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DELSA/ELSA/WD/HEA(2004)2



Organisation de Coopération et de Développement Economiques
Organisation for Economic Co-operation and Development

05-Mar-2004

English - Or. English

DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS COMMITTEE

DELSA/ELSA/WD/HEA(2004)2
Unclassified

OECD HEALTH WORKING PAPERS NO. 11

THE SLOVAK HEALTH INSURANCE SYSTEM AND THE POTENTIAL ROLE FOR PRIVATE
HEALTH INSURANCE: POLICY CHALLENGES

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JEL Classification: I11, I18, I19.

JT00159340

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ACKNOWLEDGEMENTS

The authors wish to thank the Slovakian Ministry of Health for helping to arrange their mission to Slovakia, during which much of the information contained in this report was collected, and for its generous assistance. The OECD Secretariat would also like to acknowledge the following organisations, who generously offered their time for interviews and provided useful material (as well as any others that may have been inadvertently omitted): the Slovak Ministry of Health, particularly the Health Reform team; the Private Doctors' Association and the Hospital Association; the Health Insurance companies and a private commercial insurer; and the association for the defence of patients' rights. The authors also wish to thank Martine Durand, Peter Scherer, Rick Imai and Elizabeth Docteur from the OECD Secretariat, for their invaluable comments on this paper.

SUMMARY

1. This paper analyses the Slovak health insurance system and the policy challenges it faces. It describes the structure of health coverage and health sector reforms being implemented by the Slovak government. It provides a preliminary assessment of the possible impact of such reforms, with a focus on the health insurance system and the possible introduction of private health insurance (PHI). It assesses how private health insurance would impact upon the health system, particularly equity, efficiency incentives facing providers and insurers, and responsiveness.

2. The Slovak health system is based upon a mandatory Bismarck-style social health insurance system. Contributions are shared between employers and employees and the state contributes for the inactive population. Five non-profit and non-competing insurers operate nationwide, one of which covers two-thirds of the population. Individuals can freely enrol with any of the insurance companies and a risk equalisation system operates across insurers. Public funding, including government and social health insurance expenditures, accounted for about 89% of total health expenditure in 2000, well above the OECD average of 72%. Out-of-pocket (OOP) expenditure is the only source of private financing, as private health insurance is virtually non-existent, and includes considerable unmeasured informal payments. Slovakia spent 5.7% of its GDP on health in 2000, one of the lowest in OECD countries.

3. Slovakia has been involved in several health sector reform initiatives throughout the 1990s, aimed at limiting the influence of the state in the health sector. An ambitious reform strategy was designed in October 2002 and started to be implemented thereafter. The strategy comprises measures to counter several of the problems still confronting the Slovak health system, including the large and growing debt of the health sector, inefficiency and poor quality of health delivery, and the lack of accountability, transparency and market incentives. The strategy places emphasis on reforming the health insurance system by reducing the scope of the mandatory benefit package and by creating an environment for health insurers to compete, while allowing for voluntary PHI to cover service gaps in the mandatory system.

4. The introduction of market-oriented reforms and incentives needs to be accompanied by clear mechanisms for governing the market, including appropriate legislation and accompanying regulation, compliance frameworks, accounting and reporting standards, and a clear division of responsibilities and powers between authorities overseeing different parts of the health system. This is especially an issue when mobilising private resources in an environment characterised by considerable hidden phenomena, such as informal payments, and poor accountability.

5. The Slovak authorities would welcome a PHI market that replaces under-the-table payments and informal waiting times with open queues, transparent fees, and open rationing. The extent to which a private health insurance market might develop is nonetheless uncertain, given the lack of a history of private cover and population distrust into third-party purchasers of health services. Certain conditions are needed to ensure that any market that develops promote improvements in responsiveness and transparency, without hampering equity objectives. These include a clear-cut definition of services to be insured by mandatory and voluntary health insurance, the establishment of rules of access to care to minimise treatment differentials between those with and without private health insurance, particularly in the case of coverage of faster access to care, and the legal separation of entities furnishing mandatory and voluntary health insurance. The report also reviews options for regulating private health insurance within the context of the EU legislation.

RESUME

6. Ce document présente une analyse du système d'assurance de santé Slovaque et les défis politiques que celui-ci engendre. Une description de la structure de couverture santé et des réformes mises en oeuvre par le gouvernement Slovaque y est présentée ainsi qu'une évaluation préliminaire de l'impact possible de telles réformes. L'accent est porté sur le système d'assurance-maladie et l'introduction possible d'une assurance maladie privée (AMP). Y figure également une évaluation de la manière dont une AMP aura des répercussions sur le système de santé lui-même et plus particulièrement en ce qui concerne l'équité et les incitations à l'efficacité auxquelles sont confrontés les fournisseurs de services et les assureurs et la réactivité du système de santé face aux besoins des utilisateurs.

7. Le système de santé Slovaque est basé sur un système d'assurance maladie sociale obligatoire du style Bismarck. Les contributions sont partagées entre les employeurs et les employés avec une contribution de l'état envers la population inactive. Cinq assureurs à structure non-bénéficiaire et qui ne sont pas en compétition entre eux fournissent la couverture maladie au niveau national dont un couvre les besoins de deux tiers de la population. La population peut s'assurer librement auprès de l'une ou de l'autre des compagnies d'assurance et il y a un système de compensation des risques entre assureurs. Le financement public, qui inclut l'état aussi bien que l'assurance maladie publique a été responsable d'environ 89% des dépenses totales de santé en 2000, ce qui est bien au-delà de la moyenne de l'OCDE de 72%. Les versements nets des ménages (VNM) sont les seules sources de financement privé dans la mesure où l'assurance maladie santé privée n'existe pas. Les VNM englobent aussi des paiements informels considérables qui ne sont pas comptabilisés. En 2000, la Slovaquie a dépensé 5.7% de son PNB pour la santé; un des chiffres les moins importants des pays membres de l'OCDE.

8. La Slovaquie a été impliquée dans plusieurs initiatives de réforme dans le secteur santé pendant les années 1990 qui ont eu pour but de limiter l'influence de l'état dans le secteur santé. En Octobre 2002, une stratégie de réforme ambitieuse a été créée et mise en oeuvre par la suite. La stratégie comprend des mesures pour résoudre les problèmes dont le système de santé slovaque est confronté, y compris la dette considérable du secteur santé, l'inefficacité et la qualité médiocre des soins de santé ainsi que le manque de comptabilité, transparence et incitations du marché. La stratégie donne une forte importance à la réforme du système d'assurance maladie santé par une réduction des services de santé couverts par l'assurance obligatoire et par la création d'un environnement dans lequel les assureurs-maladie peuvent être mis en concurrence entre eux, en permettant à l'assurance-maladie privée de couvrir les services non couverts par le système obligatoire.

9. L'introduction de réformes et incitations orientées vers le marché doit s'accompagner de clairs mécanismes pour gérer le marché, y compris une législation appropriée avec les régulations qui l'accompagnent, des normes pour assurer la conformité, des standards de transparence et de comptes rendus ainsi qu'une séparation marquée des responsabilités entre les autorités qui surveillent les différentes parties du système de santé. Ceci est particulièrement important quand des ressources privées sont mobilisées dans un environnement qui est caractérisé par des phénomènes "cachés" considérables tels que des paiements informels et une transparence médiocre.

10. Les autorités Slovaques souhaiteraient le développement d'un marché d'assurance-maladie privée qui remplacerait les paiements informels et les délais d'attente aléatoires avec un système plus transparent de liste d'attente, d'honoraires et de rationnement. Les possibilités de développement d'un

marché de l'AMP sont cependant incertaines étant donné le manque d'historique d'une couverture privée et une certaine méfiance de la part de la population envers les acheteurs des services de santé comme les assureurs. Certaines conditions sont nécessaires pour assurer que tout le marché développé encourage des améliorations en réactivité du système de santé et transparence sans pour autant gêner des objectifs d'égalité. Celles-ci incluent une définition nette des services à assurer par l'assurance obligatoire aussi bien que par l'AMP, l'introduction des règles d'accès afin de minimiser des différences de traitement entre ceux avec et ceux sans assurance privée - surtout en ce qui concerne l'accès rapide aux soins et la séparation légale des assureurs offrant l'assurance obligatoire avec ceux offrant d'AMP. Cette étude examine également les options pour réguler l'assurance-maladie privée dans le cadre de la législation de l'Union européenne.

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1. BACKGROUND

11. This report outlines some of the main policy challenges confronting the Slovakian health insurance system, and options for private health insurance (PHI). It provides a descriptive account of the reform programme, a preliminary assessment of the reform agenda in relation to the public-private mix of insurance, and indicates some of the potential challenges concerning the expected role of PHI. It also includes a review of options for private health insurance under EU law.¹

2. THE SLOVAK HEALTH CARE SYSTEM

2.1 Organisation of the Slovak health care system²

12. Following its split from the Czech Republic in 1993, the Slovak general tax-based health system was replaced by a Bismarck-style social health insurance system in 1994. Expenditure by social health insurance represents the main source of health funding. Public funding, including government and social health insurance expenditures, accounts for about 89% of total health expenditure, well above the OECD average of 72% in 2000.³ Out-of-pocket (OOP) expenditure is the only source of private financing, as private health insurance is virtually non-existent. Formal OOP accounts for 11% of total health expenditure, compared to the OECD average of 18.7%.⁴ This is however a low estimate of total OOP, due to large unmeasured informal payments (see section 2.2). Slovakia spent 5.7% of its GDP on health in 2000,⁵ one of the lowest in OECD countries. Public health spending, in absolute terms and on a per capita basis, represents one-ninth of the EU average and is among the lowest in Europe.⁶ In 2002, Slovakia spent 7% of GDP on health, while having only 6.4% available revenues (Table 2).

13. Participation in social health insurance is mandatory for the entire population. Social health insurance contributions are income-related, set at 14% of the assessment base, and shared between

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1. The assessment is made on the basis of OECD officials' visit to Bratislava in April 2003, during which discussions were held with relevant stakeholders. Other policy and technical documents were also reviewed.
 2. A descriptive diagram of the Slovakian health care system is included in Annex 1.
 3. Unweighted average for 27 countries for which data are available. Source: OECD (2003b).
 4. Unweighted average for 23 countries for which data are available. Source: OECD (2003). In Slovakia, cost-sharing is minimal but individuals have to pay a share of the cost of drugs if they prefer a drug from so-called "second category" rather than "first category". People also pay for part of the cost of medical and dental prostheses, as well as spectacle frames. Individuals can also pay directly for private health care services (European Observatory on Health Care Systems, 2000).
 5. OECD *Health Data 2003*, 2nd edition.
 6. European Observatory on Health Care Systems (2000). *Health Care Systems in Transition. Slovakia*, p. 29.

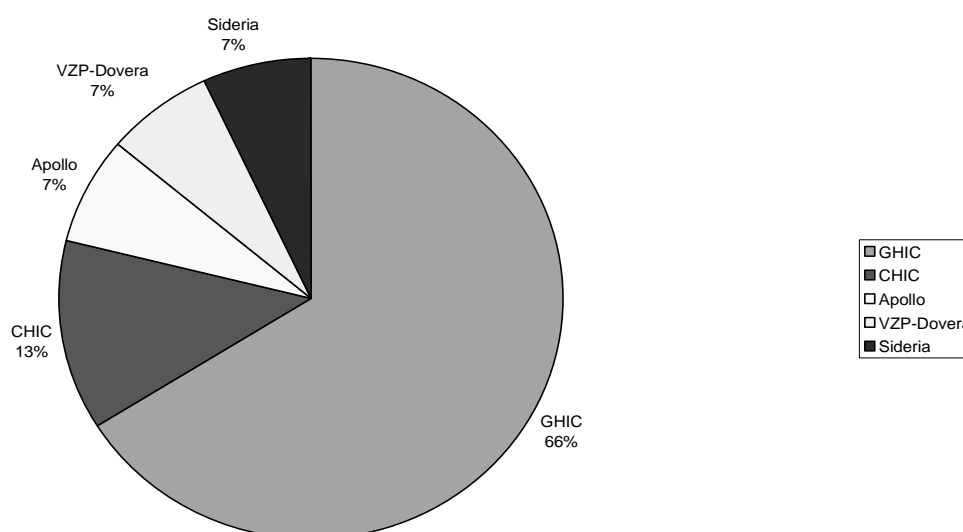
employers (10%) and employees (4%). The same 14% contribution applies to the self-employed, who are responsible for making this payment in full. There is a ceiling on individual contributions,⁷ which gives the financing structure of the social health insurance system a more regressive nature. The State pays for all unemployed and inactive persons, including dependents, elderly, soldiers, and the disabled. These constitute a large part, approximately 60%, of the population. The State contribution has been calculated to reflect the budgetary situation for the year.⁸ In 2001, State contributions accounted for 27% of total health insurance revenues (Vagac, L. and Haulikova, L., 2003).

Table 1. Sources of financing – as % of Total Health expenditure (THE)

	1997	1998	1999	2000	2001
Government	3.1	3.1	5.2	5.0	4.4
Social security schemes	88.6	88.5	84.5	84.4	84.9
Out-of-pocket	8.3	8.4	10.4	10.6	10.7
Private insurance	0.0	0.0	0.0	0.0	0.0

Source: OECD Health Data 2003

Figure 1. Breakdown of Coverage by Insurance Company (1999):



Source: European Observatory on Health Care Systems – HiTs Slovakia 2000

7. The ceiling is set at 32 000 SKK (2003), or about five times the minimum wage (6 080SKK in 2003).
8. According to the European Observatory on Health Systems (2000), while the State was supposed to pay a contribution of 13.7% of the minimum wage, it has over the years applied such contribution rate to a lower base. The New Act on Health Insurance states that: “the State pays insurance premiums for [eligible] persons of 14% of the assessment base specified by the State Budget for the current year”.

Table 2. Health sector revenues and expenditure

	1995	1996	1997	1998	1999	2000	2001	2002
Revenues from contributions	18.7	23.7	26.8	28.7	29.5	32.1	34.8	37.2
Contributions of employers	13.5	16.4	18.7	19.7	20.1	21.9	23.6	25.2
Contributions of Employees	4.2	6.1	6.8	7.3	7.5	8.1	9.2	10.2
Contributions of Self-employed persons	0.9	1.0	1.1	1.3	1.4	1.4	1.5	1.5
Contributions of Non-residents	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Others	0.0	0.3	0.2	0.3	0.3	0.3	0.3	0.3
Penalties, fines, premiums due	0.0	0.0	0.0	0.1	0.3	0.4	0.2	0.3
Premiums paid by the state	7.1	10.3	10.4	10.5	11.1	11.2	13.0	15.3
Premiums paid from NLO	0.1	0.3	0.4	0.5	0.6	0.5	0.4	0.5
Other resources	0.3	1.0	0.8	1.7	1.9	1.4	1.4	1.7
Resources of Health Insurance Funds total	26.3	35.4	38.4	41.4	43.0	45.3	49.6	55.0
Revenues of MOH chapter and others 1)	4.1	4.6	4.9	4.7	4.4	4.5	4.9	4.8
Social Insurance Agency resources for treatment	0.9	1.0	1.2	1.3	1.3	1.0	1.1	1.2
Direct payments	1.8	2.6	3.8	4.1	5.4	5.9	6.3	7.0
REVENUES	33.1	43.6	48.3	51.5	54.1	56.7	61.9	68.0
Primary care	1.3	4.3	4.5	4.2	4.4	4.7	4.9	5.1
Secondary care	0.0	0.2	1.3	1.5	1.8	1.9	2.1	2.2
Costs of hospitals	25.3	21.4	24.0	25.6	25.0	26.0	28.1	29.5
Drugs and medical devices	2.0	12.2	14.5	16.1	18.8	20.6	22.8	24.1
Others	0.9	1.1	3.4	5.0	4.1	6.9	7.7	8.0
Expenditure from MOH chapter and others	4.1	4.6	4.9	4.7	4.4	4.5	4.9	4.8
COSTS	33.6	43.8	52.5	57.1	58.5	64.6	70.5	73.7
BALANCE	-0.5	-0.2	-4.2	-5.6	-4.4	-7.9	-8.6	-5.7
COVERAGE OF DEFICIT	0.5	0.2	4.2	5.6	4.4	7.9	8.6	5.7
Third party resources (unpaid liabilities)	0.5	0.2	4.2	5.6	4.4	4.4	5.2	2.1
Extraordinary resources from privatization	0.0	0.0	0.0	0.0	0.0	3.5	3.4	3.6
Revenues, % GDP	6.1	7.2	7.0	6.9	6.4	6.4	6.4	6.4
Costs, % GDP	6.2	7.2	7.6	7.6	6.9	7.3	7.3	7.0
Balance, % GDP	-0.1	0.0	-0.6	-0.7	-0.5	-0.9	-0.9	-0.6
Debt	-0.5	-0.7	-4.9	-10.5	-14.9	-19.3	-24.5	-26.6

Source: Ministry of Health – Slovakia.

14. When the social health insurance system was introduced in 1994, 12 public non-profit insurers operated in the system. However after a few years of operation many had to close due to growing debts and restrictions imposed upon insurers. There are now 5 insurers operating nationwide, 2 of which have their solvency guaranteed by the State. The governmental guarantee has resulted in a soft budgetary constraint and limited accountability by health insurance funds, and has not prevented the two entities from growing significant and growing debt. One of these, the General Health Insurance Company (GHIC), covers about two-thirds of the population.

15. Individuals can freely enrol with any of the insurance companies. In order to reduce incentives for insurers to select risks, a mechanism for redistributing revenues across insurers was instituted in 1995. Initially, it redistributed 60% of collected revenues on the basis of the number of economically active and inactive insureds. Since mid-1999, a new mechanism has been put in place, under which 85% of collected revenues are redistributed on the basis of demographic risk adjusters (age and gender). This risk adjustment mechanism remains a source of some tension among insurers. As part of an effort to increase

transparency and accountability, a central registry of insured people, previously administered by the largest insurer, is now maintained by the Ministry of Health.⁹

16. All insurance companies offer the same package of benefits and generally contract with the same network of providers. The Slovak constitution guarantees universal and free-of-charge access to a comprehensive package of health services. The benefits covered are specified in the Treatment Act, which includes a list of procedures, drugs, spas and medical aids. The network of providers with whom insurance companies can contract is established by law and set by the Ministry of Health.

17. Almost all primary care doctors and about 74% of the specialists operate in individual, private practice. Primary care physicians act as gatekeepers, although the referral system is often bypassed.¹⁰ To operate in private practices, doctors need to obtain a licence and sign individual contracts with insurance companies. Hospitals are classified into three different categories depending on the clinical departments they operate. Almost all the hospitals, with the exception of 3 of them, are state-owned or administered by municipalities. The Ministry of Health has authority over hospital investment and planning decisions.

18. State-employed physicians are paid on a national wage scale.¹¹ GPs in private practice receive a capitation payment based on a contract with insurance companies. Capitation fees per enrollee are set by the Ministry of Finance, based on proposals by the Ministry of Health. Specialists who have privatised their practice are paid fee-for-service with regulated fees. Many specialists, whether in private practice or not, work in state-owned and administered polyclinics. The fees are based on a point scale, where the Ministry of Health sets the points for each treatment and the Ministry of Finance sets the value of each point. There is also a cap on total reimbursement by health insurance companies based on monthly limits on the volume and type of services to be delivered by providers (though insurance companies lament that providers deliver services beyond the limit, and insurers have to reimburse for those services).

19. Hospitals are paid on a broadband DRG basis since 1 April 2002, replacing the previous systems under which payments were based on bed days.¹² The Ministry of Health set minimum and maximum prices per case, and health insurance companies are allowed to purchase each “case” at a price within this range. Contract stipulations between insurance companies and hospitals are often set on the basis of historical cost and on the number of insureds treated by the hospital in the previous period.

2.2 Problems experienced by the system¹³

20. The Slovakian health care sector is plagued by several problems. The health insurance system is underfunded and financially unsustainable but promises comprehensive coverage for which resources are inadequate. The gap between revenues and outlays has been widening over the years, giving rise to growing debt. Health insurers have delayed or defaulted their payments to providers that in turn delayed payments to their suppliers. Several causes underlie the growing debt. It has proven difficult to control cost both because the Constitution guarantees free treatment for a generous health care package and because of

9. European Observatory (2000), p. 22.

10. European Observatory on Health Care Systems (2000).

11. In this case health care facilities receive a payment from health insurance companies based on a point-value scale, which was derived from the German system. The national point scale reflects resource use and intensity for each given treatment, and is applied to a “value” of the national point, which is periodically revised.

12. This was legislated into a new price Act effective since 1 July 2003.

13. Pazitny, P. and Zajac, R. (2001) provide a comprehensive account of the problems facing the Slovakian health care system.

the lack of strong budgetary constraints on providers and insurers.¹⁴ In addition, insurance companies encountered problems in collecting contributions from insurees.¹⁵ while payments by the State for unemployed and inactive persons have reflected the availability of resources in the state budget (which have not necessarily matched the outlays of insurance funds). Despite the funding constraints, however, no facilities have been closed as a consequence of their indebtedness.

21. The provision of health care suffers from problems of inefficiency, inadequate financing, overcapacity and poor management. Both insurers and providers lack market incentives for improved efficiency and quality. Soft budgetary constraints also weakened accountability and led to excessive financial risk exposure.

22. Informal payments and corruption are widespread in the system.¹⁶ Informal payments are often the result of individuals' desire to obtain fast access to care, select a certain doctor, access treatment that is otherwise unavailable. Although the benefit package is comprehensive and access to such care is guaranteed free of charge by the constitution, limited resources can significantly reduce service availability, thus creating non-explicit rationing of care. Therefore, although waiting lists and excessive waiting times are not evident, delays or barriers in accessing services do occur.¹⁷ In many cases, individuals can reduce the extent of such hidden waiting and receive the treatment with no delay when they are able to make some form of immediate payment.

23. In terms of population health status, Slovakia's health indicators are better than many Eastern and Central European countries, yet below the EU average. There is a high rate of cardiovascular deaths (twice the European average), and the level of cancer deaths is also well above the EU average. In 1997, Slovakia had the fourth highest rates of cancer deaths among 25 OECD countries.¹⁸ It also reported among the highest levels of mortality from heart conditions.¹⁹ On the other hand, communicable diseases are under control, and immunisation rates are high, when compared to both EU and OECD countries.²⁰

14. Under soft budgetary restrictions, health insurance funds and state-owned hospitals do not bear financial risks; both insurers and hospitals receive financial aid and their debts are repaid by the state. Other exceptions from accounting standards and bankruptcy procedures are granted (Pazitny, P. and Zajac, R., 2001).

15. As indicated earlier, insurees and their employers pay a contribution equal to 14% of the assessment base, while the state pays contributions for all inactive persons.

16. According to a 1999 survey by the World Bank/USAID, 71% of GP visits and 59% of specialist visits involved informal payments. It is also estimated that at least 3 in 10 hospital patients made informal payments to providers. The extent of these phenomena is estimated to have increased over the past decade (Murthy and Mossialos, 2003).

17. This occurs for example when a medical device is not available, or when a provider does not have adequate resources to deliver the treatment.

18. OECD *Health Data 2003*, 2nd edition. Comparison based on data reported by 25 reporting countries in terms of Mortality from Malignant Neoplasms in 1997.

19. OECD *Health Data 2003*, 2nd edition. Slovakia was 5th highest country among 29 reporting countries concerning death from Acute Myocardial Infarction in 1995. It was also the highest of 29 OECD countries in terms of Mortality from Ischaemic Heart Disease in 1995.

20. European Observatory, p. 4. OECD *Health Data 2003*, 2nd edition. Slovakia had the fourth highest rates of immunisation against measles and D.P.T. among 20 reporting OECD countries (1999 data).

3. HEALTH SECTOR REFORMS IN SLOVAKIA

3.1 Overview

24. Slovakia has been involved in efforts to reform its health sector since its split from the Czech Republic in 1993. Reforms have been aimed at removing or limiting the influence of the state in the health sector, which was pervasive in the Soviet-style planned system. They were also intended to address some other main problems of the system, such as growing debts, lack of market incentives, and corruption.

25. Throughout the 1990s, the reform agendas by different governments encompassed a wide range of initiatives, although not all proposed measures were always realised. Measures that were implemented ranged from privatising providers to changing reimbursement mechanisms, and decentralising management. Almost all GP practices have been privatised and 74% of the specialists are private (November 2003). The transformation of hospitals into autonomous for-profit organisations, such as shareholder-owned companies, has proceeded to a more limited extent. Several reforms have been made to payment mechanisms for both doctors and hospitals in an attempt to improve incentives for efficiency following the long period of state planning. GPs in private practice were initially paid a mix of fee-for-service and capitation, but now receive a capitation payment. Since the introduction of social health insurance, payments for hospitals have been changed several times, with different governments, moving back and forth from per diem payments to prospective payments (budgets). Some devolution of responsibilities for hospitals from the State to local municipalities has taken place, although the process of decentralisation has not progressed fast so far.

26. Overall, reforms in the 1990s seem to have lacked a systematic approach, despite the implementation of several interventions, in particular to reduce the debt of State-owned facilities. The main problems of the system – debts of health insurers that are transferred onto providers via payment delays or lack of payment, inefficient provision, obsolete capacity, and lack of accountability and transparency – were not addressed. Although a considerable amount of privatisation revenues (1% of GDP) was injected into the system, the fiscal balance has not been improved (OECD, 2002b).

27. The current Minister of Health has designed and started to implement a new strategy for health sector reform in October 2002. The new reform agenda comprises three steps: stabilisation measures, system measures and network measures. Stabilisation measures are aimed at stopping further growth of the debt. System measures intend to increase the efficiency of the health insurance system. Network measures aim at improving the quality and efficiency of providers (Pazitny and Zajac, 2001). The strategy places emphasis on reforming the health insurance system and reducing the benefit package covered by mandatory health insurance.

28. These measures are at different stages of implementation. The main initiatives underway are indicated in Box 1. Three Acts are especially relevant concerning the health insurance system:

- *New Act on Health Insurance.* The Act permits two types of health insurance: mandatory health insurance and voluntary private cover. It sets forth detailed provisions relating to required assessments and population groups eligible for state-paid premiums under the social health insurance system. The Act clarifies private health insurers' ability to define the scope of coverage by contract, while indicating that public insurance must at least cover those services mandated by law.

- *New Surveillance Act.* The Act deals with requirements for practising insurance activities, such as capital adequacy; surveillance of insurers; sanctions; transformation of social health insurers into shareholder-owned companies.
- *New Benefit Package Act.* This Act indicates which treatments are to be de-listed from the package of benefits reimbursed by compulsory social health insurance. The basic benefit package will be based on a positive list encompassing all preventive activities, diagnostic activities, and all treatments for defined diagnoses.

Box 1. Main initiatives under the health sector reform agenda

The main initiatives under the health sector reform strategy (Pazitny, P. and Zajac, R., 2001) include 6 main interconnected Acts: 1) New Act on health insurance; 2) New Act on Health Surveillance Authority; 3) New Act on providers; 4) New Act on emergency service; 5) New Act on health care; 6) New act on basic benefit package.

All draft Acts are subject to an inter-ministerial review process. The review took place between 25 March and 16 of April 2003: 4-11 August for the New Act on emergency service; 23 October – 14 November 2003, for the last two acts. All the six acts are planned to be submitted to Parliament in January 2004. The expected implementation date is April 1st or July 1st, depending on Parliamentary approval.

The Health Insurance Act covers the following areas:

1. Defines the mandatory and voluntary insurance.
2. Guarantees the coverage for every citizen - defines the term "insuree".
3. Defines the payers (employers, employees, entrepreneurs, state)
4. Defines the contribution rate (employers 10%, employees 4%, entrepreneurs 14%, state 4%)
5. Defines the assessment base for active population (for employees and entrepreneurs; minimum: minimum wage (6000 Sk), maximum: 3 times average wage (42000Sk))
6. Defines the assessment base for state for non-active population (average wage: 14 000 Sk)
7. Defines the system of annual settlements of contributions
8. Defines the system of contribution concerning the re-distribution between health insurance funds (the basis for redistribution is 95% of prescribed contributions, and the redistribution is 90% out of this 95%, so the effective redistribution rate is 85.8%)
9. Defines the basics for the voluntary health insurance

The Health Surveillance Authority Act covers the following areas:

1. Licensing of the health insurance funds (HIFs) (which must be joint stock companies).
2. Regulation of HIFs (reporting, audits, financial stability requirements, access to care conditions, requirements on how to contract providers on selected criteria - quality, performance, etc.).
3. Supervision over Providers (providing care "lege artis").
4. Supervision over HIFs (payment ability, access to care requirements).
5. Sanctions (forced administration, license withdraw, etc.).
6. The process of transformation of HIFs from public law to private law companies

The Health Care Providers Act covers:

1. Criteria to be met by provider
2. Types of providers
3. Licensing
4. Criteria for setting up the public network (every licensed provider), and the minimal network (only the providers linked to HIFs)
5. Price negotiations process
6. Chambers and their functions
7. Information system in healthcare

The Act on Basic Benefit Package:

1. Defines types of Care
2. Defines the prevention

3. Defines the basic benefit package as a positive list of illnesses (based on ICD-10). A priority list with 3002 diagnosis has been created, that are sorted by priority (e.g., first priority is diabetes mellitus). The diagnoses are grouped by co-payment levels (see table A).
4. Defines the system of categorization of DRUGS, AIDS, and PROCEDURES, that means, to every DG we create a standard therapeutic procedure that must be done, and this will be controlled and supervised by the Surveillance Authority

Table A. Category Priority list

Bands of diagnosis (ICD-10)	Reimbursement from public health insurance
I. 1 – 1642	100%
II. 1643 – 1846	90%
III. 1847 – 2148	75%
IV. 2149 – 2778	50%
V. 2779 - 3002	5%

Source: Ministry of Health, Slovakia, November 2003

29. Other measures to be implemented by the current Minister of Health include the privatisation of all state-owned facilities and insurers, price de-regulation, and the introduction of patient co-payments. These latter will be set as small lump sums. Exemptions from co-payments for indigent people will be repealed and these vulnerable groups will obtain a direct state subsidy to cover their expenses. The aims of this measure are dual: i) to demonstrate to citizens that health care has a cost, and by introducing price sensitivity to help contain cost; and ii) to collect revenues and shift cost from the public to the private system.

3.2 New rules for the public health insurance system

30. The reform of mandatory health insurance is aimed at improving the financial stability of the social health insurance system by reducing its comprehensiveness and improving the market orientation of insurers.

31. In the current system, insurers act as mere financial intermediaries between providers and users of health services. They collect revenues from insurees and their employers and from the Government, and they reimburse providers for delivered services. There is limited (if any) competition among insurers. Individuals do not switch insurers, who offer the same comprehensive package of benefits, cover the same providers, and do not differ for contributions charged. Each insurer establishes contracts with providers that set the volumes and types of services to be delivered in a given year. These contractual conditions are calculated based on historical data on the volume and type of services that each provider has delivered in the past, rather than on performance criteria of efficient or quality provision. Insurers have an obligation to contract with all providers within the network established by the MOH, which includes nearly all providers in Slovakia. Prices for different treatments are regulated and fixed by the government. In addition, soft budgetary rules limit financial risk exposure by insurance companies. As a result, there is limited space for selectivity in contracting, performance orientation, and risk or care management.

32. Over the years, insurers have run into large debts, for several reasons. Collection of contributions has been inadequate, resulting from insurees' (or their employers') failure to pay contributions and from a reduction in the contribution paid by the State for those economically inactive (the contribution that the State pays for each economically inactive person is set at the beginning of the fiscal year, based on the available resources under the national budget, which has not provided insurers with an adequate and consistent flow of funds). Expenditures have exceeded revenues by 0.6% of GDP on average between 1995 and 2002²¹ and it has proven especially difficult to contain the cost of pharmaceuticals, which now account

21. Source: Presentation to OECD staff by Zajac, R. and Pazitny, P.

for about 30% of total health expenditure by insurers (compared with 14% on average in other OECD countries).²² In addition, insurers' administrative costs may exceed the 4% threshold required by law and may represent an area for increased efficiency and accountability.

33. In the reformed system, the benefit package will be reduced. Catastrophic risks are expected to be fully covered. Benefits that are possible candidate for exclusion include (Pazitny, P. and Zajac, R., 2001):

- Additional fees for non-network providers (those without a contract with a patient's insurer).²³
- Faster treatment for planned/elective surgery.
- Additional fees for more expensive drugs, aids, and devices than those included in the basic package.
- Extra amenities, upgraded accommodation and board at hospitals.
- Dental care.
- Cosmetic surgery.

34. The mandatory contribution to the public health insurance will be maintained at 14% of the assessment base. There are also proposals to broaden the definition of the assessment base to include incomes from rents and dividends. Fees are expected to be deregulated and insurers able to negotiate payment levels with providers. The obligation to contract with all providers is also expected to be lifted. The government intends to transform insurers into private joint stock companies, which are allowed to make profits.

3.3 Separation of mandatory from private health insurance

35. Currently, private health insurance in Slovakia is almost non-existent. Some commercial insurance companies provide some types of sickness insurance²⁴ - critical illness insurance, temporary disability insurance, permanent disability insurance, disability income insurance as well as insurance covering medical care costs beyond the scope of social security scheme and travel insurance products covering the cost of health care received abroad. There is only one insurance company providing private health insurance on a commercial basis to persons who are not covered by the social security scheme (usually foreigners). This insurance covers medical and hospital costs and its share of the total insurance market was less than 0.2% in the year 2000. The Financial Market Authority (FMA) supervises and regulates the activities of private insurance companies.²⁵

22. Source: OECD (2001). Data refer to 1998.

23. While all insurers currently contract with all providers within a government-defined minimum network, more selective contracting is expected to take place in the reformed system. In order for selective contracting to occur, insurers' obligations and flexibility regarding coverage of providers within the governmentally defined networks needs to be specified. Furthermore, the mechanisms or criteria for defining the minimum network also need to be re-assessed (for example, the network could include all providers having met certain accreditation criteria relating to quality monitoring and improvement).

24. Often cash benefit policies providing income-replacement.

25. Source: OECD Regulatory Questionnaire on Private Health Insurance, response from Slovakia.

36. The New Health Insurance Act specifically introduces and defines private health insurance to be one of two types of permitted health insurance in Slovakia. However, the precise contours of its role are not clarified in the Act. For example, the Act does not specify whether private coverage may duplicate publicly covered services.²⁶ Regulation of PHI is expected to remain minimal and, indeed, pursuant to the Act, very few requirements are placed upon private health insurers. It is expected that both social health insurers (through private affiliates) and commercial insurers would be able to offer private health cover for services not included or de-listed from the compulsory package (such as those indicated above).²⁷ Yet the Act currently does not clarify this role. Insurers will not face restrictions on premium rates, which are expected to be calculated according to insurers' commercial and risk rating practices. In fact, the Act explicitly permits insurance companies to determine the scope of covered benefits on the basis of medical examinations that may be required prior to issuance of a contract. Hence, the Act envisions that private insurers may consider health status in their issuance and rating decisions. The Financial Market Authority will supervise the solvency and capital adequacy of insurers. Tax advantages for the uptake of PHI are not envisaged.

37. It will be important that all entities overseeing the public and private PHI have a means of sharing information and coordinating their efforts. This would involve some coordination between the Ministry of Health, which runs the Central Registry of the Insured Persons and generally oversees the health sector, the Financial Market Authority that oversees the financial standards of private health insurers, and the Health Care Surveillance Authority, established to supervise public health insurance. This would build upon cooperation that already takes place between the Ministries of Health and Finance in connection with public health insurance companies (the Ministry of Finance issues pricing decrees for health services, drugs and medical aids).²⁸ It would enable the government to better monitor issues that may arise in connection with the interaction between public and private health insurance. This will also help maintain a link between state health information systems and health insurance company information systems, a link that was lost with the introduction of the compulsory health insurance scheme.²⁹

38. Insurers will not face restrictions on the design of benefit packages for voluntary PHI. The Act does not clarify whether PHI will be able to cover services provided by public health insurance.³⁰ Some duplication appears to be envisioned, at least with respect to coverage relating to improved timeliness of access to care. Nonetheless, private health insurance is anticipated to serve primarily a supplementary function, by covering additional benefits to those covered by the mandatory system. Insurers will also be permitted to offer PHI for co-payments in the public health insurance system and other out-of-pocket costs. They will also be able to cover the higher fees of providers outside the network(s) of providers contracting with social health insurers for compulsory coverage. While these aspects of the PHI market are not currently spelled out in the Act, the Act specifically allows for resolution of additional issues by regulation.³¹ The Act is currently anticipated to go into effect in January 2004.

26. Discussion with stakeholders indicates that some believe a market could develop following the introduction of the Act. There is consensus, however, that a precondition for such a market is a clearer delineation of the scope of publicly covered services.

27. Both private commercial insurers and social health insurers will need to set up separate legal entities if they wish to operate both mandatory and voluntary health insurance, although those entities may come under the same ownership.

28. European Observatory (2000, p. 11) discusses cooperation and role of these Ministries.

29. European Observatory (2000, p. 15).

30. Yet, discussions with stakeholders indicate that PHI will not be able to cover such services.

31. Draft Act of [...] 2003 on Health Insurance, Part Five, Section 31.

39. Patients experiencing waiting or unavailability of services due to lack of resources would also be able to obtain faster access to care and ensure coverage of fast access to care through private health insurance. This benefit would not imply a duplication of public coverage because insurers will be able to 'insure' the shorter waiting time at the extra fee but not the service per se. Private insurees would receive faster treatment from a willing provider on contract with the insurer for such private voluntary cover. The insurer will in turn advance the cash necessary to cover the cost of the treatment. It will then receive a reimbursement by the public health insurance system after a certain period, corresponding to the initial length of the waiting period. The purpose of this reform would be to increase overall volume of services by creating a financial incentive for providers to treat private insurees. This would occur by enabling private insurers to offer payment at time and point-of-service not always provided by social insurers and possibly higher levels of payment. If these incentives do not result in overall increases in service delivery volumes, however, they would result in longer waiting times for publicly insured patients.

40. This proposed type of PHI coverage, under which the insurer partially acts as a type of lender, paying providers earlier in return for quicker access for the insured, does not have a clear parallel with PHI offerings in other OECD countries. It therefore raises some unique policy and implementation questions. For example, it presumably implies some ability of the insurer to contractually assure the timely delivery of care, and hence would also involve reaching agreements with providers in the area of waiting times. At the moment, however, the distinction between insuring for "faster service" and reimbursing for the actual service provided is unclear. To the extent insurers are charging more for "faster service," they presumably will need to pass some of this additional fee on to providers as an incentive for quicker delivery of services. The division between service fees and fees for speedier access could thus become murky, and may undercut efforts to continue cost controls, whether through fee-related requirements or otherwise. Following fee deregulation, providers will be allowed to receive higher payments for treating private insurees or for treating them faster than those publicly insured. The same provider will be able to contract both with public and private insurers.

4. PRELIMINARY ASSESSMENT OF THE INSURANCE REFORM

4.1 The reform approach

41. The government reform programme seeks to replace the state-driven health system with a market-oriented one. There is an expectation that current problems of the health system can be solved by developing private markets, as the State has been unable to provide for efficiency, quality, and integrity. Large emphasis is therefore placed on the need to de-regulate, privatise, decentralise, increase competition and mobilise private resources.

42. A strong belief and a push towards a market-based system are needed to change current institutions, which in several respects are still reflective of a state-planned mentality. Nonetheless, there is also a need to establish clear mechanisms for governing the market, including legislation, accompanying regulation, compliance frameworks, accounting and reporting standards, and a clear division of responsibilities and powers between different authorities overseeing different parts of the health system. There could otherwise be a risk to shift from one set of problems, those linked to the lack of market incentives, to another set of problems, those linked to the lack of a framework within which the market would operate. This is especially an issue when mobilising private resources. Considering the extent of

hidden phenomena such as informal payments and corruption, it is essential to set the framework within which the market could deliver desired improvements in efficiency, transparency, quality, and cost control.

43. The government has seen the reform package as an integrated whole and has not negotiated in detail with the affected parties. Despite the need for broad consensus on most of the relevant decisions and efforts made to retain such consensus (for example before the new Acts were submitted to Parliament several rounds of consultations with government bodies and interested parties were held), there remains a certain distrust and limited confidence in the Ministry of Health and other government bodies. Public acceptance of the reforms seems fairly limited, and there is particular fear that the reforms would reduce entitlement to health care. Population distrust may also derive from the several changes in the health system already announced (though not all implemented) over the past few years. This could have generated uncertainty and confusion about the intended direction of the reforms. Stakeholder consensus and agreement with key elements of the reforms has not yet fully been achieved, despite the key role providers, insurers and other stakeholders will have to play in the ultimate success of several aspects of the reforms. These stakeholder groups can be powerful government allies but can also effectively obstruct change. Popular support, and the support of key stakeholders, will play a major role in determining the success of the reforms. Hence, building and maintaining trust in the government and its health reforms program will be a main and important challenge for the future.

4.2 Reforms to the public health insurance system

44. The transformation of the health financing structure into a social health insurance system did not bring about much improvement from the previous planned health system. Insurers collect contributions and pay providers with limited accountability over resource expenditure and limited powers over provider contracting and budgeting of cost. They act as financial intermediaries without performing the key insurance functions of bearing and managing risk. The current social health insurance system suffers from large indebtedness, due to the absence of incentives for efficiency in the purchasing of services, a broad coverage of health services, and lack of tight budgetary constraints.

45. The government hopes that, through the proposed health insurance reform, insurers will become the main drivers of improvements in quality, cost control, and efficiency, by competing for insurees and profits. Insurers will not have freedom to set premium levels competitively nor will they be able to tailor the basic benefit package. Both these levers will remain standardised across insurers to ensure financing equity. Rather, insurance companies will be able to differentiate their products by competing on marketing strategies and customer service. Pursuing profit maximisation, insurers will also be encouraged to become active purchasers of services on behalf of insurees. They could do so by varying payment levels and selectively contracting with providers.

46. While such reforms would increase the accountability of insurers, they may nonetheless risk delivering less than the expected benefits. Insurers may contract selectively with providers, using this lever to differentiate their products and negotiate performance improvements from suppliers of health services. The development of provider networks has however been limited in several of the OECD countries where social health insurers have been allowed to contract selectively with providers.³² Explanations for the relative scarcity of such arrangements include pre-existing historical obligations to contract with all providers, the desire not to limit choice, and the administrative simplicity of applying similar conditions to all providers. Performance-based payments have not developed extensively outside certain US experience with private health insurance markets. In addition, there can be a trade-offs between incentives for quality improvements and those for containing cost. If insurers actively seek to use their contracting leverage to

32. This is for example the case of the Netherlands, the Czech Republic, and Switzerland (selective contracting in Switzerland is allowed for one type of basic health insurance only, so-called: HMO-insurance).

extract quality improvements from providers, the improved services may come at a higher cost. On the other hand, insurers placing competitive pressures on providers to contain cost may compromise the quality of care.³³

47. Meanwhile, incentives for choice-led competition will be limited as insurers' products are not truly differentiated in terms of premiums charged and products offered. Similar models of choice-led competition in social health insurance systems in Germany, Switzerland and the Netherlands have run into problems of high transactional and informational barriers to individual switching. Insurers have incentives to seek to attract people with good risk who consume less health services. This strategy would give them an immediate cost advantage compared to their seeking to extract cost saving by negotiating with providers, managing care, and competing with other insurers on cost-efficiency. Incentives for such kind of unhealthy competition are amplified by risk equalisation mechanisms which do not fully account for differences in risk across insurers. This seems to be the case of redistribution systems based on demographic adjusters. (Experience shows that certain risk equalisation schemes may reduce the extent of risk bearing by insurers by compensating them for their higher claim costs and reducing incentives to promote efficiency.)

48. Overall, in a health insurance system where, to preserve equity, enrolment is open, premiums do not vary with individual risk and are redistributed across insurers; insurers may face few incentives to compete on performance improvements and may be enticed to compete on risk selection strategies. Conditions therefore need to be set to ensure that healthy competition takes place across insurers. These include refinements to the risk adjustment mechanism, the establishment of adequate information channels for individuals to make informed choices among insurers, effective monitoring of insurers' behaviours to detect risk selection strategies, and disclosure and financial accountability requirements. Meanwhile, a more realistic definition of the coverage that can be afforded by social health insurance and strengthening of revenue collection is needed to maintain the financial sustainability of the system.

5. A POSSIBLE ROLE FOR PRIVATE HEALTH INSURANCE

5.1 Is a market likely to develop?

49. There is extremely little private health insurance at present in Slovakia, making it difficult to predict to what extent a market may actually develop. Private health insurance markets in OECD countries with universal and comprehensive health insurance systems are often limited in size and scope, unless PHI historically had a prominent role in health coverage.³⁴ A history of private health coverage does not exist in

33. Quality measurement and comparative reporting is essential for performance-based payments to happen. However, Slovakia is far from having such systems in place.

34. For example, private health insurance had a prominent role in the health system prior to the establishment of universal health insurance as in Australia and Ireland, and this role was buttressed by continued policy support. In France, non-profit insurers, "mutuelles", had historically had an important role in covering large co-payments on public coverage gaps, and benefited from favourable fiscal advantages as their role was perceived as an important social function. The countries with the largest share of private health insurance in total health expenditures are: the USA (35.1%), the Netherlands (15.2%), France (12.7%), Germany (12.6%), Canada (11.4%), Ireland (7.6%) and Australia (7.3%) (2000 data; source: OECD *Health Data 2003*). Those with the highest share of population coverage include France (over 90%), the USA (70.3%), Canada (70%), Ireland (48%), and Australia (44%). Excluding the United States, where PHI is

Slovakia, and individuals are not used to buying insurance policies nor do they trust insurers as buyers of health services; these factors pose particular challenges to the development of such a market.

50. Some stakeholders³⁵ believe that a pre-condition for the development of a PHI market would be the granting of tax incentives to insurees or to employers. Currently, 3% of wages can be set aside for contributions to individual pension accounts, which are tax-deductible. Commercial insurers hope that similar advantages could be provided for private health coverage. However, the government does not consider stimulation of PHI to be a priority for the use of tax resources.

51. A survey carried out by one commercial insurer indicates that complementary policies covering co-payments on public systems would not alone result in demand for PHI. On the other hand, individuals might value extra services that PHI could afford, such as reduced waiting times, access to better quality care, direct access to specialists, higher standards of accommodation and board. Private commercial insurers may hence have an interest in enter the market of private health coverage,³⁶ provided the public health insurance package is actually reduced.

52. Should a PHI market develop, insurers seem more inclined to engage in direct contracting with providers rather than adopt a pure reimbursement model. This is because individuals may not be willing to accept ex-post reimbursement of the cost of care they receive. Commercial insurers might enter into agreements with the health insurer companies offering mandatory health insurance. For example, a single joint stock company could incorporate a public health insurer and a commercial insurer, offering to individuals both compulsory health insurance and supplementary private cover.

5.2 Some potential risks and opportunities

53. The proposed role for PHI might offer some opportunities, but also create some risks.

54. The government envisages that the New Health Insurance Act and the development of a private health insurance market will help formalise informal payments and make certain hidden phenomena, such as waiting times, become visible. Under-the-table payments would be substituted by open queues, transparent fees, and open rationing as a mechanism to equilibrate demand and supply. While this is expected to create some initial discontent among the population, it is hoped that, in the long run, system transparency will improve.

55. Individuals may well find it attractive to buy PHI policies in order to decrease uncertainty about payments for health or to obtain access to higher-quality care. In the context of the large informal payments that exist in Slovakia, people might fear that the introduction of co-payments, price deregulation, and the delisting of certain services from the social health insurance package might lead to further corruption and informal payments. They may prefer the certainty of PHI premiums to the uncertainty over the overall cash payments (both formal and informal) that they may face. PHI may also help extract better accountability from providers, as insurers can arguably monitor providers more effectively than patients, and can enforce negotiated prices. They may be able to induce providers to restrain from accepting and stimulating discretionary payments, although there is little experience with this possibility to date. The above-described factors may lead to demand for private health insurance.

mainly used to provide primary coverage, private health insurance accounts on average for 6.2% of total health expenditure. The unweighted average for the 19 OECD countries for which data for 2000 are available is 7.7% if the USA is included.

35. For example one commercial insurer and the consumer association.

36. They would do so as part of their non-life insurance portfolio.

56. On the other hand, there are some risks that the expected improvements in transparency, quality and efficiency may not occur because a private health insurance market will not develop, or because it will not succeed in surmounting long-held cultural practices, notably informal payments. In fact, the existence of informal payments may actually slow the development of a private health insurance market, because a mechanism – albeit not formalised – already exists to enable persons to access quicker services or certain providers. Individuals seem to have limited confidence and trust in health insurance companies as buyers of health services. They may prefer direct buying of services from doctors to paying third-party payers, which act as intermediaries between patients and doctors. They may have no guarantee and little trust that paying an intermediary insurer would assure quality care (Murthy and Mossialos, 2003).

57. In addition, even if a market develops, PHI might accentuate inequities in access to care, and hidden phenomena such as informal payments and their link to rationing of care may not necessarily disappear. For example, it is not clear how providers' would allocate treatment and time between individuals with different health insurance status. There are currently no formal waiting lists kept by hospitals or doctors, nor information on what types of services generate waiting. The development of a PHI market would not automatically result in the creation of such lists and information may not appear in an organised and formal manner, because providers would have limited incentives to do so (although insurers may have an incentive to do so in order to demonstrate the benefits of their products and to hold providers accountable). In the absence of transparent information and clear rules for prioritising access to care, there is a risk of reduced access to care for those who do not have PHI. Doctors, who exercise discretion over treatment decisions, might have incentives to show/create artificial waiting lists in order to get higher payments from insurers for treating patients with PHI (whether or not they would have faced waiting under compulsory cover).

58. Allowing private health insurance to cover the waiting time and the higher fee of doctors delivering faster treatments may well produce incentives for providers to discriminate among patients on the basis of expected income associated with treatment, rather than real need. Although this may happen already on an informal basis, formalising this activity may actually legitimise inequities. In addition, in the context of deregulated fees, it may induce a spiral of increased fees that may drive cost up also in the public mandatory system. While this may be appropriate given the current low level of health expenditure, it would hamper the financial sustainability of the mandatory system in the absence of established mechanisms to equilibrate revenues and outlays. The impact on overall health costs is more difficult to estimate, because informal payments are currently not included in cost estimates.

5.3 Development of an efficient and equitable PHI market

59. Certain conditions would be needed for the development of an efficient and equitable PHI market in Slovakia.

Definition of insurable services

60. One first priority is the definition of a realistic (based on existing resources) and clear-cut division of insurable services between mandatory and voluntary health insurance. Currently, there is still ambiguity about which health services and risks will or will not be insured by mandatory health insurance. One complication to such an effort is the existing and broad guarantee to a wide array of services under the Slovakian Constitution. There are challenges regarding how to delineate a benefit package while not cutting back on this legal right, especially since a Constitutional amendment is not anticipated. There is nonetheless an expectation that up to 25% of procedures may be de-listed.

61. OECD countries feature a wide heterogeneity in their public-private mixes of coverage. Among the most often excluded health services are dentistry, optical services, non-essential drugs, long-term care,

and cosmetic surgery. Extra hotel amenities in hospitals are also paid privately by individuals or covered by PHI. (This range of uncovered services is similar to what Slovakia envisages de-listing.) Countries also adopt criteria and procedures to guide decisions regarding coverage of new and emerging technologies. In order to proceed to de-listing, criteria for exclusions would need to be made explicit (it is at present unclear to what extent this de-listing will be linked to indicators of need). Some explicit frameworks have also been developed and used for making decisions about what should be or should not be insured.³⁷ If de-listing is extensive, exemption or subsidy mechanisms for the poor and vulnerable population groups would also need to be established.

Separation of public and private finances and practices

62. De-listing of certain services would allow a strict separation of the financing of public and private health services. Doctors in several OECD countries are allowed to work in both the publicly financed and privately financed sectors. However, transparent rules for allocation of doctors' time between public and private work are needed, for example agreed, part-time contracts that are periodically monitored. This is especially essential if rationing for publicly insured services occurs, and if it is envisaged that private resources could fill in such gaps. OECD countries differ concerning their acceptance of differential treatments of individuals based upon their insurance status, for example in the case of services with waiting times.³⁸ Explicit access rules are usually established to maintain equal treatment based on need within part of the health system (e.g., public hospitals) or in the entire health delivery system. Such rules of access (and monitoring of their application) are needed to minimise treatment differentials linked to different levels of provider reimbursement for public and private insurance, rather than based upon the different needs of patients.

Private health insurance coverage of fast access to care

63. It has been proposed that private health insurance could cover faster treatment for planned/elective surgery. In order to minimise inequities and corruption, the following would be desirable: i) Transparency on how treatment is allocated between those with and without private cover; ii) Rules/contracts concerning doctors' allocation of their time between treating patients under mandatory health insurance and under voluntary health insurance (or other private resources); iii) Private patients and insurers' payment of the full cost of each private treatment (which would make them aware of cost and reduce incentives for corruption or the creation of artificial waiting);³⁹ iv) Monitoring of, and penalties to tackle, corruption within the mandatory health insurance system. While this would lead to the creation of an "upper tier" of persons eligible for improved or different access to services (those who can afford to pay for private cover), it would encourage transparency. It would also enable doctors' to enhance their incomes, while removing some of the pressure for informal payments within the mandatory health system. Nonetheless, policymakers must consider the equity implications of such a dual coverage system.

37. For example: i) In Canada the Canadian Health Act provides for public coverage of all medically necessary insured services; ii) the 'Oregon experiment' made an attempt to determine benefits that should be financed publicly; and iii) The Netherlands model (linked to the so-called Dunning Report).

38. For example, in the Netherlands, where individuals are subject to the rules of access to care, there is no difference in speed of treatment for those with private health insurance. In Ireland and in Australia, on the other hand, people with private health insurance can jump queues in the public hospital system by using different providers in the private sector.

39. This approach differs from that currently under consideration where social insurers would reimburse private insurance carriers at the rate of reimbursement that would have applied had the person not had PHI.

Coverage of co-payments

64. According to current plans, private health insurance would be allowed to cover co-payments on the mandatory health insurance system. This may have undesirable effects. PHI for co-payments reduces individuals' incentives to consume health care parsimoniously because it removes awareness of cost. This may actually make it more difficult to achieve cost control in mandatory health insurance coverage and counteract the very idea of introducing co-payments as a mechanism to regulate demand for care. (Although given the small amount of the co-payments, these are expected to do little to moderate demand.) Co-payments are also introduced as a mechanism for shifting cost from the public to the private sector and to generate a bit of extra revenue for the public system. However, given low levels of patients' co-payments and the need to establish exemption mechanisms for the poor and the sick, little additional resources can be expected to be generated.

Tax incentives

65. The government does not envisage stimulating the development of private health insurance through tax incentives. This seems to be a reasonable policy choice given limited government resources. The Slovak health system suffers from severe underfunding and tax advantages represent foregone revenues. These resources would be better spent to guarantee adequate financing for a core package of basic services. Furthermore, while tax advantages may help encouraging purchase of private cover, other conditions such as individual and employers' confidence in the insurance products are more important factors to trigger the development of a market.

Legal separation between mandatory and voluntary health insurance

66. Both commercial insurers and the current health insurance companies will be allowed to offer private health insurance. Should the same insurer offer both compulsory and voluntary covers, these are expected to be offered by separate legal entities, although the Act might benefit from more specific clarity regarding this separation. Such legal separation is extremely desirable, and should be specified in sufficient terms to ensure complete separation of insurers' practices (reporting, budgeting, accounting, contracting with providers, reimbursement, marketing). Tie-ins between social and private health insurance should be prohibited. This is because mandatory and voluntary insurance are subject to different regulation. In the absence of such legal and de facto separation, insurers may use information gathered from their commercial practice, where they would be subject to less stringent rules, to operate the mandatory cover and may de facto select good risk in social health insurance. This may result in insurers' behaviours that are detrimental to goals of solidarity in mandatory coverage.

5.4 Options for regulation under EU Law

67. Slovakia's anticipated entry into the EU will carry with it the obligation to comply with relevant EU law. In the case of PHI, the minimal scope of the anticipated regulation of PHI is likely to conform with the provisions of the Third EU Non-Life Directive, assuming solvency standards are consistent with this directive.⁴⁰ This directive is the primary EU insurance standard applicable to PHI markets and seeks to promote competition while safeguarding certain consumer interests. Specifically, under the directive, member countries must permit the offering of insurance products by insurers based in other member states, subject to certain conditions. It focuses on protecting the financial condition of companies, and thereby

40. A detailed formal legal analysis is beyond the scope of this paper. However, the discussion which follows seeks to provide an outline of the framework of EU law in this area and highlights its possible impact on the scope of permitted regulation applicable to a PHI market in Slovakia.

seeks to assure the ability of insurance entities, including health insurance companies, to continue to deliver contractually promised benefits.

68. Regulations addressing the content of PHI contracts⁴¹ are generally not permitted under the directive, with some notable exceptions. In particular, if private health insurance policies can be substituted “wholly or in part” for the sickness cover provided under a statutory system, governments may be permitted to compel PHI insurers to comply with certain requirements relating to the “general good.”⁴² In these cases, the Directive provides governments with some flexibility to ensure that PHI products dovetail with, and do not undermine, the structure and financing of national health systems. Ireland, Germany and the Netherlands’ PHI system have received approval to retain several requirements on PHI markets pursuant to this exception. The directive specifically indicates that measures to protect the general good “may provide for open enrolment, rating on a uniform basis according to the type of policy and lifetime cover...by requiring undertakings offering [voluntary private health insurance]... to offer standard policies in line with the cover provided by statutory social security schemes at a premium rate at or below a prescribed maximum and to participate in loss compensation schemes.” Thus, the Directive highlights the permissibility of limiting PHI carriers’ ability to consider health status in certain issuance and rating decisions, within systems where PHI plays a more significant and at least partially substitutive or alternative role.

69. At the moment, the relatively minimal role envisaged for PHI in Slovakia would not appear to fall within the above-described exception. However, should a market develop under which PHI covers a more significant portion, or all of, the costs associated with publicly covered services (such as coverage for quicker access to services, or coverage at higher reimbursement levels if fees are deregulated), its role arguably would be a partial alternative to public health cover, which may permit the Slovakian government to impose stricter requirements upon PHI carriers in the interest of the “general good.” For example, the role of PHI in Slovakia may mirror that of Ireland, where the privately insured are able to access different providers from those afforded by the public health system, or the same providers on a faster basis. Ireland has been permitted to impose requirements beyond the scope of those generally permitted under the third EU non-life insurance directive. If Slovakia is accorded this flexibility, it may have an enhanced ability to respond to challenges such as promoting equity of access to private health cover by enhancing standards applicable to PHI policies.

70. Another area of EU law that also affects government action relating to PHI markets concerns “State aid” and procurement rules. “State aid” rules apply when a public body offers a direct or indirect financial advantage to an undertaking. EU rules seek to ensure that governments neither foreclose national markets nor falsify competition by prohibiting both direct state action (such as selective allocation of state subsidies), and indirect action (through preferential procurement contract awards).⁴³ Certain state action towards private health insurers, as well as other types of health insurance funds may be considered “state aid” – and hence prohibited under EU law – if it offers a financial advantage to an undertaking.⁴⁴ Indeed,

41. These standards could include specification of certain health services that must be covered by PHI (sometimes referred to as “minimum benefit standards”), or requirements requiring the offering of certain standard benefit packages.

42. European Commission Interpretative Communication (2000), *Freedom to provide services and the general good in the insurance sector*, (2000/C 43/03).

43. Hatzopoulos, Vassilis G. (2002), chapter 5, pp. 138.

44. The determination of whether a health insurance fund is an “undertaking” within the meaning of EU law is a complicated question that weighs several factors, including the organisation’s objective, whether it is compulsory, the extent to which benefits are delivered on a needs basis vs. according to contribution, its freedom to set contribution amounts and the degree of state control over the entity’s decision making,

questions have arisen concerning the compatibility of certain PHI related regulation with EU state aid rules in some EU countries.⁴⁵ To the extent PHI coverage in Slovakia is offered by affiliates of the social insurers, as well as by commercial carriers, the government will need to be careful not to accord any advantage to social insurers in this area, lest they run afoul of state aid related requirements. These standards underscore the importance of requiring social insurers to only offer PHI coverage through separate legal entities, and therefore to ensure they do not benefit from public funding provided to the social insurers. Such a requirement is already envisioned.

71. The interpretation of EU insurance directives, and their relation to health financing system regulation in the area of PHI, continues to evolve. While the structure of existing European PHI systems was clearly contemplated in drafting the Directives,⁴⁶ challenges and needs for clarification have continued to arise. Some interpretive clarifications have been issued by the Commission, and the European Court of Justice has also made rulings with respect to countries' compliance with the directive. Furthermore, the fear that EU directives may limit countries' flexibility may slow down discussions involving changes in the public/private financing mix. This was the case of reforms under discussion in the Netherlands, whereas the uncertainty around, or likely obstacles posed by, the EU third non-life insurance directive is weighing against the consideration of structural reforms towards a uniform compulsory private health insurance system for the entire population. It is therefore difficult to ascertain the precise scope of regulatory options under EU law, because the interpretation of the Directives takes into consideration PHI's particular role within individual health systems.

72. There are drawbacks to the narrow scope of permitted PHI regulation under EU law – particularly when PHI represents an area of limited experience, as is the case in Slovakia. PHI markets and contracts are often complex and may be difficult for consumers to understand. While the draft Act does require insurer disclosure of contract terms and conditions for the insured, this may not ensure transparency and readily understood policy terms; potential competition in the PHI market could be limited if consumers may have difficulty comparing insurers' offerings. More detailed information disclosure requirements for insurers and consumer protection mechanisms to address abuses and complaints could help assist with this problem. (However, as described above, governments in EU member countries are limited in their ability to restrict PHI contract terms, or mandate certain simplifications, such as the utilisation of certain standardised forms.) Furthermore, the current draft Health Insurance Act does not require insurers to file their policies or claims related information with the government. Such a requirement could help policymakers to assess the functioning of this market, and monitor its interaction with public coverage, in the future. It would be permitted under EU law, as long as the filing does not imply a requirement that policies receive government approval prior to their sale.

73. As already discussed, the introduction of private health insurance coverage into a health system can also have significant implications for equity of access to care as well as health costs. Most OECD countries with significant PHI markets – in terms of PHI's role in financing health care or the extent of population coverage – have faced challenges relating to reduced availability or affordability of private health cover for persons with above-average or high health costs. Governments in these OECD countries have often responded to these challenges by imposing requirements relating to benefits, issuance, and premiums of PHI policies. Apart from the exceptions described above, EU law restricts governments'

degree of active management of funds, and whether it is in competition with private insurance companies. Hatzopoulos and Vassilis G. (2002).

45. See *e.g.* Decision of the European Commission regarding the Irish Risk Equalisation Scheme, State Aid N. 46/2003.

46. For example, this is evident in the explicit listing of certain permitted regulatory requirements for some national systems.

ability to address some of these issues. While this may be of less concern in countries where PHI plays a minor role, even in those countries, policymakers may nonetheless face public dissatisfaction if only persons of lower health risks access the PHI market. Furthermore, the absence of consumer familiarity with insurer practices may lead to confusion when insurers apply health-related exclusions, or reduce the scope of available coverage. At the moment, EU law provides policymakers with limited tools to address PHI insurers' issuance, pricing and benefits practices, although those countries where PHI plays an alternative role have been able to accompany this role with more substantial regulations.

74. To the extent PHI is expected to play a relatively minor role in the Slovakian health system, the government must be careful to adjust its own expectations, and that of the public, to the actual potential it may fill. High expectations may lead to disappointment, particularly when there is cultural unfamiliarity with such markets. In addition, the complexity of the market and insurer activities may lead to confusion and dissatisfaction. It is therefore important that the government develops mechanisms to monitor the market, and that it has the administrative flexibility to intervene and attempt to correct problems, within the framework of permitted EU law. This can include providing consumers with the means to inform the government of problems they may face with their coverage, and government tracking of these concerns. This can be particularly important in the absence of government's ability to require prior approval of PHI contracts (a practice generally not permitted under EU law).

75. Should PHI's role become more substantial, the government may wish to explore protections to ensure broader access to PHI coverage, such as issuance or premium-related requirements. (Such requirements exist in the Netherlands, Ireland, Australia and parts of the German and U.S. PHI market.) In this case, however, it will need to ascertain the permissibility of any such interventions under EU law. At the moment, increased flexibility has been provided for countries where PHI coverage serves at least as a partial substitute for public health insurance. In the absence of a strong history of such a market in Slovakia, it may be more difficult to establish the case that PHI does, or may in the future, play a significant role in the Slovakian health system. In this regard, Slovakia is in a similar position to other EU accession countries with a limited history of PHI.

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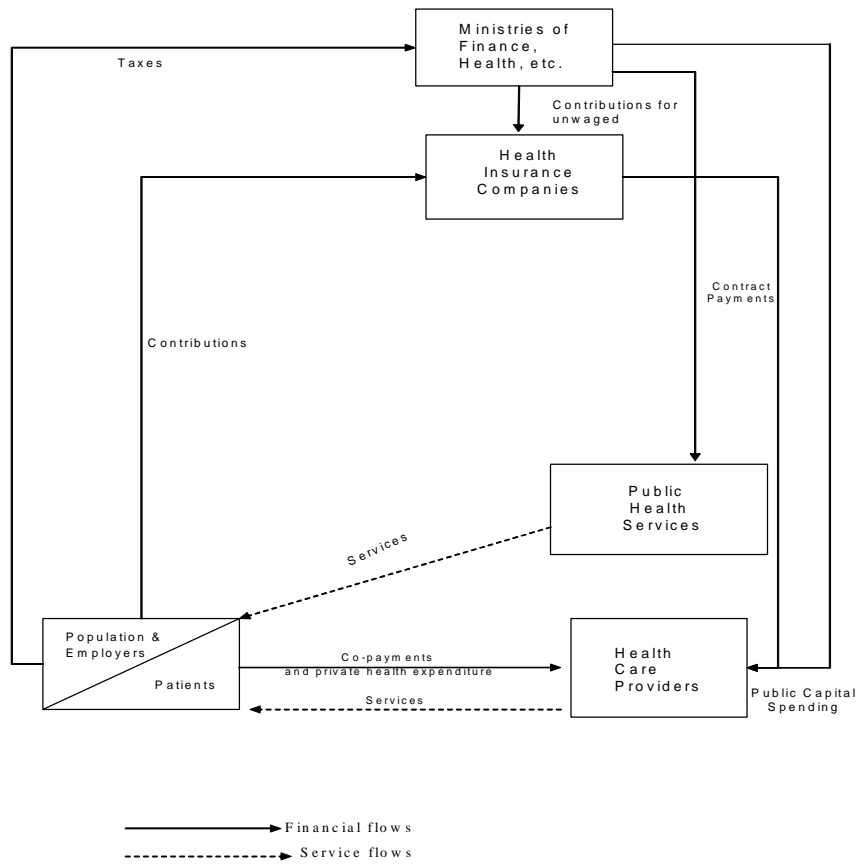
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ANNEX THE HEALTH CARE SYSTEM IN SLOVAKIA

The Health System in Slovakia, 2000



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