activities by insurance companies?**

Opinion of Slovak Medical Chamber: *The system of reimbursement for hospital care has hitherto dominated the system of prospective contractual payments for terminated hospitalization. Health insurers have differentiated hospital providers according to the examined and verified performance requirements by varying payment levels: under certain circumstances, however, the provider was motivated not only to "cure" the patient as soon as possible, but also to "relieve" a costly patient " higher "often" specialized*

workplace ". Another motivation was to hospitalize the financially less demanding patients and to get as soon as possible outpatient care. Against the medical insurance weapon, in addition to the review activity, the number of hospitalizations was limited by setting an upper limit for their number for a given period, possibly with the "answering" of authorized or approved hospitalizations in the end of the calendar year or just after the expiration. Another regulator framework on the part of the payer was management of hospitalizations by granting the insurer's consent for non-acute hospitalization or the need to report acute hospitalization to the patient's health insurance company within 24 hours.

Public procurement

11. **Some reports suggest that despite steps taken by the Ministry of Health, public procurement in Slovakia still leads to higher prices of medical equipment and material compared to for example in the Czech Republic. What are the reasons? What other measures could the authorities take to improve price performance of public procurement?**

Opinion of Slovak Medical Chamber: *we refer on these sources*

The Register of Beneficial Ownership in Slovakia: Revolutionary transparency, questionable implementation, unsure benefits Transparency International Slovakia

(21)http://transparency.sk/wp-content/uploads/2017/06/Register-of-beneficial-ownership_study2017.pdf

(22)OPEN DATA TO FIGHT CORRUPTION CASE STUDY: SLOVAKIA'S HEALTH SECTOR Author: Gabriel Sipos, Transparency International Slovakia © 2016 Transparency International.

http://www.transparency.sk/wp-content/uploads/2016/05/2016_OpenData_SlovakiaHealth_EN.pdf

DRG-based reimbursement system

12. **Do you have any information on the first phase of the DRG system which was supposed to be introduced in 2017?**

Opinion of Slovak Medical Chamber:

By the state owned health insurance company VSZP together with other two is ready to implement the DRG payment mechanism from 1.1.2017 (23).

The reimbursement mechanism is set so that in 2017 the financial impact on the provider of institutional healthcare will be neutral, ie that the DRG payment will not have a negative financial impact compared to the reimbursement for constitutional health care under the current reimbursement mechanism.

Part of DRG reimbursement is that healthcare provided to an inpatient patient who has been previously in excess of institutional healthcare is paid separately in another type of healthcare (eg joint investigation and treatment or specialized outpatient care). Monthly reimbursement to DRG's institutional healthcare provider will therefore be increased by the contractual arrangement by the amount of resources corresponding to this healthcare calculated on the basis of the reported and paid health care in 2016. This means that if, in addition to DRG reimbursement, the VHF pays the hospitalized patient provided other than institutional health care (eg, joint investigation and treatment facilities or specialized outpatient care), then it will be refunded by the provider of institutional health care.

In practice, this means that if a provider of institutional health care is also required under the DRG reimbursement mechanism to order an equal volume of joint investigation and treatment facilities and specialized outpatient healthcare for hospitalized patients, the resulting amount of funding for providing institutional healthcare will be the same in compared to the amount of funds received for the provision of institutional healthcare covered under the current reimbursement mechanism.

In 2017, a DRG-related reimbursement mechanism was launched. Also, specialized institutions that have not yet passed the scheme are negotiating with health insurance companies to switch to this form of payment. Starting in 2018, the five-year process of individual patient rate pricing begins. The aim is their full convergence into one nationwide reference base rate. This process is due to end in 2022.(See lower)

(23) <https://www.vszp.sk/poskytovatelia/drg/>

13. What is your view of the planned base rate convergence?

Opinion of Slovak Medical Chamber:

The initial expectations of the DRG project were from the point of view of hospitals - in terms of base rate convergence - the most optimistic

The base rates for hospitals for 2017 were calculated from the costs of all three health insurance companies in Slovakia in the so-called DRGs of relevant hospitals in 2015. Thus, not all hospitals were but a group of different types of hospitals that were able to provide relevant details about their cost management on case-mix cases. From these data, three groups of rates were then calculated: 1. individual basic rates; 2. total Czech reference rate; and 3. informative so-called "group basic rate" for a hospital-like character. Rates are calculated from the ratio of DRG costs of health insurers for an individual hospital and a case-mix of the cost of that hospital (1), or from DRG costs of health insurance companies to a certain group of hospitals (3). According to a similar principle, the informative nationwide reference rate is calculated "(2)

As part of hospitalization reimbursement, there are still so-called 'other healthcare facilities' in 2017, that is, hospitals that are assigned to a group of hospitals known as first-class hospitals

For the year 2018, individual and informative group baselines under 1 and 3 are then calculated on the basis of revised health insurance data on hospital care in 2016 that are processed in 2017. A similar procedure is then applied for further years. The cost of health insurance for a given year is estimated from the predicted health insurance funds to reimburse DRGs to hospitals in a given year after deducting the so-called indexable items that health insurance companies reimburse to hospitals outside the DRG model

In the case of the reference base rate for Slovak hospitals, this is the ratio of the available sickness funds to the DRG model for the year in question against the projected hospital costs predicted for that year. The calculations are jointly carried out by health insurance companies, the Ministry of Health and the Health Care Surveillance Authority.

The convergence process should take five years, during which the individual basic rates will be closer to the rate for a given group of hospitals, and at the same time it will approach the national reference base rate. The algorithm will be as follows: In 2018, individual baseline rates will approach the group's plus / minus 20%, and the group's basic rates will approach the average of the US plus / minus 20%. In 2019, this will all be with the same mechanism, dealing with a 40% difference in basic rates, and by 2020 it will have a 60% approach, 80% in 2021, and 2022 all the rates at the national reference point. Thus, by bringing rates closer to each other, the zooming range will be relatively greater.

Statement of the Slovak Medical Chamber: A simple way of convergence can be accepted as well as the planned approach period, which will also allow to improve the underlying data base. A more rational use of hospital resources can be expected as well as possible attempts to "improve" bills, as is the case anywhere. However, the problem of Slovak hospitals will be the fact that the DRG reimbursement mechanism as well as other reimbursements to hospitals for non-DRG-rated performance and hospitalization will not even cover their fixed costs and no accumulated investment debt at all in the near future. The worse would be if the personnel costs, which make up an important part of the hospital costing plan, are addressed in solving this problem.

14. Are there in your view areas which the Ministry of Finance has not yet addressed sufficiently so as to ensure a smooth transition to DRG?

Opinion of the Slovak Medical Chamber: We do not have any information on how the Ministry of Finance could be involved in this area.

Care management

15. Have you noticed any measures to rationalize hospital capacities to address high number of hospitalizations and excessive number of acute care beds except the new classification of hospitals which serves as a first step to a reduction of acute care beds?

Opinion of the Slovak Medical Chamber:

Systematic interest in rationalizing hospital capacity has in the past 15 years, however, the number of hospital beds has decreased. While in 2001 the total number of beds was almost 42 thousand, in 2010 it was only more than 35 thousand, almost 32 thousand a year. According to the National Health Information Center, over the last 5 years, most of the beds in the lungs (up to 712), thereafter in the departments for the long-term ill (331) and the eye-care departments (244). not recorded. The Ministry of Health organized a reduction of the Bed Fund in 1998-2001 and covered 1 536 beds. However, 621 acute beds were reprofilled to chronic beds and therefore the actual decrease was 915 beds

In the period of 10 years to 2011, several proposals have been made to reduce the number of hospitals or beds, for example, according to Milan Kamenec - who proposed a reduction of beds after consultation with the self-governing regions in 2006-2007. The then Minister of Health Ivan Valentovič material based on the structural methodology of the plan of hospitals in Austria and expected to reduce the size of the then bed capacity (approximately 37,000 hospital beds) by 6,200. The Health Policy Institute analysis proposed a reduction of more than 7,000 beds in 2006 and finally Maria Voleková MD, in its so-called analysis, suggested reducing the number of hospitals and the total bed fund by (24). The reduction of beds in hospitals that took place in 2011 was linked to the indebtedness of hospitals in particular, but also to the lack of finance and the prolongation of insurance companies, especially the General Health Insurance Company, which is still the largest health insurance company in Slovakia and the shareholder of which is the state. Following negotiations between the government, the health ministry, and stakeholders, the number of reduced beds has stabilized to 3,300 (25)

Hospitals have been disrupted, some have been abolished departments for reasons of low encumbrance, or only reduced the contracts of the insurance company with respect to some departments, which meant the cancellation of part of their beds. It was paradoxical that a negligible part of the canceled beds was intended for chronic patients. The professional analysis promised by the state health insurance company has never been published. It was not even the promise - that the amount of funding for hospitals that cancel beds would remain the same. On the contrary, it has decreased, and also because the private insurance companies have also added to the measures of the state insurance company by canceling the contracts. At the same time, the abolition of contracted volumes of health care by health insurance companies as a tool to reduce the network of hospital departments did not allow the law and did not allow it now. This competence belongs to and still belongs to the state represented by the Ministry of Health - see. Status of the Ministry of Health Article 3, paragraph (a), Number 6 and 7 (26)

After this reduction, systemic steps have not been taken in this direction, but the acute caretakers of chronic illness have emerged.

(24) FOND POSTELÍ V SIETI NEMOCNIČNÝCH ZARIADENÍ Slovenskej republiky 1. Časť Štúdia z materiálov MZ SR, hodnotené údaje sú za rok 2005 Marec 2007 Maria Volekova

http://old.hpi.sk/cdata/Documents/volekova_analyza.pdf

(25) Správa o realizovaných racionalizačných opatreniach vo vzťahu k transformovaným štátnym organizáciám

<Http://www.rokovania.sk/File.aspx/ViewDocumentHtml/Mater-Dokum-131045?prefixFile=m>

(26) <http://www.health.gov.sk/?statut-ministerstva>

16. Has there been any progress in 2017 to transform acute beds into long-term care (LTC, elderly care) beds (level, timeline, expected outcome in terms of costs)?

Opinion of the Slovak Medical Chamber

Transformation in bed care in 2017 by the Ministry of Health in hospitals it manages in principle has not occurred. Reports with private hospitals are also not readable for the Slovak Medical Chamber. Most of these hospitals have until recently been owned and managed by self-governing counties, some of which have been

rented to private investors. However, in the past 5-6 years, massive privatization took place in the non-owned sickness insurance sector, during which dozens of hospitals were given private investors not by rentals but by selling. Two of the largest private owners of acute general hospitals create private networks, the health policy of these investors. It is understandable that the term "synergy effect" or "specialization of hospitals" or several others will appear in the business plans of investors in relation to healthcare, which will reflect the improvement of the economic and financial efficiency of these facilities and perhaps also improving the quality of healthcare provided in them. On the other hand, however, the question is how to provide hospital healthcare and other health care plans in the state where these hospitals should be involved in the provision of acute healthcare in these facilities. In the current situation, however, the Slovak Medical Chamber must state that, in the absence of regional health policies, there is neither a consistent and sustainable state health policy nor a few government documents (the 2013 Strategic Health Care Framework, or its two implementing varieties 2014 and 2016, Government Program Statement of 2016, with a time dedicated to health, and its elaboration by the Ministry of Health) is low. The surge of the state's huge regulatory urine is more about action plans rather than strategic ones, and we will not be surprised to see that the plans of the private sphere in health care will take its own, business-oriented direction.

Opinion of the Slovak Medical Chamber

Despite the past efforts and concepts of the transformation of the fund, including the fund of acute hospital beds, there has not been a major government policy in Slovakia to address this. Changes and reductions that have occurred in the past have been motivated and implemented abruptly, not in the context of a conceptual transformation of bed care, but usually in addressing the acute need to save money. For example, in 2011 the rehabilitation of the largest, state-owned, health insurance company was done. Even then, only the number of acute beds, but also beds of intermediary and chronic care were reduced. These, for example, are currently missing.

- 17. Are you expecting to review the network of 'strategic public healthcare providers' (37 hospitals, no primary care providers)?**

Opinion of the Slovak Medical Chamber

The notion of a strategic health care provider in Slovakia does not exist and does not even exist in government documents. There are, of course, really similar devices in the given situation. Legislation recognizes the so-called minimal network of healthcare providers that have included certain hospitals (Government Regulation No. 751/2004 on the Public Minimum Network of Healthcare Providers), which has been repeatedly - often contradictory - updated. Even in 2002, a proposal by the Ministry of Health emerged defining the criteria for the so-called optimal network, but never discussed by the government. The minimum network is characterized by the number of ambulance and bed care providers of different types with which health insurance companies have to conclude healthcare contracts. Payments also apply to so-called self-governing regions, so if there were outages in the number of providers below the regional level, for example at the level of the districts, it was not the reason for the inversion. Because there are currently outages mainly in rural areas or regions, the introduction of some district standards. Integrated health care centers should also be one of the assistance solutions. a fixed network of hospitals. Small area statistics, especially smaller than the district level, are the weakness of the statistical system of the Slovak Republic. While only guidance numbers are set for outpatient providers, a nominal group of the so-called end-point or network of hospitals with whom health insurers have to conclude healthcare contracts is within the hospital's minimum hospital network. Within these hospitals, there is also an individual department with an obligation to contract, as its scope is not overwritten. Within the definition of a minimal network of acute hospitals there are still so-called hospitals in the so-called fixed network. This network includes hospitals that provide continuous health care of the scope of ureteral intake, anesthesia and intensive medicine, surgery, internal medicine or cardiology, neurology, gynecology and obstetrics, neonatology, pediatrics, pharmacies and ensure the continued availability of common investigative and therapeutic components in the fields radiodiagnostics (CT necessary), clinical biochemistry, hematology and transfusion therapy. Government regulation also established 37 landing areas for a fixed network. The catchment area consists of one to four districts. However, one-thirds of catchment areas accounted for almost 1/3 of all areas. At present, the health insurance company contracted various numbers of hospitals on the basis of fixed network criteria - from 36 contracted by the private health insurance company Dôvera, to 31 hospitals with a contract with the State General Health Insurance Company up to 26 hospitals with contracts of the smallest health insurance company Union. From this, we can see that elements of selective contracting can also be applied at present.

The last changes to this were ordered by changes in Government Regulation no. 640 / 2008,274 / 2011 and 290/2012. This year, the Ministry of Health also defined a network of urgent revenues and, within this network, those built or reconstructed with the financing of the so-called regional integrated operational program financed by the European Union. Some fixed-line hospitals, despite the fact that they do not work in the target areas of the finance program. The reduction of the number of general hospitals in the near term certainly is not possible, and we expect that new hospitals will be created, for example, a private hospital in Bratislava. The construction of a new university hospital in Bratislava will bring about changes in the hospital care system. We fear, however, that the private investor's lead time may cause such a state-owned facility to no longer emerge or be built and operated in a limited form. The fact that the activity of the hospital in the given catchment area is a sensitive issue not only in terms of health but also of the overall economy is evidenced by the recent visit by the Minister of Health in a disadvantaged area with a hospital with a catchment area of around 50,000 inhabitants, where the meeting assured the local public that the hospital continue to work and the ministry plans to provide a capital injection to the hospital.

(27).(<http://www.health.gov.sk/Clanok?mz-sr-ma-zaujeme-na-rozvoji-nemocnice-vo-velkom-krtisi>)

18. Have the authorities taken sufficient measures to contain use and spending on ancillary services such as diagnostic imaging, laboratories, transportation and medical rescue services?

Opinion of the Slovak Medical Chamber

In the case of limiting the costs of ancillary services, especially in hospitals, a few basic facts must be mentioned

1.Fact Within the framework of the reform measures in 2002-2006, substantial private capital was allowed to enter the areas of deficient ambulatory and hospital services, including auxiliary services. The purpose of this reform was to facilitate their privatization and establish favorable conditions for entrepreneurship, to suppress competition, procurement costs, lease terms, favorable contract models with health insurance companies, operating conditions, easy depreciation, all with long-term guarantees ...

2.fact Some of the tenders listed clearly had discriminatory conditions, worsened competition, often lacked transparency, and clearly lacked benchmarking and references.

3.fact The prices for these services remained high even after more than 10 years after the beginning, in some segments not only surpassed the usual prices in the surrounding post-communist countries but also, for example, in Austria and Germany.

4th fact. Many hospitals have also been pushed out of the competition, which has lost a significant source of income, for example by setting up dialysis, rescue services, modern imaging techniques, dispensing drugs and special health equipment, not only by the fact that they have been denied state capital transfers or favorable loans mainly by low payments for their performance.

Many hospitals then found themselves in a situation where, without any compensation, many of them were in bankruptcy because the performances they performed were just enough to cover operating costs, but not even the smallest investments. Health care in these segments has improved gradually but hospital services are not

5.Fact Since there was no DRG payment mechanism, important information on the profitability of hospital services was missing. At the same time, there was an important tool for rationalization, saving and systematic actions leading to a balanced management of hospitals, feedback on the cost of these services, which were implemented in the external environment by contracts between insurance companies and private operators. The most prominent was the situation in large state-run direct hospitals, but it also applied to other public hospitals in which the state was involved (joint stock companies, non-profit organizations) and, of course, to hospitals in established self-governing regions to prevent their collapse. were largely sold to a private investor.

These five quoted facts, together with many other and more important circumstances, led to the periodic and irreversible indebtedness of the largest state university hospitals. Unfortunately, the tools to reverse these trends are limited, although the outsourcing of similar services may not be better than running

hospitals. The most active in concluding unfavorable contracts with private providers of these lucrative services was the State-controlled General Health Insurance Company. Many for the insurer's disadvantageous contracts are valid until 2018 and their correction is demanding. The Ministry of Health has taken a series of steps and measures inspired by analyzes of the Financial Policy Institute, the Health Policy Institute, international benchmarking for goods and services, market mechanisms to increase competition and transparency, and to improve control mechanisms in hospitals under their administration. Setting fair conditions for procurement in public hospitals will result in savings, but they have their limits and spending on similar services and goods will continue to grow, albeit at a slower pace. However, this is already a matter of increasingly rapid technological progress, complicated disease states and general cost rises in health care.

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

Opinion of the Slovak Medical Chamber

The planned measures for the centralization of doctors in the centers are obvious, we do not yet see any measures to ensure their integration or integration of specialized and specialized medical activities with other healthcare professionals or the integration of centers' activities. No organizational, legislative or financial instruments are planned to ensure the integration and sustainability of individual applicants' projects.

Justification:

On October 18, 2017, representatives of the Slovak Medical Chamber attended a meeting with the Ministry of Health of the Slovak Republic to evaluate the comments made by the Slovak Medical Chamber on the material of the Ministry of Health of the Slovak Republic "Regional Analysis including Methodology for the Implementation and Functioning of Integrated Health Care Centers" of July and August (II. part) 2017.) Representatives of the Slovak Medical Chamber reiterated that they considered the principal problem that the key concept of integration was not defined in the document. It is mistaken for centralization or concentration. It is not clear how the interaction between physicians and academics with medical professionals in the center should be attained, what tools, what financial resources and how it will be supported. This needs to be clarified in time because, as representatives of the SLK, several times demonstrated by the Ministry of Health - lastly by providing a sample calculation of the costs of the general practitioner's surgeries for the Ministry of Health in April 2017 - current financial resources of the health care providers from the health insurance companies are insufficient to cover the necessary health care, are limited and therefore do not expect physicians to contribute to their integration. The project is not systemically secured by the MZ SR in terms of its sustainability and therefore SLK still perceives it as highly risky and thus informs its members as well. Representatives of the SLK have said they support mainly the modernization of small existing centers and only if they want the doctors themselves to maximize the potential duplicate infrastructure so that the changes are as much as possible to improve the existing working conditions of the doctors. Representatives of SLK at the same time employees of the Ministry of Health pointed out that in the documents used the definition of primary health care has been obsolete since 1995 and it would be appropriate to respect the Recommendation of the European Commission Expert Panel on this Issue of 2014 on how to define primary health care (multiprofessional team (secondary, tertiary, long-term healthcare), new job positions related to the center's activities (case-manager nurse, public health function), as well as multi-source financing (support for the operation of the center by the municipality), etc. into Slovak legislation. The current material of the Ministry of Health and Deloitte under the title "Regional Analysis including the Methodology for the Implementation and Functioning of Integrated Health Care Centers" needs to be corrected and supplemented in the light of SLK comments (organizational, legislative or financial instruments to ensure the integration and sustainability of individual applicants' projects)(28). Representatives of SLK promised cooperation and re-professional comment on the material of the Ministry of Health after its completion.

(28) SLK comments for the Ministry of Health on a set of documents for the creation of centers of integrated health care. online: <https://www.lekom.sk/slovenska-lekarska-komora/stale-vybory-slk/staly-vybor-pre-legislative/aktivitu>

Pharma expenditure

20. What is your assessment of the progress of external reference pricing system for medicines established in different phases from 2011? Has the growth in pharmaceuticals expenditure been sufficiently contained or does it remain high?
21. Are there plans to centralise procurement of (expensive) pharmaceuticals?
22. What is the current status of generics use?

Opinion of Slovak Medical Chamber :

The new system of price comparisons of drugs adopted in Law 311/2011 has made it possible to significantly reduce the prices of imported medicines. However, this has led to a rise in the re-export of imported medicines for profit. The number of distribution companies has returned unusually, many of them have not delivered medicines to the internal market but have just re-exported them. In October 2016, there were lacking 2 644 different types of medicines in the pharmacies, in January - after the effective date of the amendment to the law - there were only 365. By the beginning of 2017, the situation was practically normalized. The amendment has allowed better control of the registrant / manufacturer over the drug circulation in our territory. Exports of medicines have become possible only with the authorization of the registration / manufacturer. On the other hand, there were concerns about the adequacy of high sanctions in the case of drug disruptions. It was problematic for importers and distributors of drugs to implement urgent supplies in the so-called "emerging system" in terms of enforceability.

Manufacturers /Registrants (licensed) could log in to the system on a voluntary basis, and distributors could choose to do so by their decision to issue their powers of attorney. However, the responsibility for importing and exporting, and therefore for supplying medicines, remains - after signing into the system – left on manufacturers. The patient in the system must be given a medicine prescribed by a doctor and covered by public health insurance within 48 hours. It can be said that the amendment to the law is currently functional and supply outages are no longer recorded.

However, major changes are being prepared by another amendment to this Act. This amendment addresses a number of drug-related areas of the market and, among other things, aims at improving access to affordable medicines or increasing the use of generic medicines. It also touches on some aspects of dealing with dietetic foods or medical devices.

Here are some of the changes introduced by the Ministry of Health. We quote from the content of the explanatory memorandum to the bill:

Amendment to Act 363/2011 of the Collection of Laws effective since the beginning of 2017 - proposal of the Ministry of Health. Justification. General Section September 2017 Act on the Scope and Conditions for the Payment of Medicines, Medical Devices and Dietetic Foods on the basis of Public Health Insurance and on Amendments to Certain Acts

The amendment to the Act on the Scope and Conditions for the Payment of Medicines, Medical Devices and Dietary Foods on the basis of Public Health Insurance and on Amendments to Certain Acts aims to specify the conditions for the official determination

of prices of medicines, medical aids and dietetic foodstuffs, and consequently the extent and conditions of their payments on public health insurance; to place greater emphasis on the cost-effectiveness of treatment paid on public health insurance; introduce innovative processes in the process of categorizing medicines to ensure the efficient use of public health insurance while safeguarding the financial stability of the system; to allow new medicines to enter the market more quickly; to promote the saving effect of public health insurance resources linked to the entry of generic medicines on the market; increase the transparency of categorization and official pricing processes.

Cost effectiveness of treatment

The amendment to the law places greater emphasis on the issue of the cost-effectiveness of treatment with medicinal products reimbursed on the basis of public health insurance, clearly quantifying the cost of treatment which, in the light of public resources managed by health insurance, is considered to be efficient and effective.

Increasing the limit of additional costs incurred from public health insurance to a unit of health improvement using an investigational medicinal product that may not exceed the threshold value of the medicinal product under consideration for one year of standardized life obtained.

The threshold value coefficient for one acquired life year of standardized quality is increased. An increase in the threshold value will allow a more expensive but cost-effective medicine to be included in the list of categorized medicines and healthcare options. This expresses the willingness of the state to provide for a higher reimbursement for higher value added medicines and, at the same time, to set a lower reimbursement for lower-value medicines.

The limit of additional costs incurred from public health insurance to the health improvement unit is defined using the medicine under assessment for one acquired life year of standardized quality, which applies to each drug individually. The threshold for medicines may vary and is the result of a comprehensive assessment of the benefits of using the drug.

It introduces the possibility of achieving the cost-effectiveness threshold for the inclusion of a medicinal product in the list of categorized medicinal products through a contract for the conditions of reimbursement by a health insurance firm concluded between the registration holder and all health insurance companies

Ensuring cost-effectiveness allows you to place your medicine on the list of categorized medicines.

The monitoring of more expensive and cost-effective drugs is included in the list of categorized medicines.

At the same time, there is a defined group of medicines with a significant impact on public health insurance which cannot be included in the list of categorized medicines. These drugs will be included in the list of categorized medicines conditionally for as long as they meet the criterion of significant impact on public health insurance.

There is increasing availability of drugs for the treatment of low prevalence by reducing the limit to 1:50 000.

Three reasons for discontinuing the drug from the list of categorized medicinal products are added. If the medicinal product does not achieve cost-effectiveness, which is the main criterion for the inclusion of a medicinal product in the list of categorized medicinal products, the submitted pharmacoeconomic analysis does not meet the defined requirements, and if there is a substantial change in the terms of payment agreement between the registrant and the health insurer, to a worsening of drug availability for policyholders of any insurance company.

It complements the duty holder to substantiate the application for inclusion in the list of medicinal drugs categorized design height threshold and calculating the thresholds which may not exceed the assessment of medicines that could be included in the list of categorized drugs.

The holder will submit payment terms contracts if he wants to achieve the cost-effectiveness of the drug by taking part in the cost of healthcare.

Sharing Costs

It introduces the option of the health insurance company and the manufacturer or holder of the medicinal product to agree on the conditions under which the health insurance company will bear from the public health insurance funds part of the cost of the medicines, medical devices or dietetic foodstuffs and the remaining part of the costs such as treatment effectiveness only with high insurance premium, innovative treatment, treatment beyond the indicated indication limits in the categorization list or in other cases, will be borne by the manufacturer or holder of the registration of the medicine, medical devices and dietetic foods. The possibility of entering into such a contract and accepting a refund by a health insurance company will be governed by the Act on Health Insurance Companies.

Tools for the efficient use of public health insurance resources

The Ministry, on the basis of its own procedure, already included in the list of categorized medicinal products which, under special legislation, are designated as medicinal products with a significant impact on public health insurance, will conditionally be included in the list of categorized medicinal products. This minimizes uncertainty about the future development of the cost of medicines with a significant impact on public health insurance. Part of the risk will be transferred by the health insurance companies to holders of the marketing authorization decision for such medicinal products.

he entry of cheaper generic medicines into the market is a highly effective tool for reducing public health insurance spending on medicines. At the same time, the draft law tightens the condition for lowering the price when the first generic medicine enters the market. The minimum price reduction of 30% compared to the original drug concerned is subject to a price reduction of at least 45%. The entry of the second generic drug, the price of which is reduced by at least 10% compared to the lowest-priced first generic medicine, is introduced. The condition of a third generic drug is introduced, the price of which is

reduced by at least 5% compared to the lowest-priced second generic medicine. Based on these measures, it is intended to stimulate the natural competition of manufacturers and suppliers of medicines, thereby saving the cost of public health insurance. (The purpose of the mechanism is to stimulate the effect of lowering drug prices and the reimbursement of health insurance contributions resulting from the entry of generic medicines into the market.)

The entry of cheaper, more bio-like medicines (biosimilars)into the market is a highly effective tool for reducing public health insurance spending on medicines. At the same time, the draft law tightens the condition for lowering the price when the first biologically similar drug is introduced into the market. A minimum price reduction of 30% compared to the original drug concerned is conditional. The condition of entering a second biologically similar drug is introduced, the price of which is reduced by at least 5% compared to the lowest-priced first biologically similar drug. The condition of a third biologically similar drug is introduced, the price being reduced by at least 5% compared to the lowest-priced second biologically similar drug. Based on these measures, it is intended to stimulate the natural competition of manufacturers and suppliers of medicines, thereby saving the cost of public health insurance. (The purpose of the mechanism is to stimulate the effect of lowering drug prices and the reimbursement of health insurances resulting from the entry of biologically-relevant medicines into the market.)

The ceiling on drug prices is determined as the average of the three lowest reference basket prices. Allows a categorized drug to increase the price of the drug by a maximum of 20% if it does not exceed the European reference price.

There is a widespread regulation that applies to solid dosage forms and other drug formulations when referencing payments. This will increase the effectiveness and equalization of regulation for all drug formulations.

Conditional Categorization of Medicines as a Tool for Effective Use of Public Health Insurance Resources

Specification of the terminology specification for commonly considered drugs for the clearest identification required by application practice.

The limitation of the duration of conditional categorization is abolished, the drug will be conditionally included throughout the period when it will have a significant impact on public health insurance.

The Ministry, on the basis of its own procedure, already included in the list of categorized medicinal products which, under special legislation, are designated as medicinal products with a significant impact on public health insurance, will conditionally be included in the list of categorized medicinal products.

The Ministry decides on conditional compensation for a period of 12 consecutive months. After the end of this period, it compares the actual reimbursement with conditional reimbursement and, in the event of a difference, determines the rebalancing difference that the holder of the registration has to reimburse to health insurance companies.

By using this amendment, the ministry minimizes uncertainty about the future development of drug costs with a significant impact on public health insurance. Part of the risk will be transferred by the health insurance companies to holders of the marketing authorization decision for such medicinal products.

Social aspects of the law - limit of participation

In order to extend the non-medication limit to medication and dietetic foods, in order to reduce the financial burden on patients who use medication and dietetic foods in addition to medicines.

In order to reduce the financial burden on patients, while preserving the principle of cost-effectiveness of the use of public health insurance funds, medical aids and dietetic foods are also introduced into the limit of drug participation.

The reduced participation limit for disabled people from € 25 to € 12 over a three-month period is reduced. This reduces the financial burden on patients, while preserving the principle of cost-effectiveness of the use of public health insurance.

Removing duplication of protection limits. The patient will deduct the value of the funds coming from the most favourable protective limit that the patient is required to bear.

There is a significant reduction or total elimination of the surcharge for high-cost medicines, where the reduction in price, while respecting the reimbursement / reimbursement ratio, does not allow such a reduction or elimination of the surcharge.

It is proposed to broaden the definition of public interest for the purposes of categorization. As one of the specific circumstances under which the ministry may decide to abstain, a situation is also in place where it is necessary to provide a suitable therapeutic alternative while preserving cost-effectiveness.

Strengthening the regulation of prices of medicines for medical devices and dietetic foods

The amendment to the Act regulates the processes of categorization and official determination of prices. Decision-making processes increase transparency by introducing objective criteria for deciding whether to determine or subsequently alter the officially determined prices of medicines, medical devices and dietary foods.

An additional cost data source is defined which will allow the prices of medicines, medical aids and dietary foods paid for from health insurance to be compared effectively to the prices of medicines, medical devices and dietary foods in other Member States. The bill also sets out a more detailed procedure for comparing prices with prices in reference countries. The bill introduces new, objective criteria for deciding on potential applications for increasing officially priced medicines, medical aids and dietary foods.

Modification of the Categorization Process - Medicines

Procedures are added to the process of applying for the official price instruction of a drug not included in the list of categorized medicines, as the procedure has not been described in the law currently in force.

Specification of the terminology specification for commonly considered drugs for the clearest identification required by application practice.

Modification of the Categorization Process - Medical Devices

Enhancement of health care is ensured by the inclusion of new medical devices meeting the criteria for inclusion in the list of categorized medical devices by defining new groups so that they can be modified and supplemented. Amendments and amendments are discussed by the categorization committee. The possibility of a regular quarterly adjustment of the extent of payment in the sense of payment for a piece of tailored medical device, prescription and indication of limitation, financial or quantitative limit, and limitation of the reimbursement of the health insurance company to its prior approval. The aim is to efficiently spend public health insurance.

There is a price tagging of at least three of the Member States of the European Union by the applicant in the process of categorizing and officially determining the price of a medical device for inclusion in the list of categorized medical devices.

The list of medical devices that are not for medical purposes and cannot be covered by public health insurance is more precisely defined.

It provides for the reimbursement of medical supplies which do not have an officially determined price in at least two Member States of the European Union up to a maximum of 20% of the price of the medical device.

The objective of the provision is to ensure the financial stability of the public health insurance system by avoiding disproportionate reimbursement of medical supplies for which applicants can not prove prices in the Member States.

Modification of categorization process - special medical material

It ensures that the regulation of medical devices is also valid for special medical supplies. For the purpose of consistency of the law which introduces the terminology of special medical material in the definitions of the basic concepts and thus distinguishes the medical device from the special medical material, it is terminologically added to the paragraph in question.

The introduction of the financial limit narrows the conditions for the payment of special medical supplies as an instrument to increase the effective use of public health insurance. A price appraisal of at least three Member States of the European Union is introduced by the applicant in the process of categorizing and officially determining the price of special medical material for inclusion in the list of categorized special medical supplies.

Modification of categorization process - dietetic food

The rules for determining the maximum amount of reimbursement of a health insurance company per unit of reference dose of dietetic food are introduced. By introducing a unit price for a dietetic food, it is possible to compare the prices of dietary food introduced with the prices of dietetic foods in the Member States and to avoid overstating the price of dietetic foods in Slovakia.

The scope of the data and information published by the Ministry in the list of categorized dietetic foods is supplemented. The data will serve to compare the prices of dietetic foods in the EU Member States. It prevents misleading information about dietetic food. Addition

of information to prevent disproportionately high compensation for dietetic food from public health insurance.

Effective official monitoring of foodstuffs covered by public health insurance is in place. The participant in the case of categorization and pricing of dietetic food is the producer who is also responsible for food safety. This has resulted in an alert system and eliminates the risk to the health of patients. It will make it possible to compare effectively the prices of dietetic food covered by health insurance with the prices of dietetic foods in other Member States.

It prevents the payment of dietetic foods unsuitable for dietary regimen or diet of patients and dietetic foods of a complementary nature without special medical purpose.

It provides for the payment of dietary foods which do not have an official price in at least two Member States of the European Union of up to 20% of the price of the dietetic food

Plans of the Ministry of Health for the Year 2018

Medicines and medical devices

Several legislative changes were adopted in the course of 2017 to clarify the conditions for the reimbursement of medicines for exemption and to modify the possibilities for entry of innovative and generic medicines on the market. Regulatory limits for outpatient providers should be introduced in 2018 to combat over-the-counter medicines. Cost-effective medicines will be more centrally procured and purchased. In addition, physicians will be able to give patients a prescription where only the active ingredient is prescribed, not the specific medicine⁵⁰. During this year there will also be a gradual reference of the prices of special medical supplies and medical aids. In 2018, attention will be paid to the persistent problem of re-export of medicines, which also emerged after the Medicines and Medical Devices Act approved.

50 The Healthcare Implementation Plan (November 2017). Ministry of Health <https://www.vicpremier.gov.sk/wp-content/uploads/2017/10/IP-Zdravotnictvo-FINAL.pdf>.

E-health system and data collection

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

Opinion of Slovak Medical Chamber:

The Slovak Medical Chamber requests the refinancing of healthcare facilities by electronization (providing software and hardware free of charge, or refinancing healthcare provider expenses for eHealth, reimbursement of expected service costs, etc.) eHealth.

Justification:

Representatives of the Slovak General Practitioners Society called on physicians seven months ago to send all the invoices they had recently received from suppliers for eHealth connections to the National Health Information Centre. Missing the necessary software is currently an objective obstacle to the implementation of the project, said the company. Representatives of this medical company, who were also delegates to the SLK on 20 and 21 October 2017 in Bratislava, asked SLK to support this initiative, as all other notices, statements, comments and the like had failed. The Slovak Medical Chamber is of the opinion that if the state asks the doctors to use eHealth, it should also provide financial coverage for its connection and operation by individual providers.

Early in 2018, eHealth has been on the rise in Slovakia with many understandable problems. By far not all of them have been caused by their own doctors. The Slovak Medical Chamber does not share the optimism

of the Ministry of Health, because even after five months the basic components of eHealth - such as electronic recipe, electronic ordering and electronic patient record - do not work.

On the other hand, the drachma law of the eHealth law, which threatens to punish doctors who are not joining the eHealth system this year, does not really work. Such doctors should pay a financial fine of € 300 to 300 000 €, and the Slovak Medical Chamber should cancel their registration. This would lose the basic condition for the exercise of their profession.

24. Have there been any improvements in information systems and collection of data monitoring health services use and performance?

Opinion of Slovak Medical Chamber:

The healthcare a public health systems, social services, social security, sectoral research projects, and many others information resources represent the set of Big Data, which is now an opaque jungle rather than a space of meaningful use. The Slovak Medical Chamber registers the first steps of the Ministry of Health in the area of Health in the Consolidated Data Base of the Health Services Sector. This project is focusing on cloud services. However, the project - developed by the National Centre for Health Information - is highly relevant, lacking the concept of inclusion in the wider framework of data collection, management and evaluation. Several government projects are being evaluated in the rating of nongovernmental organization Slovakia Digital. The National Health Information Centre project is rated badly and, according to Slovakia, Digital is among the weaker. It is believed that it is not linked to any reform goals, the project has no measurable objectives, the study states literally that one year after the deployment of the system (to be constructed over three years), around 15% of the data from the previous registries and this percentage should increase to 50% in the 10th year of life. The study also reads the lack of progress in achieving the basic goals. It works only with the software creation schedule There are no specific activities to be performed individual organizations to use the software. No compliance with KRIS has been evaluated yet. All KRIS(Concept of development of information systems) should go through a review by the end of 2017. In the current form, Slovakia considers the benefit of this project to be zero in terms of computerization. According to the study, the project has to deal centrally with data consolidation, master data management, data transmission between organizations - including 1x and enough security, data quality assurance. Equally, components for centralized registry management should be built.

The project, however, plans to build a separate "sectoral" infrastructure and does not take into account existing or planned central components - in particular the process and data integration module, data integration platform support services, planned back-end bus concept with build in micro services.

However, such a procedure is in no way justified and, in our view, is fundamentally ineffective.

The services to be created (and the technological components on which they are built) are completely generic as described in the feasibility study and it is unclear why they are to be built specifically for the health sector. For some key registries to be addressed, eSo (efficient, open, reliable public government) projects financed by OPIS (the Operational Program for Informatisation of the public government) created the solution "Uniform reference data base of the health sector" (JRÚZ) available presentations and studies had exactly the same goals as the current project.

However, several alternatives are identified in the data consolidation feasibility study, but no consideration is given to the separate support of the data consolidation solution and the current registry administrators. Multi-criteria analysis appears to be highly skilful in favour of an alternative to building a new central healthcare solution

Finally, it is criticized for calculating the effectiveness of the project, and there is a lack of distinction between simple and complicated registers. The weak participation of stakeholders in the project is also criticized, although a public hearing with the possibility of submitting proposals has been criticized. Non-governmental organization Slovakia (Slovensko) Digital records some reservations of the Slovak Medical Chamber. These concern, in particular, the funding of registers, which are chaired by the medical staff chambers. These are registries of licenses and registers of healthcare workers. These registers are led by the chambers of health workers, including the Slovak Medical Chamber at the expense of these organizations, and are covered by member contributions by their members. It should be noted that since 2004, membership in the healthcare chamber has been optional.

Slovensko (Slovakia) Digital Konsolidovaná údajová základňa rezortu zdravotníctva (Consolidated data base of the health sector <https://redflags.slovensko.digital/projekty/4494>)

Health workforce

25. Are the outcomes of the residential programme for GPs satisfactory? Have there been any changes to the training of GPs?

Opinion of Slovak Medical Chamber:

The Resident Program of the Ministry of Health of the Slovak Republic continues according to the publicly available information of the Ministry of Health of the Slovak Republic in 2017. The state budget is allocated 5 mil. € for residents from the whole SR, including the Bratislava Self-governing Region. The cooperation agreements are concluded with three medical faculties: the Faculty of Medicine of the Slovak Medical University Bratislava, the Jessenius Faculty of Medicine at Komenského Bratislava with its headquarters in Martin and the Faculty of Medicine at the Pavol Jozef Šafárik University in Košice. The residency program currently addresses only the shortage and the high average age of doctors in 2 specializations - in the specialization field of general medicine and the specialization of pediatrics. According to the media statement of the Ministry of Health of the Slovak Republic, there are 272 residents in total, of which 191 for general medicine and 81 for pediatrics, the first graduates to be available in 2017.)The number of registered residents is insufficient to cover the current and expected needs of Slovak healthcare. In the state budget, more money should be earmarked to secure a higher number of residents. The residency program needs to be extended by other specialists. It is necessary to introduce a system of medium and long-term planning and provision of specialists for health care system in Slovakia. It is recommended to adopt and implement a strategy for the care of human resources in health care. It is recommended to define an optimal network of healthcare providers.

Justification:

The lack of expertise for adequate patient care in Slovakia is alarming. Based on the data from the Register of Doctors of the Slovak Medical Chamber, - in view of the current age structure of adult general practitioners by 2025 (when 51% of them will have legal entitlement to retirement) - a total of 1114 physicians need to be added to the health system of the Slovak Republic to replenish the minimum network of adult care providers, which, moreover, is still far from optimal. However, according to the available information by 2025, only 191 general doctors are expected to be added to the Resident Program. The difference is minus 923 doctors. A similar situation is with general doctors for children and adolescents (specialist pediatrics department): according to the estimated scenario by 2025, when a legal entitlement to retirement arises, 633 doctors practicing their professional practice as general practitioners for children and adolescents will remain in the healthcare system only 410, ie 40% of the original number of doctors. The Resident Program assumes that only 81 will be added to the scheme until now. The difference is minus 329 doctors who do not know which resources to replace.

Most GPs (for adults and children and adolescents) have chosen the medical profession in the past not only as a job but also as a job and mission. It was, therefore, a habit of retiring physicians long after the period of statutory retirement. However, more can not be expected with this one. At the Slovak Medical Chamber, which took place on 20 and 21 October in Bratislava, delegates - General Practitioners for Adults and General Practitioners for Children and Adolescents - were informed by the present Minister of Health of the Slovak Republic JUDr. Ing. Tomáš Drucker that they are burned up have a big problem getting paid for the time needed for minimum regeneration during holidays or the necessary training at least once a year and the competent authorities of the Slovak Republic do not create any favorable conditions for quality work, rather the opposite.

2) Doctors send state invoices for eHealth. 26. 10. 2017, online: <https://www.etrend.sk/ekonomika/lekari-posielaju-statu-faktury-za-ehealth> .html, eHealth in 2018? Forget about, say private doctors, online: www.etrend.sk/ekonomika/e-health-v-roku-2018-zabudnite-tvrdia-sukromni-lekari.html

3) MZ SR Resident Program. online: <http://www.health.gov.sk/?residents>

4) Health resort: Outpatient clinics often do the old doctors. TASR, 28 December 2016. online: <http://www.teraz.sk/english/resort-zdravotnictva-v-ambulanciach-/235569-clanok.html>

5) Statement of the General Practical Medicine Society of XXXVIII. Annual conference on 14 October 2017 in the High Tatras

[http://www.vpl.sk/files/file/XXXVIII%20konferencia/wVyhlaseenie XXXVIII konferencie vseobecnych lekarov \(SSVPL\).pdf](http://www.vpl.sk/files/file/XXXVIII%20konferencia/wVyhlaseenie%20XXXVIII%20konferencie%20vseobecnych%20lekarov%20(SSVPL).pdf)

6) Kotrbová, K., Herdová, O., Sisková, E., Karper, R. : Lack of Doctors in Slovakia - Gynecologists - Regional Data. In: Medikom no. 2/2017 June 2017, volume VII., P. 72. ISSN 1338-340X.

Kotrbová, K., Murgas, J., Herdová, O., Sisková, E., Karper, R. : The lack of doctors in Slovakia - doctors in the emergency health service - regional data. In: Medikom no. 3/2017 October 2017, volume VII., P. 18 and 19. ISSN 1338-340X.

7) Sivík, E., Kotrbová, K., Herdová, O. : The Present and Future of Institutional Health Care in Slovakia. Presentation at XXXIII. Of the Slovak Medical Chamber 20-21. October 2017, Hotel Saffron, Bratislava.

8) Missing doctors search in forty districts, 27 January 2017. Online: <https://www.etrend.sk/trend-archiv/rok-2016/cislo-23/chybajucich-lekarov-hladaju-v-styridsiaticich-okresoch> .html, Experts in addiction and prevention are missing. TV station STV1. RTVS News, October 26, 2017.

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

Opinion of Slovak Medical Chamber:

Plans to increase the competence of general practitioners for adults and general doctors for children and adolescents are repeatedly declared by the Ministry of Health of the Slovak Republic, but still unclear. The incentives to ensure higher performance are poorly understood and counterproductive.

Justification:

The emergence of primary health care teams necessary to increase the efficiency of primary health care and to support the activities of doctors is in the Integrated Regional Operational Program 2014-2020 managed by the Ministry of Agriculture of the Slovak Republic) and the follow-up implementation strategy of the Ministry of Health of the Slovak Republic for the Integrated Health Care System , but there is no organizational, legislative or financial plan to be followed in the follow-up set of documents entitled "Regional Analysis including the Methodology for the Implementation and Functioning of Centres for Integrated Health Care" of July and August (Part II) 2017 received by the Slovak Medical Chamber tools to support doctors in their implementation.

The Slovak Medical Chamber informed the Ministry of Health of the Slovak Republic in its comments sent to the collection of documents of the Ministry of Health of the Czech Republic gradually during July-September 2017) as well as the negotiations for evaluation of SLK's comments directly at the Ministry of Health on 18 October 2017. Document "Regional Analysis including Methodology for the implementation and operation of integrated health care centres "does not contain incentives to support the performance of the system, such as the legal definition of the existence of primary health care teams working under the direction of a doctor, the provision of funding for teamwork of health professionals in the center under the guidance of a doctor, professional and specialized work activities of individual team members, as well as financing of other integration tools by the state and health insurance companies and the like. The inappropriate situation therefore persists.

Health insurance companies are currently considering incentives to support doctors' performance, but in the opinion of the Slovak Medical Chamber as well as the Association of Outpatient Providers) in a totally inappropriate way, something like "if you work harder, you will introduce better patient management to more stringent quality indicators. This approach, as shown by the above-mentioned information on the lack of physicians and their overloading and burnout in the Slovak health care system, is absolutely inadequate to the current alarming situation in the area of human resources. It should be remembered that performance is also enhanced by enabling adequate labor regeneration and thereby creating conditions for physicians to exercise as advisors on the brink of burnout.

Improving the performance of physicians can no longer be achieved through coercion and quasi-negotiation; it is only possible to achieve positive incentives, notably through funding already under-funded (below the cost of real costs), yet for the benefit of the public and the financing of professional activities and the existence of supportive professional health services performed by medical professionals to relieve and support the activities of a doctor.

For example, the Slovak Medical Chamber records the available capacities of university graduates II. degree (magister) in the public health field from the Slovak universities (approximately 2000) who would be able to contribute more effectively to the dissemination of health education and education by enabling them to finance their health insurance or municipal budgets. Currently, for the absence of systematized jobs and jobs

at the level of municipalities and towns and the lack of provision of their systemic funding by the state budget, health insurance companies or municipalities, these graduates in the Slovak healthcare system are still looking for enormous applications even though based on population health data obviously necessary. Their work in a doctor's team could help at least partially eliminate the current high workload of doctors working independently in outpatient clinics. Similarly, wider engagement of available vacant capacities by other college-educated health professionals could more strongly support the exercise of doctoral competencies in long-term care and mental health and the outcomes of care in the field of healthcare professionals led by general practitioners.

9) Integrated Regional Operational Program 2014-2020, Ministry of Agriculture of the Slovak Republic. online: <http://www.ropka.sk/en/irop/>

10) Implementation Strategy: Integrated Health Care System: Modernizing Health

Infrastructure and Improving the Availability of Quality Services in Primary and Acute Health Care. Ministry of Health of the Slovak Republic, online: <http://www.health.gov.sk/?strategia-v-zdravotnictve>

11) SLK comments for the Ministry of Health on the set of documents for the creation of centers of integrated health care online: <https://www.lekom.sk/slovenska-lekarska-komora/stale-vybory-slk/staly-vybor-pre-legislativu/aktivita>

12) Trust sent a new offer, two thousand outpatients with the insurance company is still in talks, 25.10.2017, online: <http://finweb.hnonline.sk/ekonomika/1050895-dovera-poslala-novu-ponuku-dvetisic-ambulancii-s-poistovnou- still-negotiated>

27. What measures should the authorities take to limit the expected drop in GPs (e.g. more flexible immigration policies for doctors from neighbouring countries)?

Opinion of Slovak Medical Chamber:

Competent authorities should eliminate the adoption of measures to increase the burden on physicians (ordering hours, eHealth, electronic prescriptions, etc.) and take measures to stabilize human resources in the health sector in the form of better funding and provide funding for the expected services and thus improved working conditions. SLK suggestions on how to achieve a reduction in physician decline are already outlined in answers to questions no. 25 and 26 .. Making price calculations and regulating maximum profits in health care under the Pricing Act could certainly contribute as additional measures.

Justification:

Immigration of doctors from other countries is possible, but given the current working conditions of physicians in Slovakia, the low cost of medical performance and therefore the cost of SLK doctors does not expect them to be more effective. Additionally, immigration represents additional costs for Slovakia that were not planned and, given the clear cultural background, could be invested in the Slovak labour force. Foreign research shows that systems / health organizations that are capable of motivating and retaining their own employees, specifically defined as organizations supporting the eradication of burnout syndrome, real regeneration and reconditioning for the workforce, providing good access to employee training, etc., act as "Magnet" to potential other employees. Qualified workforce also acts as a "magnet" for potential foreign investors and becomes a potential international competitive advantage.)

The Slovak healthcare organizations can not afford the prescribed measures for the benefit of healthcare workers because of the poor set-up of the system of financing of health care provided in Slovakia as such. Medical performance prices are reimbursed at the 2005 price level, they do not really reflect real prices, and medical facilities are indebted without access to additional resources. According to the latest published data, at the end of August 2017, the Social Insurance Company recorded receivables amounting to CZK 236.3 million. € against health facilities within the competence of the Ministry of Health of the Slovak Republic and transformed medical facilities.) The fact that state health establishments do not even have to pay compulsory contributions to their healthcare staff means that, of course, it is very difficult to seek financial resources for the development of the workforce.

The range of potential source countries is, furthermore, very narrow for the language barrier. The education and practice of doctors from Ukraine are not content and qualitatively equivalent to the education and practice of a doctor from Slovakia. It is also worth considering the additional costs of language learning, because medical records according to the Health Care Act have to be kept in the state language in Slovakia,

etc. According to data from the Ministry of Health of the Slovak Republic in 2008 one year of study of a student of medicine in a daily study of university studies at that time it was about 33 thousand. € x 6 years of study = total 198 thous. €. Follow-up specialization study of general medicine another 8 ths. € per student and year x 3 years of study = additional 24 ths. € at prices in 2008, to which must be added the costs of language training for foreigners. The necessary investment in creating the same labor force in 2017 is undoubtedly higher. Migration policy measures - such as planning and targeted recruitment of doctors from abroad - can be accepted, but the Slovak Medical Chamber does not expect them to be more effective in view of the existing situation.

According to the SLK, the solution is mainly to adopt measures in the area of better financing of the provided health services themselves, thus making the medical and other healthcare professions in Slovakia more attractive.

1) Buchan, J.: Chat does „good“ HRM make? Table 1 Reported Characteristics of organizations with Magnet accreditation. Online: <http://www.human-resources-health.com/content/2/1/6>.

28. Have the new clinical guidelines been published? If yes, what is your assessment?

Opinion of Slovak Medical Chamber:

Doctors of the Slovak Medical Chamber are informed about the project of the Ministry of Health of the Slovak Republic for the preparation of standard diagnostic and therapeutic procedures, to be financed from the European Union funds through the Human Resources Operational Program. The Ministry of Health of the Slovak Republic is the recipient of the funds, and working teams are currently being set up by individual senior experts of the Ministry of Health of the Slovak Republic to develop approximately 150 groups of standard procedures for individual diagnoses to be established in the period 2017-2021.)

The Slovak Medical Chamber welcomes the fact that, according to the methodology for the development and implementation of standards approved by the Ministry of Health of the Slovak Republic, a description of the system of interdisciplinary multiprofessional cooperation should be included in every standard, not only for doctors but also for other professions in the system, which could potentially significantly contribute to the reduction of workload physicians, for example, in the case of setting up multiprofessional team collaboration as a standard in the primary health care system. The Slovak Medical Chamber also welcomes the fact that, according to the above mentioned methodology of the Ministry of Health of the Czech Republic, a description of the system of prevention and recommended health promotion should be included in each standard, in order to eliminate the respective disease.

On the other hand, the Slovak Medical Chamber in co-operation with the Slovak Medical Society, in preparing the methodology and statute of the Ministry of Health of the Slovak Republic for the management and creation of the standard, pointed out that the creation of methodology and standards was not mandated by the Slovak Medical Society, as an international standard, together with professional and professional societies, not only in the surrounding European countries but around the world. Similarly, both organizations have been jointly argued for the presence of health insurance representatives in the standard-setting steering group. The Slovak Medical Society and the Slovak Medical Chamber considered the presence of representatives of health insurers in the Standards Management Commission potentially disruptive and asked them to create a separate working group dealing with aspects of the financial reimbursement of the established professional standard separately after its creation without direct impact on the professional the process of creation. Also, in our opinion, the sustainability of standard diagnostic and therapeutic procedures is not ensured, given that the Commission of the Ministry of Health of the Slovak Republic only has a mandate of 5 years for the duration of the EU project. In our opinion, it should be clearly indefinite. financing of the creation and implementation of procedures from the Ministry of Health of the Slovak Republic funds was also ensured after the end of the project.

We currently do not register any new standards yet, but the Slovak Medical Chamber and the Slovak Medical Society have nominated their representatives both on the steering committee of the Ministry of Health and in the working groups of the main experts.

29. Are the GPs using sufficiently their competences to act as gatekeepers? Are you aware of plans to further broaden scope of their competences?

Opinion of Slovak Medical Chamber

The answer is contained in the answer to question no. 26. General practitioners are aware of their possibilities to operate in the Slovak system as gatekeepers, but because of the absence of primary health care legislation as a team cooperation and the lack of funding for such teamwork and other related measures, they cannot effectively apply this competence. Can only act on a limited basis according to individual options, systemic measures are missing.

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

The answer is contained in the answer to question no. 25th

Accessibility and Health outcomes

31. Does in your view the high level of private and out-of-pocket (including informal) payments affect accessibility to healthcare?

Opinion of Slovak Medical Chamber:

The Slovak Medical Chamber has no information that informal payments in Slovakia were more pronounced than in the surrounding countries, we are convinced that this is rather a symbolic issue, even if the certainty of the improvement in the area of the chamber of all doctors in Slovakia in the area of ethics through compulsory membership could be noted in this area as well, given the low income and purchasing power of the Slovak population.

As far as payments outside the covered healthcare package are concerned, these are not yet developed in Slovakia. In addition to direct payments to patients in the form of reimbursements for such medicines, medical devices and nutritional supplements not covered by public health insurance by a health insurance company, a doctor is liable to pay a penalty of € 16,596 if it requires direct reimbursement for his / her service he / or has a health insurance company reimbursed to the patient from public health insurance. The problem is that this penalty is also threatened by the medical practitioner if the health insurance has not actually paid for the care provided, and doctors do so involuntarily as co-financiers of the health care provided in particular to outpatient healthcare, which is over 80% of the nationality.

So called. the bundled package (although not actually reimbursed) is defined so broadly that it does not allow private insurance to be provided for such services that health insurance companies actually do not pay out of the funds from public health insurance or do not pay them adequately. It is recommended that health insurers begin purchasing healthcare / healthcare / health care rather than financial volumes to health care providers as they do so to comply with the relevant provision of Act no. 581/2004 Coll. (Article 7 (9) (b)) and create a space for the definition of the standard package (the health performance to be performed) and the over-standard (medical performance that can be performed and the health do not have to be done) of health services, while maintaining safety and reducing the patient's risk in the health care process.

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

Opinion of Slovak Medical Chamber:

Progress on health / outcomes is not evident. Measures in the field of health statistics are recommended - monitoring the development of data on the incidence and prevalence of chronic noninfectious diseases so that some progress can be made at all.

Justification:

Data on the development of morbidity in the Slovak population are collected in the broader spectrum of diagnoses only for infectious diseases. In chronic noninfectious diseases, the incidence and prevalence of certain diagnoses (accidents, acute coronary syndrome, stroke, diabetes mellitus and psychiatric disorders) are statistically processed through the National Center for Health Information throughout the country. The incidence and prevalence of oncological diseases are only recorded until 2007 until the end of the National Cancer Register for lack of funds, new data on the disease from this range of diagnoses are not yet available and in other cases (diseases of the respiratory system, digestive system diseases, etc. .) it is possible to work only with the data on mortality that are insufficient for the effective management of the health system in Slovakia and the improvement of the health outcomes of the population.

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We also deal with the issue of health status indicators in the answer to question 3. We mention mainly problems in Slovakia with problematic setting and evaluation of some internationally assessed indicators (OECD, ECCHI).

17) Report on the health status of the population of the SR for the years 2012-2014. Public Health Service of the Slovak Republic, Bratislava. online: http://www.uvzsr.sk/docs/info/podpora/Sprava_o_zdravotnom_obyvatelstva_SR_za_roky_2012_2014.pdf

Investments

33. How do you assess plans for a new university hospital in Bratislava also in view of the announcement of a private investor to build a comparable hospital?