ESPN Thematic Report on Inequalities in access to healthcare

Slovakia

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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Summary/Highlights

A statutory health insurance system operates in Slovakia, with quasi-universal population coverage. It guarantees access to a broad range of healthcare services. The state pays contributions on behalf of people who are economically inactive – so-called 'state insured' persons. Healthcare expenditure accounted for 6.9% of GDP in 2016, which was below the EU average, with the dominant share made up of public spending (5.4% of GDP).

In addition to the Ministry of Health, health insurance companies (which purchase healthcare services from providers in order to ensure access to healthcare for insured persons), and the Healthcare Surveillance Authority, self-governing regions play an important role. Regions are responsible, inter alia, for issuing permits for healthcare facilities, as well as for surveillance of healthcare provision. In cases where healthcare providers ignore their duties, regions can impose sanctions. Regions are expected to take part in improving the network of providers if healthcare accessibility is deteriorating. This responsibility is of key importance, as data for OECD countries show that Slovakia has the highest difference, in terms of the density of doctors, between predominantly urban regions (6.8) and rural regions (2.7): this is driven to a large extent by the strong concentration of doctors in the national capital region.

Only a minor part of the population faces barriers in access to healthcare, according to EU-SILC data. In 2016, 2.3% of people reported unmet needs for medical examinations due to cost, long distance or waiting lists. The incidence of unmet needs due to these reasons was higher among persons aged 65 or over (3.8%) and persons in the lowest income quintile (3%).

A significant variation in the distribution of health workers across regions may contribute to the fact that long distances are viewed as a barrier to healthcare accessibility. The most favourable conditions can be found in the Bratislava and Košice regions, where the two largest cities are located. The regions of Trnava, Trenčín and Nitra face limited availability of medical workers. Density of healthcare workers decreased in most regions between 2008 and 2014.

Out-of-pocket (OOP) medical payments reached 2.4% of total household consumption in 2015. The highest proportion of OOP payments was spent on pharmaceuticals (43%) and therapeutic goods (28%). Outpatient care accounted only for 3%, which was much lower than in many OECD countries. On the other hand, payments for inpatient care represented 16% of OOP payments, which was well above the OECD average (9%). Expenditure on prescribed drugs varied according to the socio-economic status of the household head. Households where the head was in paid work spent 36.7% of their total health expenditure on prescribed drugs. For households of unemployed persons it was more than half (54.6%). In the case of old-age pensioner households the proportion was even higher (57%).

The health status of the marginalised Roma population is worse than that of the majority population, reflecting poorer access to healthcare services. An atlas of Roma communities (Mušinka et al., 2014) shows that almost 58% of municipalities with Roma settlements do not have the services of a general practitioner (GP); 69% are without paediatric outpatient services, and 68% are without dental services. Difficulties for the marginalised Roma population concern not only poor access to general healthcare services, but also discrimination in terms of the reproductive rights of women and their access to good-quality, affordable contraception.

The health condition of people in marginalised Roma communities is a subject of public policy concern. It has been addressed by several strategic documents. The current strategy for Roma integration (up to 2020) sets policy objectives related to healthcare access, other related policy measures, and processes for monitoring and evaluation.

1 Description of the functioning of the country's healthcare system for access

Universal and free-of-charge access to a basic package of healthcare services is guaranteed in Slovakia. The law defines lists of free preventive examinations, essential pharmaceuticals without co-payments, diagnoses eligible for free spa treatment, and priority diagnoses (Smatana et al., 2016: 75).[1] All citizens are obliged to pay health insurance contributions, except for specified economically inactive groups,[2] for whom the state pays contributions.[3] Health insurance companies collect and administer insurance contributions (from employees and employers, the self-employed, voluntarily unemployed people, as well as those categories covered by state payments). If people fail to pay contributions, they are only entitled to emergency care. According to OECD data (OECD, 2017), population coverage for a core set of services amounted to 93.8%, which is below the proportion in most other OECD countries. According to one estimation (Smatana et al., 2016), 4% of inhabitants in Slovakia are not covered by statutory health insurance because they live abroad and pay health insurance contributions in their place of (temporary) residence.

Patients can choose which general practitioner, specialist and/or hospital they use. In addition they can choose their health insurance company, which (as well as collecting contributions) purchases healthcare services from providers. Contributions are re-allocated among insurance companies according to an index that takes into account various risk-related characteristics of insured persons. There are three health insurance companies in Slovakia. The state-owned company *Všeobecná zdravotná poisťovňa* (VsZP) has a dominant position. The market share of the two private health insurance companies (*Union* and *Dôvera*) is much lower. Surveillance of health insurance, healthcare provision and healthcare purchasing is the responsibility of the Healthcare Surveillance Authority. Most hospitals belong to the public sector. Hospital care is financed through payments from health insurance companies and direct state subsidies. Almost all GPs, pharmacies and diagnostic laboratories, and a considerable majority of specialists, are private.

Self-governing regions play an important role in the health system in Slovakia. They are responsible for issuing permits for healthcare facilities, as well as for surveillance of healthcare provision. In cases where healthcare providers ignore their duties, regions can impose sanctions, which can take form of financial sanctions or withdrawal of licences. Sanctions are normally based a recommendation from the Healthcare Surveillance Authority. Regions are expected to take part in improving the network of providers if healthcare accessibility is deteriorating.

Healthcare expenditure accounted for 6.9% of GDP in 2016, which was below the EU average. Healthcare per capita spending, adjusted for differences in countries' purchasing powers, reached EUR 2,150. Public sources of spending represented more than three quarters of total health spending. Spending on medical goods was the largest single element of healthcare expenditure (35%), followed by expenditure on inpatient care (30%) and outpatient care (29%). The share of expenditure on medical goods was higher in Slovakia than in most OECD countries (OECD, 2017). Slovakia also spends more than other countries on pharmaceuticals, even after controlling for differences in purchasing powers: in 2014 it spent EUR 396 per inhabitant, compared with EUR 402 for the EU as a whole.

[1] The basic package also includes mental healthcare. Dental care is covered by health insurance only to a limited extent, and is conditional on having had a regular dental examination in the past year. The remaining part of dental care is covered by patients.

[2] Dependent children, students, persons on parental leave, registered unemployed people, persons on long-term sickness benefits, pensioners, and the caregivers/personal assistants of severely disabled citizens.

[3] Asylum-seekers and undocumented migrants do have access to healthcare, but not on the basis of public/statutory health insurance. Their healthcare costs are met by the Ministry of the Interior.

Although statutory health insurance covers most healthcare costs in Slovakia, out-of-pocket (OOP) payments also play a significant role. In 2015 they represented 22.8% of total health expenditure. OOP payments in Slovakia consist mainly of: a) co-payments for prescribed pharmaceuticals and medical durables; b) user fees for various health services, including stomatology care and spa treatment; c) direct payments for over-the-counter pharmaceuticals, vision products and dietetic food; d) above-standard care, preferential treatment and care not covered by health insurance; and e) standard fees (Smatana et al., 2016). Standard fees include, for example, those for 24/7 first aid medical services, ambulance transport, or prescriptions. Certain patients benefit from rules on the maximum quarterly amount of co-payments, mostly those from the most vulnerable population groups.

While the number of practising doctors in Slovakia (3.4 doctors per 1,000 inhabitants) was close to the EU average (3.5) in 2014, the number of practising nurses (5.8 nurses per 1,000 inhabitants) was far below it (8.4). Slovakia is the only country where the number of nurses per 1,000 inhabitants declined in the period 2000-2014. This is reflected in the low overall ratio of nurses to doctors (1.7, compared with 2.5 in the EU). The uneven geographical distribution of physicians is another negative feature of the healthcare system in Slovakia. As the OECD 'Health at Glance 2017' report (OECD, 2017: 95) shows, physician density per 1,000 inhabitants was significantly higher in the Bratislava region (6.8) than in central Slovakia (3.1) and eastern Slovakia (3.3). Among OECD countries, Slovakia shows the highest difference, in terms of density of doctors, between predominantly urban regions (6.8) and rural regions (2.7): this is driven to a large extent by the strong concentration of doctors in the national capital region (OECD, 2016: 158).

In Slovakia, patients are not able to approach a specialist directly. They are required to consult a GP, who may then refer them to a specialist. Slovakia has a very high number of doctor consultations per person, together with Hungary and the Czech Republic. In 2014, there were 11 consultations per person per year in Slovakia, compared with the EU average of 7. According to the OECD, the healthcare system's characteristics contribute to frequent consultations: "some countries which pay their doctors mainly by fee-for-service tend to have above-average consultation rates (e.g. the Slovak Republic, the Czech Republic and Germany), whereas other countries that have mostly salaried doctors tend to have below-average rates (e.g. Sweden and Finland)" (OECD, 2016: 162).

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

According to EU-SILC data, bad or very bad health was reported by 14.1% of persons (aged 16 years or over) in the first (lowest) income quintile in 2016, compared with 5.7% of individuals in the fifth quintile. A significant difference between the bottom and top of the income structure can be also found in relation to the consequences of health problems. In 2016, long-standing limitations in usual activities due to health problems were reported by 30.3% of persons (aged 16 years or over) in the first income quintile and 18.6% of persons in the fifth quintile. The same holds true when looking at different age categories, as Table 1 shows. Elderly persons have worse health than people of working age, but both categories show a lower incidence of bad or very bad health and long-standing limitations than people in higher income quintiles. The existence of a socio-economic gradient in health has also been confirmed in terms of social class (EGP schema), after controlling for key socio-demographic variables, including age and sex (Džambazovič – Gerbery, 2014). The finding that class membership is also linked to risky behaviour (frequent alcohol or tobacco consumption, lack of preventive medical examinations) points to one of the potential mechanisms that can generate health inequalities (Gerbery – Džambazovič, 2015).

Table 1: Determinants of healthcare use: differentiation of health status in socio-economic categories (%, 2016)

	Self-perceived health (bad or very bad)				Self-perceived long-standing limitation (some or severe)			
	SK		EU		SK		EU	
Age	16-64	65+	16-	65+	16-64	65+	16-64	65+
Total	6.5	36.8	5.6	19.4	20.4	72,8	17.1	47.8
First quintile	9.0	49.0	10.2	24.3	23.6	75.4	23.7	52.2
Second quintile	7.4	40.2	7.0	21.3	22.7	79.2	19.2	51.8
Third quintile	7.1	33.3	5.4	20.0	22.1	71.3	17.6	48.5
Fourth quintile	6.4	32.2	3.6	17.4	20.8	67.1	14.1	45.3
Fifth quintile	3.6	28.2	2.5	11.7	14.5	63.7	12.0	37.5

Source: Eurostat website.

Access to healthcare seems to be unproblematic for a majority of population. In 2016, 2.3% of people reported unmet needs for medical examinations due to cost, long distance or waiting lists. The incidence of unmet needs due to these reasons was higher among persons aged 65 or over (3.8%), which may lead to serious consequences, taking into account their underlying health condition. The higher risk among older persons is also confirmed by fact that the incidence of unmet needs among retired persons was 4.2%. As in the case of health status, access to healthcare varies according to level of income. While unmet needs for medical examinations were reported by 3% of persons in the first quintile, in the fifth quintile it was only 0.9%.

Healthcare costs represented a barrier to healthcare access in 2016 for only a very minor part of the population (0.8%). This is in line with the fact that health insurance covers quite a broad range of healthcare and related services and that OOP medical payments made up only 2.4% of total household consumption in 2015 (the OECD average was 3%).[4] While OOP payments in OECD countries went, on average, mainly on outpatient care (42%) and pharmaceuticals (36%), in Slovakia the highest proportion was spent on pharmaceuticals (43%) and therapeutic goods[5] (28%). Spending on outpatient care, which in many OECD countries accounts for a considerable share of total spending, was only 3% in Slovakia. On the other hand, payments for inpatient care represented 16% of OOP payments, which was well above the OECD average (9%). This allocation of household spending reflects the structure of OOP payments mentioned in the previous section (with the rather limited scope of direct fees for standard healthcare and services).

Attention should be paid to the high proportion of OOP payments on pharmaceuticals. Although they involve payments for various products, fees for medicaments represent their core. Data from the household budget survey (Statistical Office of the Slovak Republic, 2015) show that expenditure on prescribed drugs varies according to the socio-economic status of the household head. Households where the head is in paid work spend 36.7% of their total health expenditure on prescribed drugs. The households of unemployed persons spend more than half (54.6%). In the case of old-age pensioner households the proportion is even higher (57%). It is therefore clear that the burden is unevenly distributed between different households.

Payments related to healthcare services are regulated by law. They consist mainly of payments for over-the-counter pharmaceuticals, dietetic food, and care not covered by

[4] This paragraph relies on OECD (2017).

[5] Therapeutic goods include, for example, corrective eye products or hearing aids.

public health insurance (Smatana et al., 2016). In recent years, new legislative changes have been introduced in order to address some 'innovative' practices by providers (for example, payment for air-conditioning in waiting rooms). Since 2015 the legislation defines the list of non-medical services which are subject to payment by patients. In addition, the role of self-governing regions in controlling charges has been reinforced (Smatana et al., 2016). Legislative changes, which came into force in January 2018, have increased the maximum amount of co-payments, at the same time extending the list of patients who are protected by them.[6]

Distance to a healthcare provider hampers access to healthcare for only 0.3% of the population aged 16 or over. But experts warn (Smatana et al., 2016: 176) that lengthy travelling distances are one reason behind unequal access to medical services in Slovakia. As Table 2 shows, there is a significant regional variation in the distribution of health workers across the regions. The most favourable conditions can be found in the Bratislava region (Bratislava is the capital city), followed by the Košice region, where the second largest city is located. On the other hand, the regions of Trnava, Trenčín and Nitra face a limited availability of medical workers. Density of healthcare workers decreased in most regions between 2008 and 2014.

Table 2: Regional distribution of health workers per 100,000 inhabitants

	Physicians per 100,000 inhabitants		Dentists per 100,000 inhabitants		Nurses per 100,000 inhabitants	
	2008	2014	2008	2014	2008	2014
Bratislava region	652.5	674.5	84.3	78.9	1 035.2	990.6
Trnava region	255.0	256.9	43.4	39.0	509.5	470.2
Nitra region	259.6	263.4	39.8	37.8	488.8	473.5
Trenčín region	256.7	269.6	42.7	45.0	494.8	464.1
Žilina region	314.5	366.6	44.5	46.1	606.0	573.1
Banská Bystrica region	296.3	275.9	46.1	39.8	620.6	503.5
Prešov region	261.5	274.8	44.5	44.1	570.3	506.6
Košice region	349.9	394.6	61.4	58.4	678.1	621.9
Slovakia	344.8	342.6	50.7	48.7	624.1	574.9

Source: Smatana et al. (2016: 176).

Although the overall picture on healthcare accessibility, as indicated by EU-SILC data, is positive, there is additional evidence that distorts it. Living conditions in marginalised Roma communities represent one example of this evidence. The poor health status of Roma communities has been well described, and is explicitly linked, inter alia, to an insufficient level of healthcare (see, for example, the strategy for integrating the Roma population). A lower accessibility of healthcare services was reported in the 'Atlas of Roma Communities' (Mušinka et al., 2014), which is an authoritative source of information on Roma settlements and their infrastructure in the Slovak Republic. The study shows that almost 58% of municipalities with Roma settlements do not have a GP, 69% are without paediatric outpatient services, and 68% are without dental services. The average distance to the nearest GP represents 6 kilometres. Visiting paediatric services requires travelling on average 9 kilometres, and in the case of dental services it is 8 kilometres. As in the case of the general population, healthcare access by marginalised Roma communities is unevenly distributed across regions: the regions in

[6] https://www.vszp.sk/poistenci/zdravotna-starostlivost/uhradzanie-doplatkov-za-lieky.html

the eastern part of Slovakia (Banská Bystrica, Prešov, Košice) show the worst accessibility.

Table 3: Accessibility of healthcare services in municipalities with Roma settlements (2013)

	Without GP		Without paediatric outpatient services		Without dental services	
	% of municipalities	Average distance in km.	% of municipalities	Average distance in km.	% of municipalities	Average distance in km.
Bratislava region	22.2	7	44.4	10	55.6	11
Trnava region	29.0	5	48.7	8	50.0	7
Nitra region	39.6	7	56.7	9	54.5	8
Trenčín region	31.7	6	46.3	7	39.0	8
Žilina region	29.6	6	40.7	8	40.7	8
Banská Bystrica region	68.1	7	79.7	9	75.2	8
Prešov region	67.9	7	74.9	9	76.1	8
Košice region	66.4	6	73.4	8	73.4	7
Total	57.8	6	68.9	9	67.9	8

Source: Mušinka et al., 2014: 58.

Note: 'Average distance' refers to distance to the nearest service of a given type.

Similar conclusions have been reached on the basis of ethnographic surveys. For example, Belák (2015:205) points to the experiences of healthcare professionals who reported lower accessibility of healthcare services for Roma in marginalised communities, as well as their lower quality and effectiveness. On the other hand, the provision of healthcare services in this context often requires additional effort from healthcare professionals that goes beyond their responsibilities – including, for example, social counselling and psychological support, which makes the situation even more problematic.

The difficulties of the marginalised Roma population concern not only poor access to general healthcare services, but also discrimination in respect of the reproductive rights of women and their access to good-quality, affordable contraception.[7] A report of the Centre for Reproductive Rights (Centrum pre reproukčné práva, 2017) mentions examples of ethnic segregation in hospital gynaecological wards (with separate, overcrowded rooms for Roma women), lower-quality services, longer waiting hours, and degrading and violent behaviour by hospital staff. In addition, women from marginalised Roma communities lacked information concerning planned medical procedures and were confused regarding the request for informed consent. The report concludes (2017: 29) that even though the legislation guarantees access to good-quality healthcare and non-discrimination, the provision of gynaecological and obstetric services to women from marginalised Roma communities is accompanied by violations of human rights, repeated discrimination, segregation and violence.

The health condition of people in marginalised Roma communities is a subject of public policy concern. It has been addressed in several strategic documents. The current strategy for Roma integration (up to 2020) sets policy objectives related to healthcare access, other related policy measures, and processes for monitoring and evaluation. One of the tools to tackle poor health and inadequate healthcare access in marginalised Roma

[7] http://diskriminacia.sk/romske-zeny-ponizovane/

communities was the national project 'Healthy communities'. Within the project, more than 200 health assistants worked directly in the communities, focusing on health education, health assistance, and deepening trust in the healthcare system. As the outcomes of the initial national project were not clear, [8] a new project called 'Health regions' – run by the Ministry of Health – was launched in 2016, with the aim of improving access to healthcare, health literacy and health-related behaviour. However, improving access to healthcare requires investment in infrastructure, including roads, buildings for healthcare facilities, financial resources for establishing new ambulances, etc.

3 Discussion of the measurement of inequalities in access to healthcare in the country

The National Health Information Centre regularly publishes data on the use of healthcare services and facilities, the number and structure of staff, and other information that can be used to analyse some aspects of inequality in access to healthcare – especially the geographical distribution of health workers and healthcare services. The annually produced Health Statistics Yearbook is of great relevance in this respect.

Accessibility indicators, which are based on EU-SILC data, show low values over a long period, which means that access is overall good. On the one hand, this may reflect the nature and coverage of health insurance in Slovakia. On the other hand, there are vulnerable population categories that face structural barriers in accessing healthcare (e.g. marginalised Roma communities). It remains an open question as to what extent their experiences are covered by the EU-SILC indicators.

From a methodological point of view, it would be helpful to create 'longitudinal' versions of the indicators of healthcare accessibility. They could refer to 'persistent barriers to medical examinations' and allow the dynamics of inequalities in healthcare to be studied.

It seems that indicators relating to geographical variability are important for Slovakia. Differences between urban and rural areas, in particular, are too large and should be more carefully monitored.

Taking into account the situation in marginalised Roma communities, there should be an effort to develop comparable indicators of healthcare accessibility covering those (mainly central and eastern European) countries with significant Roma populations.

[8] https://www.aktuality.sk/clanok/492581/mala-to-byt-pycha-slovenska-skoncila-fiaskom-a-obrovskymi-dlhmi/

References

Belák, A., 2015: Segregovaní Rómovia a zdravotné politiky: etické a praktické rozpory [*Segregated Roma and health policies: ethical and practical contradictions*]. In: Podoláková, T. – Hruštič, T. (eds): Čierno-biele svety. Rómovia v majoritnej spoločnosti na Slovensku. Bratislava: VEDA.

Centrum pre reprodukčné práva, 2017: Vakeras Zorales. Hovoríme nahlas. Skúsenosti rómskych žien so zdravotnou starostlivosťou o reprodukčné zdravie na Slovensku. Bratislava.

Džambazovič, R. – Gerbery, D., 2014: Sociálno-ekonomické nerovnosti v zdraví: sociálno-ekonomický status ako determinant zdravia [*Socio-economic inequalities in health: socio-economic status as determinant of health*]. In: Sociológia, Vol.42, No. 2, p. 194-219.

Gerbery, D. – Džambazovič, R., 2015: Rola protektívneho a rizikového správania vo vzťahu k nerovnostiam v zdraví [*Role of risk and protective behaviour in relation to health inequalities*]. In: Pauhofová, I. – Želinský, T. (eds): Nerovnosť a chudoba v EÚ a na Slovensku. Ekonomická fakulta TU v Košiciach.

Mušinka, A. – Škobla, D. – Hurrle, J. – Matlovičová, K. – Kling, K., 2014: Atlas Rómskych Komunít 2013 [*Atlas of Roma Communities 2013*]. Bratislava: UNDP.

Office of the Plenipotentiary of the Slovak Republic for Roma Communities, 2011: *Strategy of the Slovak Republic for Integration of Roma up to 2020*.

OECD, 2016: *Health at a Glance 2016*. Paris: OECD.

OECD, 2017: *Health at a Glance 2017*. Paris: OECD.

Smatana, M. et al., 2016: *Slovakia – Health system review*. Health Systems in Transition, Vol. 18, No. 16. European Observatory on Health Systems and Policies.

Statistical Office of the Slovak Republic, 2015: Príjmy, výdavky a spotreba súkromných domácností na Slovensku [*Income, expenditure and consumption of private households in Slovakia*]. Bratislava.