Benefits and risks associated with managed care

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The article aims to introduce the concept of managed care by providing a brief overview of its fundamentals, origins and application, its main elements as used around the world, the motivation for introducing managed care, its main benefits and risks as well as an overview of managed care and its perception by health insurers in Slovakia. The goal of this article is to provide the Slovak public with information on managed care in order to maximize the benefits and minimize the risks associated with its possible further implementation in Slovakia.

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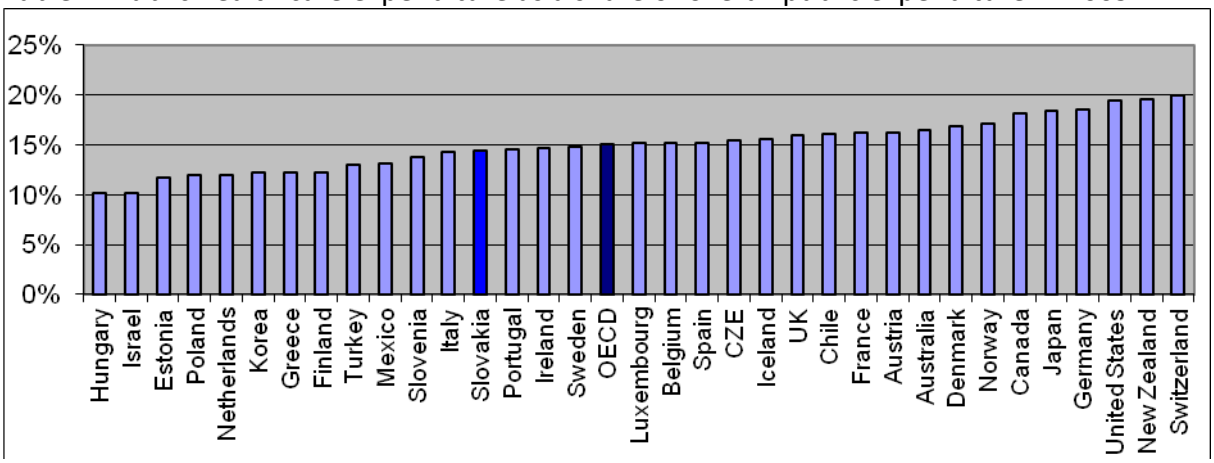
1. Introduction

The state should pay more. This reasoning is often offered as a solution to health care sector problems in Slovakia. However, this argument ignores the unfavorable state of public finances, as well as the fact that Slovak public health care expenditure is close to or even higher than that in similar countries. OECD figures on health care expenditure as a proportion of overall public expenditure confirm this. In 2009 public health care expenditure in Slovakia amounted to 14.4% of overall public expenditure, the OECD average reached 15%. In the Czech Republic the figure amounted to 15.4%, in Hungary it reached 10,1%, in Poland 11.9%, in Estonia 11.7% and in Slovenia 13.8%. Comparing data on public health care expenditure as a share of GDP or public health care expenditure per capita brings similar results. Importantly, such comparisons are only relevant when countries of similar wealth are taken into account. Richer countries usually yield higher figures, as the share of luxury services connected with health care grows with rising income.

Table 1: Public health care expenditure as a share of overall public expenditure in 2009



Source: INEKO based on OECD data (2002 for Netherlands, 2007 for Greece, 2008 for Turkey, Australia, Portugal and Japan)

Table 2: Public health care expenditure in 2009

	% GDP	Per Capita, USD, PPP	% total public expenditure
Slovakia	5,99%	1369,277	14,44%
Czech Republic	6,92%	1769,452	15,41%
Hungary	5,19%	1053,116	10,11%
Poland	5,32%	1006,058	11,94%
Slovenia	6,80%	1893,129	13,80%
Estonia	5,28%	1049,034	11,66%
OECD Average	6,95%	2273,19	15,02%

Source: INEKO based on OCED data

Rather than calling for an increase in public expenditure, especially when public finances are tight, we should look to reform the flawed system. Desirable and frequently discussed

measures include better regulation, allowing private ownership of hospitals – which goes hand in hand with professional hospital management, stronger competition in the health insurance sector, fees for low-priority treatments as well as fees for visiting a doctor and hospital stays (with exceptions or limits built-in for the most needy).

However, there is another way to preventing unnecessary costs, which has to date been but marginally discussed in Slovakia: managed care helps avoid duplicate or superfluous tests, prescribing expensive drugs when similar cheaper alternatives are available, rising hospital indebtedness as well as possible diseases and complications avoidable with the help of preventive care. The idea behind managed care rests on coordinating the use of health care by fostering cooperation between providers and insurers; and/or on motivating patients as well as health care providers by ensuring that they bear a part of the financial risk associated with the received/ provided care.

Fundamental characteristics of managed care include the following:

1. Providers work in groups, ranging from associations of independent providers to individual companies employing practitioners. Group members share clinical and financial risks.
2. Providers are paid based on "capitation" contracts with insurers or the insured. Providers regularly receive a fixed sum per insured regardless of the volume of services she is provided. In an alternative model a provider is compensated directly for delivered services (fee-for-service payments). By paying providers fixed sums, managed care discourages them from carrying out unnecessary procedures to inflate costs and revenue.
3. Providers actively participate in managing health care alongside insurers and the insured; they share the costs as well as the associated risks.
4. Modern managed care programs use motivational means such as awarding points to reward desired und discourage unwanted behavior in the insured (for example the insured may gain certain benefits in exchange for points they earned).

Among the main advantages of managed care are the following:

1. Higher efficiency of health care provision, meaning providing health care in similar quality and extent with lower costs, or improving the quality of services without raising costs. Higher efficiency is achieved mainly by making insurers, providers and the insured share financial risk.
2. Providers and pharmaceutical companies are less motivated to inflate costs by prescribing unnecessary or unnecessarily costly tests and treatments or disregarding preventive care.
3. Reduced information asymmetry due to insurers, who are better informed about delivered health care, leading to fewer negative effects of the providers' information advantage.

Main risks of managed care include:

1. Cost cutting may result in lower quality services if competition in the insurance market or state oversight and health care quality enforcement are insufficient, or if there is significant information asymmetry in the market (if the insured, compared with providers and insurers, lack information on costs and quality of treatments).

2. Less competition or even the emergence of monopoly structures in both provider and insurance markets due to closer relations between providers and insurers as well as between insurers and their insured.
3. More difficulty in receiving services from providers not included in a contract (the level of difficulty depends on the way a particular contract deals with services from outstanding providers).

In our opinion, the main barriers to managed care provision in Slovakia include a vague definition of services paid for from public expenditure, lacking competition in the insurance market, inefficient management of large hospitals, high information asymmetry between health care providers and patients as well as insufficient oversight over and enforcement of treatment quality. Addressing these barriers could help minimize the risks associated with managed care.

2. Managed Care

The basic idea behind health insurance is that in exchange for a fee paid by the insured an insurance company covers the costs of her health care to an agreed extent (or to the extent required by law). Thus the insurance company takes on the risk of possible health care costs, in other words, if the need for health care services arises, the insurance company covers the costs. The insurer's risk may be higher compared with the hypothetical risk borne by an uninsured person herself. If she were uninsured, chances are, she would try to keep her costs down by paying for the optimal amount of treatment. Her responsibility for her health care costs would be associated with a high risk. However, if she pays an insurance company to take on her risk and is herself no longer directly responsible for her costs, her risk declines. It is likely she will receive more treatment than necessary. The amount of financial risk associated with health care delivery also depends on the providers' motivation. If they do not share the risk the probability of increasing costs tends to be higher.

Managed care lowers the risk transferred to the insurance company. The idea behind managed care is based on coordinating healthcare to prevent unnecessary or avoidable claims within the delivery of services while maintaining the required level of quality. Such claims include duplicate or superfluous tests, prescribing more expensive medication when cheaper alternatives are available, excessive hospitalization or claims resulting from the occurrence of illnesses and complications that can be avoided with prevention and quality therapy. The health care provided can be coordinated based on insurer-provider cooperation defined in the contract; and/or on motivating patients as well as health care providers by ensuring that they bear a part of the financial risk associated with the received/ provided care.

Individual managed care systems around the world vary by the goods and services provided as well as by the difficulty of obtaining services outside the contractual network. Older systems typically allow the insured to seek outstanding services only when referred by their general practitioner or if they pay extra. Newer systems seek to motivate patients stay within their network by awarding benefits if they do. If the insured venture outside their network, they lose benefits, points needed to obtain them, etc. A guaranteed status quo for the insured is also common, meaning entering a managed care system may only bring advantages, no penalizations occur.

Managed care as a system is an alternative to uncoordinated health care delivery. Here the insured freely choose and alternate their providers. No system of integrated services aimed at providing the best quality at the lowest cost possible is in place. In other words, patients' choice of providers is unlimited. Providers decide on (or recommend) treatment, with neither them nor their patients bearing financial risks or answering to incentives associated with the choice.

Fundamental characteristics of managed care include the following:

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3. Providers actively participate in managing health care alongside insurers and the insured, they share the costs as well as the associated risks. Providers decide on most suitable treatments. However, when diverging from recommended procedures, providers should be able to justify their decisions.
4. Modern managed care programs use motivational means such as awarding points to reward desired und discourage unwanted behavior in the insured (for example the insured may gain certain benefits in exchange for points they earned). Similar motivational means may be used in relation to providers.

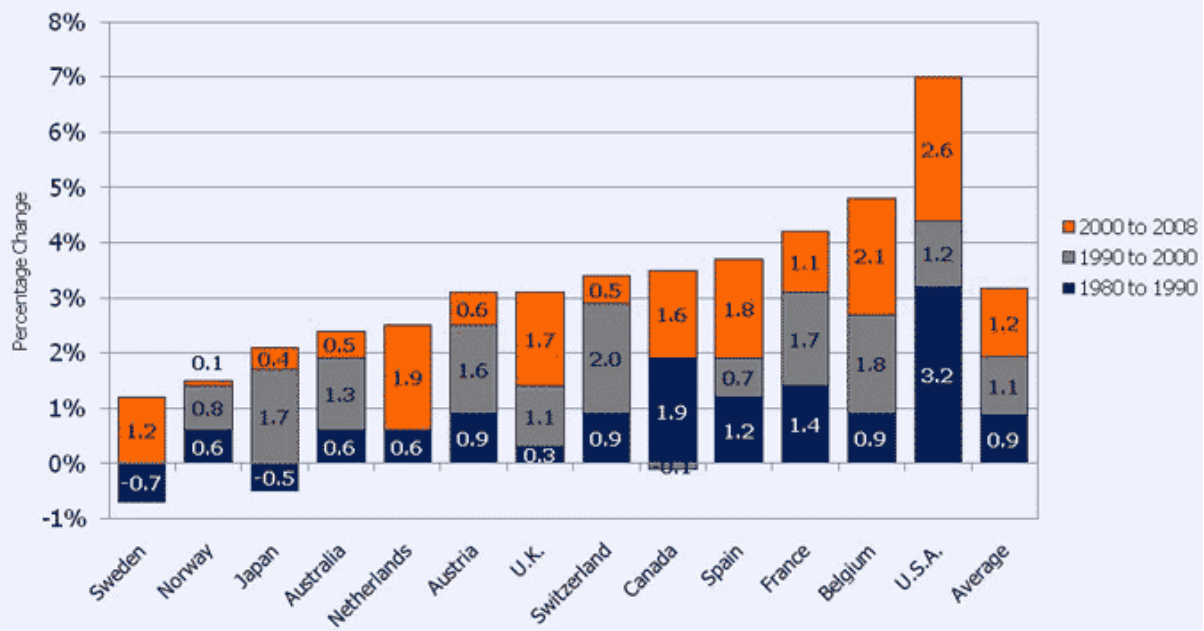
3. Managed care origins and rationale

Managed care formally originated in 1973 in the USA with the signing of a law allowing the creation of HMOs (health maintenance organizations). HMOs are both for-profit and non-profit insurers that finance healthcare for their insured from selected providers based on pre-defined rules. This signaled a shift from traditional, generally non-profit healthcare financing (e.g. fee-for-service plans or indemnity plans). In traditional systems patients had an unlimited selection of providers. They had not agreed on specific rules with their insurers limiting their choice to a specific network of providers, in order to better manage their health care. Another difference between HMOs and indemnity plans rests in financing providers. Indemnity plans are based on benefits in cash. Patients pay for care directly to the provider and are later reimbursed by their insurer in cash. Conversely, HMOs work on the principle of benefits in kind, meaning a patient receives the majority of healthcare services free of charge (without any direct payment) and insurers reimburse the majority of costs of those services directly to providers.

Managed care was created in reaction to a sharp rise in health care costs. It was also created as an alternative to state control of costs, administered through public budgeting (providers received a budget, which effectively limited their costs, costs above the budget were not reimbursed) or via state decisions on what services the insured were entitled to based on their age, health state, etc.

The goal of these changes was to slow down the rise of medical costs and to increase health care quality at the same time. Indeed, a slower growth in US healthcare costs along with improvements in efficiency and competition for funding occurred in the 1980s (see graph). However, patient surveys carried out in the end of the 1990s also showed patients believed cutting costs came at the expense of service quality. Furthermore, in health care as well as in other sectors, the 1990s saw an increase in competition for customers, who demanded ever more personalized products. Discontent with the limited selection of providers emerged as more patients than before demanded the right to choose their services and providers. Several states reacted by introducing stricter controls on health care quality, while insurers responded with a wider range of health care plans as well as a loosening of the tight oversight of costs within managed care. A sharp rise in health care costs since 2000 was one of the consequences.

Graph: Change in the health care costs to GDP ratio in selected OECD countries



Source: Kaiser, 2011 (a)

The graph shows that the USA saw the sharpest rise in health care expenditure in the 1980s (the health care expenditure to GDP ratio grew by 3.2%), 1990s brought about a significantly slower growth, while the new millennium saw another sharp rise.

The origins and importance of managed care in the US were influenced by the specific US financing structure of health care, where several health insurance modes coexist side by side (INEKO, 2009):

1. Traditional insurers (fee-for-service plans or indemnity plans). Traditional insurers reimburse treatment selected by the insured from any provider. Due to broad provider accessibility traditional insurers are more expensive than insurers with a limited provider network. The insurer does not cover the full cost of treatment; patients pay a basic fee themselves. Patients also share a part of the costs above this fee; however, for the most part they are covered by the insurer. Insurers generally

define an annual ceiling for patient expenses. Costs exceeding this ceiling are reimbursed by the insurer in full. From the patients' point of view, traditional insurers are more demanding in terms of administration as they require completing forms in order to reimburse costs of care. Traditional insurers' market share among employers dropped from 73% in 1988 to 1% in 2011.

2. Managed care organizations. Managed care insurers primarily pay for treatment from selected providers (emergencies such as injuries may be an exception). Due to established relations with providers, treatment is cheaper. Managed care organizations' market share continues to rise. Nearly all US employers currently conclude contracts with a managed care organization. These include:

    a. Health Maintenance Organizations (HMO). The majority of HMOs are for-profit insurers. HMOs place patients with selected providers with whom they closely cooperate or whom they employ. Payments are agreed upon in advance. A key role is played by general practitioners (GPs). GPs decide on their patients' further treatment in accordance with HMO standards (thus they are also called Gatekeepers). HMOs as insurers cover nearly all costs associated with treatment; the patient pays but a small proportion. HMOs are less demanding regarding administration from the patients' point of view as health care costs in the HMOs network of providers are more easily controlled. The share of HMOs in the employers' market has risen to 31% in 1996, but has since fallen to 17% in 2011.

    b. Preferred Provider Organizations (PPO). PPOs are provider associations, which conclude contracts with multiple insurers or employers. Based on these contracts they offer the insured more favorable conditions. Compared with HMOs, those insured by PPOs have better access to providers outside of their network (e.g. they need no referral from their GPs). However, they still pay more and have to fill in forms in order to be reimbursed. Those insured by PPOs generally pay more in additional fees than HMOs patients. The market share for PPO insurance among employers increased from 11% in 1988 to 55% in 2011.

    c. Point of Service (POS). Like HMOs, POSs assign a key role to GPs, whom the insured choose within the insurers' network. The GPs become patients' 'point of service,' deciding on their further health care. Like PPOs, POSs allow treatment outside of insurers' networks. However the insured face higher additional fees and are also responsible for administering all outstanding payments. The share of POS in the employers' market increased to 24% in 1999, but has declined to 10% in 2011.

3. High Deductible Health Plans with Savings Options (HDHP/SOs). HDHP/SOs are all Indemnity plans, HMOs, PPOs and POSs, that fulfill two conditions:
    - The premium may be lowered by a deductible if the insured agree to directly cover their costs up to a certain level. Only costs above this level are covered by the insurer. In 2011 the deductible amounted to $1000-1200 per person or $2000-2400 per family.

- The insured or employers are allowed to save for their direct payments in special accounts.

The share of HDHP/SOs in the employer market grew from 0% in 2005 to 17% in 2011. It is primarily used by larger companies with more than 1,000 employees.

Table: Individual insurance programs' market share in the employer market by number of employees

	Traditional insurers	HMOs	PPOs	POSs	HDHP/SOs
1988	73%	16%	11%	0%	0%
1993	46%	21%	26%	7%	0%
1996	27%	31%	28%	14%	0%
1999	10%	28%	39%	24%	0%
2003	5%	24%	54%	17%	0%
2006	3%	20%	60%	13%	4%
2011	1%	17%	55%	10%	17%

Source: Kaiser, 2011 (b)

This table highlights the development of the various forms of managed care, currently used by nearly all US employers. PPOs are the most common, as they offer favorable conditions to insurers and employers but allow patients to seek treatment outside of their networks as well. The table also shows a sharp rise in demand for plans with deductibles.

Multiple analyses explore the rise of managed care and its influence on health care costs and quality (see Miller, 1997; CBO, 1994; Cutler, 1997). According to Cutler, in 1997, only 5% of privately insured Americans made use of managed care in 1980, in 1987 the proportion rose to 25% and in 1995 to 75%. The proportion of those insured with HMOs, the strictest form of managed care, rose from 16% in 1987 to 48% in 1995, while the share of those insured by PPOs rose from 11% to 25% over the same period. However, substantial differences exist between individual states. While 80% of privately insured Californians subscribed to managed care, the share was close to zero in Alaska or Wyoming. According to Cutler's study the average per capita health care expenditure in California in 1980 was 17% higher than the national average, but fell back to the national average level by 1993. Similar comparisons show that a **10% rise in insurance by HMOs may amount to a 0.5% slow-down in the growth of health care expenditure annually. Cost savings arise mainly due to cutting back on the length of hospital stays, while the number of hospital stays remains unchanged.**

Among the largest US managed care providers is Kaiser Permanente, a company insuring 8.7 million Americans and employing 167, 000 employees, including more than 14,000 doctors. The insurance branch of Kaiser Permanente operates as a non-profit while providers are for-profit businesses. Within managed care, Kaiser Permanente places emphasis on preventative care, compensating doctors with fixed incomes rather than for particular procedures as well as on chronic illness management, which emphasizes out-patient care in order to minimize expensive hospital stays. (Source: Wikipedia: Kaiser Permanente).

Managed care is currently experiencing a renaissance in the USA, enjoying popularity among an increased number of the insured. Managed care attracts employees, whose employers no longer cover the full extent of their ever rising insurance fees. Employees instead receive a fixed grant to use towards a medical plan of their choice. The demand for managed care is also associated with the government-funded Medicaid program, designed to cover medical care costs of poor Americans working with both non-profit and for-profit private insurance companies. Medicaid is the largest healthcare program in the USA, at least one in five Americans used Medicaid in 2011, for a minimum of one month. Since the 1990s the share of Medicaid clients who receive managed care increased to 72% in 2009 and continues to grow (source: The Economist, 2011).

4. Main elements of managed care and their application

A free choice of health care provider is the norm in Slovakia as is in most of Europe. However, several characteristics of managed care are used around the world, Slovakia being no exception:

- Insurers conclude contracts with selected providers, which are compensated with standard fees as well as for fulfilling quality and efficiency criteria agreed upon in advance.
- The initial approval of a revision practitioner is necessary for further treatment.
- Analyses of health care consumption are carried out.
- Generic substitution or prescription is used.
- Capitation, i.e. the premium paid to providers is based on the number of those insured rather than on the number of performed treatments.
- Emphasis is placed on a transition from in-patient care to single-day out-patient care.
- Until April 2011, referral letters from GPs were a requirement for an appointment with a specialist in order to regulate patients' access to the provider network (gate-keeping function).

While managed care has above all flourished in the USA, another example is the UK's National Health Service (NHS). It consists of four state companies, integrating health care provision and financing. The UK shows that managed care is not limited to the private sector. The majority of the US population use plans with some elements of managed care. Apart from those mentioned, further practices are typical of managed care:

- Managed care and standardized treatment for chronically ill and other seriously ill patients (disease management programs).
- Search for high risk individuals among the insured, healthcare consulting and multiple provider coordination in order to avoid complications and serious illnesses (case management).
- Higher additional fees for patients who choose expensive treatments when less costly alternatives with similar effects are available and those who select treatment outside their network.
- Provider cooperation for better coordinated patient care (e.g. sharing and exchanging health information, diagnostics, treatment and therapy results, planning hospital admission and discharge and patient transfer to after-care).

- Integrating provider and insurer motivation to choose more cost-effective treatments while maintaining a required level of quality and achieving comparable improvements in patient health.
- Selecting standard treatments based on analyses of previous treatments and achieved results.
- Healthy lifestyle, illness and disease prevention counseling.
- Using bonuses and/ or financial motivation to stimulate the insured to choose providers within their networks.
- Bonuses and/or financial motivation for the insured who maintain a healthy lifestyle and make use of preventive care (e.g. motivational plans based on bonuses for desired behavior such as exercise, buying healthy foods, meeting appropriate goals, safe driving). Among the best developed motivational programs is The Discovery Group's Vitality program in South Africa.

5. Rationale for introducing managed care

Within the insurer – provider – patient triangle, insurers have the most obvious interest in introducing managed care, as they cover the majority of healthcare costs. They are thus naturally motivated to keep their costs down and, in a healthy competitive environment, also to spend efficiently. Indirectly, this may also be in the interest of the providers, if for example, lower costs translated into bonuses. Patients may also be interested in lowering costs. However, there are two obstacles to patient motivation:

1. If additional fees for treatments are low or non-existent and the insurance fee is fixed and regulated (as is the case in Slovakia), patients are not motivated to lower the costs of treatment.
2. If patients are interested in lowering costs, they will most likely lack information on the need for, structure and the price of the offered treatment (there is typically an informational imbalance to the disadvantage of patients, providers and insurers generally have more information).

Patients, on the other hand, have an obvious interest in raising the quality of the care they receive. As long as there is competition in the insurance market, insurers are also keen on maintaining a high level of quality. Providers will be motivated to provide high quality services, if competition in the provider market is functional and the informational imbalance is low.

States use a wide variety of measures to regulate these relations. They may regulate health care quality standards, patient fees, supervise the quality of provided services, define minimum standards of provider networks, directly own providers or regulate prices of services. Generally, the state's ultimate goal in health care is to provide the broadest possible access to quality services, while keeping the state's limited resources in mind. However, in a non-transparent environment this goal may be hindered by corruption or conflicts of interest, especially if the state finds itself both in the role of a regulator and an owner of insurance companies and health care providers. But the state-funded Medicaid program in the United States and the British NHS system show that regulation and managed care need not be mutually exclusive.

6. The benefits and risks of managed care

Benefits of managed care include:

1. Managed care may increase the efficiency of provided healthcare: it may secure the same extent and quality of healthcare for less money or more health care of better quality for the same money. This may be achieved by making providers and the insured co-responsible for costs, through better coordination of treatments and providers, an emphasis on preventive care, healthy lifestyle, risk factor and patient tracking, early diagnostics etc. Competition among providers and insurers plays an important role. Decreasing the information imbalance by providing patients with more information on services and their prices is a key element in increasing patient participation in lowering costs.
2. Managed care prevents providers from inflating costs through unnecessary treatments, duplicate tests, lack of preventive care, prescribing more expensive drugs etc. Managed care equips insurers with better tools to manage health care costs, including provider compensation.
3. Managed care helps resolve the issue of information imbalance. A better informed insurer has a better overview of provided healthcare and can limit the negative effects of the providers' informational advantage when deciding about treatment. This saves patients transaction costs associated with treatment (cuts the time necessary to decide on a provider, brings benefits from better treatment coordination, etc.).
4. Managed care may help balance the unlimited desire for good health with limited public resources. This may manifest through limiting provider debt or shortening health care provision delays, which result from insufficient funds.
5. Managed care may foster innovation in monitoring and compensating services as well as monitoring patient health. Thanks to innovation, insurance companies may develop faster and generate more competition in the market.

Risks of managed care include:

1. Cost cutting may result in lower quality services if competition in the insurance market or state oversight and health care quality enforcement are insufficient, or if there is significant information asymmetry in the market (if the insured, compared with providers and insurers, lack information on costs and quality of treatments).
2. Less competition or even the emergence of monopoly structures both in provider and insurance markets due to closer relations between providers and insurers as well as between insurers and their insured.
3. More difficulty in receiving services from providers not included in a contract (the level of difficulty depends on the way a particular contract deals with services from outstanding providers).

7. Managed care in Slovakia

We approached Slovak insurers to find out whether they have made use of managed care or are planning to. The general conclusion is that Slovak insurers do not practice managed care by working with select providers and insured. However, all Slovak insurers use certain elements of managed care, while the insurers Všeobecná zdravotná poisťovňa and Dôvera are currently considering introducing further managed care practices. Dôvera is planning to introduce '*motivational programs for the insured, aiming to reward a responsible attitude to*

one's health.' The insurer Union completed three separate managed care projects from 2007 to 2009 (e.g. managing diabetes mellitus patients), however all three '*have been put on hold as the results did not yield the expected benefits.'*

The next section offers insurers' answers to the following question: '***"What managed care elements do you currently use or plan on introducing in the foreseeable future?"***

Všeobecná zdravotná poisťovňa (VšZP health insurer):
'*VšZP currently does not use any complex (integrated) managed care system (i.e. a managed care program with selected providers and patients). VšZP currently makes use of some managed care elements with the goal of securing the basic goals (increasing efficiency/ decreasing costs and increasing quality from the patients' point of view). Individual measures used at the time being include:*

- *Motivating providers to cut medication costs (the savings are mirrored in the prices of provided health care). This project is being implemented in general adult, child and teenager out-patient care and in specialized out-patient care. Simultaneously, providers receive information in the form of reports and benchmarking.*
- *Supporting prevention programs with the aim of decreasing future health care costs. VšZP regularly evaluates and adjusts its preventive programs as needed in order to use programs which benefit patients the most.*
- *Mechanisms designed to provide higher patient comfort combined with lower costs (e.g. VšZP does not cover hospital stays if out-patient care is sufficient for the relevant procedure).*

VšZP is considering using further (adequate) managed care programs in the future.'

Zdravotná poisťovňa Dôvera (Dôvera health insurer)
'Managed care introduced the majority of measures commonly used by insurance companies providing public health insurance today. Tools we regularly use include:

- *Motivating out-patient care providers to avoid over-prescribing lab exams and drugs. This is achieved by determining provider compensation based on an evaluation coefficient, which compares providers with the mean within their specialization. Simply put, the more drugs, lab tests and hospital stays above the standard deviation from the mean providers prescribe, the lower their evaluation coefficient will be.*
- *Revision practitioners' prior consent with more expensive treatments, medication or healthcare resources.*
- *Capitation, where providers are reimbursed a fixed monthly fee for providing services to a group of registered insured.*
- *Consumption and efficiency data analyses of provided health care (utilization reviews and claims management).*
- *We are preparing motivational programs for the insured, aiming to reward a responsible attitude to one's health.'*

Zdravotná poisťovňa Union (Union health insurer):
'1. *Daily patient management of health care providers based on individual requirements and situation specifics. If a client requests a new provider due to problems with her PZS*

(healthcare providers – note by INEKO) regarding health care provision, a revision practitioner selects a similar alternative to provide health care among our PZS. The same procedure is followed if providers face capacity problems regarding waiting lists for treatments. In a particular case we arranged for cardio care from a new provider in a short period of time when the original provider could not provide coronary catheterization on time. We would like to point out that our waiting lists are kept to a minimum and we monitor them continuously in order to respond swiftly, as was the case with coronary catheterization.
We keep track of patient complaints and requests regarding health care. We also evaluate compliance with quality criteria within individual facility types and direct patients to higher quality facilities.

2. *On-going 'LIENKA' project*
With the aim of introducing innovative, transparent and objective payment mechanisms, Union zdravotná poisťovňa, a.s. has launched the LIENKA project (Lab Indication and Efficient Definition of Criteria for their Acceptance). This is a pilot project based on an innovative system designed to increase laboratory diagnostics efficiency by using process management. Our standard diagnostic procedure model and a transparent definition of payment criteria for SVLZ procedures (common exam and treatment components - note INEKO) form the premise for providing quality health care as well securing efficient, economic and targeted public health care expenditure.
***Scope of project activities:** The standard procedure model will gradually be applied within individual lab medicine specializations: clinical, biochemistry, haematology and transfusion medicine, microbiology, generics, pathology, anatomy, clinical immunology and allergology, radiology, physical medicine, balneology and therapeutic rehabilitation.*

3. Aiming to efficiently spend public health insurance funds while using cutting edge treatment, we implemented the following projects in the course of 2007-2009:

- *Kidney transplantation among relatives*
- *TVT-tape implantation for stress-related incontinence*
- *Managing the insured – patients with diabetes mellitus*

The projects were implemented in cooperation with respective healthcare providers (personal visits to worksites across Slovakia), patient associations, as well as direct contact with the insured (call center, letters). All three projects have been put on hold as the results did not yield the expected benefits.'

8. INEKO recommendations

A complex managed care system based on closer insurer - provider cooperation and integration may result in more efficient services. An OECD analysis suggests the Slovak health care system presents room for improvement in terms of efficiency. According to the OECD, reforms in the Slovak health care sector could increase the average life span by four years, solely by raising efficiency, requiring no extra expenditure (OECD, 2010). Raising efficiency is a key condition to stability in the health care sector. Efficiency is becoming even more important in the face of unfavorable economic development and budget austerity as well as rising costs associated with ever more common chronic diseases, R&D in medication, procedures and equipment and population aging.

In our opinion, the main barriers to managed care provision in Slovakia include a vague definition of the extent of services paid for from public expenditure, lacking competition in the insurance market, inefficient management of large state-owned hospitals, high information asymmetry between health care providers and patients, insufficient oversight over and enforcement of treatment quality as well as a high concentration in the insurer and (to a certain extent) provider market. Addressing these barriers could help minimize the risks associated with managed care. In order to minimize these risks INEKO recommends:

1. A more precise and perhaps narrower definition of patient claims possible within publicly financed health care. A list of goods and services paid for by compulsory health insurance should be compiled and regularly updated, including detailed quality requirements such as maximum waiting time, technical and staff requirements, distance-from-provider requirements etc. The currently used catalogue of treatments may be used as a starting point.
2. More competition in the health insurance market. Possible measures include (1) dividing and at least partially privatizing VšZP and welcoming new companies into the market, (2) letting insurers create plans with varying deductibles and (3) introducing differentiated fixed nominal insurance fees, which would allow insurance companies to appeal to their clients.
3. More competition in the provider market. Possible measures include (1) privatization or long-term leasing of hospitals, (2) reversing the requirement that insurance companies conclude contracts with a set minimum provider network, etc.
4. Decreasing information asymmetry by providing patients with more information on the price and quality of services. Possible measures include (1) publishing regular insurer and provider rankings, including rankings of hospital departments and individual doctors, (2) introducing transparent receipts for goods and services, allowing patients to keep track of what they are paying for and how much.
5. Standardizing diagnostic and treatment procedures and substantiating insurance payments (e.g. by introducing a DRG system in hospitals).
6. Strengthening oversight over and enforcement of health care quality. Resolving the state's conflict of interest is crucial, as the state-controlled regulator also regulates state-owned providers. Allowing private investment in state-owned providers would be a step in the right direction.
7. Strengthening oversight over possible concentration in the insurer and provider markets.

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