ZEVA meeting Tirana 10-12 September 2015

National Report Slovakia

This report is not an official statement of Slovak Medical Chamber

It has been through a lot of things, in the Slovak healthcare, but not far from positive, since the last meeting ZEVA 2014 in Bratislava.

Our report is distributed as follows
1. The developments in healthcare system at political and economic level
2. Events in the health care system at the technical (professional) level
3. Activities of Slovak medical chamber

1. The developments in healthcare system at political and economic level

a. Government efforts to complete the reorganization of existing projects and new health care projects
b. Health insurance
c. Regional health care, public and private providers
d. Wages and salaries in the health sector
e. Organizations in healthcare
f. Education

1a. The Slovak Government approved back in December 2013 a document entitled ***Strategy of Health Care for the years 2014 - 2020.*** The document produced by the Institute of Health Policy at the Ministry of Health Care outlines the direction of health care in the next 15 years. Initial analysis is short and mainly citing sources from OECD http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?doclanguage=en&cote=eco/wkp%282010%2925 , the International Monetary Fund https://www.imf.org/external/pubs/ft/wp/2012/wp12173.pdf and two materials of domestic origin prepared to order, one of which is prepared by the Financial Policy Institute of Slovak Ministry of Finance called **Low on health for a lot of money. http://www.finance.gov.sk/Default.aspx?CatID=8789** These report materials are cited in particular the sections in which they writes about the ineffectiveness of healthcare in the Slovak Republic. Expenditure growth for healthcare purposes in the years 2006-2012 in Slovakia exceeded growth in expenditure in relation to gross domestic product of most OECD countries, although the absolute amount was lower than in most of these countries. Within the countries, of the so-called Visegrad Four (Czech Republic, Hungary, Poland and Slovak Republic), our growth could compare only the Czech Republic.
By expressing so-called efficiency, the hard performance indicators (mortality, morbidity, and longevity, life expectancy in good health or sick leave) have stagnated. The document proposes a number of close and distant targets in health care, including: the introduction of DRG, implementation of e-health, reduction of beds for acute care pertaining to the conclusion of around 30 general hospitals, the establishment of standards of care for hospital and outpatient care, the creation of centres of integrated primary health care. The document is missing as the establishment of so-called basic package of healthcare covered by public health insurance, or the possibility for additional insurance or supplementary health insurance. But it still considers the introduction of a single health insurance company.

Within the submission of comments to the disclosure of this governmental document, there were very few, that would include meaningful proposals. A range of government departments, state and public institutions as well as other organizations in the health sector or outside did not understand the importance of this government-approved document. This also applies to the Slovak Medical Chamber. In the middle of 2014 Slovak Medical Chamber have understand, that although the implementation of this document is questionable, it hide behind a fairly substantial financial funds. A Chamber arose, when in August 2014 another - already elucidated - material from the Institute of Health Policy Ministry of Health of the Slovak Republic called ***Implementation Strategy - an integrated system of healthcare delivery: Modernization of health infrastructure and improving an access to quality services in primary and acute inpatient health*** have appeared. In August 2014 Slovak Medical Chamber could see, that the matter is serious. In the game were funds, financed from the European Union, targeted for health care for the years 2014-2020. In the negotiations on the European Union's finances for the next programming period, the European Union did not want to even hear about its finances in the health care sector. The situation changed when Slovakia submitted, during the negotiations, the concept of integrated healthcare supported by the two basic documents cited above. The package of 300 million Euros was divided in the primary outpatient care with approximately of 140 million € and further 160 million in infrastructure of reduced network of hospitals. The money could apply all regions of Slovakia except Bratislava capital region, whose gross domestic product exceeds half of the average domestic product of the European Union. At its annual congress in September 2014 Slovak Medical Chamber discussed his attitude toward the project and eventually rejected it because of its poor transparency and suspicion of corruption.
In the coming months, however, the Chamber decided careful collaboration, or rather the process of monitoring, and co-organized with the Ministry of Health of 16 December 2014 joint meeting and later send representatives to eight so-called "round tables" on outpatient integrated care, which are forums for different aspect of this integration. Initially doctors mind in particular, that according to the plans of the Ministry of Health should urgently build a total of about 140 primary health care centres in the regions, often where there is already quite adequate infrastructure. Also objected to who should be the owners of these resorts and how they come into. Part of these reservations were sanded on both – "round tables ", and after discussion with representatives of working and monitoring group of the European Commission in February 2015 both personally and by teleconference.
Activities of the Ministry of Health, however, during the months of July and August faint and Slovak Medical Chamber assumes that until the general parliamentary elections should be held in late February or early March 2016, a lot of major should not take a place.

Another politically and organizationally high explosive have clearly been a material about resolution of the Slovak Government to build a new university hospital in the capital city of Bratislava. Slovakia still has not a worldwide superior General Hospital, with sufficient capacity, infrastructure and human resources. Due to lack of funds, the Slovak government decided to implement the project through a public-private partnership (PPP). According to the concept of the rule, the price of this hospital should not exceed 250 million €. A body, which would contract to build and operate this hospital during the next 30 years, will earn during this period around 5, 0 billion €, coming from the public health insurance. Controversy sparked not only the method of financing, but also a placing of that hospital and parameters that should be fulfilled. A company GFK was selected in an international competition, to investigate the feasibility of the project selected. It reproached her that their findings were based on outdated data to support the PPP, while the reality is supposedly now different. Also the place to be for the hospital in Bratislava does not meet the parameters chosen for its

location. Unable to land a helicopter there, there is ample parking there, and it is lacking the amount of land, on which to build a planned university campus, and other operations and institutions. Yet performance parameter of hospital should overcome the existing parameters of the three public hospitals in Bratislava at incomparably higher quality. Mode payments for performed health care should be the same as for the other hospitals, already in connection with the salary mechanisms of assessing and DRG. The hospital should be completed in late 2018.

The long-term problem of Slovak health care is not just a **bad planning by the central or regional level authorities – this planning practically does not exist - but also the lack of transparency and huge corruption at all levels.** These factors significantly affect viability, even partial plans of health policy, while also significantly contributing to the inefficiency of healthcare. Also this year, like the last, it was characterized by uncovered several corruption cases. These included non-transparent purchases of medical equipment, medicines and special medical material by public or publicly controlled non-profit hospitals. For one of these cases detected incidentally in a small non-profit hospital, in which board of trustees had the state majority the previous Ministry of Health had to resign in October 2014 after public pressure, and at the request of the Prime minister. Even the president of the Slovak Parliament, whose name has been associated with several companies, performing similar businesses, has later resigned. Interestingly, the director of the hospital maintained its position yet. Business with the state can be lucrative, especially if there is a rigged competition, not only in the healthcare sector. That case, a small hospital with a capacity of less than 200 beds and a catchment area of around 40,000 inhabitants concerned the unlawful purchase of CT device, with artificially inflated specifications for 1.6 million €, with comparable or identical machines costs - including installation and maintenance - of around 600,000 euro. In this series of scandals it is mentioned the fact that, that in public procurements (competitions) for the like apparatus, an average of only 1.3 menu (offers) came for one to race. In the Czech Republic, which also does not excel in transparency of healthcare they have at least three offers.
Corruption circumvents our drug policy. At a higher level, it is an unclear work of so-called Categorization commission of the Ministry of Health of the Slovak Republic, which - among other things – decide on the amount of payment for drugs from public health insurance. Lobbying for favourable conditions is daily activity of the representatives of pharmaceutical companies, drug distributors and distributors of medical material. Yet we are missing public minutes of the proceedings of this committee, which decides about millions. Unlike the hospitals that are - finally - required all orders over 5000 € and tenders published on the internet. And also that but not only that makes the medication and special medical material missing unreasonable amounts of money. Expenditure on these items has long been more than a 30% of healthcare spending and Slovak citizens are at the forefront of consuming products covered by public health insurance. In addition to the medicines people reimbursed the second highest amount of payments in OECD countries, since by far not all drugs are fully covered by health insurance. And that was not enough - for the right paid (over the counter) drugs people annually pay over 300 million €.
Had previous health ministers have tried this intolerable situation to influence?

In 2011, the legislation has set strict rules for the manner of appointment of medicine prices, which had to be the second lowest in the European Union. This resulted not only in reducing the unit prices of drugs, but on the other hand, a in a dramatic rise in re-exports of medicinal products from Slovakia to the European Union countries where the drugs had higher prices. A series of amendments to the laws suspended part of this trend, which threatened with supply disruptions of drugs in Slovakia. Then re-export has become an important part of business not

only distributors, but also pharmacies and pharmacy chains. Drugs were often physically not in Slovakia and remained in warehouses in other countries.
The new rules of 2011 set out the obligations for doctors. They should join - because of tax obligations - all relevant benefits (over 10 €) received from pharmaceutical companies and distributors. Originally, it was in the annual accounts of tax returns, now on a quarterly basis. These benefits shall be disclosed separately on the website of Ministry of Health. Obligations are also related to the education of health professionals, funded by pharmaceutical companies, such as participation in educational events, including conventions. However, since the health professionals failed to meet these obligations, precisely this role has transferred for pharmaceutical companies. Interestingly, managers of health care that do not provide direct medical care, but influence the purchase and implementation do not have that obligation. According to the pharmaceutical companies they will spend on education this year around 90 million € (!). Proposals for the creation of a special independent fund for the financing of these activities have not been heard yet.
Government and Ministry of Health have established corruption line - telephone, mail and postage, with minimal popular with minimal response in the public. For example, the Ministry of Health has taken on its e-mail hotline for five years only six such notices that could pass police. It was completely absurd attempt of the Ministry of Health to get to the Act on Health Care Providers obligation that all (!) health workers are obliged to retrain against acts of corruption in the state-run Slovak Medical University (!). This ridiculous proposal Ministry finally withdrew.

1b. Health insurance

Significant progress towards a fairer allocation of funds of public health insurance was the introduction of additional criteria - the so-called PCG (Pharmacy based Cost Groups http://www.healthpolicyjrnl.com/article/S0168-8510%2803%2900162-3/abstract?cc=y=)This mechanism has contributed to better reimbursements for health insurance companies that insure polymorbid and old citizens of the Slovak Republic. In contrast, all government political groups rejected or ignored define the basic package of health services financed from public health insurance. Slovak Medical Chamber is not able to imagine such a situation of operating next DRG reimbursement system. In doing so, the new catalogue enforcement has already been defined.
The Constitution of the Slovak Republic states, that health care is financed from health insurance. Details have yet to establish a separate law. At the time of adoption of the Constitution, it looked nice and smoothly. It has been shown, that simple it does not.
The contribution for health insurance share mainly economically active people and companies with employees in the form of monthly advances, with any possible annual re-calculation. For economically inactive persons (e.g. children, pensioners, economically active persons working abroad and non-paying posts with us, or unemployed) pays contributions to health insurance the state. Such persons are almost twice as many (3.5 million) as economically active and state contribution per person is only a fraction of the average contribution of companies and economically active persons. That is a significant part of the income of health insurance. The amount of contribution for economically inactive persons is not determined by a special law on health insurance but by the State Budget - hence politically. Despite the growth in health spending it is almost regularly below 5% of GDP, which is in comparison with some other OECD countries also compared relative few. Unfortunately, these funds are often landless scatter. Total spending on healthcare of public finances reach 4 billion €. This is around 65 Euros per person/ per month. Citizen of the Czech Republic accounts for two times, citizen of Austria 4.5 times more, and citizen of Germany six times more.

From these contributions pay the health insurance companies the health care. Creation of reimbursement policies, however, came with absurd traits. Although the law stipulates that it is a State through the Ministry of Health who determines the amount of payment for defined performances (for example outpatient procedures, or hospitalization in hospital), actually they are the health insurance companies, and they do it therefore with no legal authority. The amount of payment shall be laid down first by available resources and then they begin to negotiate with the providers 'contract prices "and the scope of health services. Then, during the contract period come the politicians with various legislative changes, which often increase costs of providers, so that their activity sometimes becomes a loss. This was the case this year, when the politicians addition to the authorized waive the fees for services paid by health insurance, abolish the fees that insurance paid not - for example, for many ears introduced fees for priority examination, the number of which may not exceed the set limits. The same is unfunded wage increases in the state healthcare sector.
Moreover, the insurance companies began to vindicate the function of the regulator of network providers, their numbers and location. It has done so through the newly concluded contracts for this activity yet has no legal authority. It's a unique authorization of the Ministry of Health, which sets standards of staffing, equipment and material distribution of health care providers through prescriptive. They are however unfortunately only concerning with the so-called minimum standards, and in recent years the Ministry has failed to identify the so-called optimum level. As a consequence we have in Slovakia surplus of outpatient specialists, often with minimal time jobs, while the aging providers in primary health care threaten to lack.
At the end we can say that the dominant operator ordering and reimbursing healthcare remains in our country the state, with his healthcare insurance company, which has more than 3 million policyholders. Second is a private health insurance company with more than 1.3 million policyholders. It is a company, which owns a business in the pharmacies (pharmacy chain), the distribution of drugs in outpatient care with a chain of polyclinics and private hospital network of regional hospitals. Two years ago he sold the network of laboratories. Its business strikingly impressed as a closed circle. An undertaking is in other fields like food

1.c Regional healthcare, public and private providers
The Slovak Republic is at the time divided into eight self-governing regions. Unlike - for example, from industry - the public administration and health services are distributed relatively evenly. But already now there are the administrative areas where, the in terms of geographical, demographic, human, transportation and other factors, becomes even basic health care less accessible. The current organization of the state while repealing the possibility for regional planning of health care and, therefore, with the exception of one county is a regional health care in shambles. This applies particularly to the care beds, either acute or chronic. Most of the regional hospitals were privatized, mainly through the transfer of management responsibilities from governments of cities and regions for private companies. The most common form was renting these facilities. The most active of private companies was the one that currently owns 14 hospitals, the last two won 3 months ago. While cities and theoretically autonomous regions could invest in infrastructure of such hospitals, they do not for the money or do not want to. Overall, this network of regional hospitals - formerly belonging to the government - is privatized to 80 percent. State currently owns a network of large state - mostly acute hospitals, as well as psychiatric hospitals and is still the dominant provider, often in different ways favouring its hospitals (upper payment, deleveraging, and priority in investment activities). According to the Antimonopoly Office of its business in the health sector does not threaten competition. The lack of regional coordination of healthcare stands currently bad in the light of planning the so-called integrated health care system. Self-governing regions were and are eligible for the issuance of permits for the operation of

licensed health care facilities, especially ambulances. However, the process was chaotic, there were frequent political and economic pressures and it lacked appropriate norms. Slovak Medical Chamber argues that while it lacked its self-regulating functions. Since 2002 he has been out of the process and completely excluded. And here is an example of a bad regional regulation and planning: currently, the average age of primary care physicians is more than 54 years, which is alarming. Conversely, the average working time of medical specialists is between 0.2-0.4 per ambulance by region. Specialists are concentrated around the cities; the primary sector threatens similar concentrations around the planned integration centres. Coordinating role in the region, the Ministry of Health given up long ago, regions and municipalities do not have the legal competence and the Medical Chamber is weaned. The worst situation is thereby in so-called community care, linking care primarily about ever growing population of disabled seniors. In the so-called nursing services, competence of providers at the community level by law is relatively well defined. Years, however, lacks any legal link to provide basic health care. For years is absent an integrating element of this care - the Law on Long Term Care (LTC) and its method of financing. It is the shame of past and current governments that have not done so. It has fatal consequences especially for frail seniors at home and institutional care. According to some experts - also from the Slovak Medical Chamber - would have long-term care – social and health care together – its management - fully pass the competence of municipalities and regions. Its performance could convert different types of public and private organizations.
The fact that regions cannot plan health and social care can have fatal consequences for the availability of certain services. Private health care providers of acute hospital facilities plan (although without the support of the law and closed contracts) specialization of their facilities, that these are economically profitable. While this is commendable in terms of business, in terms of region, it may not be beneficial.

1. d. Labour, wages and salaries in the health sector

a strike by doctors in some - mainly public hospitals in 2012 - was adopted a special law on wage claims doctors. Although its implementation was longer than the law presumes this year reached a basic average salary of doctors required level of 2.3 times the average wage in the national economy. Although there was a relatively significant increase in the cost of hospitals because of this amount was based on the royalties received by employees, this measure had some positive effects. In particular, the team stabilized workforce of doctors in hospitals and reduce its departure abroad. The increased interest of young graduates of medical studies to work in Slovak hospitals although less than hoped for. Willingness of surgeons to work overtime also increased.
Salaries also increased paramedical staff - nurses. This increase was initially occur even in 2012, after an increase in doctors' salaries, voted almost Slovak parliamentary unanimous - an increase in the salaries of nurses. This law, however, the Constitutional Court suspended at the initiative of the Slovak Medical Chamber. She accepts her arguments that the law is not covered by finances and presents a danger for the provision of healthcare. Slovak Medical Chamber The complaint filed because it was concerned that many of its members, providing ambulatory health care will have to raise salaries and their nurses without them increased payments by health insurance companies. In 2014, they increased the salaries of nurses in government health facilities. It is therefore nurses paid disproportionately by type of employer they work for. The non-profit organizations as well as private and regional hospitals have not increased salaries because the government and the Ministry of Health argued just verdict of the Constitutional Court of the past and by the absence of legislative impact on these entities. The difference in salaries of nurses in state facilities and other facilities is now around € 400 it currently works in the healthcare around 40,000 workers. The share of nurses decreases

gradually but steadily. Thousands of nurses working abroad (Austria, Germany) as nursemaids

1e. Organizations in healthcare

The Association of organization of health care providers, but also those who do not provide health care, but are members of other organized interest groups is high.
Among the most active organizations including chambers of health professionals established by the special law belong:

Slovak Medical Chamber www.lekom.sk
Slovak Chamber of Dentists www.skzl.sk
Slovak Chamber of Pharmacists www.slek.sk
Slovak Chamber of Nurses and Midwives www.sksapa.sk
Slovak Chamber of paramedical staff www.skszp.szm.sk
Slovak Psychologists www.komorapsychologov.sk
Slovak Chamber of other health professionals www.skizp.sk
Slovak Chamber of orthopaedic technician www.skort.sk
Slovak Chamber of medico-technical staff www.sekmtp.sk
Slovak Chamber of Paramedics www.skzz.sk

Other active professional organizations established but under the general law on civic associations are:

Trade Union of Doctors - LOZ www.loz.sk
The Association of Hospitals of Slovakia www.asociacianemocnic.sk
Association of Faculty Hospitals of the Slovak Association of Faculty Hospitals SR
Slovak Medical Society www.sls.sk
Slovak Medical Society has more than 80 specialized associations and regional operating bodies ranging from educational associations, to regional interesting groups of doctors or health professionals.
Association of Private Physicians www.aslsr.sk
Slovak Medical Union of Specialists www.slus.sk
Association of general practitioners for children and adolescents www.detskylekar.sk
Slovak Accreditation Council for continuing education www.saccme.sk
Slovak company of practice / family medicine www.sprl.sk

Other important organizations established by the state:

Ministry of Health www.health.gov.sk
Office for Healthcare Surveillance www.portal.udzs-sk.sk
National Health Information Centre www.nczi.sk
State Institute for Drug Control www.sukl.sk

Other organizations established by the civic law:
In the health sector is active more than 130 civic associations of patients that are aimed at specific groups of diseases.
Furthermore it works umbrella organization to protect the rights of patients www.aopp.sk

One of its member is the Association of informed patients www.ipac.sk

1F. Education

Education of health professionals is divided - as in other countries - for undergraduate and postgraduate. In the case of doctors, there are three medical faculties providing undergraduate education, founded by the Ministry of Education, Youth and Sport of the Slovak Republic and one Medical University, founded by the Ministry of Health.
Postgraduate medical education is provided by the Slovak Medical University, established by the Ministry of Health. The provision of postgraduate education may also provide medical faculties, but they must have proven accreditation for this activity.
Checks on accreditation and supervision on compliance with the terms of the so called Accreditation Council (http://www.health.gov.sk/?akreditacna-komisia) carries out the Ministry of Health. Slovak Medical Chamber unfortunately is not a member of this Council – it can be a member by the law, but was not invited.
After graduating in general medicine, the student will obtain a qualified professional fitness for the profession of a PYSICIAN. Other obtained basic competences after graduating in health care in the Slovak Republic are:

DENTIST
PHARMACIST
NURSE
Midwives
PHYZIOTHERAPEUT
Community health workers
Medical laboratory specialist
Nutrition assistant
Dental hygienist
Radiological technician
Paramedic
Dental technician
TECHNICIAN FOR MEDICAL DEVICES
OPTOMETRIST
Pharmacy Technician
MASSAGER
Optician
Orthopaedic technician
Medical Assistant
Sanitarian
LOGOPEDIST
PSYCHOLOGIST
Remedial teacher
Laboratory diagnostician
PHYZICIST

In the event, that after graduating from an accredited undergraduate study in those fields they want to tax experts to begin work in the health sector in the provision of health care, they are obliged to register in the register of health professionals that manage relevant medical chambers. Medical Associations that worker concerned shall issue a license. Thus equipped

the doctor cannot provide health care alone. In order for it to carry out, she or he must attend at least part of postgraduate studies. Further education of medical workers then provides:
- Specialization course and (sub specialization)
- Preparation for the performance of certified work.
- Continuing education and training.

Specializations

In the case of doctors, they are undergoing specialized studies after the so-called assignment specialization. This assigns Slovak Health University usually at the request of a physician and usually with the consent of the employer by a licensed physician began to work. The period of study and practice as well as the content of study and practice are governed by regulations that are compatible with the regulations in the European Union. Usually after two or three years after allotment of specialization and completion of relevant practice takes place so-called advancement examination. After passing this test, organized by faculties of medicine or the Slovak Medical University, the process of obtaining further specialization lasts usually two or three years. Depending on the type of the department is carried out by specialized examination after the next two or three years. In general medicine (primary care) is an exemption for a period of specialized training, which lasts three years and three months and ends with the specialized examination. There is also so-called supplementary study and practice of general medicine for doctors who have completed specialization in internal medicine completed with examination after two years.
In the category of physician specialization it can be obtained within a field of qualifications according to Art. 24 (or equivalent to Art. 24) of Directive No 2005/36 / EC, or through the recognition of the education according to § 35 paragraph section 1 of the national Act of No. 578/2004 on healthcare workers. The specializations are:
Anaesthesiology and Intensive Medicine *, Angelology, Vascular Surgery * Dermatology and Dendrology * Paediatric Surgery *, Dialectology, metabolic disorders and nutrition, endocrinology *, Physiotherapy, balneology and medical rehabilitation * Gastroenterology *, Gastroenterology Surgery *, Geriatrics *, Gynaecology and Obstetrics *, Haematology and Transfusion *, Herpetology *, Thoracic Surgery *, Surgery *, Infectious Diseases *, Cardiac surgery, Cardiology *, Clinical biochemistry *, Clinical pharmacology *, Clinical Immunology and Allergology *, Clinical microbiology *, Clinical Oncology, Laboratory Medicine *, Medical genetics, Maxillofacial surgery, Nephrology *, Neurosurgery *, Neurology *, Neuropsychiatry *, Nuclear medicine *, Ophthalmology *, Orthopaedics *, Otorhinolaryngology *, Pathological Anatomy *, Paediatrics *, Plastic Surgery *, Neurology and Phtisiology *, Occupational medicine *, Psychiatry *, Radiotherapy *, Radiology*, Rheumatology *, Tropical Medicine *, Accident and emergency medicine *, Urology *, Public Health *, Internal Medicine *, General medicine *, Special laboratory and diagnostic methods in haematology and transfusiology.
The sign * are marked specializations which in the case of Slovak Republic are included in Annex V of Directive 2005/36 / EC. In the event of such a qualification obtained in another Member State shall proceed in accordance with the so-called automatic system of recognition of qualifications according to § 36 paragraph. 1. point. a) To d). In cases where it is not possible to meet these provisions (underlined specialty), the procedure is also used in this document as specialist according to § 36 paragraphs 2-4 of the national Act 578/2004 Coll. on health care workers. So the specialisations indicated by asterix* are international recognised.

Subspecialisations'

In Slovakia, there is still no indication of the EU Directive specialization - in called sub specialization, which can be obtained upon passing the initial specialization in the art as its superstructure:

Specializations in so - called. subspecialties for doctors to have acquired specializations listed the above are: algesiology, acupuncture, andrology, epidemiology, foniatry, gerontopsychiatry, gynaecological sexuology, gynaecological urology, hygiene of children and youth, food hygiene, environmental hygiene, clinical occupational medicine and clinical toxicology, aviation medicine, mammalogy, maternal - fetal medicine, drug addiction medicine, medical informatics and biostatistics, neonatology, health protection against ionizing radiation, oncology in gynaecology, surgical oncology, oncology in urology, orthopaedic prosthetics, palliative medicine, paediatric endocrinology, paediatric gastroenterology, hepatology and nutrition, paediatric gynaecology, paediatric haematology and oncology, paediatric cardiology, paediatric immunology and allergology, paediatric anesthesiology, paediatric infectious disease specialist, paediatric intensive care, paediatric nephrology, paediatric neurology, paediatric ophthalmology, paediatric orthopaedics, paediatric otorhinolaryngology, paediatric respiratory medicine and phtisiology, paediatric rheumatology , paediatric emergency medicine, paediatric urology, preventive occupational medicine and toxicology, assessment medicine, psychiatric sexology, reproductive medicine inspection medicine, forensic medicine, physical medicine, ultrasound in obstetrics and gynaecology, health education, health ecology, general care of children and adolescents, health services at work.

Studies in subspecialty are built on some of the major related specializations and takes two or three years.

The certified medical activities for physicians include:

abdominal ultrasonography in adults
diagnostic and interventional oezofago - gastroduodenoscopy
diagnostic and therapeutic colonoscopy
adolescent medicine
echocardiography
endoscopy of the respiratory system
endoscopic retrograde cholangiopancreatography
pharmacoeconomics
chemotherapy of infectious diseases
interventional radiology
invasive diagnosis and interventional treatment in cardiology
clinical trials in medicine
comprehensive diagnostics and therapy in congenital and acquired disorders of haemostasis
drug addiction medicine
perfusiology
physical medicine
productive and therapeutic haemoferesis
psychotherapy
processing, cryopreservation and quality control of stem cell transplants
transplantation of hematopoietic stem cells
quality assurance in transfusion medicine

Regarding the activities of certified medical practitioner acquired a certificate for different activities, varying study duration and the necessary practice and the different ways to build on the basic specialization exist. For each certified health activities, the minimum standards are issued by the Ministry of Health.
For all specializations, and sub - specializations, certified medical activities, the Ministry of Health has published minimum set of standards for study and practice.

Continuing education and training

Another type of education of health workers is the so-called continuing (medical) education (CME)

Financing of education

Post-graduate training of health workers can be paid:
▪ by means of employers
▪ from the total budget of autonomous regions or municipalities
▪ from the total budget, health insurance companies,
▪ by reimbursement of medical workers who are adult learners,
▪ from the state budget,
▪ by funding from the foundation and other legal entities and natural persons,
▪ from other sources.

Funding from the state budget is now not eligible and amount of payment for post-graduate training of health workers is determined by a special regulation

Continuing education is governed by the law of health professionals No 578 / 2004. According to the law, lifelong learning is the duty of health workers. It may be filled by specialization course and certification training in an accredited educational institution, but especially by fulfilling the individual components of continuing education , the individual components of continuing education, as defined in the Regulation of the Slovak Government on ways to further education of health professionals (No. 322/2006 Coll, as amended) referred to in its Annex No. 1

INGREDIENTS of the continuing education and training of health workers are:

A. **Immeasurable component**
1. Self - study in the relevant field,
2. Exercising the professional medical practice at relevant field.

B. **Measurable component**
1. The single educational activities at the local level or local level (typically a course or training not exceeding three hours duration organized in smaller functional clusters such as workplace health care provider, including expert working sessions in smaller functional units for employees of the provider and single training activity organized at the district level which exceeds the minimum duration of three hours and is less than five hours).
2. The single training activity organized at the district level, which have the minimum duration of five hours,
3. One training activity organized at the regional level, which have the minimum duration of

five hours,
4. The single training activity organized at the national level with the expected number of participants over 200, which have a minimum duration of five hours,
5. The single training activity organized at the national level with the expected number of participants more than 500, which have a minimum duration of five hours,
6. Professional internship at an accredited workplace of health care provider, which aims to deepen knowledge under the expert supervision of a healthcare professional with appropriate professional qualifications for other work in other workplace as is the usual place of health care professional
7. Accredited educational activities,
8. Educational activities by the participants themselves, within the framework of theoretical and practical training in a professional, specialized training, or certification in courses, educational activities, or professional training under leadership and teaching of vocational subjects in the field of study, by which is obtained a professional qualifications for pursuing the medical profession, or lecturing in the form theoretical, or theoretical and practical work in an accredited educational program of continuing education, organized by educational institutions, chambers, professional societies of Slovak Medical Association or other internationally recognized scientific societies, or professional associations and providers
9. Publications in the periodical or non-periodical publications which have a technical nature and their content relates to the medical profession and health care
10. Research activities, such as participation in research projects and research intentions regarding the field of medicine.

In the case of doctors, some educational activities (1-5 and 7) are credited and accredited by organization, that it has obtained authorization from the UEMS-EACCME® and that acts now as a National Accreditation Authority for CME. A member of this authority was the Slovak Medical Chamber. The conflict arose then, when the Slovak Medical Chamber, which legally controls the execution of individual doctors in the educational CME cycle, left this SACCME authority. Chamber blamed the lack of transparency in the allocation of credits and checked by primarily for live events, often sponsored by pharmaceutical companies and has launched its own CME system with electronic control and with participation by the committee evaluating quality. These activities Ministry of Health still refuses seeing the SACCME as the only crediting authority. That's why Slovak Medical Chamber addressed the main founder of SACCME - that became a civic association – the Slovak Medical Society, which was co-founder of SACCME, to the signing of a memorandum on the joint action. It should be signed at the next congress of the Slovak Medical Chamber in September 2015.
Here are the organizations controlling CME in healthcare sector in Slovakia

Slovak Medical Chamber http://www.lekom.sk/
Slovak Chamber of Dentists http://www.skzl.sk /
Slovak Chamber of Pharmacists http://www.slek.sk/
Slovak Chamber of Nurses and Midwives http://www.sksapa.sk/
Slovak Chamber of other health care professionals, assistants, laboratory assistants and technicians http://www.skvvzp.sk/
Slovak Chamber of dental technicians http://www.zubnytechnik.sk/
Slovak Chamber of laboratory technicians, assistants and technicians http://www.sekmtp.sk/
Slovak Psychologists http://www.komorapsychologov.sk/
Slovak Chamber of orthopaedic technician http://www.skort.sk/
Slovak Chamber of physiotherapists http://www.fyzioterapeutov.sk/

Slovak Medical Society http://www.sls.sk/
Association of Private Physicians http://www.aslsr.sk/
Association of paramedical schools http://www.aszssr.sk/

To know more about the education of health professions see the following materials:

Education for Health Professionals in the Slovak Republic. (ISBN 978-80-969507-6-8) [RTF]education of healthcare professionals in the slovak republic www.health.gov.sk/Zdroje?/.../Education_of%20He

Accreditation of Further Education for Health Professionals ACCREDITATION – Ministry of healthcare in slovak Republic www.health.gov.sk/Zdroje?/.../Accreditation_of_Fur.. .

2. Events in the healthcare system in Slovakia at the professional level

In this section we will discuss nor the introduction of the new technologies treated, nor the success or problems of medical science and clinical research.
In terms of the Slovak Medical Chamber for the main event of the year we consider the beginning of the transformation of primary care. Within it began to strengthen the professional competence of physicians in primary sector. It started with the first steps and we hope that competent authorities will not stop a big cleaning in ambulatory care: doctors in primary sector should gradually gain competences in diagnosis and treatment, initially on frequently occurring, and costly chronic "lifestyle" diseases, such as high blood pressure, diabetes mellitus, chronic bronchitis, Alzheimer's disease, or depression.
Development in the provision of primary health care has long been unsatisfactory. During the reign of communist, physicians in primary sector undervalued and gradually, even after the change of the political system, they became the only kind of dispatchers between them, specialists in outpatient care and hospitals. Gradually lost their clinical skills and the fourth generation of primary care physicians after World War II have forgotten what all the ancient predecessors have done. The resulting poorly managed health care system began to suffer from fragmentation and uncoordinated activities, waste of financial and human resources, and the generally low efficiency. The number of visits to doctors in Slovakia is the highest in the EU, reaching 12 to 13 visits per year. These intentions of the Ministry of Health encounter some resistance of ambulatory specialists, who are worried about their ambulance in which they invested considerable resources. However, this is not to be a desired situation in the care. The specialists must receive only complicated, but not neglected cases referred to above diseases from the primary care. This, however, requires general practitioners to regain the skills. It requires reshape their financing in a combination of capitation payments, payments for services and payments for results. This should be done to improve the professional inspection activities of the primary sector, not only by health insurance companies, but also by the relevant specialists. They should have fewer, but more complex patients and financial volume of existing fees must not be reduced.
Primary sector doctors in their work should be promoted not only by nurses, but also by the social sector, carers and other workers, in order to strengthen community level of primary health care.
We consider it important and indeed, but important the launching of the resident program for those interested in obtaining specialization of primary care physician. It has become one program for the young doctors who will participate on specialist training funded by a third party.

In the resident program may sign up:
1.First graduates of medical school, immediately after graduation.
2. Other graduates of medical faculties - condition: age to 36 years, even the non-inclusion of any specialized study,
b. already enrolled for the specialized study, which is scheduled to end at the earliest 10.31 2015
Financing resident program and the residents themselves will be ensured first year from the EU, then from the national resources and will consist of:
Money for wage compensation on medical worker, studying in specialized study.
From a health professional expenses, for studying specialized study at expenses for specialized training and paid to educational institution pursuant to a special regulation
From a health professional expenses for studying in the specialized training paid educational institution for carrying out the final specialization exam fee, for issuing a diploma of specialization, according to a special regulation.
Currently, the enrolment for first year is closed, and the program will be attended by 130 doctors.
The Ministry of Health, as well as Slovak Medical Chamber are hoping that the gradual replacement of older physicians in primary sector by younger graduates in resident program will reduce the average age of these doctors, who at that time are 55 years old.
Placing residents will happen to the demands of self-governing regions. Just placing residents could be the problem because there is not a defined and legally correct procedure for the exchange of older doctors, and fair phasing out of their permits.

3. Activities of the Slovak Medical Chamber
Primary event in the life of the Slovak Medical Association is its annual general assembly, The last one took place on 19 and 20 September 2014
Some assembly resolutions are presenting here by the Slovak Medical Chamber
a. In a resolution in the paragraph No 6 of the General Assembly is written, that the Slovak Medical Chamber rejected in the censure vote, suspension of ´the current the President of the Chamber
b. Assembly have noted the report of the Council of the Slovak Medical Chamber, its bodies, committees and sections.
c. Assembly approved the contributions of members to 2015 in the amount of € 119 for physicians aged 30 to 65 years and the contribution to the activities of the medical register
d. The Assembly approved the weighty document – "Medical deontological code (code of ethics)" - and obligate the bodies of the Chamber and its members to follow him. So far, the Chamber managed health care professional with code of ethics, adopted by the Parliament of the Slovak Republic back in 2004 and left it unchanged. Slovakia is perhaps the only country in the world, where Parliament has defined professional ethics of the members of professional associations in healthcare, irrespective of their voluntary membership ...
e. The Assembly approved an amendment of the Code for the Protection doctor
f. General Assembly amended several other regulations of the Slovak Medical Chamber
g. It also has signed several resolutions on the need to create an integrated health care system, but rejected its actual shape. Assembly called for more transparency in the process, fairness and professional public participation in its creation, as well as clear and accurate information campaign to the citizens of the Slovak Republic.
h. The Assembly instructed the Council of the Slovak Medical Chamber of organizing a professional conference on the integration of health care with the participation of professional public, as well as experts and officials from the Ministry of Health.

i. The assembly took note of the material tasks and objectives presented by the president of Slovak Medical Chamber and endured it for a wide debate to its members. Slovak Medical Chamber in this material considered necessary:
a) to define an optimal network of outpatient care,
b) to take its own control of the competencies, professionalism and ethics of providers of ambulatory health care
c) to improve the process of filling of posts for doctors in outpatient health care network with the participation of the Slovak Medical Chamber

Expert Conference on integrated healthcare was held in December 16, 2015 at the Ministry of Health. Subsequently, in January 2015 the representatives of the Slovak Medical Chamber attended the hearing organised by representatives of the European Commission in Slovakia on the introduction of an integrated health care. The reason for involvement of the European Commission is, that despite initial disapproval, it finally nodded funding for infrastructure of primary health care in so-called integrated centres in the amount of 140 million € and infrastructure financing of selected hospitals in the amount of 150 million €. After said hearing it has been held a teleconference with some experts from the ES. The Chamber sent his comments to ES in a written form.
Since March 2015 to June 2015, representatives of the Chamber participated in the so-called "round tables" on integrated health care.

Slovak Medical Chamber also had actively participated in the so-called commenting rounds of draft laws, which affected health. Most of the comments were-as usual-rejected. These draft laws submitted to the government amendment and finally to the Parliament were accepted without our comments. The comments covered among other things, compulsory membership doctors performing medical care in the medical chamber, and if not, extending competences or Slovak Medical Chamber to all registered doctors. Very important comments were those related to the functioning of the so-called minimum network of health care providers as well as defining the so-called optimal network. Views were sought on the management of waiting lists of doctors - applicants for admission to outpatient care - and mechanisms of their entry procedure, regulated under participation of the Slovak Medical Chamber.