Slovakia

1. Introduction

Slovakia is relatively small country with 5,5 mil. inhabitants, located in the center of Europe. The GDP per capita is circa 50% bellow EU average, but in certain areas the standard of living is relatively very high (Bratislava region GDP per capita is over EU average, and significantly over EU average taking into the account purchasing power and not currency parity).

The health care system in the country is developed, with large capacities, based on the principle of free access on the point of delivery for most services, with costs financed dominantly on the base of compulsory social health insurance. The performance of the health care system in Slovakia was recently evaluated by WHO, showing that the system is similar to other CEE accession countries (Table 1).

Table 1: Ranking of Health Care Systems: Selected Countries (1)

	Overall	Health	Fairness	Cost (2)
France	1	4	26	4
UK	18	24	8	26
Germany	25	41	6	3
US	37	72	54	1
Slovenia	38	62	82	29
Czech Rpb.	48	81	71	40
Poland	50	89	150	58
Slovakia	62	88	96	45
Hungary	66	105	105	59
Estonia	77	115	145	60
Russia	130	127	185	75

Source: World Health Organization, 2001

(1) Based on 1997 data for 191 countries. Highest = 1.

(2) Based on total spending per head in international dollars.

The processes of reforming the Slovak health care system started immediately after "Velvet Revolution" in 1989, bringing important changes into the system (especially privatization and change from general taxation to social health insurance system of financing care), but is far from to be finished. Policy making and implementation failures during the reform created large scale of additional problems, main of them today are connected with finance.

To support changes, the system of health management academic education and training was created/updated relatively soon, but its current quality and capacities are still not sufficient. There are two main streams to prepare/train health managers. The first, represented by the Faculty of Economics of Matej Bel University is more generalist approach, and the graduates are provided with comprehensive base of economics, management and health care

courses. However, the number of such graduates is very small, and there is limited perspective to increase it. The second (Faculty of Health Care and Social Work of University of Trnava and the School of Public Health of the Slovak Health Care University) is dominantly based on medical disciplines, and management courses represent marginal part of curricula. This type of education and training, co-ordinated mainly by medical doctors, has limited chance to produce new effective health managers.

Under these circumstances the capacity of education/training institutions to influence the quality of management of health care establishments is really limited and there will be large problems to change the situation (probably only by involving more private funds into the system, and creating real conditions for public private mix of delivery of health management training).

The health policy is not represented by any specific system of studies, few hours on this issue are taught in Banska Bystrica and Trnava. There is only one specialized health policy center in Banska Bystrica, but there is no permanent staff there, and the capacities (not marginal) of this center are mobilized only on the case by case principle.

There does not exist any consistent central health policy in Slovakia, yet, but the need to create real health policy making, implementation and analysis capacities in the country should become very urgent quite soon, as the result of development trends in the society and in the health care sector. As independent health policy research is hardly to be financed from private resources, and the public finance capacity will be limited for certain period, this area should be considered as one of important fields of future foreign aid, needed in spite (or because?) Slovakia is close to EU memberships.

2. Country profile

From early medieval (after the defeat of Moravian state by Hungarian troops) Slovakia was a part of the Hungarian Empire. The system of public administration in Slovakia was an integrated part of Hungarian public administration, characterized by the relatively strong position of municipalities. Many of basic features of Austro-Hungarian public service became the basic of public administration system of the first Czechoslovak state, established on 28th October, 1918.

This period 1918 - 1939 was characterized by development of democratic civil service in market economy environment. In spite of relatively centralized management of public administration from Prague (capital of Czechoslovakia), the public service system of the country showed many features of modern public administration (like well developed civil service law, strong status of municipalities) a was orientated to the development of impartial and professional civil service system.

In 1945, after the second world war Czechoslovakia was re-established as the unitary state. The Communist Party of Czechoslovakia won the democratic elections of 1947, and then in February 1948 took over all powers in the state.

The period between 1948 and 1989 may be characterized as the period of so called „socialist democracy“ and a planned economy. The public administration system was reorganized to serve to the Communist Party, and became fully dependent on its political masters.

After the „Velvet Revolution“ in 1989, the process of a gradual transition to pluralistic democratic public administration system started in Czechoslovakia. Most of tasks of formal restructuralisation accordingly to western standards were realized in the early stage of transition period. The first proposal of the reform of public administration in Czechoslovakia

defined following most important tasks of revitalization of democracy (Nemec, Berčík and Kukliš, 2000):

- to create real self-government institutions
- to divide executive and legislative power on all levels
- to create new organization of civil service with two levels of administration
- to change the territorial structure of Czechoslovakia
- to restructuralise the central government and the system of control of the civil service

The first democratic elections were hold in Jun 1990 and became the basis for most of changes in the public administration system in Czechoslovakia. The self-government of municipalities with high level of independence has been re-established. The system of National Committees ("socialist" form of local government, combining in one office both local state administration and self-administration functions) was abolished and replaced by 38 district local general state administration offices and 121 subdistrict local general state administration offices. Local self-government, with representatives elected directly by the local population, was constituted in municipalities, which are territorial and legal entities. Within limits set by the law, local governments have their own budgets and assets. Local governments may issue ordinances, which are binding on all individual or corporate bodies within their jurisdiction. These ordinances may be superseded or invalidated only by parliamentary acts. In some cases, local governments may be delegated additional powers necessary for administration of the state and financed by state funds. Interference with the powers of local self-government is possible only by legislation passed by the Parliament.

From January 1st Slovakia became independent country after friendly and smooth splitting of former Czechoslovakia. Much later (1996) the second wave of public administration reform started, characterized by the parallel solution of a radical change of the territorial and administrative structure of the state, and by the establishment of the uniform two-tier (regions and districts) system of offices of general state administration with a concentration of a broad range of tasks and responsibilities. The reform was realized with the goal to increase effectiveness and quality of public administration and create a customer-friendly and responsive system serving to citizens. The costs of reform were much higher than planned, but results very limited (Audit ústrednej štátnej správy, 2000).

After general elections in 1998 the new Slovak government refreshed the issue of public administration reform, as one of their main goals. The main idea of the reform was argument that decentralization would solve all inefficiencies (Stratégia decentralizácie a reformy verejnej správy, 1999). The start of the reform was more times postponed because of lack of political consensus between political parties, and only massive interventions of Prime Minister Dzurinda in beginning of 2001 pushed the processes forward, calling the realization of public administration reform as the main government priority. After it in very (too) short time all expected basic legislation was approved by the Parliament – following laws were the most important:

- Civil Service Code (July)
- Public Service Code (July)
- Law on Creation of Territorial Self-Government - Regions (July)
- Law on Elections of Territorial Self-Government Bodies (July)
- Law on Transfer of Competencies of the State to the Regional and Local Self-Administration (September)
- Amendment of the Law on Municipalities (October)
- Amendment of the Law on Municipal Property (October)
- Law on the Property of Territorial Self-Government (October)

- Amendment of the Law on Budgetary Rules (October)
- Law on Remuneration and other Aspects of Performing the Position of the Head of Territorial Self-Government (October)
- Law on Financial Control and Audit (October)
- Law on Ombudsman (December)

Important Law on Transfer of Competencies defined the set of competencies to be transferred to regional and local self-government. According to it really large number of competencies is transferred in 2002-2003. Municipalities get new responsibilities in areas of road communications, water management, evidence of citizen, social care, environmental protection, education (elementary schools and similar establishments), physical culture, theatres, health care (primary and specialised ambulatory care), regional development and tourism. Regional self -government become responsible for competencies in areas of road communications, railways, road transportation, civil protection, social care, territorial planning, education (secondary education), physical culture, theatres, museums, galleries, local culture, libraries, health care (polyclinics and local and regional hospitals), pharmacies, regional development, and tourism. A large set of these competencies was re-allocated from direct ministerial responsibility (hospitals, education, etc.).

The elections in autumn 2002 gave political power again to Dzurinda cabinet, and the reforms plans were not changed. The decision of the EU about enlargement in May 2004 (Slovakia included in the group of countries to be accepted as new members) created additional pressures to incorporate main principles of European administrative space - openness, participation, accountability, effectiveness and coherence, and the principles of subsidiarity and flexibility into the daily administrative practice. Important steps in this directions were already realised, but many problems remain, and/or may appear. The main problem of current reform measures is overestimate of potential of decentralisation, changing it from reform tool to reform goal (as apparent also from the name of the reform document – "strategy of decentralisation and the reform"), and current territorial structure that is too fragmented. The newly established self-governing regions are too small to be accepted as NUTSII level. The number of municipalities is extremely high (2875 municipalities), many municipalities are too small (68,4 % of municipalities are bellow 1000 inhabitants) – such fragmentation increases transaction costs of the system and does not create environment for effective realisation of self-government functions on the local level.

3. Health care system in Slovakia

The objective of the old pre-1989 health care system in former Czechoslovakia was to provide a comprehensive system of health care for all members of society. The decision on medical care provision were made by the Federal Government and the national Czech and Slovak Ministries of Health - and were generally made on political or administrative grounds. The only accountability in the old system was to Communist Party.

Under the old system both services and medicines were free to the patient, but until 1987 there was no individual choice of practitioner. The supply of service was constrained by plan, and the purchaser and provider were one. Economic resource allocation played no part in determining services whose level and distribution, influenced by social, medical and administrative considerations, were determined by political decision. No cost-benefit calculations were undertaken. There were no economic incentives, either for individuals or for the system to improve performance, and there was chronic and sometimes acute excess demand for services.

However when transition began the Czechoslovak system was far from the crisis state of the Polish and Soviet systems (Davis, 2001). If necessary everybody was able to get appropriate health care on relatively high international medical standard. Most of equity consideration were achieved (however there were also special medical institutions which provided higher quality care for high-ranking officials). The old system is often described as obsolete and inefficient, but with apr. 5 % health care expenditures of GDP most of demand was covered without important waiting lists. Relatively high quality of care was characteristic in spite of insufficient quantity and quality of equipment.

Nevertheless many felt on the eve of transition that much more could be done with a more economically rationally organized, decentralized and responsible system, and the opportunities for improvement were certainly there.

General trends of health policy in Slovakia after 1989 (health care was responsibility of the national Slovak level and not the federal Czechoslovak state formally already from 1968) were defined by Programmatic Statements of Government and main reform documents (first of them published in 1990). The most important goals of the reform were as following:

- Creation of a system of "health care for everybody" (system of public health), as described by the document "National Public Health Program".
- Universal access to defined scope of health services and benefits.
- The basis of creation, realization and control of health policy shall be free decision of citizens.
- Cancellation of a state monopoly in health care, plurality of provision of health care, privatization, increased participation of self-government in health care system.
- Public health shall be dominant part of a health care system.
- Dominant position of primary care in health care system.
- The right of citizen to choose provider.
- Compulsory health insurance.
- Citizen's participation in relation to protection and improvement of its own health.
- Multi-resource financing of health care.
- Improved economic and financial management in health care establishments.
- To stop an impairment of health status of citizens.

To achieve proclaimed goals new legislation was adopted soon. From many, we mention the most important legal documents, providing the basic frame for the health care system in Slovakia as follows:

- the Constitution of the Slovak Republic,
- the package of laws related to the creation of insurance scheme,
- the Law on Treatment Order,
- the Law on Health Care,
- the Law on Health Protection of People.

The Constitution of the Slovak Republic

The Constitution of the Slovak Republic is the highest level institution and guarantee of human rights in Slovakia. This Constitution from the 1st of September 1992 is in principle a modern one and provides for a standard system of human rights in a democratic society. In its part on economic, social and cultural rights it provides that everybody has the right on protection of health, and that on the base of insurance system the citizens have the right to get free medical care and medical auxiliaries according the provisions of complementary law.

The Law on Treatment Order

This law provides for most important principles related to qualifying conditions for benefits, scope of cash and in kind benefits, and organization of health care. It regulates the extent of the health care to be provided under compulsory health insurance plan, the conditions under which it is to be provided, the reimbursement schedule, the categorization of drugs (for different levels of co-payment) and rules on health insurance coverage of medical aids. It also defines the indications for reimbursement of spa treatment.

We may quote the most important parts of this law:

- On the base of health insurance there are provided health services, medicaments and medical aids as indicated on the base of health needs. This indications are based on current achievements of medical and biomedical sciences, and shall guarantee effective treatment, following therapeutical and pharmaco-therapeutical rules. Health services provided according this law are listed in annex 1. The list and categorization of medicaments are provided by annex 2. The medical aids list is in annex 3.
- Insurance companies reimburse to contractual health care establishments costs of health care provided according the list of treatments, medicaments and medical aids (annexes 1-3). The prices of service, of medicaments, and of medical aids are defined by price regulations (issued by the Ministry of Finance).
- Specialized health care is provided to patient only on the base of referral of general practitioner, or referral by other specialist.
- On the base of health insurance patients shall get only defined daily dose of medicaments.

The Law on Health Protection of People

This Law defines rights and obligations of state administration, municipalities, other legal and physical persons, the realization of state administration and state supervision in the field of protection of health of people.

The Law on Health Care

This Law deals with provision of health services, organization and management of health service, defines right and obligations of legal and physical persons in connection with health care. It delegates the main regulatory, planning and managerial tasks to the Ministry of Health.

It declares:

- „Everybody has the right to get health care, including medicaments and medical aids. Health care is provided by state health establishments, municipal health establishments, medical establishments run by legal or physical entities, and is provided on the base of existing accessible know-how of medical and other biomedical sciences".
- „Health care is provided for citizen:

a/ free, on the base of compulsory health insurance
b/ on the base of additional insurance contracts
c/ free, from the state budget resources
d/ on the base of financial resources of charities, legal or physical entities
e/ based on co-payment or full participation of receiver of health care".

- „Citizen, getting health care, has the right on care according the kind and level of health problem. She/he has the right to choose doctor or health establishment. In the case of

emergency she/he has the right to get medical care in the nearest medical establishment available to handle appropriate health care".

The set of laws on health insurance

Slovakia, similarly to most of other CEE countries introduced so called "Bismarck" system of social health insurance, to replace old general taxation system of financing of the care. The main set of laws regulating health insurance was passed in 1994, creating the base of establishing of 13 health insurance companies, most of them disappeared from the "market"; coming to 5, existing in 2002. The change to health insurance system was supported by typical arguments of plurality, independence and competition. However, because the Constitution and consecutive set of laws guarantee to any citizen universal and free, at the point of delivery, access to health care, and this package shall be delivered by all insurance companies for the price that is regulated by the Ministry of Finance, some level of plurality and competition was visible only in the starting phase of the insurance system, when the services to insured were to some extend different.

3. 1 Current situation of the health care system in Slovakia

To present the most important information and data about the current situation of the Slovak health care system we use following main indicators/areas:

1. Health status of inhabitants.
2. Access to care.
3. Clinical quality of care and satisfaction (clients quality of care) for process and for results (quality of care).
4. Efficiency and economy of care

Health Status in Slovakia

The health status in Slovakia is improving in most important indicators during the 1989-2000 period, similarly to other more developed CEE countries (Czech Republic, Hungary, etc.). There are no data to assess what are the main factors behind this positive trend, to what extend this is caused by increased quality of health acre and to what by other factors (changes in living style, improving environment, etc.).

The Table 2 provides most important indicators of health status developments. It shows that the life expectancy is significantly improving, but is still bellow EU levels (WHO 2002). The difference in life expectancy between man and woman is relatively large, but decreased from 1990. The quality adjusted life expectancy in Slovakia was 66,6 years, significantly lower compared to lowest level in EU in Portugal with 68,9 years (Slovensko 2001, p. 499). Mortality is very slowly going down, but is much higher compared to EU, especially for cerebrovascular mortality (26,6 % of deaths in Slovakia). The specific feature is respiratory mortality, bellow EU levels, and not becoming important cause of death.

Table 2 Main indicators of health status in Slovakia

		1985	1990	1995	2000
Life expectancy	SR men	66,9	66,6	68,4	69,2
	SR women	74,7	75,4	76,3	77,2
Death/1000 Inhabitants	SR	10,2	10,2	9,8	9,8
New-borns mortality	SR	11,1	8,4	7,9	n.a.
Infant mortality	SR	16,3	12,0	11,0	8,6

Source: UZIS, different tables, www.uzis.sk

The emerging problem after 1990 is natural increase of number of inhabitants. The natural increase in 2000 was only 2427 persons, compared to 4821 in 1999, 72,2% less than in 1995 and 90,4% less than in 1990. There are only few regions where the number of live births exceeds the number of deceased (Zdravotnicka rocenka SR, 2000).

The indicators of health status show that negative factors connected with transformation (stress, decreasing living standard of large proportion of inhabitants, increased consumption of drugs) were overweighed by other positive factors, medical quality of health services might be one of them, especially thanks to significant improvements of equipment of providers and medicaments available.

Access to Care: Universality and Equality

As already mentioned, according to the legislation the access to most services is free at the point of delivery. Overall there is no evidence of any group or citizen has been denied access to any free service they have a right to receive. General practitioners, dentists and opticians cannot refuse to treat patients. But where waiting lists exist for specialists, because there are no formal and effective precedence rules for access, unequal treatment may occur. And with hospital care it is common to make additional illegal or non-legal payments for extra services, for example for a separate room. A systematization of these practices through additional co-insurance is likely to be introduced.

On the other hand, because of corruption and other factors access is not equal. There are no Patients' Charters, and complaints generally find no responsive addressee. This is important because more than two-thirds of Slovaks claim that they have had to bribe to ensure good care (Miller, Grodeland and Koschechkina, 1998, estimate for Slovakia the likelihood that bribes must be offered to medical doctors to be on the level of 89%). Bribes have been estimated to amount of a tenth of health costs (recent unpublished study financed by World Bank estimates this amount for 3 mld. Sk).

The question of access to health services in Slovakia represents two-dimensional issue. On one side, the widespread and popular commitment to universal access to health care, free at the point of use, is still dominant feature of health policies, realized via a comprehensive legal basis to such access and it is the electorate's preferences that sustain these laws and regulations that mark the limits to organizational and operational change. The 1998 Slovak government Programmatic Statement (www.government.gov.sk), prepared at the time of increasing financial crisis of the system is symptomatic:

"The government will guarantee generally accessible and high quality health care for all citizen. Within the frames of the basic health insurance is assures to any citizen equal access to and equal quality of basic health services".

On the other side, the real inequality in access is increasing; to large extend as the result of deepening financial crisis and shifting, yet unofficial, financial burden to citizen. The increasing inequality of access to health services in Slovakia was already recognized by most important international organizations, like World Bank (see fairness) and OECD.

Quality of care

It is very difficult to asses developments in quality of care after 1989, as there are no any indicators available. As mentioned in evaluation of health status developments, there are significant quality improvements on supply side, mainly in:

- the structure and quality of equipment available in health establishments,
- the structure of medicaments available and used for treatment.

After 1989 several barriers limiting the possibility to import top "Western" technologies were dismantled, and the regulation concerning what can be purchased and prescribed weakened. Such trend delivered contradictory outcomes – on one hand improvements of technical aspects of quality of services, on the other hand (relative) "oversupply" of technologies and expensive drugs, as one of purposes of financial problems of the system.

Compared to positive technical developments, the trends in other aspects of health care quality are more controversial, however difficult to prove. In spite of many promises no government was able to introduce systematic medical and organizational audit of health providers, telling more about how the care is delivered by doctors and what are the conditions in which it is delivered to patients. The case of mis-treatment of the Slovak President in 2000 (Slovensko, 2000) clearly showed basic weaknesses in daily delivery of care, but was not used as impetus for changes.

The organizational (patient's) quality of care improves, but very slowly. Compared to the old system, there is choice of provider, but patient is still very far from becoming the central subject of the system. The document "Patient Rights" was prepared and published only in 2000 and some establishments did not develop it for local conditions, yet. Queuing in front of ambulance, without the chance for exact appointment, is typical for large proportion of, including private, providers.

Economic Performance of the Health Care System in Slovakia: Outcome of (short-term?) failure to create and realise consistent health policy(?)

Main problems of the system after 1989 are connected with finance. The underfinancing of the system at the starting point of reforms after 1989, and decrease of the economic performance of the country as the result of transition, represent objective factors, laying behind financial insufficiencies of health care system in Slovakia. However, there are significant subjective, wrong reform design and implementation connected, factors, bringing the system close to collapse.

The Table 3 describes overall financial performance of the health care system in Slovakia after 1995, when the financial problems started to be apparent.

Table 3: The economic performance of the health care system in Slovakia (mld. Sk)

	1995	1996	1997	1998	1999	2000	2001	2002
Total health insurance system resources	26.3	35.4	38.4	41.4	43.0	45.3	49.6	55.0
Resources from the Ministry of Health	4.1	4.6	4.9	4.7	4.4	4.5	4.9	4.8
Resources from Social Insurance Company	0.9	1.0	1.2	1.3	1.3	1.0	1.1	1.2
Direct payments from inhabitants	1.8	2.6	3.8	4.1	5.4	5.9	6.3	7.0
Total resources	**33.1**	**43.6**	**48.3**	**51.5**	**54.1**	**56.7**	**61.9**	**68.0**
Primary care costs	1.3	4.3	4.5	4.2	4.4	4.7	4.9	5.1
Šecondary ambulatory care costs	0.0	0.2	1.3	1.5	1.8	1.9	2.1	2.2
In-patient care costs	25.3	21.4	24.0	25.6	25.0	26.0	28.1	30.1
Medicaments and health aids costs	2.0	12.2	14.5	16.1	18.8	20.6	22.8	24.1
Other costs	0.9	1.1	3.4	5.0	4.1	6.9	7.7	8.3
Ministry of Health costs	4.1	4.6	4.9	4.7	4.4	4.5	4.9	4.8
Total costs	**33.6**	**43.8**	**52.5**	**57.1**	**58.5**	**64.6**	**70.5**	**74.6**
Balance	**-0.5**	**-0.2**	**-4.2**	**-5.6**	**-4.4**	**-7.9**	**-8.6**	**-6.6**
Deficit coverage	0.5	0.2	4.2	5.6	4.4	7.9	8.6	6.6
External debt	0.5	0.2	4.2	5.6	4.4	4.4	5.2	3.0
Privatization grants	0.0	0.0	0.0	0.0	0.0	3.5	3.4	3.6

Source: Pažitný and Zajac, 2002 (2002 data – estimated)

The data show that in spite the economic performance of the system, and the necessity to improve it, was on the agenda of all Slovak governments, the real results are dissatisfactory. From 1997 the system systematically consumes 10-15% more compared to resources available and this trend did not change in spite of many implemented measures. The main sources of dis-balance of the system are analyzed in the following text:

A: Resources of health care system in Slovakia

As apparent from the Table 4, the system heavily depends on public finance based resources, part of them coming via health insurance system, part directly from the state budget. The participation of patients in the form of direct payments/co-payment is still rather limited and much lower than in most developed countries (respecting dogma of universal free access to care). With this the total amount of resources is more or less directly limited by the performance of the national economy that is much bellow EU average (also in purchasing parity terms), and just recently reached the level of pre-transition period.

Table 4: Resources of health care system in Slovakia

		1995	1996	1997	1998	1999	2000	2001
Resources in mld. Sk	Health insurance	20.1	26.1	29.2	32.2	33.2	35.1	37.7
	General taxation	11.2	14.9	15.3	15.2	15.5	15.7	17.9
	Direct payments	1.8	2.6	3.8	4.1	5.4	5.9	6.3
	Total	**33.1**	**43.6**	**48.3**	**51.5**	**54.1**	**56.7**	**61.9**
Resources in %	Health insurance	60.6	59.8	60.5	62.4	61.4	61.9	60.8
	General taxation	33.9	34.2	31.6	29.6	28.6	27.7	29.0
	Direct payments	5.4	6.0	7.9	8.0	10.0	10.4	10.2
	Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: Pažitný and Zajac (2002)

The insurance premium was set on 13,7% from income related base (14% from 2002), but the state is expected to pay into the health insurance scheme for large group of persons without regular income (children, pensioners, etc.), representing about 3,5 mil. from total 5,5 mil. of inhabitants. As indicated by the Table 5, the state contributes for this group of citizen

on very low level, setting the amount to be paid on yearly basis in the Parliament, when voting on the state budget. By this the rules of the game fare different for main actors:

- the private sector that has to pay by fixed rate,
- and the state that did not contribute minimum full amount (at least 13,7% from minimum wage) for any of evaluated years,

and as the consequence, the system is not provided with expected amount of resources.

Table 5: Contributions of the state into the health insurance system

	1995	1996	1997	1998	1999	2000	2001
Contribution per insured person, Sk	181	269	269	270	283	283	336
Total contribution, mld. Sk	7.1	10.3	10.4	10.5	11.1	11.2	13.0

Source: Zdravotnicka rocenka SR 2001

B: Costs of health care system in Slovakia

The limited amount of resources cannot be explained as the main purpose of bad financial performance of the health care system in Slovakia. As there is limited space to increase revenues, the focus should be cost-containment measures, efficiency and economy of the system to balance demand, supply and resources available. However, very few was done in this respects during the entire period after 1989. The most important inefficiencies could be defined as excessive employment, low economic performance of hospitals and ineffective drug regulation policies.

The problem of employment is highlighted by the Table 6, showing that total number of health personnel is similar to pre-reform period, in spite of "over-employment" was accepted as main problem from the beginning of post 1989 changes (the decrease 1995-97 is statistical but not real, because of methodology did not react to privatization in time).

Table 6: Employment in health care (persons)

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
State sector	n/a	n/a	n/a	n/a	n/a	n/a	86 450	86 033	83 188	86 023
Non-state sector	n/a	n/a	n/a	n/a	n/a	n/a	19 919	32 702	32 971	34 750
Total	129 468	125 581	127 414	121 464	108 715	96 935	106 369	118 735	116 159	120 773

Source: Statisticka rocenka SR, 2002

As apparent from the Table 3, the costs for drugs raised by 100% between 1996 and 2002 (data for 1995 do not include costs of drugs consumed in hospitals). The increase can be explained to some extend by changing structure of drugs used (import of more effective but also more expensive medicaments for international market prices), but is caused also by ineffective regulation system on drug prescription. Tools of evidence based medicine are still not used for setting of the rules which medicament, to whom and under what circumstances to prescribe, leaving the space open for lobbying of pharmaceutical firms, bribing doctors to prescribe more expensive drugs, and larger amounts of drugs than necessary. Insurance companies have lists of doctors, prescribing 10-20 times more than average costs, but there is no mechanism to handle this. In this non-effectively regulated environment the costs for drugs almost reached the costs of hospital system.

The most costly part of the health care system in Slovakia is in-patient care that did not change very much during the entire period. Data, showing main problems of performance of hospitals are provided by Tables 7-10. Table 7 clearly shows problem of pertaining deficit and lack of capacity/will to manage fixed costs of hospitals.

Table 7: Performance of hospitals

	1996	1997	1998	1999	2000	2001
Number of patients	1.055.757	1.090.672	1.109.210	1.059.533	1.063.611	n/a
Change %	2,6	3,3	1,7	-4,5	0,4	n/a
Costs, mld. Sk						
Fixed costs	15,4	17,7	19,3	19,3	19,7	21,6
Variable costs	6,1	6,4	6,3	5,7	6,3	6,5
Total costs	21,5	24,1	25,6	25,0	26,0	28,1
Total costs – change %		12,1	6,2	-2,3	4,0	8,1
Revenues, mld. Sk	19,8	22,9	22,3	20,2	22,5	24,9
Balance, mld. Sk	-1,7	-1,2	-3,3	-4,8	-3,5	-3,2

Source: Zajac and Pazitny, 2002

The Table 8 shows that there are minimum changes in bed capacity and use during the period 1991-2000, presenting that extensive trends in in-patient care continue.

Table 8: Management of beds capacity in in-patient care

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Average length of treatment	12,9	13,4	12,7	11,2	11,5	11,3	11,2	10,1	9,1	8,9
Use of beds in days	276	274	268	280	289	290	286	284	254	258
Beds/number of doctors	8,4	8,1	8,6	7,9	7,9	7,5	7,0	6,5	6,4	6,2
Beds/1000 inhabitants	7,6	7,6	7,9	7,1	7,5	7,5	7,3	6,7	6,6	6,5
Use of bed capacity %	75,6	75,0	73,4	76,6	79,3	79,5	78,4	77,9	69,5	70,7

Source: Zdravotnicka rocenka SR (more volumes)

Table 9 indicates that numbers of staff were not reduced during the period of running of large deficits, and over-employment persists. Wages are calculated as the part of fixed costs of hospitals, and with increased rates per employee, account for larger and larger proportion of total costs.

Table 9: Structure of employment in hospitals

	1995	1996	1997	1998	1999	2000
Doctors	10,567	8,000	9,243	9,416	9,323	9,761
Nurses	30,334	24,546	28,738	28,846	27,497	28,037
Other medical staff	13,036	11,208	13,194	13,396	13,468	12,644
Administrative staff	21,329	17,158	19,193	18,644	17,712	19,982
Others	1,871	1,593	1,810	1,805	1,790	1,181
Total	77,137	62,506	72,178	72,107	69,789	71,605

Source: Zajac and Pazitny, 2002

Table 10 presents detailed data on costs and revenues per selected categories of employees and suggest that the efficiency of use of man-power does not significantly increase.

Table 10: Individual performance of staff in hospitals

	1996	1997	1998	1999	2000	2001
Number of diagnoses/employee	1,064	862	844	839	823	835
Number of diagnoses/doctor	8,311	6,729	6,462	6,278	6,041	6,110
Revenues/doctor (Sk)	2,478,107	2,473,468	2,366,756	2,166,794	2,309,061	2,541,271
Revenues/nurse (Sk)	807,704	795,539	772,538	734,652	803,901	889,445
Revenues/employee (Sk)	317,186	316,748	309,053	289,451	314,767	347,342
Costs/employee (Sk)	342,973	332,994	355,175	358,614	363,248	392,534

Source: Zajac and Pazitny, 2002

C: Coping with deficits: shifting the burden to the private sector

None from number of reform measures was able significantly to influence negative economic performance of the health care system in Slovakia, producing large debts every year. Instead of stronger pressures to higher efficiency within the system, the system worked in favor of these creating debts, and penalized private sector suppliers for problem caused mainly within the system, by health professionals and health establishments, allowed for rent-seeking behavior. This solution of shifting of debt burden out of health care sector is very interesting, and really non-standard one. It clearly shows that the level of development of relations between the state and other sectors is still far from international standards, leaving too much space for the state to manage its own problems (imbalance between resources available and scale of "free" services promised to citizen) on the costs of others, in this case mainly of private sectors and of patients, pushed to bribe to get appropriate services. The Table 11 shows how the deficit is developing and how it is covered.

Table 11: Scale and structure of external debt of health care system in Slovakia

December:	1995	1996	1997	1998	1999	2000	2000	2001	2001	2002
Non-paid drugs delivered by pharmacies	0.9	0.8	2.1	3.8	3.6	4.0	4.7	5.9	6.6	8.0
Credits and other similar resources	0.6	0.7	1.7	1.9	4.4	4.0	4.4	4.4	5.8	5.9
Non-paid social contributions	0.4	0.4	0.7	1.8	3.0	4.5	4.4	3.1	4.2	4.1
Non-paid drugs from other suppliers	1.2	1.2	2.3	3.6	3.7	3.8	3.8	3.9	3.8	4.5
Non-paid food and other material supplies	0.6	0.7	1.0	1.9	2.6	2.7	2.2	3.5	3.7	4.6
Non-paid energies	0.4	0.4	0.6	1.0	1.1	1.5	1.7	2.0	2.5	2.9
Total	4.0	4.2	8.4	14.0	18.4	20.5	21.1	22.7	26.6	30.0

Source: Zajac and Pazitny, 2002

The data and information provided by the analysis of the economic performance of the system show that health care reform measures did not have significant positive impact on the economy of health care system and main problems causing inefficiencies, mainly:
a/ oversupply of medical personnel, mainly doctors,
b/ oversupply of facilities, mainly hospital beds,
c/ lack of capacities to manage demand (rationing),
d/ ineffective management of hospitals,
e/ ineffective drug management,
f/ limited prevention and lack of incentives to protect health status on the side of the patient,

still persist, and are solved to large extend on the costs of the private sector and consumers of health care.

Such development trends indicate important gaps in the area of health policy: the problems of health system, and their main purposes are real, well-known, and still grow, but none government was able to solve at least some of them during the entire period after changing to insurance based system of financing of health care in 1993. The state health policy was from beginning not in active, forward-pushing, position in the health reforms process: opposite, it was not able to predict potential negative outcomes of changing environment.

After 1989 pressure groups quickly developed as doctors, hospitals, pharmaceutical companies, health insurance companies, but not citizens, vied for power and resources. The more conservative nature of Slovak public opinion helped the bureaucracy to retain their policy and operational powers. The choice of insurance-based health funding had been made, without public discussion, before the division into two independent republics. Most of the key problems that then emerged were the direct consequences of the funding switch, as the logic of the insurance solution worked itself out through market segmentation, the collapse of pooling solutions, fewer providers, state enforced premium redistribution and less competition.

The lack of capacities in policy making and policy implementation area is obvious, and has many negative impacts, "paid" in the final phase by the most important player – the patient, in monetary, and non-monetary (decreasing quality ad access) form. Some changes seems to occur under recent (2002-3) government, but are very slow. The health policy area was not developed and supported, but event neglected, during the whole 1990-2002 period, and capacities cannot be created "during the night".

4. Public administration/management education in Slovakia

According to our information, public administration was not recognised as an independent academic field of study in Slovakia before eighties. Top public servants got education outside (mostly in Moscow), or in special „Universities of politics„ established by the Communist Party in Prague and Bratislava. Middle and low level public servants did not get any specialised public administration education, with negative impact on quality of civil service. This situation influences also current structure of public servants, most of them still do not have PA university degree.

The necessity to change „materialistic„ approach (according to defined economic theory only employees in „material sectors„ of economy - industrial branches, agriculture, forestry, mining, building industry created national income), and to start to promote also sector of services, was recognised only in seventies.

4. 1 Academic PA/PM programs

In 1977 the first faculty preparing university graduates for all branches of services sector was established as the part of the University of Economics Bratislava in Banska Bystrica, after four years of existence in the form of the local branch of this University.

From early beginning of existence of this faculty more and more attention was given to a development of study programs preparing specialists also for so called „non-productive„ branches of economy, including public administration. As the result of these developments first study program in „Economic of non-productive services and state administration„ was established in this faculty in 1986. At the same time similar programs were established also in the Czech Republic (Prague, Ostrava and Brno).

Faculty of Economics of Tourism and Services remained unique university level institution realising PA program until radical changes after 1989 started. However, many subjects from PA/PM field were included into the curricula also in other faculties of University of Economics in Bratislava, mainly in the Faculty of the National Economy (for example high quality courses on public finance).

After 1989 new of PA and similar programs were established in Slovakia, especially as a result of two main important factors:

- the society started to feel necessity of academically trained professional public administrators, prepared to realise effective public administration and public management roles
- liberalisation of a system of academic studies in Slovakia - each university has the right deliberately to decide on structure of faculties and study programs

Based on this, current structure of public administration academic programs was established. According to recent legislation (2002 University Law), three levels of public administration/public management (PA/PM) studies are available to students:

1. Bachelors degree studies in PA/PM (3 years). Students get degree „bakalar„.
2. Masters degree studies in PA/PM (2-3 years). Students in this form get degree „inzinier (Ing.)„ or „magister (Mgr.)„.
3. Postgraduate degree studies in PA/PM (3-5 years). Graduates get the PhD. degree.

There are following academic institutions in Slovakia in which in which specialised PA/PM degree programs are taught:

1. Matej Bel University Banska Bystrica - Faculty of Economics (more business school than school of economics). PA/PM education is delivered in co-ordination of two departments of this school:
   - the Department of Public Economics
   - the Institute for Local and Regional Development

   within the frames of the program "Public Economics and Public Administration", with four specialisations.

2. University of Economics Bratislava - Faculty of the National Economy (character of this school is between typical school of economics and business Faculty). PA/PM studies represent one of specialisations within the study branch National Economy.

3. University of P. J. Safarik Kosice. In this University the specialised Faculty of Public Administration was established in November 1998. Before this PA studies were realised within the frames of Faculty of Law by the Institute for Public Administration.

4. University Trencin - this University created PA academic program in the Faculty of Socio-economic Relations, as the specialisation within broaden study program on human resources.

5. University of Cyril and Metod Trnava, Faculty of Philosophy. This faculty started from 1998 two study programs related to PA/PM - Law in the Public Services and Management and Economics of Public Services. Both programs were not accredited, yet (and probably will not be accredited soon), and had to be closed.

There are also other university programs with some features of PA/PM degree program, we shall list in this part, but not evaluate in details later. We provide the list of faculties providing such types of courses:

1. Matej Bel University Banska Bystrica, Faculty of Political Sciences and International Relations
2. Matej Bel University Banska Bystrica, Faculty of Law
3. Comenius University Bratislava, Faculty of Philosophy, Department of Politology

4. Comenius University Bratislava, Faculty of Management
5. Comenius University Bratislava, Faculty of Law
6. University Presov, Faculty of Philosophy

Concerning the structure of PA/PM programs in Slovakia it is necessary to stress that the system of university degree programs (branches and specialisations) is under heavy reconstruction today, as the consequence of new university law. Because of this current names and structures of respective programs might be changes in short time.

Most of PA/PM academic degree programs in Slovakia are developed on the base of economic studies, more (Bratislava) or less (Banska Bystrica, Trencin) dominated by economic and management disciplines. Only PA degree in Kosice has character between economics/management/legal studies.

4. 2 In service PA/PM training

In-service training in public administration in Slovakia is highly decentralized, as the result of the system of personnel management in public sector that was highly decentralized before 2002, when the new Civil Service Code and Public Service Code were adopted. There are many institutions participating in some form of in-service training. Probably the most important from them (at least according to the number of trained civil servants) is the Institute for Public Administration in Bratislava (organization of the Ministry of Interior of the Slovak Republic), with branches in Kosice and Banska Bystrica.

This Institute is responsible for compulsory training of employees of local state administration, according to the governmental ordinance Nr. 157/1997 on specific qualification assumptions needed for executing some activities in regional and district offices. Additional main training courses of this Institute are as following:

- three years long training for public administration, focused on legal issues,
- three years long training for public administration, focused on socio-legal issues,
- two years long training in archive,
- training City-manager,
- training basic principles of auditing,
- a lot of short term courses.

Because of decentralised personnel management in Slovak public administration there exist a lot of state owned training centres, mostly related to each respective ministry. We provide list of most of them:

1. Institute for Training and Services, Ministry of Building and Public Works

This Institute realizes between many activities post-entry pre service training for selected professionals within state administration offices, focused on public procurement, housing, regional development - length of each course is 5 days.

2. Institute for Foreign Trade and Education, Ministry of Economy

Between many other activities this Institute organizes 12 days long training course for managers in public administration.

3. Secondary School of Fire Brigades, Ministry of Interior
4. Institute for education and technique, department of training in civil protection, Civil protection branch
5. Agroinstitute, Ministry of Agriculture
6. Institute for Education and training in Forestry and Water Economy, Ministry of Agriculture
7. Institute for Education and Training of Veterinary Doctors, Ministry of Agriculture
8. Slovak Agency for Environment, Ministry of Environment
9. Training Centre of the Ministry of Labour, Social Issues and Family
10. Centre for Education of the National Labour Office
11. Training Centre for Employees of the Ministry of Finance
12. Institute for Further Education of Health Care Employees, Ministry of Health
13. Slovak Institute for Technical Norms
14. Institute for Further Education of Employees of Justice Branch, Ministry of Justice
15. Research Institute of Geodesy, Cartography and Cataster
16. State Pedagogical Institute, Ministry of Education of the Slovak Republic)

There also private and semi-private for profit and not-for profit bodies, providing training courses for a lot of specific groups, including public servants. Between many we might mention one specific body - the Foundation for Self-government Training, founded by the Association of towns and municipalities of Slovakia (described in previous section).

4. 3 Health care administration, management and policy dimension of PA/PM education

From all mentioned institutions there is only one, where PA/PM education is closely combined with health care administration, management and policy education and training. The Faculty of Economics at Matej Bel University in Slovakia has as the part of its PA/PM program the specialization “Economics and Management of Health Services”. As this studies are unique, we include in depth analysis of them in the next section, to get more homogenous picture about the system of education and training practices in the area of health care administration, management and policy there.

5. Current education and training practices in the area of health care administration, management and policy in Slovakia

The necessity to educate health administrators was recognized already by the old regime. The first activities in this area were realized by the training institute of the Ministry of Health of the Slovak Republic – IPVLF (as already indicated, health care was the responsibility of national states after federalization of Czechoslovakia in 1968). The post-graduate training in health administration/management was compulsory pre-condition to be appointed to the position of director of hospital or polyclinics, or to other managerial posts - the requirement of “second attestation” in health administration was incorporated in binding regulative document – health care job description. However the training in health

administration/management by IPVLF dominantly focused on health care organizational aspects, included very few from management sciences (no surprising, as the hospital directors were not expected to be independent managers in old centralized system), and was delivered by medical doctors.

The creation of the Faculty of Economics of Services and Tourism (FECSR) of the School of Economics Bratislava in Banska Bystrica in 1977 represents important step in development of health administration/management studies in Slovakia. The importance of services in the national economy was for the first time really recognized in the system of academic studies, and the Faculty became responsible for education (masters degree level) of managers for all service branches, including health care services. By this, already in eighties, health care economics was incorporated into the curricula of the study branch "Economics of non-productive services and public administration), and new channel to prepare administrators/managers of health establishments was created. However, as the non-written rule (valid also today) provided that the hospital director is to be medical doctor, the graduates of these studies were usually not able to get higher than to the positions of economic vice-directors of health organizations.

By this, already before 1989 some system of preparation of health administrators/managers (but not health policy experts – as health policy was the single responsibility of the Communist Party) existed in Czechoslovakia. However, the contents of both types of studies (IPVLF and FESCR) was based on "socialist ideology" and rules of centrally planned and managed economy.

The massive health care reform after 1989, created the need for education and training of "new" managers for health care establishments. The reaction of existing bodies (IPVLF and FESCR) was different. IPVLF reacted to changes very slowly and this pushed small progressive group of medical doctors to establish (but still holding also their positions in IPVLF, in the School of Public Health, created on July, 1st, 1991) independent private non-profit organization "Health Management School - HMS", to deliver management training for medical doctors within the frames of this new institution. FESCR (converted from 1992 to the Faculty of Economics of the Matej Bel University – EF UMB) reacted very fast and changed the curricula and the contents of studies during the period of two years (already in 1992 the curricula were similar to existing similar Western masters programs).

The processes of establishment of HMS and changing the system of studies in EF UMB were supported by the program TEMPUS, and the main partner to support necessary developments was the Academic Hospital in Groningen, Netherlands.

Very soon after the TEMPUS health management program finished, new foreign partner came to Slovakia, to help to continue in changes. USAID decided to finance the program of establishment of health management studies in Central Europe, and allocated responsibilities to manage this program to AIHA. AIHA selected by competition US universities to execute the program in selected CEE countries, and the University of Scranton, PA, was chosen to serve in Slovakia.

The AIHA health management program started in mid nineteen's, with four institutions involved – University of Scranton, as the donor's representative, two already existing bodies – HMS and EF UMB and newly established Trnava University, with its Faculty of Nursing and Social Work (later Faculty of Health Care and Social Work).

The AIHA program was really comprehensive and its main phase lasting for three years, produced a lot of important outcomes. The main tools serving to update the system of health management (but still not health policy) education and training in Slovakia were creation of scientific Journal of Health Management and Public Health, organization of yearly Health Management Symposia, exchange of teachers and students, support of participation of Slovak experts in international conference on the topic, writing of core textbooks, and many

others. By the end of the program in 1998 all three Slovak partners became well functioning health management centers, and the sustainability was achieved.

The importance of academic education and training in health care was recognized in late nineteen's also by other institutions, and some new actors entered the field, creating its current structure, as described in following parts.

5. 1 Economics and Management of Health Care studies in Banska Bystrica (EF UMB)

EF UMB is also today the only body in Slovakia that delivers health management (and to some extend also health policy) education as the part of public administration/management studies. The study branch "Public Economics and Administration" (the name may change, and the accreditation would be extended also to PhD degree level in near future, as the result of new university law in Slovakia) represents still unique academic program in the country, fully compatible (from the point of view of curricula) with leading similar programs in developed countries.

The studies include three main phases. In the first phase (1^{st}-3^{rd} year) the curricula includes mainly business administration and economics subjects (like Microeconomics, Macroeconomics, Economic Policy, Quantitative Methods, Management, Marketing, Business), and small proportion of core PA/PM subjects (like Public Economics, Public Administration, Social Policy, Non-profit Management). In the second phase (4^{th} year) the knowledge in Pa/PM is further developed by courses like Public Finance, Public Services, Non-profit Sector, and others. The last, specialization phase (4^{th} and 5^{th} year), overlaps to some extend with the second one, and provides students with specific knowledge on selected area of public sector management, in our case, in specialization "Economics and Management of Health Care" via health care economics, management and policy courses.

Most courses are delivered by PA/PM and health economics experts, but a part of them is delivered also by medical doctors, working part time for the Faculty (like Clinical Management, Public Health). By this the graduates get very comprehensive knowledge, and are very flexible, able to adopt to different positions in health care sector, in other public sector organizations, but also in private for profit sector, in case there is no effective demand in the area of their specialization.

The Faculty is involved also into the on-job training of health care managers. In past years it delivered one year training course "Economics and Management of Health Insurance Company", recently the Faculty run two years training program for managers of non-profit organizations, where also some health care managers participate (the number of applicants for training in health management is not sufficient to open specialized course only for this group).

5. 2 Other education and training practices in the area of health care administration, management and policy

From other two USAID/AIHA health management program only one exists today – the Faculty of Health Care and Social Work of Trnava University (FHCSW). As the it became for HMS more and more difficult to survive as private body in health management training system (increasing competition and decreasing inflow of foreign aid), the main representatives of HMS decided to return back, and to incorporate their activities within the frames of the training institute of the Ministry of Health (at that time called SPAM) that was converted in 2002 to the "Slovak Health University". By this the existing "School of Public Health - SPH" of the "Slovak Health University" became new (real) actor in the field of

health management training in Slovakia, and by this the circle IPVLF – HMS – SPH was concluded.

Except of mentioned two (from three – together with EF UMB that was already discussed) dominant actors in the field of health management education and training – FHCSW and SPH, there are also some other recent attempts to introduce this type of education and training into activities of Medical Faculties in Bratislava, Martin and Kosice, Faculty of Health in Presov, but such activities do not go beyond including some specific courses into the curricula of academic education or training courses.

The Faculty of Health Care and Social Work of Trnava University

The Faculty has accreditation for the study branch "Public Health", providing it with the right to deliver masters degree in this area (again, this name may change, and the accreditation would be extended also to PhD studies in the field, as the result of recent reform). Within this study branch the students can choose in the last (5^{th}) year the specialization "Health management". The responsibility for this specialization is on the Department of Health Management, consisting form 50 % of medical doctors and 50 % of other specialists.

The curricula of the branch and specialization are dominated by medical courses, supported by extensive language preparation of students. The first four years include only two courses related to our topic – Health Policy (12 hours) and Health Management (36 hours). In the phase of specialization (one semester), the students get following courses – Health Policy in Public Health, Health Financing, Organization of Health Care, Public Health Advising, Biostatistics, Ethics in Management, and Insurance.

The School of Public Health of the Slovak Health University

As already indicated, the history of this School is interesting story. Created in 1991, but with limited scale of activities in health management training in the beginning, and some of its teachers creating private non-profit HMS (but simultaneously continuing in the School) for certain period to deliver this type of training. Significantly interconnected with Trnava (FHCSW) – the same names appearing in the list of members of the Department of Health Management in Trnava and in Bratislava (Dr. Hlavacka simultaneously serving also as the top civil servant – director – in the Ministry of Health and as the medical doctor in the hospital).

The most peculiar issue connected with the school is the process of the creation of the "Slovak Health University". The University was created by the specific law voted by the Slovak Parliament in 2002, as the result of lobbying of medical doctors focused on increasing of the status of SPAM (training institute of the Ministry of Health). It is not accredited for any degree, yet, in spite any academic education institution cannot be created without preliminary accreditation. It is not part of the standard university system in Slovakia, but is linked directly to the Ministry of Health.

The School delivers (more or less illegally) masters degree program in Public Health (3 years studies) and training courses for medical employees. The Public Health program includes also topics on health economics and management. The Department of Management of the School organizes every year short term training courses for medical employees, like Management of Spas, Health Management and Finance, Management of Health Establishment, Health Management, Salaries in Health.

Thanks to direct link to the Ministry of Health the school has more or less monopolistic position in training of health professionals (other training courses are mostly not recognized by the Ministry, and by this are not officially valid for qualification assessments), including these in management positions.

Because of its character, and program, for health management education and training analysis purposes, we list this school as training institution in annex.

5. 3 Conclusions and recommendation for new initiatives

As described in part three, the Slovak health care system is recently in deep crisis, especially from the point of view of finance. There are more purposes of such situation, some of them objective (like the level of performance of the national economy, limiting the amount of resources to be able to allocate to health care), but many could be solved also in short term - limited quality of managers of health care establishments and lack of capacity in health policy making between them.

Quality of health management/managers and health management education

Low economic performance of health care establishments, especially hospitals, represents one of important purposes of financial crisis of Slovak health care, as already showed. The hospital system is year by year in "red figures", as they are not able to balance costs and revenues. There is no doubt that this negative trend is connected also to the factor of the quality of hospital management and hospital managers. What is the relation between this problem and the system of health management education/training?

To answer our question, we have to focus, as minimum, on two dimensions. The first dimension is the quality and scale of health management education and training and the second is the capacity of the system to accept well educated and trained managers.

The analysis in previous part shows that the system of education and training of health care managers in Slovakia has still some reserves, in contents and in scale, too. The number of graduates from Banska Bystrica is very limited, in average 5-10 per year. The graduates are very good generalists, but need some additional experience from health care system practice. The education and training in Trnava and Bratislava are very much based on medical courses, and the graduates are really not provided with sufficient knowledge of management and related disciplines.

However, the main problem is (at least today) outside of the education/training system. The tradition that the health establishments directors are medical doctors, and the role of economic managers is limited, still persists in Slovak health system. Doctors and their interests dominate the system, and the space for effective manager is very limited. As the state was not able to react on bad economic performance of hospitals, and just recovered debts of public health care system (see Table 2), there are also no incentives to manage health providers organizations in effective way. Under these circumstances, the system is not ready to accept well educated and trained managers, and the best try to find other opportunities in different branches of the national economy (this is also one of purposes, why EF UMB and also FHCSW did not decide to increase number of graduates in the field).

The situation in the sector may change very soon. Current Slovak government decided to privatize most of health care establishments (hospital sector remained in hands of the state till 2002), or to transfer them into hands of local and regional self-government, and will (at least promises) not recover any additional debts. In case, the external environment will

change, the pressure to change the system of management of hospitals will be created, and the need for effective managers should appear. It is no doubt, the system of health management education and training would need to improve, to be able to react on such demand.

Health policy dimension

It is not only the author of this country study, but also many other sources (Slovensko 2001, Slovensko 2002) argue that there is no consistent health policy in Slovakia. The main purposes of problems of health care system are well-known, described, and publicly named (misbalance between the amount of resources available and the scale of care provided free at the point of delivery, as the main of them), but none of Slovak governments before 2002 was able to react on them.

The sources of such situation could be found by investigating interests of main "players" (Nemec and Lawson, 2003) – none of them promoting necessary changes, but are connected also with really limited policy-making and policy implementation capacity of public administration system.

Health care policy-making, policy implementation, and policy analysis issues are taught only in few courses, and there is neither capacity, not demand to improve the situation. There are really few experts on these issues in Slovakia, yet, and such situation will not change fast. The government demands health policy advice only exceptionally, most decisions are not discussed with academic and scientific circles.

There is only one health policy "think-tank" formally established in Slovakia – The Center for Health Policy and Strategy in Banska Bystrica, non-profit organization, based on voluntary memberships (there is no permanent staff). Because of its structure and territorial location outside of the capital, the capacity of the Center to influence health policy in Slovakia is very limited, but not marginal (the Center provided certain expert studies, mainly on health financing, funded via Phare or World Bank).

Conclusions and recommendations

Facts provided by the analysis prove that the basic system of health management education was already created in Slovakia, and its current performance is in accordance with the real demand from the health sector. However, recent changes of health care system may significantly increase demand for well educated and trained health management professionals, and the current education/training system will have significant difficulties to react. All existing education/training institutes are public sector bodies, and could be expected not to be flexible enough to increase both capacities and quality (low level of salaries, limiting the chance to hire additional good quality staff might be dominant barrier of this). The private sector is not involved in the area, yet (as the system of public-private mix to deliver certificated training is not supported by the Ministry of Health that still protects monopolistic position of its training institute in the field).

Taking into the account current situation and possible perspective, the recommendation for the area of health management education/training is straightforward – the capacities to deliver health management education/training have to be increased, and pluralistic delivery system is to be created. The main source to finance the capacity growth would be probably private finance, or external resources, as the public finance system cannot be expected to support such processes in more significant way. Much more co-operation between existing institutions is needed.

The system of health policy making, implementation and analysis is more or less not created, yet. The pressure for it may arise very soon – as the health care system is closer and closer to collapse, and there will be no additional resources to recover its debt from privatization or similar non-regular incomes, like today, systematic and effective measures to revert the trends of its development would be needed for any government (as the collapse of health care system may cause large political changes in short period). To react to such demand will be not simple, and many new young brave people have to be attracted to contribute (the "old generation" is very much out, to free from heritage of "command society" is not so simple), and additional transfer of knowledge from developed countries might be needed, too. To "get them" additional public or external resources have to be found to finance the system, as the private sector could not serve in this way very much (vested interests as one of purposes). Taking into the account the limited local public finance capacity, the area of health policy might be accepted to be financed by foreign donors/borrowers (in spite Slovakia is close to become EU member), directly by providing funds, or indirectly by providing expertise and know-how.

6. References

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Annexes

1. Academic Programs in Health Management in Slovakia

A: Faculty of Economics, Matej Bel University, Banska Bystrica

1. Name of the program: Verejna ekonomika a sprava (Public economics and administration), specialization: Ekonomika a management zdravotnictva (Health economics and management).
2. Accreditation: full accreditation for bachelor, masters and doctoral studies.
3. Contact address: Helena Kuvikova, EF UMB, Tajovskeho 10, 974 01, Banska Bystrica, Slovakia, kuvikova@ef.umb.sk, www.econ.umb.sk
4. Established: 1987

5. Number of students: students are regularly admitted for five years long combined bachelor and masters program, full time. The average number of students per year is 10-15 per year. The part-time studies and doctoral studies are not regular and depend on demand.
6. Degree: Ing. (Master of Public Management)
7. Main partners: University of Scranton (USA), Masaryk University Brno (Czech Republic).
8. Curricula:

a/ Main (compulsory) courses bachelor level: Microeconomics, Macroeconomics, Mathematics, Statistics, Management, Marketing, Informatics, Public Economics, Public Administration, Economics of Municipalities and Regions, foreign languages (2), World Economy, Accounting, Enterprise Management, Human Resources Management, Public Services, Non-profit Organizations, Demography, Public Sector Control/Audit.

b/ Main (compulsory) courses master level: History of Economic Theories, European Union, Public Economics II, Quantitative Methods, Social Insurance, Non-profit Sector, Social Development, Logistics, Insurance Mathematics, Public Finance, Business Games, Health Economics, Health Law, Health Policy, Health Insurance, Clinical Management, Health Sociology and Psychology, IT in Health Care, Non-profit Marketing.

9. Impact in the country: The program started with high expectations, as there was clear potential for demand. However, the real acceptation of graduates in the health care system was very limited, and because of this the willingness of students to apply for the program decreases. The staff representing the program represents the core of the Center for Health Policy and Strategy in Banska Bystrica, independent non-profit "think-tank" in health policy area. This center is irregularly, time to time, invited to participate in health policy analysis activities. The main examples was award of one part of Phare financed program in 1996 (financing of hospitals) and World Bank financed program in 2002 (hospital versus out-patient treatment of minor diseases). Its name and representatives are well-known in the country, but the real impact on health policy making is still very limited, as the government is not very proactive in the way to co-operate with other sectors when preparing main policy documents.

B: Faculty of Nursing and Social Work, Trnava

1. Name of the program: Verejne zdravotnictvo (Public Health), specialization Zdravotnicky management (Health Care Management)
2. Accreditation: full accreditation for bachelor, masters and doctoral studies.
3. Contact address: Bohumil Chmelik, FOSP TU, Univerzitne namestie 1, 917 00 Trnava, www.truni.sk
4. Established: 1994
5. Number of students: students were regularly admitted for five years long combined bachelor and masters program, full time. The average number of students per year was about 10 per year. The part-time studies and doctoral studies are not regular and depend on demand.
6. Degree: Mgr. (Master of Health Management)
7. Main partners: University of Scranton (USA).

8. Curricula:

a/ Main (compulsory) courses I-V. year (except of specialization): Anatomy, Biophysics, Biology, Biochemic, Physiology, Nursing, Health Law, Biostatistics, IT, Philosophy, Psychology, foreign languages (3), Hygiene, Microbiology, Anatomy, Internal Medicine, Surgery, Pediatric, Primary Care, Epidemiology, Pharmacology and Pharmacoeconomics, Oncology, Health Policy, Radiology, Infectious Diseases, Health Management, Gynecology, Social Medicine, Social Work, Risk Calculations, Health Programs, Health Ethics, Public Relations.

b/ Main (compulsory) courses of specialization (V. year): Health Financing, Managed Care, Insurance, Management Ethics, Advising in Public Health, Public Health Policy.

9. Impact in the country: The program started as the result of AIHA activities in Slovakia. Similarly to EF UMB program the graduates have limited chance for "fast track" in health management system. The interest of students to apply is limited. Internal staff involved into the realization of the program is not significantly involved in health policy making and analysis in the country.

2. Training Programs in Health Management in Slovakia

As described in the main text, the main, almost "monopolistic" provider (as the outcome of Ministry of Health training policies) of training programs today is the School of Public Health of the Slovak Health University.

School of Public Health of the Slovak Health University

1. Contacts: Ladislav Badalik, Svatopluk Hlavacka, Skola verejneho zdravotnictva SZU, Limbova 12, 83303 Bratislava, www.doktor.sk/spam
2. Training programs:

A: Master of Public Health (for university graduates – "executive" MA program)
Main courses: Epidemiology, Biostatistics, Economics and Management of Health Care, Health Protection, Environment, Health Law, Health Sociology, IT in Health Care, Health Pedagogic, Health Education, Health Promotion, Social Pediatric, Social Psychiatry, Social Gerontology, Social Pharmacy, Bioethics, Patient Rights, International Health.

B: Training for head nurses of spas – 3 days
Contents: managerial tasks, motivation, managerial psychology, conflict management, change management, management of quality, strategic management

C: Health Management and Finance – 12 days
Contents: health management and financial management

D: Management of Spas – 4 days
Contents: management and marketing of spa organization, balneotherapy, managerial skills of head nurse

E: Management of Health Establishment – 3 days
Contents: strategic management, change management, health policy

F: Health Management – 3 days
Contents: strategic management, managerial psychology, change management, conflict resolution

G: Remuneration in Health Care – 1 day
Contents: remuneration system for public health organizations, financial management, labor relations, performance management and appraisal