PREVENTIVE HEALTH CARE IN RELATION TO HEALTH INSURANCE SYSTEM IN SLOVAKIA

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Abstract:

Introduction: Preventive measures in a field of health care are cheaper than addressing the consequences of neglected diagnosis and treatment. Aim of this study is to present the Slovak legislation and national plans in the field of preventive health care. This issue is discussed in relation to financing of health care from the health insurance.

Methods: This study was conducted by using the method of content analysis of selected legislative and non-legislative documents and statistical reports of the Slovak ministries (finance, health) and of health insurance companies.

Results: In Slovakia, universal and selective preventive health care is available for health care payers. Number of people who undergo the preventive examination differs in selected areas and the expenditure on medical treatment and addressing the consequences of neglected prevention are still high. Control plans are vague and do not cover concrete steps leading to achievement of goals presented. Access of marginalized groups of population to the preventive health care is still at very low level.

Conclusion: The system of preventive health care measures in Slovakia is relatively well-defined in legislation and supports the provision of preventive care. However, it is not enforced. There are no serious sanctions in case of neglecting patient´s obligations and people are not motivated to undergo preventive examinations. Only sanctions that in some cases work are financial. The detailed research of access of people from socially disadvantaged environment to the preventive care is desirable.

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Introduction

Health is a key factor in the development of society. Health and equality in health (not only in providing health care) are considered to be the fundamental rights of every citizen. Maintaining and improving health is the best investment for a strong economy and a satisfied company (Government Resolution No. 11, 2008). Prevention is one of the most important areas of health care with significant impact on the early diagnosis of many serious diseases and also state policy should focus on support of this area. Prevention is cheaper than treatment and savings can be invested in further research (Kováčová, 2016).

In the case of Slovakia, preventive health care can be universal and selective, both paid from the public health insurance (in case that a concrete physician has an agreement with a health insurance company). The fundamental legal source is the Act no. 577/2004 Coll. on the Scope of Health Care Reimbursed on the basis of Public Health Insurance and on the Payment for Services related to the Provision of Health Care as amended (further as "SHCR") (Act no. 577/2004 Coll. as amended, 2019). National health care policy is defined as strategic development policy and is based on WHO strategic framework. The document "Strategic health care framework for years 2014 – 2030" applies "Health in all Policy" approach with general access to health care, regardless age or social group. This policy has four main priorities: chronic diseases, infectious diseases, environment and health, tobacco and alcohol. Two main fields of interest are highlighted: cardiovascular and oncological diseases (MHSR, 2011).

Recently, two new control plans have been added to the existing (Eliáš, 2018b). National oncology program is aimed at reducing the incidence of cancer and mortality, as well as improving the quality of life of cancer patients (Eliáš, 2018). National plan for the control of infectious diseases sets a general framework to prevent the spread of infectious diseases, as well as care for patients with infectious diseases (Eliáš, 2018a). One of the most discussed programs due to spreading measles, National Immunization Program is regularly updated. It is aimed to reduce and eliminate the incidence of infectious diseases through the consistent provision of immunization in particular of the pediatric population (most vulnerable are Roma people and refugees) (RPHA in Michalovce, 2019).

The health care system in Slovakia comes from and consists of universal coverage, compulsory health insurance, a basic benefits package. A competitive insurance model is based on selective contracting

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and flexible pricing. Health care, with exceptions, is provided to those insured free at the point of service as benefits-in-kind (paid for by a third party) (Szalay, 2011).

Data and methodology

This study was conducted by using of content analysis of selected legislation and additional non-legislative documentation. Act no. 577/2004 Coll. on the Scope of Health Care Reimbursed on the basis of Public Health Insurance and on the Payment for Services related to the Provision of Health Care as amended was discussed as a primary source of information on preventive health care measures.

Slovak data and related information on actual legislation, strategies and a current status of the health prevention in Slovakia were acquired from official websites of the National Health Information Center and Regional Health Care Authorities in Slovakia. Statistics published by the Ministry of Finance of the Slovak Republic and the Ministry of Health Care of the Slovak Republic were also an important source of information.

Informed consent was not necessary as no human beings were examined.

Results and Discussion

In 2016 analysis of the Health Consumer Powerhouse (HCP), Slovakia reached 24th place in the ranking, based on 48 indicators, such as access to care, rights of patients, range of services, etc. This analysis points out few deficiencies in Slovak health care system. One of the most important is life years lost due to insufficient health care. Slovak people lose more than 12 years of life expectancy on average (Health care in Slovakia deteriorates, 2016).

However, according to the Euro Health Consumer Index (EHCI), developed by the Swedish Health Consumer Powerhouse, Slovak healthcare has improved significantly year on year. For the year 2017 Slovakia ranked in the 13th place in the rankings, while it was in the 23rd place a year ago (SITA, 2018).

Table 1. Vaccination schedule 2019

YEAR OF BIRTH	AGE	KIND OF VACCINATION	TYPE OF VACCINATION
2019	3rd month of life 5th month of life 11th month of life	diphtheria, tetanus, cough (acellular vaccine), hepatitis B virus, invasive hemophilia infections polio (DTaP-VHB-HIB-IPV) pneumococcal invasive disease (conjugated vaccine (PCV), simultaneous administration with hexavaccin)	1st dose (primary vaccination) 2nd dose (primary vaccination) 3rd dose (primary vaccination)
2018	15th - 18th month of life (latest)	measles, mumps, rubella (MMR)	primary vaccination
2014	6th year of life	diphtheria, tetanus, cough (acellular vaccine) polio (DTaP-IPV)	revaccination
2009	11th year of life	measles, mumps, rubella (MMR)	revaccination
2007	13th year of life	diphtheria, tetanus, cough (acellular vaccine) polio (DTaP-IPV)	revaccination
X	adults (30 years old)	diphtheria, tetanus (DT **)	revaccination every 15 years

Source: The Vaccination plan of the Public Health Authority of the Slovak Republic (2019).

Universal and selective prevention measures

In Slovakia, universal prevention is provided for all citizens regardless of their gender, employment, social status or other potential factors. The most important aspect is the age of the citizen, as focus and scope of the prevention is tailored to the age of the citizen. General examination should last more than 30 minutes and a physician should assess the overall family history, workload and the current status of

the vaccinations. The patient can undergo other special examinations when recommended by the general physician.

Children should undergo four compulsory vaccinations. Adults should undergo one revaccination, as it is described in the vaccination calendar (Table 1). If the compulsory vaccination is ignored, it is possible to impose a fine of € 331 and according to the draft law, unvaccinated children will not be able to attend pre-school facilities from 2020 (Matkovská, 2019).

Table 2. Vaccination status - example of measles, mumps and rubella

YEAR OF BIRTH	TOTAL NUMBER OF CHILDREN IN YEAR	NUMBER OF VACCINATED	NUMBER OF REJECTED VACCINATION
2015	56 013	53 073 (94,8%)	1740
2014	55 404	53 072 (95,8%)	1620
2013	54 991	52 481 (95,4%)	1838
2012	55 636	53 367 (95,9%)	1712
2011	55 039	53 494 (97,2%)	1073
2010	55 478	54 590 (98,4%)	572

Source: Public Health Authority of the Slovak Republic website (2019).

Table 2 shows that number of unvaccinated children has a raising tendency. This trend is visible in more than two Slovak regions (Luprich, 2015; Stančíková, 2017).

Table 3. Universal prevention

	GENERAL PREVENTION	DENTAL CARE	GASTROENTEROLOGY	VACCINATION
CHILDREN, ADOLESCENTS	17 examinations from 0 to 15 years of age (9 of them in the 1st year of life)	2 preventive examinations per calendar year		4 basic vaccinations 3 revaccinations
ADULTS	1 preventive examination at a general practitioner once every two years special examination with medical justification (covered by insurance) special examination without medical justification (paid by the patient)	1 preventive examination per calendar year	screening once every 10 years for citizens older than 50 years of age screening once every 5 years for people with higher risk of colon and rectal cancer (without age restriction)	

Source: SHCR (2019).

Selective prevention is mainly divided by gender. Women are provided with gynecological health care and men with urological health care. The age of the citizen played a significant role also here.

According to statistics and Report on revision of expenditures in health service, gynecological outpatient clinics are worse in prevention. Slovakia lags behind in the screening rate on breast cancer behind all reference groups, the rate of preventive examinations for the gynecologist is slightly better than the V3 average and significantly worse than the EU-28. The country has also problem with influenza vaccination in the most vulnerable age group of elderly people, when the number of vaccinated people in Slovakia is lower than 20% in comparison with the EU28 where the amount is app. 50% of older population (Dančíková et al., 2018).

Table 4. Selective prevention

SELECTED GROUP	TYPE OF HEALTH CARE
WOMEN	1 examination by a gynecologist per year after the age of 18 or from the first pregnancy 1 ultrasound of the breasts once in two years cervical cancer screening for women aged 23-64: the first 2 cytology cycles are performed at a one-year intervals if negative results, the patient continues to be at a 3-year intervals up to the age of 64 years screening at age 64 ends when the last 3 cytological findings are negative a pregnant woman one preventive examination every month of pregnancy and six weeks postpartum 3 examinations during pregnancy 1 preventive dental examination two times during the same pregnancy
MEN	once every three years a complex preventive urological examination for 50+ years old
DONORS OF BLOOD, ORGANS AND TISSUES	a complex preventive general examination once per year
ACTIVE ATHLETES	a partially (50%) paid preventive examination in the specialization field of physical education once a year for athletes below 18 years of age

Source: SHCR (2019).

Table 5. Preventive examinations in 2015 – 2017 (Slovakia)

	2015	2016	2017
PREVENTIVE EXAMINATIONS	963 844	970 740	960 425
EXAMINATIONS IN TOTAL (AMBULANCE + VISITS)	6 181 561	6 193 303	5 914 376

Source: The National Health Information Center (2019).

One of Slovak health insurance companies – "Dôvera" found out that more than 30% of preventive examinations were not realized according to legal provisions. In 2015 – 2017 they covered 584 000 preventive visits. Data showed that only one third of entitled people really undergo the prevention. The further investigation pointed out that app. 105 000 examinations were realized without complete laboratory examination and 32 500 without any laboratory examinations (8% of preventive examinations in years 2016 – 2017). At least 700 preventive visits were only fictitious (expenditures app. EUR 12,000) (Dôvera, 2018).

Financing of preventive health care

Social insurance in Slovakia does not include also health insurance. The competencies in these two fields are divided between the Ministry of Labour, Social Affairs and Family of the Slovak Republic (social insurance) and Ministry of Health of the Slovak Republic (health insurance). Presence of health insurance is among others one of the conditions of residence permission (Saia, 2014).

The Slovak social health insurance (SHI) system provides universal coverage for a broad range of benefits since 2010. Solidarity is considered to be its main principle and insured person has guaranteed an annual free choice of one of three nationally operating health insurance companies. The main sources of revenue in the health system are contributions collected by the health insurance companies, collected from: (1) employees and employers; (2) the self-employed; (3) the voluntarily unemployed; and (4) the "state-insured". The "state-insured" is a term used for the group of mostly economically inactive people for whom the state pays contributions (one-third of the total resources from SHI contributions). Because of the broad definition of the SHI benefit package voluntary health insurance (VHI) plays only a very marginal role (Szalay, 2011).

Within the framework of universal and selective prevention, prescribed by the law, the examinations mentioned in Table 3 are basically covered by the public health insurance. If further examinations during the general preventive examinations are recommended by the attending general physician, they are reimbursed by the insurance. If they are requested by the patient himself or herself, they are fully paid by the patient.

In the case of dental care, if the insured person undergoes dental preventive examinations as scheduled by the law, the treatment is reimbursed by health insurance. However, in practice patients often pay for additional medical treatment of for a better material to be used. There is no price regulation in this area, so if patient would like, so called "higher standard" can be chosen, covered by additional direct payments.

Along with dental care, higher standard is mainly offered by private health care companies. It typically consists of preventive programs and comprehensive examinations. If the attending physician has no agreement with health insurance company, so the care can be partially covered by the insurance, these programs are fully covered by the patient. This level of health care is preferred by people who are able to pay for it, because it has more advantages in comparison with state health care facilities. One of them is a time saving, because all examinations run out at once, usually without long waiting periods, with ordering at the exact time and at one place. It can be also provided by the employer as one of the non-financial benefits within an employment relationship.

The health care allowance is one of the benefits in providing material assistance. It provides the citizen in material need and the individuals who are jointly assessed with the citizen with the costs of reimbursement for health services related to healthcare. Health care allowance of EUR 2,00 belongs to a citizen in material need and to any natural person who jointly assesses with a citizen in material need (Ministry of Labour, 2019).

Slovak health expenditures in November 2018 to 5.7% of GDP, with 6.5% of GDP in the EU28. Public health insurance expenditure amounted to EUR 4,576 million in 2017 (MFSR, 2018).

Marginalized Roma communities (MRC) and preventive health care

Roma people are one of the most vulnerable groups in relation to access to health care, including prevention, in general. The main reasons are social exclusion and poverty (less than 341 € per month) in many cases. Language barriers, low level of education, high unemployment rates, financial barriers (payments for treatment, distance of health care facilities from segregated communities), group norms (traditions, culture) stronger than state norms, housing conditions and racism of majority support the deepening differences (Košice Region, 2016).

Strategy of the Slovak Republic for the integration of the Roma by 2020 is based on European norms and strategies and in the field of health it has a few priorities: to improve hygiene in settlements and urban concentrations (hygiene standard, access to drinking water...); to ensure availability of healthcare services and to improve real availability by removing obstacles; to reduce the incidence of infectious diseases by increasing awareness and to increase the number of persons who undergo preventive vaccination. Goals are also to raise awareness of parenthood, reproductive health, maternity and child care; to implement educational activities aimed at the prevention of drug addiction and sociopathological phenomena, including violence against women and domestic violence against sexual abuse and trafficking in human beings and to stabilize, optimize and expand the network of community workers in the field of health education and create conditions for Roma employment while implementing the pilot project of community workers in the field of health education into hospital facilities, in order to prepare patients from marginalized communities, especially in gynecological, pediatric and health care departments, for communication with health care staff, as well as with other patients or visitors (MISR, 2012).

Action Plan on Health, adopted for the implementation of the mentioned Strategy, has the budget of EUR 4 112 892,00. Total public spending in 2017 for social inclusion of people at risk of poverty or social excluding people with disabilities, they are estimated at € 435.6 million, what is 0.51% of GDP and 1.27% of total public expenditure. EU and co-financing created 29% (EUR 125.3 million) of this.

Real improvement on the basis of financial sources already invested is very questionable. However, there are some positive examples. Project „Healthy communities" can be mentioned. It is the most important tool in Slovakia, which is explicitly focused on social inclusion in the field of health. Total spending in 2017 amounted to EUR 1.26 million, of which the state budget was EUR 390 000. The project is aimed at improving the health situation of excluded groups, in particular MRC. By the end of 2017, EUR 11.3 million was contracted out of ESIF funds and co-financing from the Healthy Communities. The project is implemented by the state-funded organization Healthy Regions

established by the Ministry of Health of the SR. Health Roma mediators are one of the symbols of this project. Nowadays 213 Roma Health Mediators work in 218 Roma communities (Hellebrandt, 2019).

Conclusion

Prevention is an essential tool for a functioning health system that, according to the OECD, helps to improve health of the population effectively and cost-effectively. In particular, the state should strengthen prevention through promoting a healthy lifestyle, such as healthy eating, movement, and consumption reduction alcohol and tobacco; vaccination programs that help to prevent infectious diseases directly; screening and monitoring of e.g. tumors and interventions that have an impact on socio-economic and environmental determinants of health (Dančíková, Grajcarová, Kozák, & Marek, 2018).

In Slovakia, the legal framework for preventive health care is defined sufficiently. The possibilities for citizens to undergo preventive examinations are described and if followed, they are fully or partially covered by public health insurance. What is needed, is to support the confidence of people for their own health, because only small part of them undergo preventive examination on a regular basis.

The access to health care for members of marginalized Roma communities is an isolated and serious problem. Partial data are available, as well as goals set in strategic documents, however, there is a need for more detailed research of the barriers and the motivation of socially excluded people to follow generally binding rules.

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