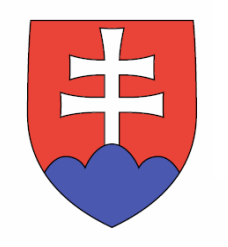

Ministry of Health of the Slovak Republic

Operational Programme Health

August 2007
Bratislava

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1 Document Summary

The Operational Programme Health (hereinafter "OPH") is a programming document of the Slovak Republic for drawing assistance from funds of the European Union (hereinafter "EU") for the healthcare sector for the 2007 – 2013 period. It contains the strategy, aims and also defines years-long measures to attain them, which are to be carried out with the help of national funds and of the European Regional Development Fund ("ERDF"). On the basis of Government Resolution of the SR No. 832/2006 of 8 October 2006, the Managing Authority for the OPH is the Ministry of Health of the Slovak Republic.

The OPH has been elaborated on the basis of Council Regulation (EC) No 1083/2006 laying down general provisions on the European Regional Development Fund (hereinafter referred to as "ERDF"), the European Social Fund (hereinafter referred to as "ESF") and the Cohesion Fund (hereinafter referred to as "CF") and repealing Regulation (EC) No 1260/1999, and of Regulation (EC) No 1080/2006 of the European Parliament and of the Council on the ERDF and repealing Regulation (EC) No 1783/1999.

Under the "Convergence" objective, supported can be on the level NUTS II, i. e. their 2000 – 2002 gross domestic product (hereinafter referred to as "GDP") per capita measured by purchasing power parity is less than 75% of the Community average. All regions of NUTS II of the Slovak Republic (Western, Central and Eastern Slovakia) except for the Bratislava region fulfil this condition. The West Slovak region consists of the following self-governing regions (NUTS III): Trnava region (TT), Trenčín region (TN), Nitra region (NR); The Central Slovak Region consists of the following self-governing regions (NUTS III): Banská Bystrica region and Žilina region; The East Slovak Region consists of the following self-governing regions (NUTS III): Prešov region and Košice region.

The OPH strategy creates conditions for the convergence of the Slovak Republic (hereinafter referred to as "SR") towards the EU level in the area of healthcare. Concurrently, it helps considerably to keep the overall SR economy convergence to the EU-15 average in line with sustainable development.

The OPH ties up with the objectives and priorities of the National Strategic Reference Framework 2007 – 2013 (hereinafter referred to as "NSRF") as the basic programming document of the SR for cohesion and regional policies, whereas the OPH implements and details the specific priority of the NSRF "Modernisation of Healthcare Infrastructure".

The introduction part of the document shortly describes the process of document preparation, partnership principle implementation, the results of ex-ante evaluation and of the strategic environmental assessment.

The analytical part of the document provides information about the population health condition in the Slovak Republic, health care system (hereinafter HCS), health infrastructure, material-technical base and equipment of inpatient and outpatient healthcare providers in the Slovak Republic. Results of analyses together with the experiences of the programming period 2004 – 2006, the SWOT analyses, definition of the main disparities and development factors are the backgrounds for identification, specification of needs and strategic directing of the investments from the ERDF.

Strategic plan follows the results of the complex analysis, defines regional focus in the context of innovation and cohesion growth poles and the thematic focus of intervention into the inpatient

and outpatient health infrastructure. The OPH strategy focuses mainly on the development of the conditions necessary for the improvement of quality of the provided healthcare through the modernisation of healthcare infrastructure with the aim to improve the economic effectiveness, strengthen the economic and social cohesion and achieve harmonised, balanced and sustainable development. Fulfilment of this programme context shall bring benefits in the form of diminishing economic, social and regional differences, which arose in the past and are connected with the ongoing economic and social restructuring and with aging of population. At the same time, the convergence of the least developed regions shall accelerate due to improved conditions within the innovation and cohesion growth poles and thanks to increased and improved quality of effective healthcare that would be financially sustainable in relation to public financing and thus would have a positive impact on human capital development and on employment.

With regard to the identified needs of the healthcare infrastructure of the Slovak Republic, the individual OPH priority axes are defined within the next part.
Priority axis 1 – Hospital healthcare system modernisation
Priority axis 2 – Health promotion and health risks prevention
Priority axis 3 – Technical assistance

In the text is specified the focus and justification of priority axes through which the OPH shall be implemented, objectives and framework activities together with the indicators on the OPH and individual priority axis level.

Horizontal priorities of the NSRF, complementarity and the borderlines together with other operational programmes are elaborated and described in the following chapters of the OPH.

Within the framework of the whole financial allocation of the Slovak Republic for the 2007 – 2013 period, the amount of **250,000,000 EUR** is allocated for the "Convergence" objective. On the basis of the defined obligatory level of co-financing of the SR, the objective allocation of the EU funds shall be supplemented from national public sources (from the state budget and budget of the self-governments).

The implementation part describes the OPH implementation system pursuant to Council Regulation (EC) No. 1083/2006 in accordance with the SF and CF Management System for the programming period of 2007 – 2013 and in accordance with other related documents. This part defines the authorities involved in the programme management and implementation, system of monitoring, evaluation, publicity, financial management, control and audit.

2 Operational Programme Preparation Process

2.1 Partnership Principle Implementation

Partnership is one of the fundamental principles of the EU structural policies in terms of cooperation of the European Commission (hereinafter referred to as "EC") with a Member State, its national, regional and local authorities as well as economic and social partners and other entities. Council Regulation (EC) No 1083/2006 laying down general provisions on the ERDF, ESF and CF (hereinafter referred to as "General Regulation") lays down the principles and rules of partnership, programming, assessment and management, including financial management, monitoring and control on the basis of joint responsibilities of the Member States and the Commission. Partnership includes preparation, implementation, monitoring and assessment of the operational programmes.

The partnership principle has been already respected while preparing the "Modernisation of Healthcare Infrastructure" specific priority in the frame of the NSRF, namely in form of work groups, work meetings and bilateral meetings related to this document. For the specific priority purposes, a work group was established at the MOH SR consisting of the relevant ministerial sections representatives, a National Health Information Centre representative and a Public Health Authority of the SR representative. The representatives of higher territorial units, health insurance companies and professional community (e. g. Slovak Chamber of Physicians) were also participating in the OPH elaboration. While formulating the specific priority, the MoH SR was communicating with the Ministry of Construction and Regional Development SR (hereinafter referred to as "MCRR SR") and the Office of the Government's Plenipotentiary for Roma Communities of SR as well. In the next stage, the NSRF including the specific priority "Modernisation of Healthcare Infrastructure" was a subject to inter-ministerial commenting proceedings involving not only the ministries, but also higher territorial units, non-governmental organisations, representatives of involved governmental agencies, Association of Towns and Communities of Slovakia, Union of Towns and Cities of Slovakia, and more.

While specifying individual areas of the OPH, the MoH SR based its work on the documents available and policy papers related to higher territorial units.

Pursuant to the decision of the Slovak Government from 8 October 2006 on updating the NSRF, due to the elaboration of technical revisions of the European Commission and the definition of priorities in the Slovak Government Manifesto 2006 – 2010, with the aim of updating the OPH, a smaller work group with relevant institutions in health the sector and representatives of social-economic partners was established.. While establishing the work group consisting of 25 subjects, including all UTUs involved (Annex 2), the peculiarity of the sector, the effect on environment (publishing the OPH on the web site www.enviroportal.gov.sk and cooperation with the MoE SR during the environmental impacts evaluation – SEA) and equality of opportunities among men and women (objective dimension is respected within the health sector) was taken into consideration.

The OPH objectives within the period of preparation, implementation, monitoring and evaluation of the operational programme pursuant to Article 11 of Council Regulation (EC) No. 1083/2006 are ensured within the programming period 2007 – 2013 in a close cooperation of involved partners with respect to the valid SR legislation and standard practice.

The OPH Monitoring Committee comprises of the most representative selection of partners on the national, regional and local level and in economic, social, environmental or other sphere and functions pursuant to national regulations and practice, taking into consideration the necessity to enforce the equality among men and women and the support of sustainable development, while respecting the requirements related to the protection and improvement of environment.
The OPH completion was based on the participation and comments submitted by the work group members during the work group meeting (21 November 2006) as well as during the inter-ministerial commenting proceeding from 15 November 2006 to 23 November 2006. During the inter-ministerial commenting proceeding, 74 subjects including 25 members of the work group were addressed. The total number of raised comments is 210. The members of the work group raised 124 comments, mostly of general nature (formal and grammatical text modifications, proposals on the legislation re-evaluation in the health sector). 79 comments were accepted and 45 were not accepted. Fundamental comments of partners together with their justification are stipulated in Annex 7.
Regarding the continuous updating and ongoing technical negotiations with EC, the negotiation of the work group on 21 August 2007 was arranged. The members of the work group did not raise any fundamental comments. The programme was discussed with the Government Plenipotentiary for Roma Communities of SR on 23 August 2007. The Government Plenipotentiary for Roma Communities of SR shall be invited into work group and other relevant commissions in the process of the OPH implementation based on the principle of partnership.

2.2 Ex-ante Evaluation

According to a General Regulation, every Member State shall be obliged to make an interim evaluation (ex-ante) for the NSRF, as well as for respective operational programmes under the "Convergence" objective.
The OPH ex-ante evaluation for 2007 – 2013 focuses on the following objectives:

- evaluation of analytic background documents, including SWOT, identification of disparities and development factors;
- evaluation of suitability, justification and consistency of the OPH strategy, i.e. examination of its internal logic so as to secure logical relations between the analyses results, objectives, priorities, financial resources and measurable indicators, including evaluation of its expected impacts;
- evaluation of coherence of the OPH strategy with the SR and EU policies and policy documents;
- evaluation of quality of the existing and suggested management systems in terms of their utility and effectiveness for the management, monitoring, evaluation and financial management processes.

For the purposes of the OPH ex-ante evaluation, the MoH SR selected an independent external evaluator in accordance with Act No. 25/2006 Coll. on public procurement and on the amendment and supplementation of certain acts, as amended by Act No. 282/2006 Coll. on healthcare and healthcare-related services and on the amendment and supplementation of certain acts.
The external evaluator has to make an OPH ex-ante evaluation from the following viewpoints:

- examination of suitability, relevance and feasibility of the proposed strategy in the light of its linkage to the SWOT analysis and achievement of its objectives;

- evaluation of the internal logic of the strategy so as to secure the logical relations between the analyses results, objectives, priorities, financial resources, measurable indicators, including evaluation of its expected impacts;
- evaluation whether the OPH priorities and objectives are well defined, consistent and balanced, and whether they reflect qualified opinions concerning the relevance, possibility of quantification and of achievement of the objectives;
- evaluation whether the OPH is a suitable tool to fix the problems encountered in the Slovak health sector, and whether it represents a step towards a positive change of the socio-economic situation in Slovakia; evaluation of the foreseen OPH impacts on the economic and social situation in Slovakia;
- evaluation of suitability and effectiveness of financial resources in the light of expected impacts;
- examination of suitability of the proposed OPH strategy, as regards its compliance with relevant EU regulations, directives and strategies, national and regional Slovak documents in this area, and their contribution to the achievement of the EU cohesion policy goals and of the SR national policies' objectives;
- evaluation of the overall compliance between the OPH and NSRF (in the field of analyses, strategies, priorities, objectives and indicators);
- analysis of adequacy, quality and effectiveness of the implementation system, and concurrence in preparation of proceedings and criteria for the project selection;
- evaluation of horizontal priorities incorporation;
- evaluation of suitability and effectiveness of financial resources in the light of expected impacts.

The ex-ante evaluation was performed in 6 phases during the period from 27 November 2006 to 5 March 2007. The individual phases are described bellow.

1. Evaluation of the analysis of the OPH and its priorities/priority axes (including SWOT), the regional projection of the analysis, the classification of identified key disparities according to their severity and development potential in this area, including recommendations (completed by a report submitted on 8 January 2007).
2. Evaluation of the OPH justification and consistency, including the suggested priorities, objectives and proposed amount and structure of investments intended for those priorities, i. e. the suggested financial framework, including recommendations (completed by a report submitted on 15 January 2007).
3. Evaluation of the expected results and impacts of the scheduled interventions, contribution to the quantification of goals of the suggested interventions (completed by a report submitted on 15 January 2007).
4. Evaluation of the coherence of the strategy with the policies and strategic national and regional documents of the Slovak Republic and with the policies and strategic documents of the Community (completed by a report submitted on 28 January 2007).
5. Evaluation of the proposed implementation system of the OPH – procedures of management, monitoring and evaluation and financial management from the perspective of their functionality and effectiveness, including recommendations (completed by a report submitted on 8 February 2007).
6. Evaluation and recommendations regarding the draft of the overall OPH document (completed by a report submitted on 5 March 2007).

During the entire ex-ante evaluation process, the MoH SR and external evaluator were consulting each other.

A summary of the results and recommendations of the ex-ante evaluation, including their incorporation and recommendations, which are to be respected to the biggest possible extent during further preparations of the operational programme implementation documents, is stated bellow.

Evaluation of the socio-economic analysis and strategy relevance in relation to the identified needs

Compared to the analysis presented in the version of the operational programme from December 2006, the analytic section is better regrouped and has a better evidentiary value, including regional information and information on healthcare providers in the Bratislava region involved in the national system. However, certain adjustments oriented towards data unification and easier comparison of regions are still indispensable in order to present some kind of information. The analysis as well as parallel discussions with operational programme processors pointed out the weak points of the current healthcare statistics, which is unsatisfactorily oriented on system performance and population health gain. The analysis should also be completed with some data related with aging population.

The analysis of strengths and weaknesses had been examined pursuant to recommendations, which led to better specifications of basic disparities and development factors.

Collection of necessary data allowing decision-making in the healthcare system shall represent a continuous task in the course of the whole programme realization. Gathering of the required data shall be of special importance in the initial stages of implementation and preparation of the providers' restructuring plans.

Evaluation of the strategy justification and its consistence

The operational programme objectives on the priority axes level were to a great extent detailed, respecting the recommendations formulated by the ex-ante evaluation, including the adjustments of Priority Axis 2 related to the health support and prevention of health risks in relation to other operational programmes. Priority Axis 1 – Hospitals Healthcare System Modernisation - was modified so as to focus clearly on healthcare provision and to avoid overlapping with Research and Development or Education operational programme. Seeing the ongoing strategy specification, basic indicators were defined concerning outputs and results of the priority axes.

Examination of strategy coherence with the national policies and Community policy guidelines

Thanks to implemented modifications, the programme is fully consistent with the recommendations for workforce health protection stated in Council Decision (EC) No. 702/2006 as well as with the conclusions of the Goteborg and Lisbon Strategy reformulated by the National Reform Program.

Evaluation of expected results and impacts

Considering the priority axes modification and focus on individual fields of healthcare provision in compliance with the EC guidelines on cohesion as well as the amount of funds allocated for the operational programme, one might anticipate improved accessibility and quality of provided healthcare and increased effectiveness of funds use in the health sector.

Considering the modified priority axes and supported operations, the programme implementation should provisionally lead to restructuring of faculty hospitals, national facilities and of a part of regional facilities focusing on one-day and long-term care measurable in bed occupancy and average length of hospitalisation in respective categories (results), and strengthening of outpatient care with respect to accessibility and preventive function measurable on the output side by availability of necessary modern technical diagnostic equipment and by number of performed

preventive examinations in selected specialisations. The programme realization is expected to improve the management of respective providers thanks to a quick and accurate data exchange between the individual providers, between the providers and other involved parties (state authorities, health insurance companies) (result) by implementing the management information systems and securing their compatibility (output). The programme realization shall also result in a mutual cooperation of individual providers in a given region aimed at securing provision of effective and purposeful services to the inhabitants of the given locality/region (output – number of partnerships arisen, result – number of contracts concluded with the health insurance companies).

Evaluation of the suggested OP on Healthcare implementation system

The suggested system of management, monitoring and evaluation has been elaborated pursuant to methodological guidelines of the central coordination authority. It is standardised and feasible in relation to the existing implementation system. A successful programme implementation is going to depend on availability of the necessary human and technical resources stated in the guidelines and internal manuals, but even more on phasing of individual measures according to the schedule.

2.3 Strategic Environmental Assessment

The strategic environmental assessment pursuant to Act No. 24/2006 Coll. on Environmental Impact Assessment and on the Amendment of Certain Acts (hereinafter "Act“) considering the support for the sustainable development was carried out in order to assess environmental aspects of proposed interventions of OPH as a strategic document with national reach.

The Act is wholly harmonised with Directive 2001/42/EC of the European Parliament and of the Council of 27 June 2001 on the assessment of the effects of certain plans and programmes on the environment

Within the mentioned process the direct and indirect impacts of proposed OPH strategies on environment were assessed.

Procedural process of the strategic environmental assessment was performed in accordance with the Act. Successful external procurement specialist selected under the public procurement (Environment, a.s., Centre of biostatistics and environmentalitic) elaborated “Report on Assessment of Strategic Document OPH” in accordance with the procurement contract and the Report delivered on September 11, 2007. The Report was consequently delivered to the Ministry of Environment of SR (hereinafter "ME SR“).

The Environmental Report on Strategic Document OPH and the proposal of the strategic document OPH were in compliance with the Act published on the website of the Ministry of Health of the SR and on www.enviroportal.sk website on September 12, 2007. Herewith the documents were publicly allowable for 21 days up to October 2, 2007. There were no comments delivered regarding the documents within closing date.

Ministry of Health of SR with cooperation of the Ministry of Environment of SR organised public hearing of the documents under the Act up to date of publication (October 2, 2007) of The Environmental Report on Strategic Document OPH and the proposal of the strategic document OPH. The public hearing was performed on October 1, 2007 from 10, 00 to 12, 00 a.m. with the participation of author of the Report and the Ministry of Health of SR representatives.

The Environmental Report of Strategic Document OPH (hereinafter "Report“) mentions in particular chapters as follows:

I. basic data of Coordination body of the OPH - Ministry of Health of SR;
II. basic data of OPH as a strategic document with national impact;
III. basic data of current condition of the concerned territory environment (Convergence objective in SR conditions);
IV. basic data of expected impacts on environment inclusive impacts on population health;
V. proposed prevention, elimination, minimisation and compensation measures of each impact on environment and health;
VI. arguments for selection of considered alternatives and description of the assessment process including difficulties with providing needed information e.g. technical lacks or doubts;
VII. environmental impacts monitoring proposal including health impacts;
VIII. presumably significant cross-border environmental impacts including health impacts;
IX. kick-and-rush summary of provided information;
X. information on capital intensity (when the nature and the range of the OPH enable it).

Arrangements, selection and implementation of the operation programme projects will be realized considering the observance the environment protection and improvement principles according Act No. 543/2002 Coll. on Nature and Countryside protection and on the Amendment of Certain Acts.

The implementation of OPH respects EC legislation in the area of protection and improvement of environment regulations as follows:

- exercitation of energy intensity decreasing principles within projects realisation in the framework of OPH priority axes 1 and 2
- individual judgement of particular projects supported by MH SR in accordance with valid legislation of SR (e.g. within construction procedure).

Buildings intervention (healthcare infrastructure facilities) within OPH are realised with regard to environmental aspects consist in energy intensity decreasing and capital efficiency of buildings' increase. Power/energy saving in the process of building new or restoration of present buildings is asserted under the Directive of the European Parliament and of the Council No 2002/91/EC of December 16, 2002 on buildings energy economy (O.J EC L 001. of 4.1.2003) that is included in the Act No. 555/2005 Coll. on Buildings Energy Economy and on the Amendment of Certain Acts valid of January 1, 2006. This act exercises obligatory energy certification of new and renovated buildings and determines minimum requirements on their energy economy. There is applied indicator – "average decreasing of buildings energy intensity" couched in percentage, which defines average ratio of decrease energy demand for healthcare infrastructure buildings heating that are supported via priority axis 1 and 2. Introduction and exploitation of energy renewable resources, restoration and modernization of present sources of power and hot wire instruments and power efficiency increase is also sustainability assumption.

The Report mentions that whatever activity, described in OPH, may and must influence the population health condition. It anticipates that activities development in produced document will positive influence the population health and possible negative effects will be marginal or on lover-level as up to now. Systematic industry technological processes emission decrement whose resumption is supposed suggest it.

Activities within the OPH are in compliance with its global aim focused on improvement of conditions influencing health condition of the productive-age and unproductive-age population through increasing of the quality, effectiveness and accessibility of healthcare and health support under healthcare infrastructure and not straightly on environmental problems solving.

Individual projects in appraisal process will be assessed also by the environment impact criteria pursuant the Act.
Projects in the area with necessity of special air protection under the Act No. 478/2002 Coll. on Air Protection will be supported on condition that tighten environmental conditions (e.g. BAT introduction regardless of charges adequacy, more strictly emission limits etc.) because these are areas were is necessary to improve air quality or air sound condition is necessary to sustain.

Conclusion summary mentions expected OPH results with favourable impact on environment improvement through activities of Priority Axis 1 - Hospital Healthcare System Modernization and Priority Axis 2 – Health Promotion and Health Risks Prevention as follows:

- liquidation of old capacities inconvenient to present legislation requirements
- building up of new capacities satisfactory all requirements of legislation valid in SR also in the environmental area
- restoration and modernisation of healthcare infrastructure of buildings and operating facilities under valid legislative requirements in the SR
- introduction of latest technical and operating, sophisticated, diagnostic, technological, information and instrumental equipment (BAT technologies).
- solving of building power economy

- change in fuel basis of the sources of energy used for production of heat and hot water to the use of renewable resources in accordance with OP on Environment
- disposal of selected types of dangerous waste in accordance with OP Environment

Ministry of Environment of SR (ME SR) pursuant the Act named professionally competent person to elaborate expert review of the Report on Assessment of Strategic Document OPH used the register of experts for environmental impacts assessment.

Professionally competent person elaborated expert review pursuant the Act on environmental impacts assessment process and the Environmental Report on Strategic Document OPH. The expert review was elaborated on October 4, 2007 and was delivered to the processor of final statement (ME SR).

Expert review proved potential of positive impacts on environment and development of human sources of the OPH strategy as well as the possibility of elimination or minimisation of negative environmental impacts of the strategic document implementation providing designed indicators fulfilment and securing of monitoring of environmental and socioeconomic optimalisation of its implementation via individual projects.

Expert review advised endorsement of the strategic document. Results of the environmental impacts assessment process are incorporated into the OPH.

The final statement to the environmental impacts assessment process was issued by ME SR on October 5, 2007. The statement includes recommendations to endorse OPH as a strategic document with national reach.

All documentation of the environmental impacts assessment process is available trough Coordination Body for OPH. Final statement of ME SR to the environmental impacts assessment process regarding OPH as a strategic document with national reach was published on the website of the Ministry of Health of the SR and on www.enviroportal.sk website.

Monitoring of the environmental impacts in OPH is provided by the indicator “Average decrease of energy intensity of buildings that are used by supported healthcare infrastructure facilities“. Monitoring of this indicator will be ensured on individual projects level and consequently will be evaluated on whole strategic programme document level.

3 Current Situation in the Health Sector

3.1 Background Point in the Health Sector

The need for a reformation of the health sector formed one of the priorities since the beginning of the 1990s. Reforms of the health sector in the Slovak Republic started with the "Velvet revolution" in 1989 and their objective was to transform the socialist health sector into a system oriented more on market. Healthcare system was defined by the generous scope of the provided services, where the demand as well as supply exceeded the available sources. These contradictions caused the constant growth of deficit, growing debts and prolonging waiting periods. Financial problems reached the top in 2002.

In 2003, legislative changes in the health care system were introduced, targeting the reduction of the role and influence of the state, restructuring and changes in ownership of healthcare providers.

In spite of all until now performed steps and measures, functioning of the healthcare system within the current pluralistic health insurance system and pluralistic principle of the reallocation mechanism is economically uneven.

Investments into the healthcare infrastructure were performed in the previous period. For clearness, we present an overview of investment and drawing of capital outlay into the healthcare system in the period of 2001 – 2006 from the state budget of the Slovak Republic (chapter MoH SR) without other public and private resources.

Table 1: Overview of financial resources volume invested into the healthcare of the SR

Year	Drawing capital outlay in mill. EUR)
2000	53.064
2001	60.865
2002	59.656
2003	45.783
2004	36.699
2005	43.184
2006	27.307
Total	**326.558**

Source: MoH SR, 2007.

In economical terms, the scope of investments can be evaluated according to the share of gross fixed capital in comparison to the GDP. In general in developing economies this value is set around 25% and in more stable economies around 15 to 20%. Between the year 2000 and the first half of 2006, the indicator level in the healthcare and social services sector in Slovakia was from 7.8% to 15.2%, while in 2005 it was 9.5%. This level is usually considered as a significant under-capitalization.

3.2 Healthcare System in the Slovak Republic

Healthcare system in the Slovak Republic is based on healthcare providers, who, based on a license/permission, perform a set amount of healthcare services in healthcare facilities. The basic division of healthcare facilities defined according to Regulation No 770/2004 Coll. on Determining Signs of Individual Healthcare Facilities is following: inpatient healthcare facilities and outpatient healthcare facilities.

3.2.1 Inpatient Healthcare

Inpatient healthcare is aimed at providing healthcare to people whose health condition needs constant healthcare connected with a presumed placement in a healthcare facility exceeding 24 hours.

According to Regulation of the Ministry of Health of the Slovak Republic No. 770/2004 Coll. the inpatient healthcare facilities are divided into:

- general hospitals;
- specialised hospitals;
- natural treatment spas and healing spas;
- medical institutions;
- hospice centres;
- nursing care homes;
- bio-medical research facilities.

On the basis of the current material "Report on programme rationalisation in the healthcare system of the SR" approved by Resolution of the Slovak Government No. 462/2007 on 23 May 2007, the total number of inpatient healthcare facilities in the Slovak Republic is 172, whereof:

- 73 hospitals are general hospitals (GH) including general hospitals with polyclinic, teaching hospitals (TH) and teaching hospitals with polyclinic,
- 52 hospitals are specialised hospitals and
- 47 inpatient healthcare facilities include the rest of these facilities.

Table 2: Number of inpatient healthcare facilities in the Slovak Republic

Inpatient healthcare facilities including outpatient departments	WS			CS		ES		"Convergence" objective	BA	SR
	TT	TN	NR	ZA	BB	PO	KE			
General hospitals	6	10	8	6	13	13	11	**67**	6	**73**
Specialised hospitals	3	1	5	4	6	9	8	**36**	16	**52**
Others (natural treatment spas, healing spas, spas, hospice centres, nursing care home, biometrical research facilities)	3	5	1	7	10	12	4	**42**	5	**47**
Total	12	16	14	17	29	34	23	**145**	27	**172**
Total (NUTS II)	42			46		57		**145**	27	**172**

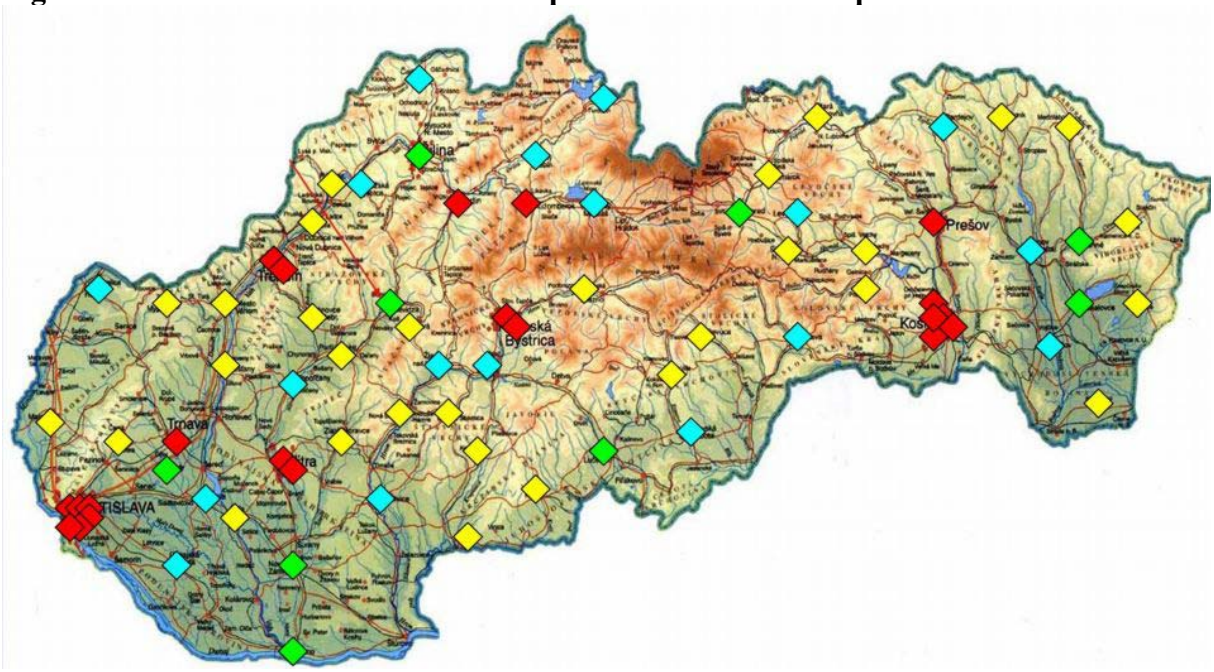
Source: MoH SR, 2007.

Table 2 legend

TT - The Self-Governing Region of Trnava NUTS III
TN – The Self-Governing Region of Trenčín NUTS III
NR – The Self-Governing region of Nitra NUTS III
ZA – The Self-Governing Region of Žilina NUTS III
BB – The Self-Governing Region of Banská Bystrica NUTS III
PO -The Self-Governing Region of Prešov NUTS III
KE - The Self-Governing Region of Košice NUTS III
Objective – regions under the "Convergence" objective
SR – The Slovak Republic

Full-area illustration of the main inpatient healthcare facilities distribution on the map of the Slovak Republic (figure No. 1) with colour differentiation of general – teaching hospitals according to the number of beds and specialised hospitals confirms the existence of a developed network of healthcare infrastructure. The technical condition of the material and technical basis of the hospitals healthcare infrastructure within this document is analysed in detail in Chapter 3.4.1.

Figure No. 1 Informative location of hospitals in the Slovak Republic



General Hospitals up to 200 beds, 200 – 400 beds, over 400 beds,
General Hospitals – Teaching: _TH__
Specialised Hospitals: _SH__

Annex 4 carries the detailed overview of all kinds of inpatient healthcare facilities (infrastructure) together with their localisation and division into:

- **General hospitals:**
  - general hospitals;
  - general hospitals with polyclinic;
  - teaching hospitals;
  - teaching hospitals with polyclinic.
- **Specialised hospitals:**
  - institutes of cardiovascular diseases;
  - oncological institutes;
  - institutions and sanatoria for the pulmonary diseases;
  - hospitals of central bodies of state administration;

- psychiatric hospitals;
- children's healthcare facilities;
- other.

- **Natural treatment spas and healing spas**
- **Medical institutions**
- **Hospice centres**
- **Nursing care homes**
- **Bio-medical research facilities**

Due to a complex and nationwide view on the inpatient healthcare system in the Slovak Republic, one of the elements of the analysis and of the overall overview of the healthcare facilities network is also the Bratislava region. However, this region shall not be supported and included into the Operational Programme Health (regarding the requirements specified by the "Convergence" objective).

As it is stated in the next table No. 3, the majority of healthcare facilities have the legal status of a business company – legal person (Inc., Ltd., non-profit organisation), whereas the owner or co-founder can be also state authorities and self-administration bodies.

Table 3: Number of inpatient healthcare facilities of the healthcare provider/owner in the NUTS III, NUTS II regions

Healthcare provider/owner	WS			CS		ES		Objective "Convergence"	BA	SR
	TT	TN	NR	BB	ZA	PO	KE			
The Ministry of Health SR (including Inc. and non- profit organisations with 100% interest of state)	4	3	6	13	6	8	11	**51**	10	**61**
Other central bodies of state administration - the Ministry of Defence SR, the Ministry of Interior SR and the Ministry of Justice SR (including Inc. with 100% interest of state)	0	1	0	0	1	2	0	**4**	2	**6**
Public (self-governing region, municipality)	4	4	2	2	5	3	1	**21**	1	**22**
Other (Inc., Ltd., non-profit organisation)	4	8	6	14	5	21	11	**69**	14	**83**
Total	12	16	14	29	17	34	23	**145**	27	**172**

Source: MoH SR

The analysis of relations and consequences between the hospitals healthcare infrastructure and growth poles is based on categorisation of **inpatient healthcare facilities** according to their type in the scale of official classification described within Chapter 4.1.6 (Table 53).

96 % hospitals (general and specialised) in the scope of the "Convergence" objective are in growth poles (innovation growth poles, cohesion growth poles).

A closer division of single healthcare facilities according to growth poles is in Chapter 4.1.5 and 4.1.6 "Background for regional intervention concentration" and "Inpatient Healthcare Facilities and Growth Poles", Table 53.

From the total number of 67 hospitals within the "Convergence" objective 100% are in the innovation and cohesion growth poles, whereof 40 facilities are general hospitals with polyclinics (outpatient part).

32 specialised hospitals from the total number of 36 specialised hospitals are included within the "Convergence" objective in the innovation and cohesion growth poles, representing 89 %, the rest of 4 specialised hospitals (representing 11%) is in the view of their diagnoses and treatment nature necessarily situated in places with specific climatic conditions, which are outside of innovation and cohesion growth poles.

3.2.2 Outpatient Healthcare

Healthcare facility for outpatient healthcare is defined as a facility assigned to provide healthcare to a person, whose health condition does not require a continual 24-hour care. Outpatient healthcare is provided by wards of general outpatient healthcare, specialised healthcare, daily centre, polyclinic, home nursing agency care and facilities of common examination and therapeutic departments (CETD), mobile hospices and ambulance service.
As it is stated in Table 4, in the overview of the outpatient healthcare facilities number within their division according to the regions of the Slovak Republic, there were in the 2005 altogether 8798 outpatient healthcare facilities, of which 7596 facilities are included in the "Convergence" objective.

Table 4: Review of outpatient network according to Upper Territorial Units (UTU) and number of healthcare facilities

Outpatient healthcare practices - types	WS			CS		ES		"Convergence" objective	BA	SR
	TT	TN	NR	ZA	BB	PO	KE			
Number of healthcare facilities	**860**	**919**	**1115**	**1078**	**1073**	**1199**	**1352**	**7596**	**1202**	**8798**
General outpatient department	322	327	377	353	371	381	427	**2558**	334	**2892**
Specialized outpatient department	498	541	678	665	636	753	856	**4627**	793	**5420**
Medical rescue service station (MRS)	*	5	*	2	3	1	1	**12**	9	**21**
AHNC (agencies of home nursing care)	10	10	15	19	15	27	21	**117**	7	**124**
Mobile hospice	*	*	*	*	*	*	1	**1**	1	**2**
Daily centre	5	10	8	8	6	9	10	**56**	9	**65**
One-day care facility	2	1	1	1	3	4	5	**17**	7	**24**
Polyclinic	3	3	4	13	5	5	5	**38**	13	**51**
CETD facility	16	15	24	14	28	13	18	**128**	17	**145**
Other outpatient facility (multi-type outpatient care)	4	7	8	3	6	6	8	**42**	12	**54**
Number of healthcare facilities (NUTS II)	**2894**			**2151**		**2551**		**7596**	1202	**8798**

Source: Statistical Office SR 2005

Due to the privatisation of polyclinics and increase of outpatient healthcare providers' individuality, the polyclinics (as they are defined pursuant to Regulation 770/2004 §5 according to Act 578/2004 §7 subsection 2 letter d), having the role of functional units of some general and specialised hospitals using the common examination and laboratory components – services, have gradually ceased. Functional, available, secure and timely undemanding logistics of patient healthcare within the polyclinics "under one roof" has been corrupted. Outpatient facilities are located individually in various premises (family houses, public and private buildings and so on) The result of this process is uneconomical and ineffective fragmentation of outpatient healthcare.

Analysing the individual types of healthcare facilities concentrated in one common premise according to the complexity and based on the number (5 or more) medical specializations:

- general medicine (for adults, children and for adolescents);
- gynaecology;
- internal medicine;
- specialisation in identified diagnoses, that are the most frequent cause of death, e.g.:
    - surgery and injury surgery (external reasons of diseases and deaths);
    - cardiology and neurology (circulatory system diseases);
    - clinical oncology and radiological oncology (tumours);
    - pneumology and phtiseology, clinical immunology and allergology (respiratory system diseases);
    - gastroenterology (digestive system diseases).

we came to the conclusion that from the total number of 7,596 facilities the number of these defined subjects in 2007 (5 and more outpatient facilities) is 217 public and private facilities, where 181 facilities exists within the "Convergence" objective – see Table 5.

The technical condition of the material and technical basis in the outpatient health infrastructure within this document is analysed in detail in Chapter 3.4.2.

Table 5: Number of outpatient healthcare facilities defined as polyclinics and healthcare centres according to the NUTS III regions

Region NUTS II	Region NUTS III	Number of facilities / number of outpatient facilities	Number of facilities / number of outpatient facilities (NUTS II)
WS	Trnava Self-Governing Region	14 / 218	66 / 778
	Trenčín Self-Governing Region	26 / 233	
	Nitra Self-Governing Region	26 / 327	
CS	Žilina Self-Governing Region	26 / 290	46 / 504
	Banská Bystrica Self-Governing Region	20 / 214	
ES	Košice Self-Governing Region	31 / 418	69 / 744
	Prešov Self-Governing Region	38 / 326	
"Convergence" objective		181 / 2026	181 / 2026
Bratislava Self-Governing Region		36 / 598	36 / 598
Slovak Republic		217 / 2624	217 / 2624

Source: Common Health Insurance Company 2007

The analysis of relations and consequences between the healthcare infrastructure of outpatient facilities and growth poles is based on categorisation according to their type in the scale of official classification described within Chapter 4.1.7 – "Outpatient healthcare facilities and growth poles".

Almost all outpatient healthcare facilities (polyclinics and healthcare facilities) within the "Convergence" objective are in growth poles (innovation growth poles, cohesion growth poles).

A closer division of single outpatient facilities according to the growth poles is in Chapter 4.1.5 and 4.1.7 "Background for regional intervention concentration" and "Outpatient Healthcare Facilities and Growth Poles", Table 54.

141 polyclinics and healthcare centres from the total number of 181 polyclinics and healthcare centres included within the "Convergence" objective are in the innovation growth poles, what represents
77.9%. 14 polyclinics and health centres are included in the cohesion growth poles in the innovation growth poles interest area, which represents 7.7%. 25 polyclinics and health centres are included in the cohesion growth poles outside the innovation growth poles interest area, which represents 13.8%. One healthcare facility is out of growth poles, what represents 0.6%.

National Transfusion Service
As a result of increasing requirements of healthcare facilities for blood products, clinical-therapeutic procedures and in order to improve the quality and safety of blood products, in 2004 the National Transfusion Service (NTS) was founded as a special outpatient healthcare facility, which shall fulfil the roles connected with the complex production of blood products in the conditions of maximum effectiveness, together with securing of haemotherapy of the best possible quality and safety in the desired volume with the aim to reach national self-reliance in its provision. The NTS secures that blood and its components, regardless of their planned usage, had comparable quality and safety throughout the whole transfusion chain in all regions of the Slovak Republic. Priority by blood withdrawal, processing, distribution and usage of blood and blood components is the protection of public health and functioning prevention of spreading of communicable diseases.

NTS has 11 transfusion workstations (including workstation with head office in Bratislava), which are geographically and ragionaly equally located on the territory of SR and on 100% are situated in the inovation growth poles. Scheme of transfusion workstations (TW) by regions (NUTS II) and upper territorial units - UTU (NUTS III)

Region of western Slovakia – NUTS II (WS):

- UTU Trnava
  - TW Trnava
- UTU Trenčín
  - TW Trenčín
- UTU Nitra
  - TW Nitra
  - TW Nitra – detached workstation Nové Zámky

Region of central Slovakia – NUTS II (CS):

- UTU Žilina
  - TW Žilina
  - TW Martin
- UTU Banská Bystrica
  - TW Banská Bystrica

Region of eastern Slovakia – NUTS II (ES):

- UTU Košice
  - TW Košice
- UTU Prešov

- TW Prešov
- TWPrešov - detached workstation Poprad

Bratislava

- TW Bratislava

All transfusion workstations are performing activities for venue region as follows:

- Registration of blood donors in the information system
- Blood collection for pre collection examination (blood picture /or only haemoglobin)
- Blood donor examination by doctor
- Blood collection in collection room
- Collection of autology blood from patients
- Haemaferezy execution (productive and curative)
- Blood donors recruitment with cooperation of Red Cross
- Realization of field (mobile) collections
- Component blood processing collected in own institution. from collection centres, from contracted stations
- Laboratory Blood donors examination: a) imunohematological b) virological and bacteriological
- Laboratory patients examination – specific imunohaematological examination
- Participation on internal and external revision of laboratory examinations condition
- Updating and revision of operating procedures condition
- Storage, expenditure , distribution and transport of blood products
- Continuous consilium transfusion service
- Stock level and blood transport coordination in regions
- Execution of internal special audits
- Education of haematology and a transfusiology – postgraduate education of all healthcare staff categories

3.3 Analysis of the State of Health of Citizens of the Slovak Republic

3.2.1 Main Characteristics of the State of Health in the Slovak Republic

Good health of population creates the basis for sustainable economic growth. Health is important for well-being and the quality of life[1]. According to various international organisations, the minimum level of health belongs to the principal human rights, as only a healthy human being has the capacity to grow personally, earn their living and realise their dreams. There is a reciprocal relation between health and economy. Health represents the input capital for production and reciprocally the means produced by economics are used for the maintenance and improvement of the state of health. Since a healthy population spends less financial means on healthcare, it is possible to invest these resources more effectively into other sectors. In relation to workforce as the basis of competitiveness of economics, health is one of the most important factors influencing its level and quality. Healthy workforce is a synonym for a prosperous and productive workforce creating higher profit. On the other hand higher morbidity causes absence from work, which in turn influences higher costs on production.

Comparing to member states of the EU 15, the Slovak Republic reports a lower level of population health condition (comparable to other new member states). Differences in the health of population among individual states can be shown by means of indicators of health (for example average life expectancy at birth, standardised rate of population mortality).

Since 1970, the average life expectancy at birth in the Slovak Republic has an upward tendency, however in comparison with the other EU member states the average life expectancy at birth in 2004 fell by 5 years (see Table. 6).

Table 6: Average life expectancy at birth

Average life expectancy at birth	1970	1980	1990	2000	2004	Growth through years 1970 - 2004
The Czech Republic	69.6	70.3	71.5	75.2	75.9	9.05 %
Hungary	69.3	69.1	69.5	71.9	73.0	5.34 %
Poland	69.9	70.4	71.0	73.9	74.9	7.15 %
Austria	70.0	72.8	76.0	78.7	79.5	13.57 %
Slovakia	**70.3**	**70.5**	**71.1**	**73.5**	**74.4**	**5.83 %**
EU	**70.8**	**73.7**	**75.2**	**77.5**	**78.3**	**10.59 %**
EU 15	**71.8**	**74.2**	**76.5**	**78.8**	**79.5**	**10.72 %**

Source: WHO

The main causes of hospitalisation of the Slovak population are circulatory system diseases, representing 15.4% of total hospitalisations, followed by digestive system diseases 9.5%, tumours 8.9%, respiratory system diseases 8.4% and external reasons of diseases and deaths 8.3%.

Since 2000, these diagnoses together are the cause of overall hospitalisation of the Slovak population in almost 50%. In 2005, their rate was 50.42%.

The most frequent diseases in women are circulatory system diseases representing, in 2005, 13.9% of total hospitalisation of women. The second most frequent diseases in women are tumours representing 8.3% of total hospitalisation of women.

[1] WHO, Zdravie 21

The most frequent diseases in men are circulatory system diseases representing, in 2005, 17.4% of total hospitalisation of men. The second most frequent diseases in men are external causes of diseases and deaths representing 12% of total hospitalisation of men.

A detailed division of hospitalisation of men and women according to the diagnoses in 2000 and 2005 is listed in Annex 9.

Main causes of high mortality rate of the population of the Slovak Republic (as it is stated in Table 7 and Chart 1) are[2)] diseases having the highest share in morbidity of the Slovak population:

- **circulatory system diseases**
- **tumours**
- **external causes of diseases and deaths**
- **respiratory system diseases**
- **digestive system diseases**

Tumours and particularly the circulatory system diseases are causal and stand significantly before the other three reported groups of diseases. This negative status and trend is noticeably supported by the analysis of the health condition of the marginalised Roma population, where the share of cardio-vascular diseases in untimely mortality is in comparison to the major population 2.5 times more frequent (detailed information is listed in Chapter 3.3.2).

The total share of five main causes of death of the Slovak population (hereinafter only "diseases of group 5") has since 1968 upward tendency. While in the European Union in 2004 the mortality rate of these five causes was 86%, in the Slovak Republic it was more than 93%.

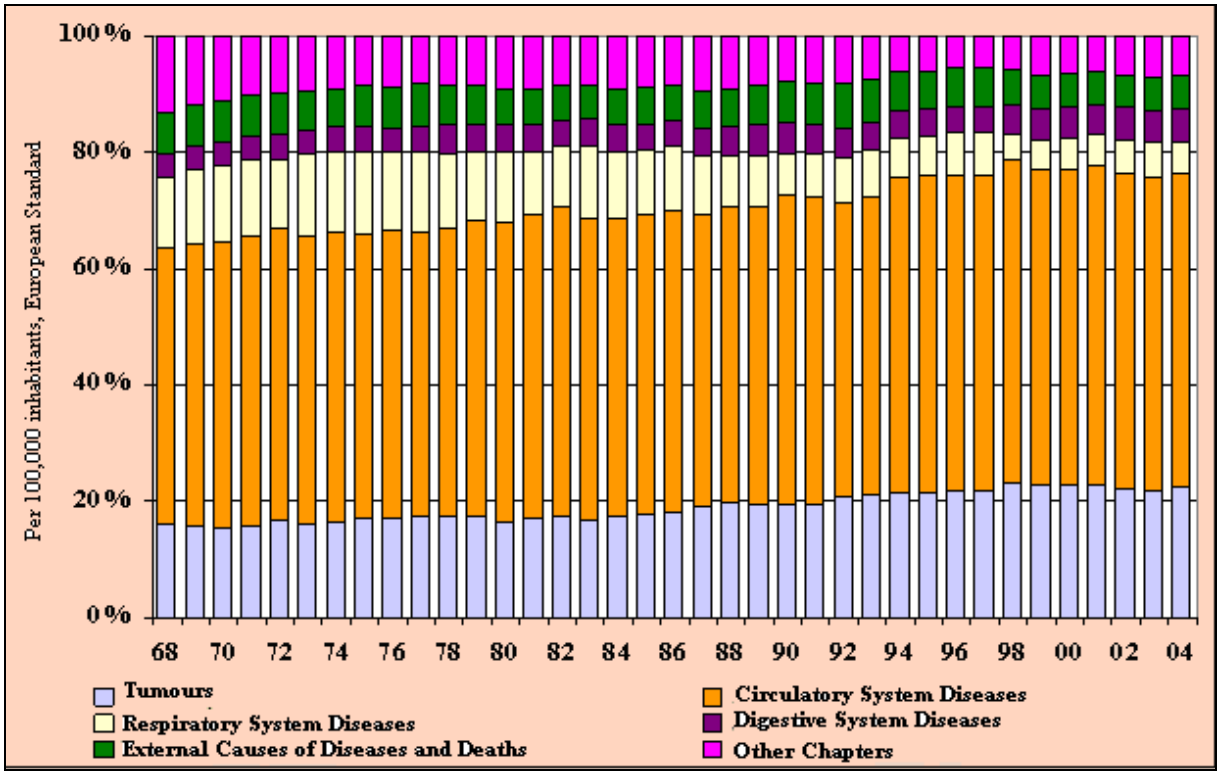
Table 7: Standardised rate of mortality per 100,000 inhabitants, comparison of the SR and EU 15 and EU in 2005

Causes of Deaths	SR	EU 15[3]	EU
Circulatory system diseases	508.68	220.98	498.73
Tumours	208.32	176.13	202.26
External causes of diseases and deaths	55.84	37.34	65.17
Respiratory system diseases	55.2	47.68	45.85
Digestive system diseases	49.92	30.57	46.89

Source: Statistical Office of SR 2005

[2)] description of diseases qualifying under the individual diagnoses is listed in Annex 8
[3] 2004

Chart 1: Development of the standardised rate of mortality in the SR according to selected causes of deaths[3)]



Source: Statistical Office SR, worked out by NHIC 2005

The SR population suffers mostly from circulatory system diseases and the fact that this diagnosis is the greatest cause of the mortality of the Slovak population is confirmed in Table 8 and in Chart 2.

Mortality of men and women caused by this disease is the highest in every region of the Slovak Republic.

The second most frequent cause of death of men and women in all regions of Slovakia are tumorous diseases. Differences within the individual regions are not significant. The largest share of tumorous diseases in women has breast cancer (15% of all tumours in 2005 - according to the statistics of the WHO).

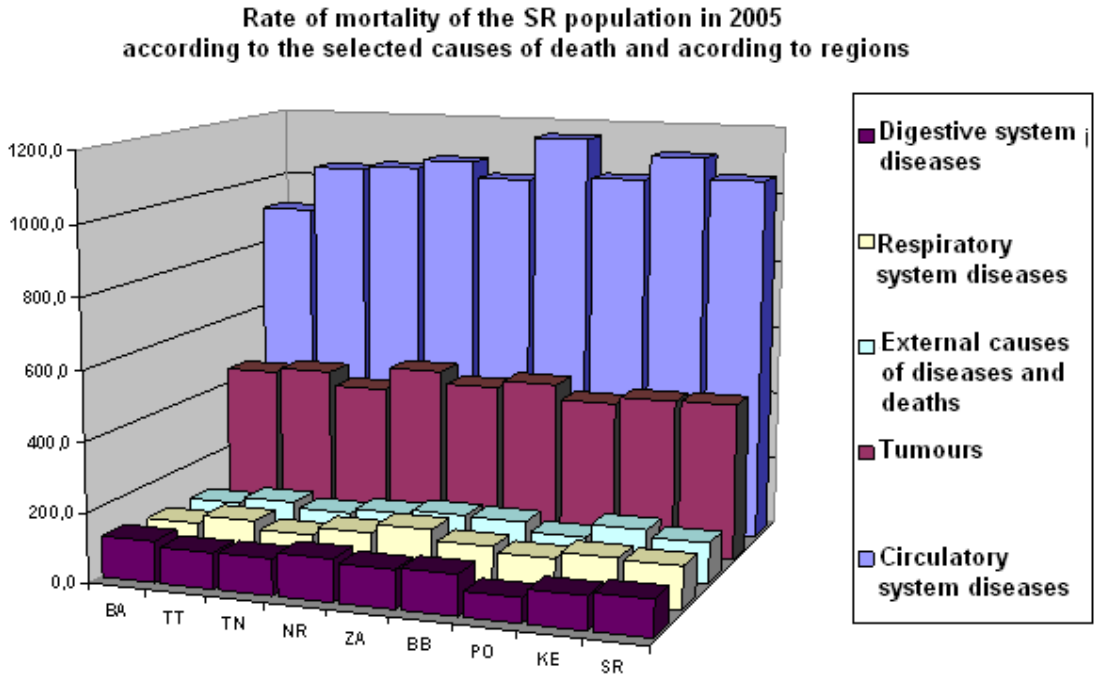
The mortality of the Slovak population is affected in the lowest level by digestive system diseases, external causes of diseases and deaths and respiratory system diseases.

Table 8: Mortality rate* of the SR population according to the selected causes of death and regions

Cause of Death	WS			CS		ES		BA	SR
	TT	TN	NR	ZA	BB	PO	KE		
Circulatory system diseases	1060.36			1097.45		1083.75		911.0	1059.3
	1044.9	1055.4	1080.8	1033.8	1161.1	1048.2	1119.3		
Tumours	455.13			461.80		439.50		446.9	452.2
	460.4	419.1	485.9	451.1	472.5	429.4	449.6		
Respiratory system diseases	119.56			138.10		116.25		104.5	121.6
	127.9	103.8	127.0	153.6	122.6	106.6	125.9		
External causes of diseases and deaths	113.06			127.95		117.85		100.0	116.7
	119.0	103.0	117.2	129.5	126.4	98.4	137.3		
Digestive system diseases	109.86			113.2		82.95		118.6	104.1
	103.3	104.6	121.7	110.6	115.8	71.0	94.9		

Source: NHIC 2005
**number of deaths per 100,000 inhabitants*

Chart 2:



Source: NHIC 2005

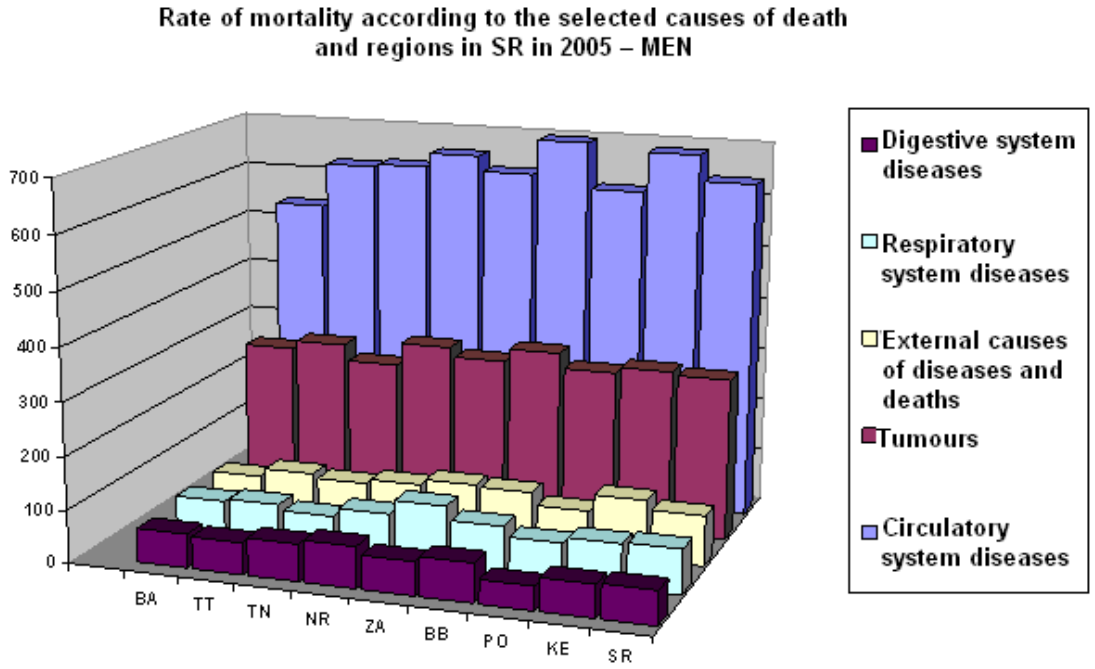
As it is stated in Table 9 and Chart 3, the mortality of men is affected in the highest rate by circulatory system diseases followed by tumours and external causes of diseases and deaths. Respiratory system diseases and digestive system diseases in men affect the mortality of men in the lowest rate.

Table 9: Mortality rate according to the selected causes of death and regions- MEN

Cause of Death	WS			CS		ES		BA	SR
	TT	TN	NR	ZA	BB	PO	KE		
Circulatory system diseases	639.73			663.80		647.85		542.6	637.3
	627.0	632.5	659.7	630.5	697.1	609.8	685.9		
Tumours	301.26			314.85		304.7		290.6	304.6
	307.1	276.8	319.9	302.4	327.3	298.9	310.5		
External causes of diseases and deaths	92.10			105.15		96.0		77.7	94.9
	94.2	86.6	95.5	106.9	103.4	79.9	112.1		
Respiratory system diseases	80.33			101.55		75.80		76.5	84.2
	81.8	71.3	87.9	114.4	88.7	70.2	81.4		
Digestive system diseases	69.16			68.3		53.05		63.8	63.8
	59.7	69.8	78.0	63.1	73.5	44.9	61.2		

Source: NHIC 2005

Chart 3:



Source: NHIC 2005

Within the next parts of the analysis concerning the mortality of men, which is divided into the pre-productive, productive and post-productive age, the focus is on the first four diagnoses that are the most frequent cause of death of the SR population – circulatory system diseases, tumours, respiratory system diseases and external causes of diseases and deaths.

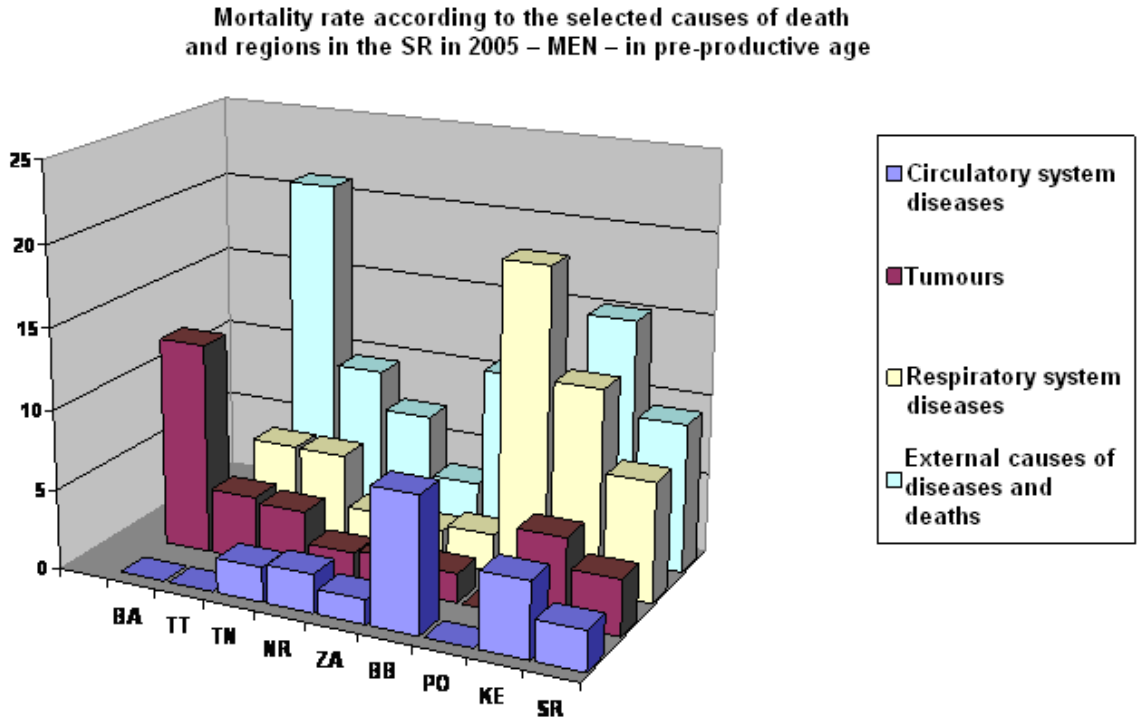
The mortality of men in pre-productive age differs from the mortality trend of men and globally from the population of the SR. As it is stated in Table 10 and in Chart 4 the most frequent causes of death are the external causes of diseases and deaths followed by respiratory system diseases. Circulatory system diseases have the lowest share on the mortality of men in pre-productive age.

Table 10: Mortality rate according to the selected causes of death and regions - MEN in pre-productive age

Cause of Death	WS			CS		ES		BA	SR
	TT	TN	NR	ZA	BB	PO	KE		
External causes of diseases and deaths	12.5			6.95		11.35		0.0	9.3
	21.0	9.5	7.0	3.2	10.7	7.6	15.1		
Respiratory system diseases	4.53			2.2		15.9		0.0	7.4
	5.6	5.6	2.4	2.0	2.4	19.3	12.5		
Tumours	3.23			1.9		2.65		13.1	3.5
	4.1	3.8	1.8	2.0	1.8	0.0	5.3		
Circulatory system diseases	1.53			4.95		2.35		0.0	2.5
	0.0	2.2	2.4	1.5	8.4	0.0	4.7		

Source: NHIC 2005

Chart 4:



Source: NHIC 2005

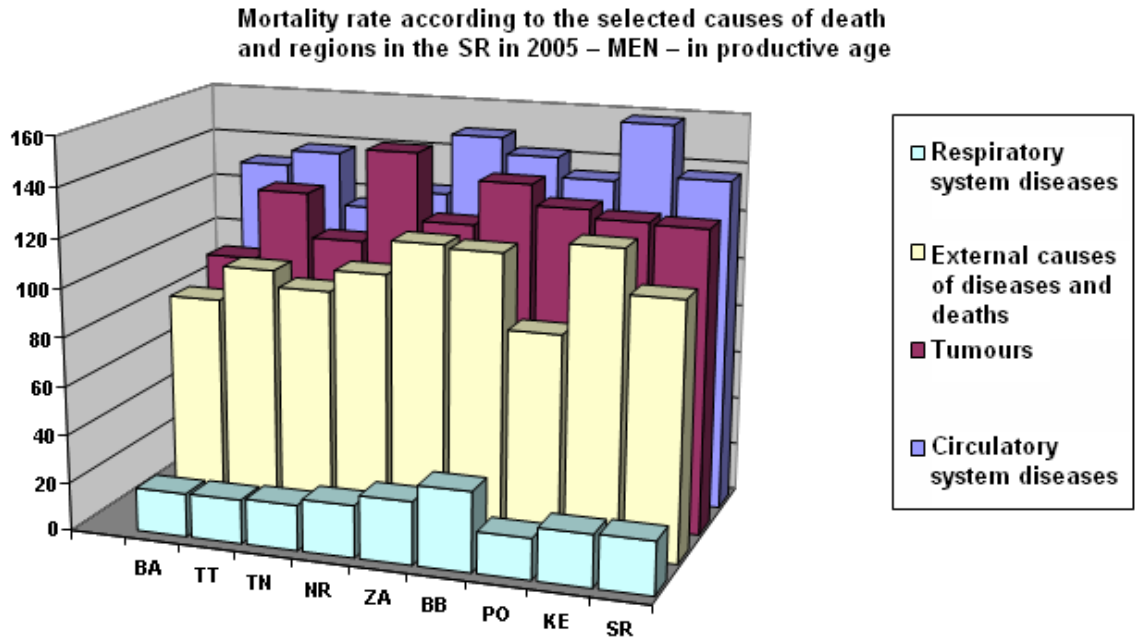
As it is stated in Table 11 and Chart 5, the order of the causes of men mortality in pre-productive age copies the order of overall mortality of men. Circulatory system diseases are on the first place followed by tumours. External causes of diseases and deaths have also a high mortality rate.

Table 11: Mortality rate according to the selected causes of death and regions- MEN in productive age

Cause of Death	WS			CS		ES		BA	SR
	TT	TN	NR	ZA	BB	PO	KE		
Circulatory system diseases	125.86			145.6		146.1		131.4	136.9
	138.0	115.8	123.8	149.0	142.2	134.0	158.2		
Tumours	127.9			128.45		127.35		98.4	124.8
	127.4	109.1	147.2	119.4	137.5	129.1	125.6		
External causes of diseases and deaths	101.43			118.2		105.1		88.8	105.2
	102.9	96.3	105.1	118.9	117.5	87.2	123.0		
Respiratory system diseases	19.5			29.35		19.25		17.9	21.8
	18.2	18.8	21.5	25.9	32.8	17.0	21.5		

Source: NHIC 2005

Chart 5:



Source: NHIC 2005

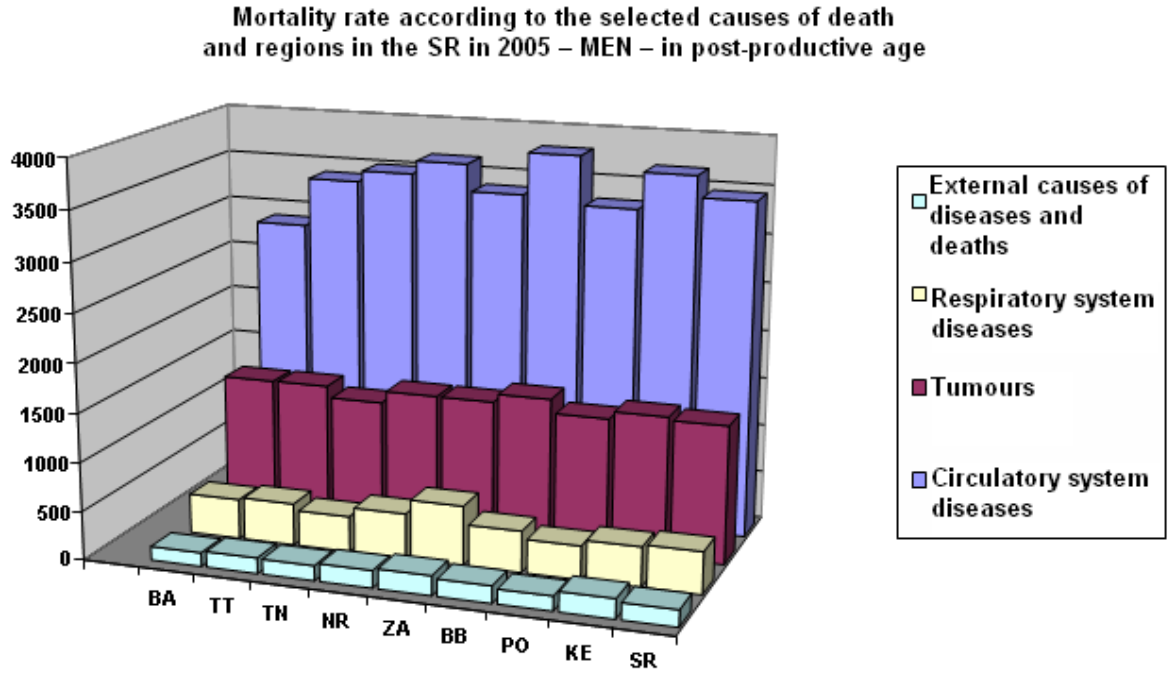
Generally, the highest mortality within all age groups has the group of men in post-productive age. As it is stated in detail in Table 12 and Chart 6, the largest share of mortality of men in post-productive age have circulatory system diseases. Its share several times exceeds the other causes of death. The second highest mortality rate of men in productive age has tumours.

Table 12: Mortality rate according to the selected causes of death and regions- MEN in post-productive age

Cause of Death	WS			CS		ES		BA	SR
	TT	TN	NR	ZA	BB	PO	KE		
Circulatory system diseases	3508.7			3577.75		3479.85		2881.9	3449.3
	3384.5	3501.2	3640.4	3361.0	3794.5	3292.2	3667.5		
Tumours	1382.8			1467.35		1407.2		1417.0	1415.3
	1419.7	1301.8	1426.9	1424.5	1510.2	1368.0	1446.4		
Respiratory system diseases	420.23			518.3		377.35		408.4	431.6
	433.0	364.9	462.8	612.1	424.5	346.2	408.5		
External causes of diseases and deaths	165.3			189.85		177.25		141.6	172.4
	160.8	155.2	179.9	203.0	176.7	151.1	203.4		

Source: NHIC 2005

Chart 6:



Source: NHIC 2005

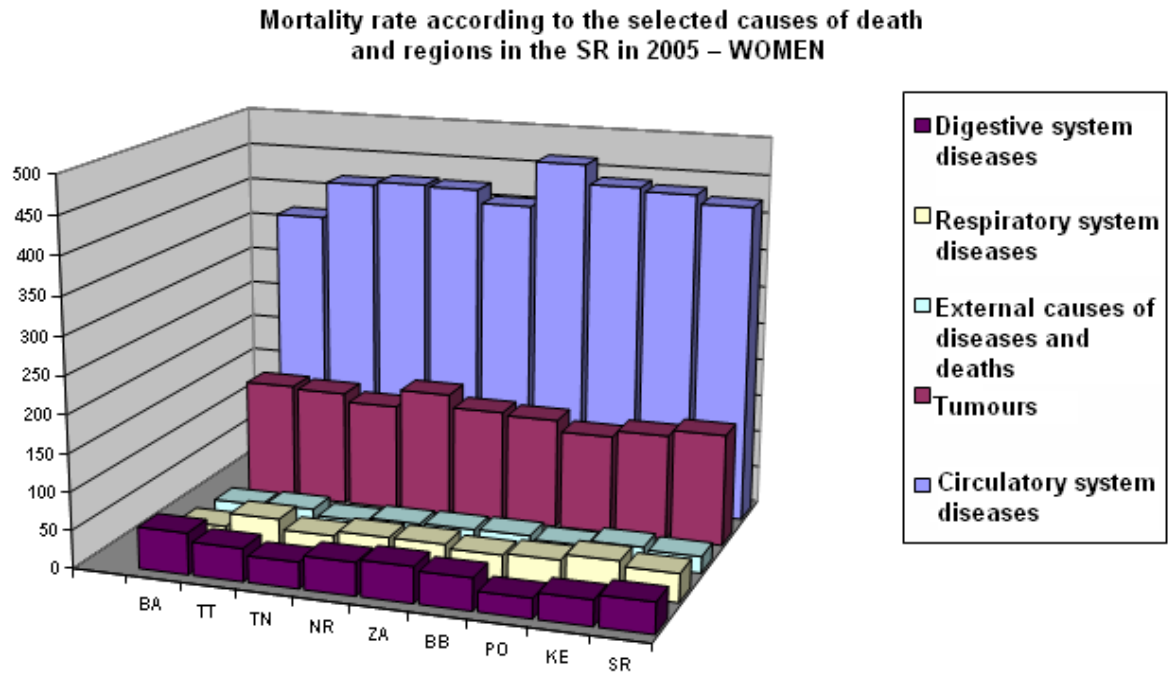
The mortality of women in general is affected the most by circulatory system diseases and tumours. As it is stated in Table 13 and Chart 7, the circulatory system diseases rate several times exceeds the mortality rate of women in the Slovak Republic caused by other diseases. The second most significant cause of death represents tumours. Their mortality rate significantly exceeds the other three diseases.

Table 13: Mortality rate according to the selected causes of death and regions - WOMEN

Cause of Death	WS			CS		ES		BA	SR
	TT	TN	NR	ZA	BB	PO	KE		
Circulatory system diseases	420.61			433.7		435.88		368.41	421.98
	417.84	422.93	421.08	403.39	464.01	438.38	433.39		
Tumours	153.88			146.98		134.82		156.30	147.61
	153.35	142.35	165.95	148.70	145.26	130.51	139.14		
Digestive system diseases	40.7			44.9		29.9		54.8	40.3
	43.6	34.8	43.7	47.5	42.3	26.1	33.7		
Respiratory system diseases	39.28			36.51		40.45		28.00	37.46
	46.17	32.52	39.16	39.17	33.86	36.45	44.45		
External causes of diseases and deaths	20.96			22.78		21.83		22.26	21.89
	24.78	16.43	21.69	22.61	22.96	18.47	25.20		

Source: NHIC 2005

Chart 7:



Source: NHIC 2005

Within the next parts of the analysis concerning the mortality of women, which is divided into the pre-productive, productive and post-productive age, the focus is on the first four diagnoses that are the most frequent cause of death of the SR population – circulatory system diseases, tumours, respiratory system diseases and external causes of diseases and deaths.

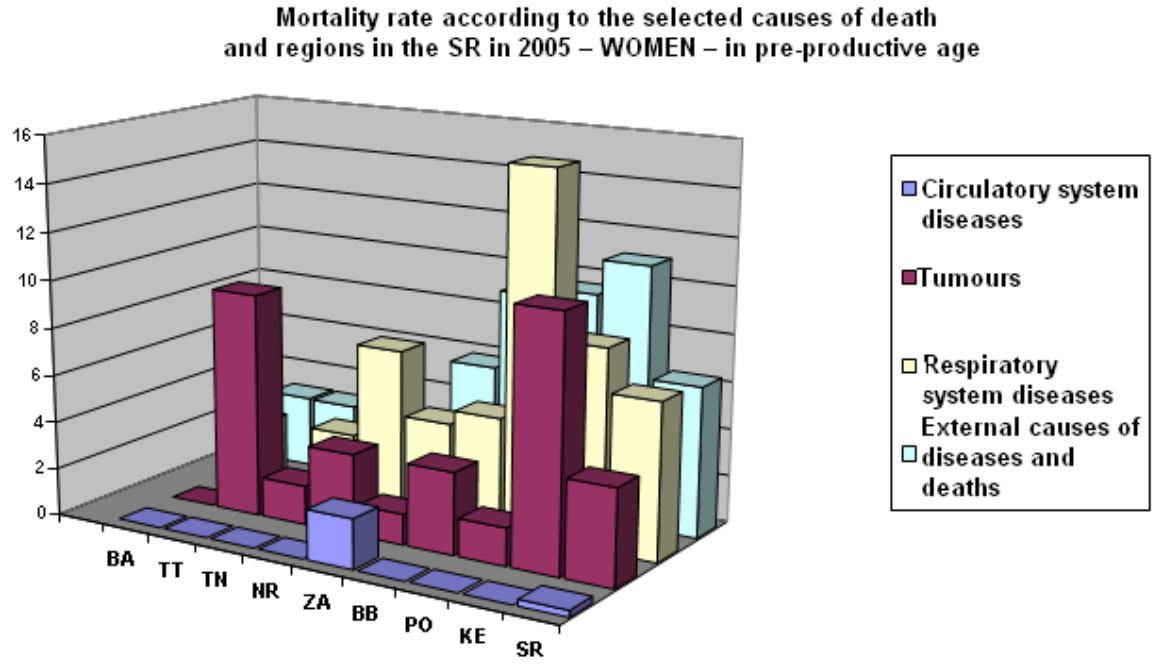
According to the data in Table 14 and Chart 8, women in pre-productive age die mostly (similarly as men in productive age) of the external causes of diseases and deaths. Respiratory system diseases and tumours represent also a significant cause of mortality of women in productive age.

Table 14: Mortality rate according to the selected causes of death and regions - WOMEN in pre-productive age

Cause of Death	WS			CS		ES		BA	SR
	TT	TN	NR	ZA	BB	PO	KE		
External causes of diseases and deaths	2.12			7.49		10.28		3.07	6.35
	3.04	3.33	0.00	5.82	9.17	9.56	11.01		
Respiratory system diseases	3.30			4.49		11.82		2.77	6.58
	0.00	2.96	6.95	4.19	4.79	15.26	8.39		
Tumours	4.82			2.37		6.07		0.00	4.04
	9.41	1.66	3.39	1.30	3.45	1.58	10.57		
Circulatory system diseases	0.00			1.05		0.00		0.00	0.28
	0.00	0.00	0.00	2.10	0.00	0.00	0.00		

Source: NHIC 2005

Chart 8:



Source: NHIC 2005

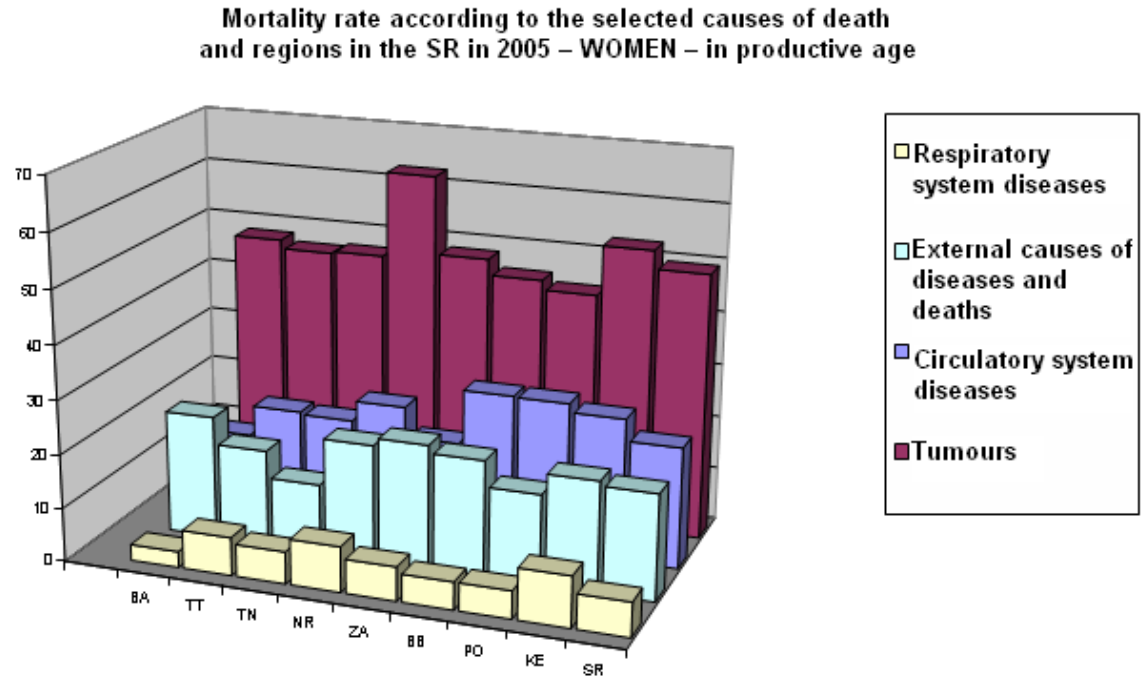
Mortality of women in productive age is different from the mortality of men in productive age. While the most frequent cause of the mortality of men in productive age are circulatory system diseases, the mortality of women in productive age is affected mostly by the tumours that are the cause of death twice more than he circulatory system diseases. According to the statistics of the WHO, 19% of the deaths of women in productive age in the Slovak Republic in 2005 caused by tumours were the result of breast cancer. As it is stated in Table 15 and Chart 9, significant share of the mortality of women in productive age hold also external causes of diseases and deaths.

Table 15: Mortality rate according to the selected causes of death and regions - WOMEN in productive age

Cause of Death	WS			CS		ES		BA	SR
	TT	TN	NR	ZA	BB	PO	KE		
Tumours	52.15			46.91		48.37		48.16	49.64
	46.57	47.00	62.89	48.38	45.45	43.74	53.00		
Circulatory system diseases	21.26			23.19		27.36		14.46	22.57
	20.27	19.84	23.69	18.09	28.30	28.17	26.56		
External causes of diseases and deaths	17.41			22.25		18.33		22.92	19.68
	17.86	12.81	21.58	22.99	21.51	16.69	20.58		
Respiratory system diseases	7.22			5.75		7.31		3.00	6.39
	7.16	6.01	8.50	6.32	5.18	5.18	9.44		

Source: NHIC 2005

Chart 9:



Source: NHIC 2005

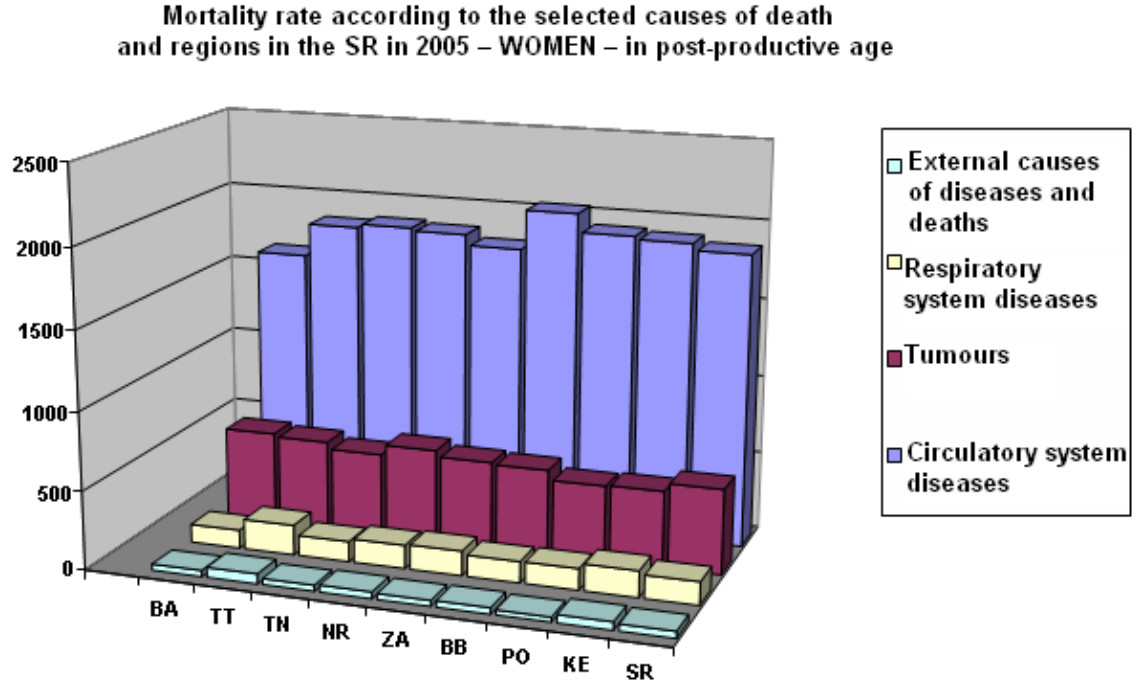
According to the data in Table 16 and Chart 10, we can see that mortality of women in post-productive age is affected by the circulatory system diseases followed by tumours and respiratory system diseases. External causes of diseases and deaths are the rarest cause of death of women in post-productive age.

Table 16: Mortality rate according to the selected causes of death and regions- WOMEN in post-productive age

Cause of Death	WS			CS		ES		BA	SR
	TT	TN	NR	ZA	BB	PO	KE		
Circulatory system diseases	1857.76			1911.3		1911.65		1637.8	1860.4
	1847.7	1871.9	1853.7	1785.5	2037.1	1920.9	1902.4		
Tumours	561.9			546.3		483.65		587.9	540.6
	569.1	525.7	590.9	551.5	541.1	480.3	487.0		
Respiratory system diseases	156.9			146.85		153.4		116.9	147.4
	191.7	129.6	149.4	157.8	135.9	137.2	169.6		
External causes of diseases and deaths	48.86			39.45		41.55		39.7	43.1
	64.1	38.8	43.7	38.4	40.5	31.9	51.2		

Source: NHIC 2005

Chart 10:



Source: NHIC 2005

Generally, the mortality of the Slovak population is affected mostly by the circulatory system diseases also when considering gender and age. Exceptions are men and women in pre-productive age, where the most frequent cause of death represent external causes of diseases and deaths. Another exception is represented by women in productive age where the most frequent cause of death is tumours, among which 19% of deaths are caused by the breast cancer.

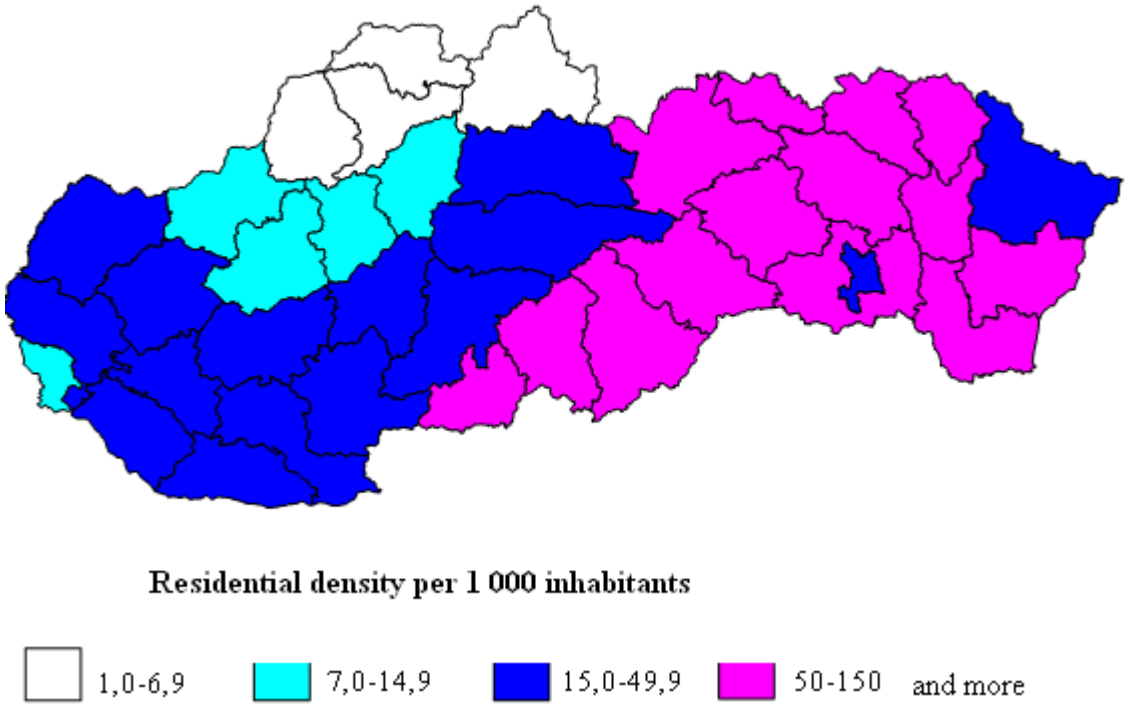
3.3.2 Selected Characteristics of Health Condition of Marginalised Roma Communities

Marginalised communities are groups of inhabitants, which from various objective and subjective reasons, do not have equal access to education, healthcare, employment and other areas of social life. Marginalised groups of inhabitants include for example disabled, unemployed, children and youth, seniors, refugees, homeless, and the Roma community living in separated and segregated settlements and localities.

The Roma community living in separated and segregated settlements and localities is counted among the most threatened groups of population in Slovakia. In comparison to the majority population, the worse health condition of the disadvantaged Roma community has a major impact on increased costs of the society on treatment, sick leave, hospitalisation and invalidity and it creates one of the objective reasons of marginalisation of this community.

Space distribution of the Roma population in Slovakia according to the latest population census in 2001 points out that the biggest concentration of the Roma population is in the Self-governing region of Prešov, followed by the Self-governing region of Košice and Banská Bystrica. Residential density of the Roma population in Slovakia is non-homogeneous – Image 2. The biggest concentration is in the eastern part of the Slovak Republic, where the Roma population creates whole Roma settlements.

Image 2: Residential density of the Roma population in Slovakia



Source: Public Health Authority SR 2006

The Roma population has its specific character that makes it different from the major population. It has progressive age structure, i.e. high portion of child population and low portion of inhabitants over 60 years of age.

Principal determining factors influencing the lower quality of the Roma population health condition are nowadays mainly: insufficient level of health awareness, low standard of personal hygiene, absence of drinkable water sources, absence of canalisation, missing garbage disposal, absence of sanitary facilities, low standard of accommodation and ecologically hazardous environment connected with polluted and devastated environment. Particularly alarming is the situation in the isolated Roma settlements where the quality of accommodation often does not fulfil basic hygienic standards; there are unhealthy eating habits, insufficient nourishment, increasing rate of consumption of alcohol and tobacco products, spreading drug addiction causing higher risk of HIV infections and hepatitis of type B and C.

All these factors reflect in the short life of the segregated Roma population inhabitants (in comparison to the major population, average life expectancy of the Roma population is lower; men live 55 years (majority 70.3 years) and women 59 years (majority 77.8 years)). There is high rate of mortality of new-borns and infants, low average age of dead when compared to the major group, high frequency of illnesses, chronic diseases, permanent decreasing of physical and mental performance.

The most frequent diseases among the population in Roma settlements (mostly children) are diseases of infectious aetiology caused and spread due to the insufficient hygienic and social-economic conditions and improper way of life of the Roma minority.

For example, from the total number of 326 cases of tuberculosis in 2006, 62 cases were notified within the Roma population what represents 19.1% of occurrences.

The highest share of diseases of bacillary dysentery (66% - 68%) was detected for the last 3 years in the Roma population. A similar situation was detected by the occurrences of viral hepatitis A (53% - 59%). For example in 2005, the morbidity of the Roma population probably exceeds the morbidity of the majority population. It was estimated at 61.0/100,000 inhabitants, while the SR population morbidity was 9.8 per 100,000 inhabitants.

Each year in the Roma community there is detected a high rate of invasive meningococcal infection, in 2006 representing 71% of the total population.

Occurrence of scabies detected within the last three years in the Roma population was 30% of the total occurrences reported in the SR, which represents a relatively high share. Table 17 contains an overview of the occurrences of the selected diseases within the Roma population.

Table 17: Selected infectious diseases within the inhabitants of the Roma population in the period of 2004—2006. Portion from the total occurrences in the SR.

Disease	2004		2005		2006	
	Number of diseases in the Roma population	% from the number of reported diseases	Number of diseases in the Roma population	% from the number of reported diseases	Number of diseases in the Roma population	% from the number of reported diseases
Salmonellosis	568	4.3	550	4.4	400	5.1
Bacillary dysentery	557	67.5	362	67.8	276	65.9
Other diarrhoeal diseases	734	11.4	687	8.7	752	9.6
Meningococcal diseases	16	51.6	18	40.0	22	71.0
Viral hepatitis A	318	52.6	310	58.6	233	57.1
Scabies	400	27.8	347	28.2	281	31.5

Source: ÚVZ (Public Health Authority) SR 2006

According to the materials of the Public Health Authority SR approved by the Government of the Slovak Republic, in 2006 the high rate of untimely mortality within the Roma population is caused mainly by cardiovascular diseases, which occur 2.5 times more frequent in comparison to the rest of the population. A significant role causing the high occurrence of the cardiovascular diseases in the Roma population plays frequent consumption of animal fats, meat, sweets and sweetened beverages, low consumption of fruit and vegetables, consumption of soft tack instead

of brown bread, obesity, smoking (often from the very young age), missing physical activity and consumption of alcohol. Due to this improper way of life, the organism of the Roma population has a lack of protective factors – specifically vitamin C, beta-carotene and vitamin B6. High mortality of cardiovascular diseases is connected also with the high prevalence of the diabetes and occurrence of chronic infections.

3.3.3 Acute Clinical Healthcare (curative)

Pursuant to Regulation of the Ministry of Health of the Slovak Republic No. 770/2004 Coll. the treatment of diseases of Group 5 is ensured in general and selected specialised hospitals that are defined according to the system of inpatient healthcare in Chapter 3.2.1. From the total number of 172 inpatient healthcare facilities in the SR, 73 are general hospitals and 52 are specialised hospitals, where of 67 general hospitals (or 36 specialized hospitals) are within the "Convergence" objective.

In 2005 in the Slovak Republic, the number of hospitalisations due to diseases of Group 5 in comparison to the number of hospitalisation due to all diseases (stated in Table. 18) was 50.42% and within the "Convergence" objective it was 50.58%. The analysis shows that the highest number of hospitalisations due to different diseases holds the circulatory system diseases representing 15.4% of the total number of hospitalisations.

From the regional viewpoint, the highest number of hospitalisations occurs in the eastern part of Slovakia.
In the regions of Prešov and Košice, the number of hospitalisations is higher than the average of other Slovak regions by 27%.

Table 18: Number of hospitalisations due to the diseases of group 5 in the NUTS III regions in 2005

Región NUTS II	NUTS III Region	Circulatory system diseases	Tumours	External causes of morbidity and mortality	Respiratory system diseases	Digestive system diseases	Selected diseases in total	Percentage of selected diseases within all diseases	All diseases
WS	TT	13,841	10,080	9,127	7,278	9,547	49,873	51.07%	97,657
	TN	20,434	11,052	10,311	9,787	11,688	63,272	51.63%	122,553
	NR	19,612	12,220	10,554	10,294	14,059	66,739	50.35%	132,552
	Total	53,887	33,352	29,992	27,359	35,294	179,884	50.99%	352,762
CS	ZA	18,204	11,106	10,542	10,501	12,369	62,722	49.31%	127,187
	BB	22,060	10,823	11,899	11,223	12,850	68,855	53.00%	129,920
	Total	40,264	21,929	22,441	21,724	25,219	131,577	51.17%	257,107
ES	PO	27,520	13,462	12,761	18,108	14,931	86,782	49.66%	174,760
	KE	26,596	14,577	12,311	15,151	15,379	84,014	49.78%	168,770
	Total	54,116	28,039	25,072	33,259	30,310	170,796	49.71%	343,530
"Convergence" objective		**148,267**	**83,320**	**77,505**	**82,342**	**90,823**	**482,257**	**50.58%**	**953,399**
BA		**15,943**	**11,642**	**10,447**	**6,908**	**10,632**	**55,572**	**48.70%**	**114,122**
SR		**164,210**	**94,962**	**87,952**	**89,250**	**101,455**	**537,829**	**50.42%**	**1,067 521**

According to the International Disease Classification (IDC – 10) 21 groups of diseases are defined
Source: NHIC 2007

According to the data stated in Table 19, the average duration of hospitalisation in 2005 within all diagnoses was 8.3 days and within the selected diseases (diseases of group 5) 7.7 days.

Table 19: Number of hospitalisations and average duration of hospitalisation according to the diseases of group 5 in 2005

Disease	Number of hospitalisations	Average duration of hospitalisation in days
Circulatory system diseases	164,540	9.0
Tumours	95,034	9.1
External causes of morbidity and mortality	88,808	5.6
Respiratory system diseases	89,446	8.2
Digestive system diseases	101,758	6.5
Selected diseases in total	**539,586**	**7.7**
All diseases*	**1,070,268**	**8.3**

**According to the International Disease Classification (IDC – 10) 21 groups of diseases are defined*
Source: NHIC 2007

Analysis of the population health condition in the Slovak Republic clearly showed the immediate necessity of acute clinical inpatient treatment of diseases of Group 5 that can be secured only in selected general and specialised hospitals.

Condition of the material and technical basis of the health infrastructure of general and specialised hospitals is analysed in detail in Chapter 3.4 *"Health infrastructure analysis in the Slovak Republic"* and in subchapter 3.4.1 *"Facilities of inpatient healthcare"*.

3.3.4 Disease Prevention

Disease prevention is an inherent part of population healthcare. As per Act No. 576/2004 Coll. on Healthcare and Healthcare-related Services, prevention is defined as:

a) educational and information activities aimed at protecting, preserving and restoring a person's health,
b) active search for possible causes of diseases, their elimination and disease prevention,
c) search for pathological processes in their symptomatic period with the aim of providing treatment preventing their clinical manifestation,
d) active disease monitoring with the aim of preventing the deterioration of a person's health.

The importance of prevention is in early tracking of disease risk factors. These influence the population health condition and take the largest portion in mortality.

At present, statistical monitoring is possible for preventive examinations provided by radio diagnostic departments and outpatient centres, clinical oncology departments and outpatient centres, gynaecologic outpatient centres, and general care and dentistry outpatient centres.

The following tables 20 to 23 and charts 11 to 14 show a development trend in the number of preventive examinations in reviewed departments and outpatient centres at the level of individual regions over a 5-year period.

Gynaecological prevention measures focus on the prevention of cervical cancer and, in cooperation with radio diagnostic centres, the discovery of breast cancer.

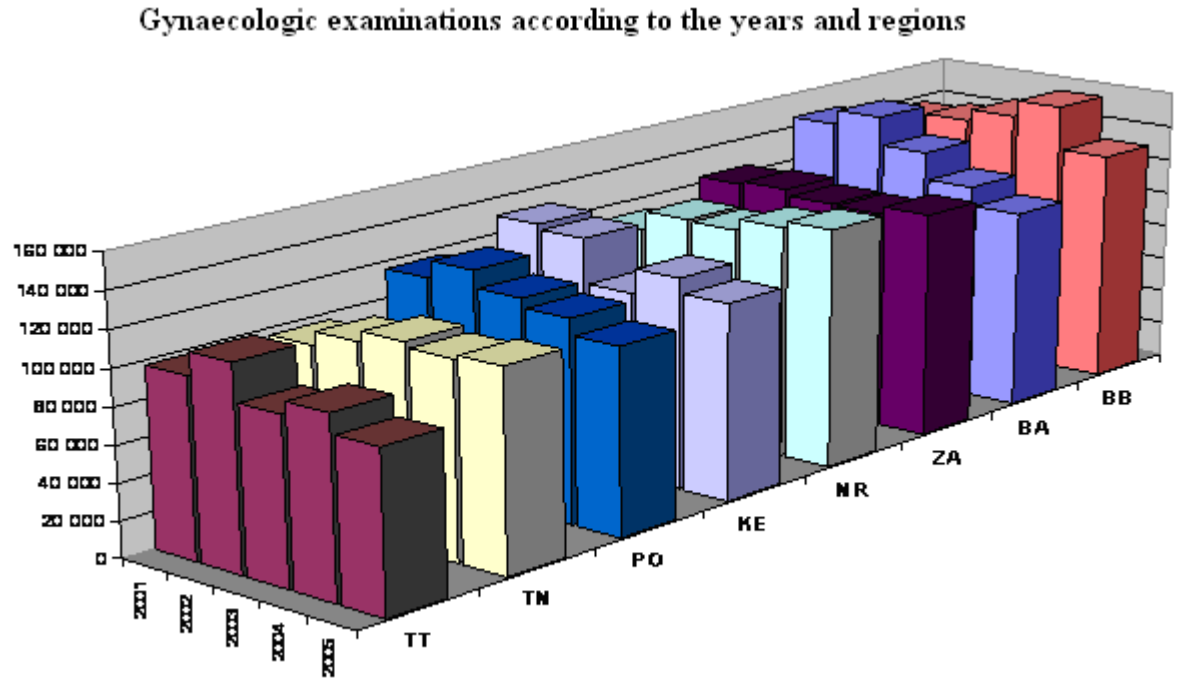
As shown in Table 20, the number of preventive gynaecologic examinations in Slovakia decreased in 2005 by 5.2% compared to 2001. During this period, the number of preventive examinations only increased in the regions of Trenčín, Nitra, and Žilina.

Table 20: Gynaecologic examinations

NUTS II Region	NUTS III Region	2001	2002	2003	2004	2005
		Number of examinations	Number of examinations	Number of examinations	Number of examinations	Number of examinations
WS	**TT**	97,878	110,836	90,651	97,777	87,285
	TN	96,587	104,301	110,239	107,231	109,611
	NR	112,684	123,124	122,454	128,919	132,837
	Total	307,149	338,261	323,344	333,927	329,733
CS	**ZA**	124,124	125,922	122,432	121,891	126,254
	BB	136,587	139,681	146,646	156,537	131,592
	Total	260,711	265,603	269,078	278,428	257,846
ES	**PO**	116,217	125,827	116,356	111,384	102,590
	KE	130,265	127,487	102,875	116,736	108,558
	Total	246,482	253,314	219,231	228,120	211,148
"Convergence" objective		**814,342**	**857,178**	**811,653**	**840,475**	**798,727**
BA		146,031	154,539	138,273	122,888	112,131
SR		**960,373**	**1,011,717**	**949,926**	**963,063**	**910,858**

Source: NHIC 2005

Chart 11



Source: NHIC 2005

The analysis based on tables 21 and 22 and common chart 13 indirectly indicates that in the case of women's most frequent form of cancer, breast cancer, the mortality rate of this diagnosis decreases with the increasing number of preventive examinations.

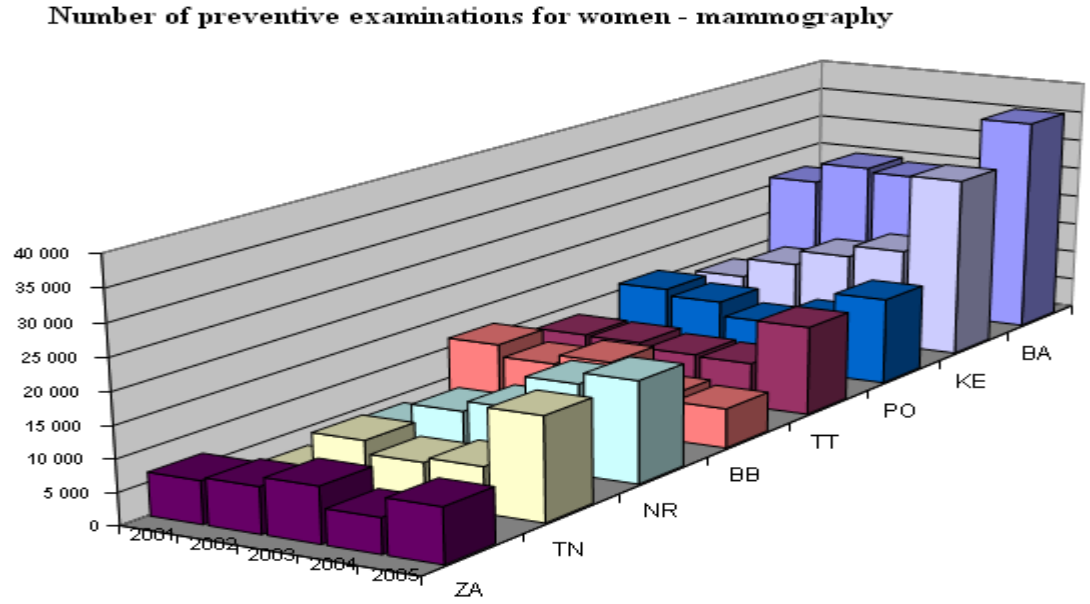
In case of early diagnosis, this disease is curable. There is no legislation in Slovakia concerning women's obligation to undergo screening mammography, so their survival rates are 30-40% lower compared to other EU countries with active screening programmes.

Table 21: Number of preventive examinations for women - mammography

NUTS II Region	NUTS III Region	2001	2002	2003	2004	2005
		Number of examinations	Number of examinations	Number of examinations	Number of examinations	Number of examinations
WS	**TT**	8,336	8,224	7,395	7,162	14,332
	TN	2,273	8,409	6,397	7,175	16,146
	NR	3,654	7,406	9,122	14,279	16,070
	Total	14,263	24,039	22,914	28,616	46,548
CS	**ZA**	6,684	7,194	8,669	5,495	8,523
	BB	11,705	9,793	11,268	7,059	6,325
	Total	18,389	16,987	19,937	12,554	14,848
ES	**PO**	11,345	10,248	7,870	9,603	14,078
	KE	8,949	12,170	14,659	16,595	29,688
	Total	20,294	22,418	22,529	26,198	43,766
"Convergence" objective		**52,946**	**63,444**	**65,380**	**67,368**	**105,162**
BA		21,638	25,040	24,350	21,630	35,636
SR		**74,584**	**88,484**	**89,730**	**88,998**	**140,798**

Source: NHIC 2005

Chart 12



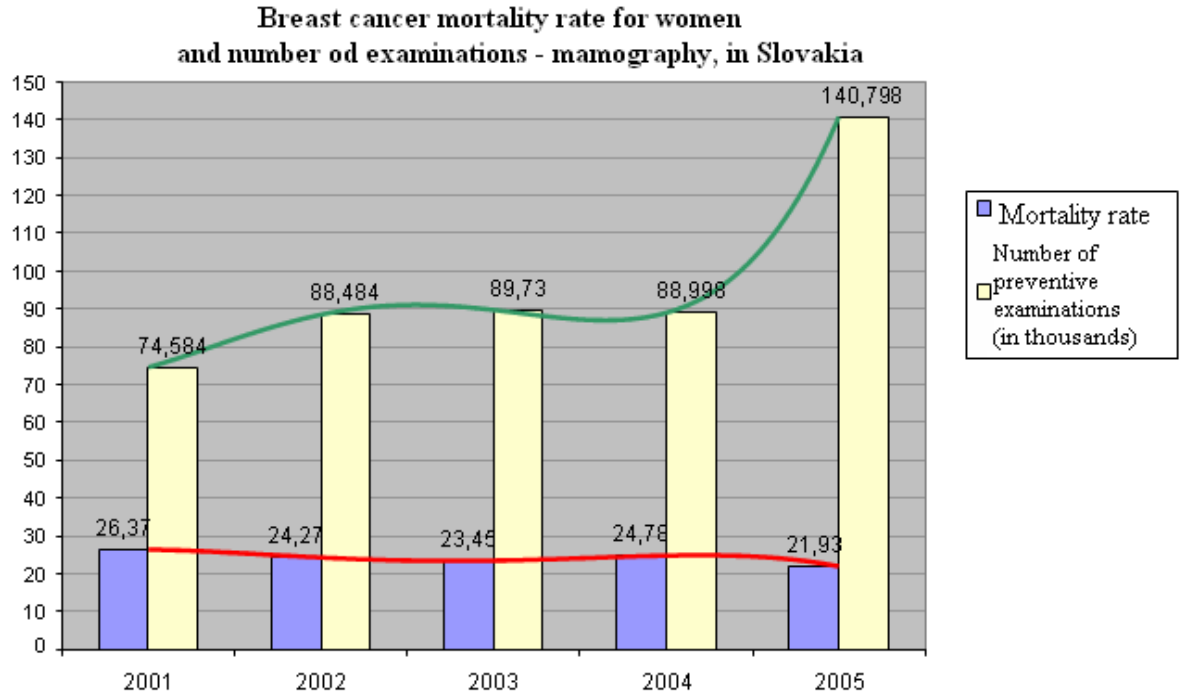
Source: NHIC 2005

Table 22: Breast cancer mortality rate for women in Slovakia

Year	Mortality rate
2001	**26.37**
2002	**24.27**
2003	**23.45**
2004	**24.78**
2005	**21.93**

per 100,000
Source: WHO 2007

Chart 13



**per 100,000*
Source: WHO 2007

From the analysis of tumorous diseases in women, which is based on limited accessibility of extensive information about the prevention of diseases and the WHO statistics (of all tumorous diseases in women, breast cancer is the cause of death in 15%) came out the result that by the most common tumorous disease in women, breast cancer, with the increasing number of preventive examinations diminishes the mortality rate of women.

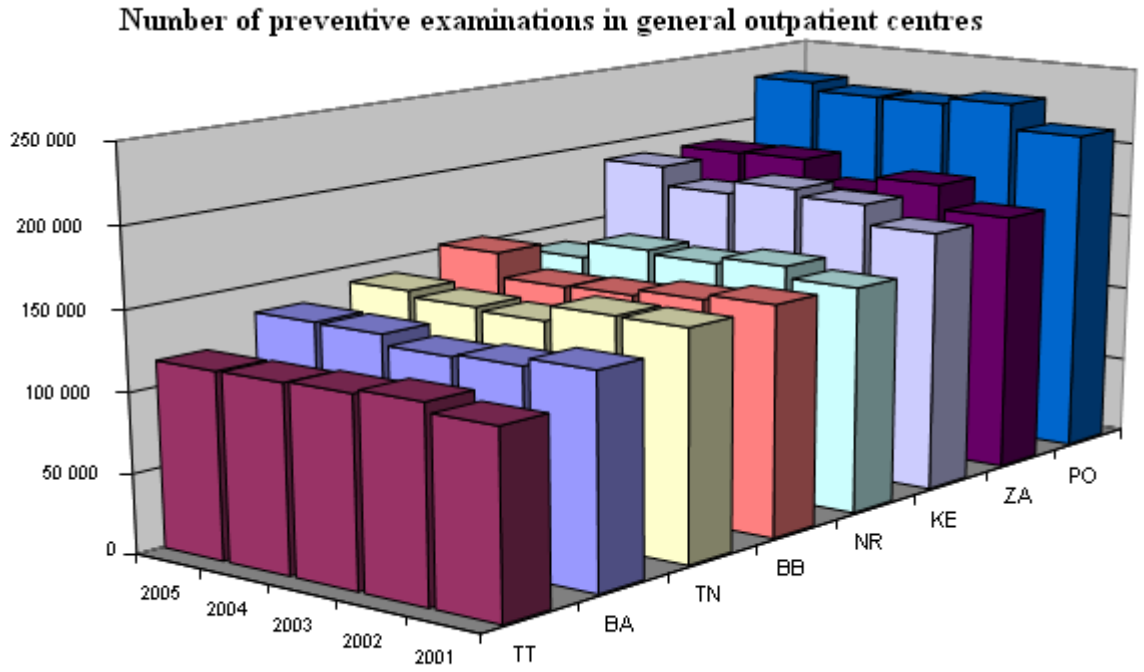
Primary preventive examinations in general outpatient centres focus, in cooperation with specialised medical care centres, on diseases affecting circulatory, respiratory and digestive systems. A development trend in the number of preventive examinations in general outpatient centres is approximately the same in all regions, with a slightly increasing tendency in most of them.

Table 23: Number of preventive examinations in general outpatient centres

NUTS III Region	NUTS III Region	2001	2002	2003	2004	2005
		Number of examinations	Number of examinations	Number of examinations	Number of examinations	Number of examinations
WS	TT	115,015	120,863	118,202	116,998	116,557
	TN	144,833	145,112	135,051	137,063	140,804
	NR	144,348	151,789	147,557	149,906	139,207
	Total	404,196	417,764	400,810	403,967	396,568
CS	ZA	167,121	183,409	173,279	190,350	189,599
	BB	146,091	142,688	138,818	137,788	153,387
	Total	313,212	326,097	312,097	328,138	342,986
ES	PO	211,249	228,157	223,884	224,256	229,989
	KE	167,653	180,578	185,427	176,905	189,711
	Total	378,902	408,735	409,311	401,161	419,700
"Convergence" objective		1,096,310	1,152,596	1,122,218	1,133,266	1,159,254
BA		132,984	128,008	126,267	133,017	133,446
SR		1,229,294	1,280 ,04	1,248,485	1,266,283	1,292,700

Source: NHIC 2005

Chart 14



Source: NHIC 2005

An analysis concerning women's cancerous diseases, based on a limited availability of extensive information concerning the prevention of these diseases and WHO statistics (among all cancerous diseases in women breast cancer causes 15% of deaths), results in a finding that in the case of women's most frequent form of cancer, breast cancer, the mortality rate of this diagnosis decreases with the increasing number of preventive examinations.

Preventive examinations accompanied by the prevention of disease occurrence through active search for pathological processes, with the aim of treating and preventing their clinical manifestations, need to be carried out with a certain periodicity. In negative cases, active disease monitoring is necessary with the aim of preventing the deterioration of a person's state of health.

3.3.5 Economy of Health Condition

Bad population health condition in the SR and necessary cure and care as a consequence directly influence the length of sick leave. This factor is important as far as national economics is concerned and it also indicates the population health condition (mainly of economically active population). The average number of people on sick leave per day reached 70,500 in 2004.

Sick leave has a negative financial impact on public expenses, puts an excessive burden on the health insurance system, and adversely affects the economy of the state due to loss of produced value.

Table 24: Sick leave in days per one worker in EU countries of EU in 2003

	Sick leave
Czech Republic	24.9
Hungary	15.6
Austria	12
Slovakia	**18**
EU	**12.6**
EU 15	12.94 (the latest figure as of 1999)

Source: WHO 2007

The sick leave rate reported in the EU countries was 12.6 days per worker in 2003. As far as the neighbouring countries are concerned, only the Czech Republic reported a higher sick leave rate (24.9) than Slovakia (18). The latest sick leave data reported in the EU-15 are available for 1999.

The primary indicator of public expenses in relation to the population health condition is represented (besides the sick leave rate) by the sum of costs for the provision of healthcare itself. The following table demonstrates the use of public expenses on healthcare in the Slovak Republic according to age groups (pre-productive, productive and post-productive age) and sex in four years (2002 – 2005).

Table 25: Overview of public expenses on the provision of healthcare (in thousand EUR)

		TOTAL	WOMEN	MEN
Pre-productive age	**2002**	48,441	22,337	26,104
	2003	53,823	24,197	29,626
	2004	52,457	24,485	27,972
	2005	45,892	20,946	24,946
Productive age	**2002**	80,377	44,398	35,979
	2003	83,772	42,371	41,401
	2004	85,739	46,138	39,601
	2005	86,537	46,728	39,809
Post-productive age (total 60+, women 55+, men 60+)	**2002**	98,169	58,987	39,182
	2003	108,645	65,430	43,215
	2004	115,164	68,739	46,425
	2005	126,804	75,808	50,996
Total (all age groups)	**2002**	226,987	125,722	101,265
	2003	246,240	131,998	114,242
	2004	253,360	139,362	113,998
	2005	259,233	143,482	115,751

Source: Statistical Office of SR 2006 (recalculated by the exchange rate 38 SKK/EUR)

Table 26: Average annual expenses per insured person (in EUR)

		TOTAL	WOMEN	MEN
Pre-productive age	**2002**	150	141	159
	2003	173	159	187
	2004	175	167	183
	2005	154	144	164
Productive age	**2002**	205.5	218	193
	2003	214.5	226	203
	2004	219	228	210
	2005	223.5	234	213
Post-productive age (total 60+, women 55+, men 60+)	**2002**	544.5	528	561
	2003	607.5	585	630
	2004	641	607	675
	2005	705.5	663	748
Total (all age groups)	**2002**	900	887	913
	2003	995	970	1,020
	2004	1,035	1,002	1,068
	2005	1,083	1,041	1,125

Source: Statistical Office of SR 2006 (recalculated by the exchange rate 38 SKK/EUR)

The above healthcare expense data (table 26) indicate the total public health insurance expenses. The expenses stated below (table 27) provide a more detailed analytical quantification of inpatient healthcare costs according to diseases within "Group 5".

The economic costs of hospitalisation between 2000 and 2005 indicate a persisting negative trend and rise in expenditures for all "Group 5" diseases, but the expenditures on circulatory system diseases are significantly higher than the expenditures on other groups of diseases. According to ICD-10, „Group 5" diseases, out of the total of 21 diseases, account for almost 50 % of all expenses – costs of inpatient healthcare in Slovakia.

Table 27: Inpatient healthcare costs according to "Group 5" diseases in Slovakia in 2005

Basic diseases according to ICD-10	Hospitalisations		Average time of treatment (number of days)	Average hospital costs[2] per day of treatment (in EUR[3])	Costs of average time of treatment (in EUR[3])	Costs of all hospitalisations (in million EUR[3])	% of total expenses
	Number	% of total hospitalisations					
	A.	B.	c)	d)	(E) = (D) x (C)	(F) = (E) x (A)	g)
Circulatory system diseases	164,540	15.40	9.00	87.86	790.71	130.10	16.67
Carcinomas	95,034	8.90	9.10	87.86	799.49	75.98	9.74
External causes of diseases and deaths[1]	88,808	8.30	5.60	87.86	491.99	43.69	5.60
Respiratory system diseases	89,446	8.40	8.20	87.86	720.42	64.44	8.26
Digestive system diseases	101,758	9.50	6.50	87.86	571.07	58.11	7.45
Total for selected diagnoses	539,586	50.42	7.68	87.86	674.74	364.08	46.65
Total for all diagnoses	1,070,268	100.00	8.30	87.86	729.21	780.45	100.00

[1] *including injuries, poisonings, and some other consequences of external causes*
[2] *general and specialised hospitals – subsidised and non-profit organisations*
[3] *recalculated based on the NBS exchange rate 33.184 SKK/EUR as of July 26, 2007*
Source: NHIC 2007

The development of outpatient healthcare costs per day of treatment given in Table 28 between 2000 – 2005 showed a significantly increasing trend, while the number of days of treatment was decreasing. The total outpatient healthcare costs were increasing from 2000 to 2003, but they have had a significantly decreasing trend since 2003.

A trend concerning the number of visits in outpatient centres per person in Slovakia was decreasing in 2000 – 2005; in comparison with the EU, however, the frequency of such visits is still significantly above the EU average as indicated by Table 29.

Table 28: Outpatient healthcare costs in Slovakia

Year	Costs per day of treatment[1] in EUR[3]	Number of days of treatment	Total costs in mil. EUR[2]
2000	22.06	81,330	1.79
2001	23.81	83,336	1.98
2002	28.87	70,977	2.05
2003	37.33	54,331	2.03
2004	50.12	29,152	1.46
2005	54.53	17,091	0.93

[1] ***polyclinics***
[2] ***recalculated based on the NBS exchange rate 33.184 SKK/EUR as of July 26, 2007***
Source: NHIC 2007

Table 29: Frequency of visits in outpatient centres per person and year (days)

Year	Slovakia	EU	Difference	Rozdiel v %
2000	16.26	6.67	9.59	143.78
2001	14.61	6.69	7.92	118.39
2002	14.48	6.75	7.73	114.52
2003	12.96	6.80	6.16	90.59
2004	13.00	6.83	6.17	90.34
2005	12.45	6.84	5.61	82.02

Source: WHO 2007

The analysis of women's health condition indicates that breast cancer is the most frequent cancerous disease in women. The mortality rate of this diagnosis decreases with the increasing number of preventive examinations.

This disease is among those oncological diseases that are the most frequent causes of death for productive-age women. 2000 new cases appear every year, 10-15% of which are in the III. and IV. stage (i.e. 200-300 women). Still, early treatment is highly successful and considerably improves the quality of life for productive-age women. The cost of the therapy for one patient in Slovakia is SKK 1.2 billion (with annual costs of SKK 1.4 million per patient and an average survival time of 3 years) excluding ancillary treatment costs (antibiotics, antidepressants, infusions, anticoagulation treatment, etc.).

As a result of the existence and occurrence of "Group 5" acute clinical diseases and causes of deaths of inhabitants of Slovakia, significant funds are spent on healthcare and the provision of such healthcare (especially in the present healthcare infrastructure) is demanding and costly.

3.3.6 Conclusion of the health condition analysis concerning the inhabitants of Slovakia

The analysis was carried out on the basis of the latest available official statistical information comparing the population health condition in Slovakia and the EU based on the primary health indicators – average life expectancy at birth and standardised death rate of the population.

The main reasons behind the high levels of morbidity and mortality of the Slovak population are the following categories of diseases – "Group 5":

- circulatory system diseases
- carcinomas
- external causes of diseases and deaths
- respiratory system diseases
- digestive system diseases

On average, the average life expectancy for the Slovak population is 5 years lower than in the EU countries.

The "Group 5" diseases account for many more deaths in Slovakia than in the EU-15, as in Slovakia the number of deaths is twofold in case of circulatory system diseases; it is more than 15% higher in the case of carcinomas and respiratory system diseases, and almost 50% higher in the case of digestive system diseases and external causes of diseases and deaths. Although the mortality rates are being successfully reduced, they are still high above the average of the other countries.

Cancerous diseases and especially circulatory system diseases are causally, negatively significantly above the other three categories of diseases.

In terms of time, the negative mortality rate trend has been increasing since the 1970s. The negative trend is especially apparent with the marginalized Roma population.

The negative state of health and mortality of the Slovak population are analysed in detail, in terms of the main causes of morbidity and mortality, according to age (pre-productive, productive, and post-productive) and gender at the level of the healthcare infrastructure of self-governing regions (NUTS III) and western, central, and eastern parts of Slovakia.

The circulatory system diseases are the most frequent cause of death for the Slovak population regardless of gender and age. This negative phenomenon is present with productive-age and post-productive age men as well as post-productive age women.

The cancerous diseases are the most frequent cause of deaths for productive-age women, breast cancer accounting for 19% of them. Preventive examinations accompanied by prevention of disease occurrence through active search for pathological processes, with the aim of treating and preventing their clinical manifestations, need to be carried out with a certain periodicity. In negative cases, active disease monitoring is necessary with the aim of preventing the deterioration of a person's health condition.

The external causes of diseases and deaths have the highest share in the mortality rate of pre-productive age men and women.

In the analysis of the population health condition in Slovakia, special attention is paid to the Roma community. A high early mortality rate of the Roma population is to a great extent caused by cardiovascular diseases.

The analysis confirms the importance and especially effectiveness and economic efficiency of preventive healthcare in comparison with curative – inpatient healthcare.

The analysis, in its part dealing with the economy of healthcare, points out the sick leave rate and the costs of the healthcare system.

The conclusion of the health condition analysis concerning the Slovak population presents an unfavourable finding confirming a poor state of health of the Slovak population caused by the existence and occurrence of the five diseases, which, at the same time, are the most frequent cause of death for the Slovak population (circulatory system diseases, carcinomas, respiratory system diseases, external causes of diseases and deaths, and digestive system diseases).

As a result of the existence and occurrence of these acute clinical diseases and causes of deaths of inhabitants of Slovakia, significant funds are spent on healthcare for each individual and the provision of such healthcare in the present healthcare infrastructure is demanding and costly.

From the social point of view, these unfavourable facts result in a lower quality of life and standard of living, shorter average life expectancy at birth and, from the perspective of the whole society, an excessively high sick leave rate, shorter productive age with a very negative impact on labour productivity and finally on added value, which is important for the whole society as the main socio-economic criterion of efficient and prosperous society.

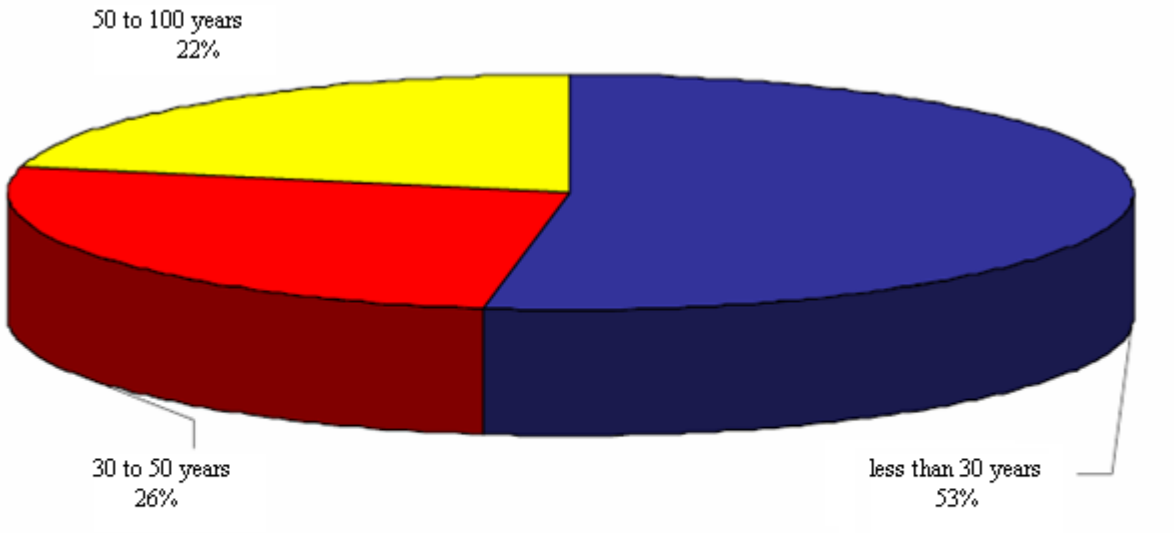
3.4 Analysis of Healthcare Infrastructure in the Slovak Republic

3.4.1 Inpatient Facilities – General and Specialised Hospitals

Buildings and operating facilities

The average age of hospitals is 34.5 years. If all the buildings are classified under the following three categories: **new** buildings (less than 30 years), **middle aged** buildings (30 to 50 years) and **old** buildings (more than 50 years), then the share of new buildings is slightly over 50%. A large portion of facilities are in general beyond their operating life and may be regarded as written-off, but that does not mean that they are no longer usable, but it is an important signal concerning the current condition of the hospital infrastructure and the need for its restoration in the nearest future.

Chart 15: Age structure of Slovak hospitals, nationwide level

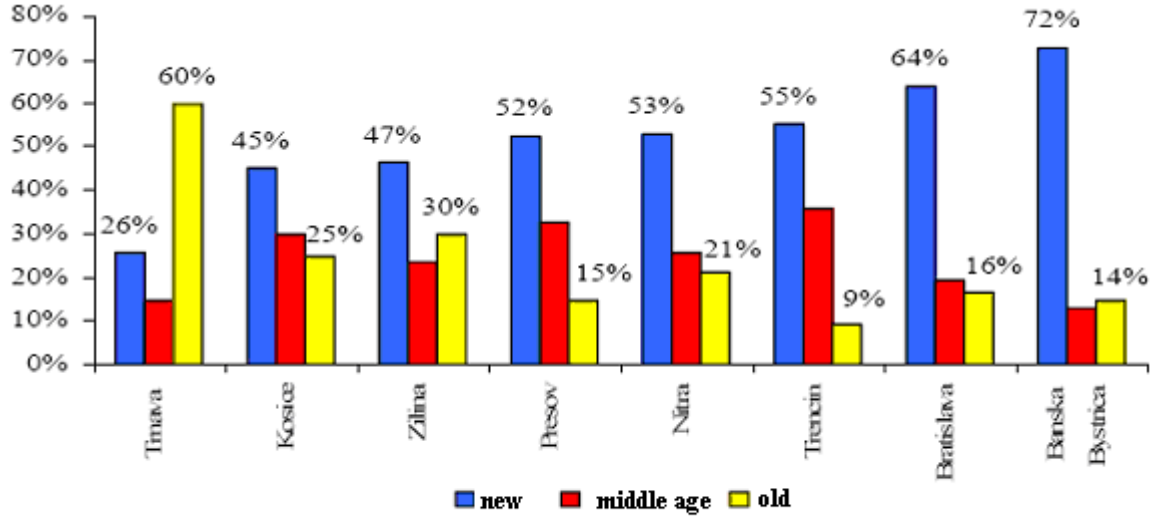


Source: Sanigest International Analysis – Hospital Assessment Slovakia 2004

Based upon the previous segmentation, a noteworthy feature of Slovak hospitals infrastructure is the fact that 41% of facilities are 10-30 years old, 22 % are old (over 50 years) and only 12% were built in the last decade.

According to NUTS III regions, the regions of Banská Bystrica (72%) and Bratislava (64%) take the highest share of new buildings (i.e. less than 30 years old), while Trnava (26%) a Košice (45%) take the lowest share. In spite of the fact that the region of Banská Bystrica takes the highest share of new buildings, the region of Bratislava has the highest share of facilities younger than 10 years (17%). The regions of Trnava (60%) and to a lesser extent also Žilina (30%) have the oldest buildings. The case of the Trnava region is noteworthy, because the share of old buildings is almost triple of the national average.

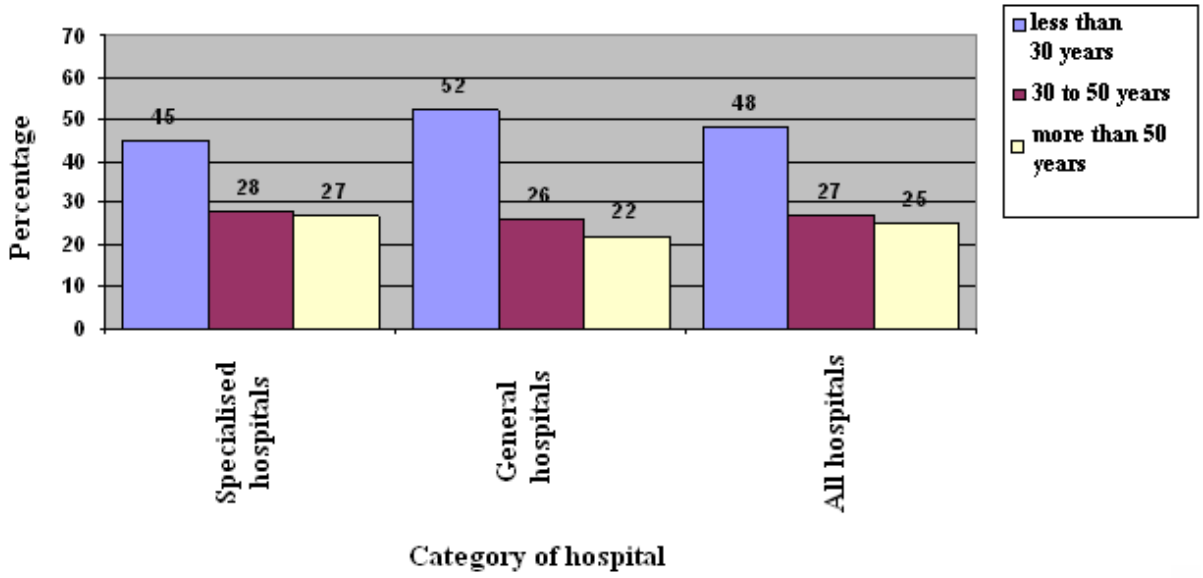
Chart 16: Segmentation of buildings according to their age and regions



Source: Sanigest International Analysis – Hospital Assessment Slovakia 2004

In terms of hospital categories, the data show that specialised hospitals have the worst state of their infrastructure. They have the highest share of buildings older than 50 years (27%) and only 2% of new infrastructural facilities have been built over the past 12 years.

Chart 17: Building age by category



Source: Sanigest International Analysis – Hospital Assessment Slovakia 2004

The most critical conditions (poor and unacceptable) are reported in the case of general hospitals, where 30% of them report a critical state (poor and unacceptable technical and operating condition of buildings). The situation concerning specialised hospitals is similar, 43% of them require repairs and 12% of them are in a poor condition.

Table 30: Technical and operating condition of buildings by hospital category

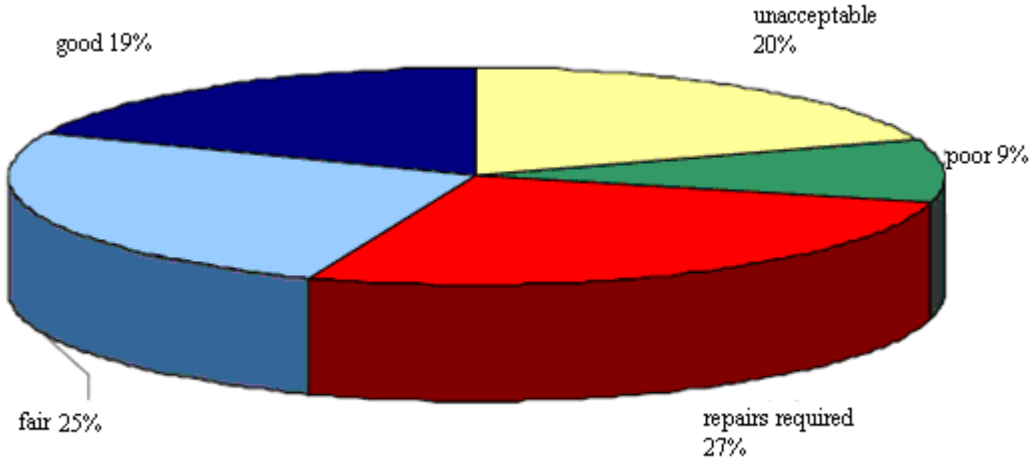
Hospital category	Good	Satisfactory	Repairs required	Poor	Unacceptable
Specialised hospitals	7 %	38 %	43 %	12 %	1 %
General hospitals	2 %	41%	27 %	17 %	13 %
All hospitals	4%	40 %	35 %	14 %	7 %

Source: Analysis of the company Sanigest - Slovak Hospitals Evaluation, 2004

The overall condition of the infrastructure is also affected by the condition of facades and roofs of hospital buildings.

Nearly 30% of hospital roofs are in a poor or unacceptable condition and one fifth of roofs needs to be replaced completely.

Chart 18 General assessment of hospital roofs by category



Source: Sanigest International Analysis – Hospital Assessment Slovakia 2004

As far as the hospital categories are concerned, the worst condition of roofs is reported in general hospitals with as many as 60% of roofs being unfit (repairs required, poor, unacceptable) and as many as 40% of roofs in specialised hospitals urgently require repair (repairs required, poor, unacceptable).

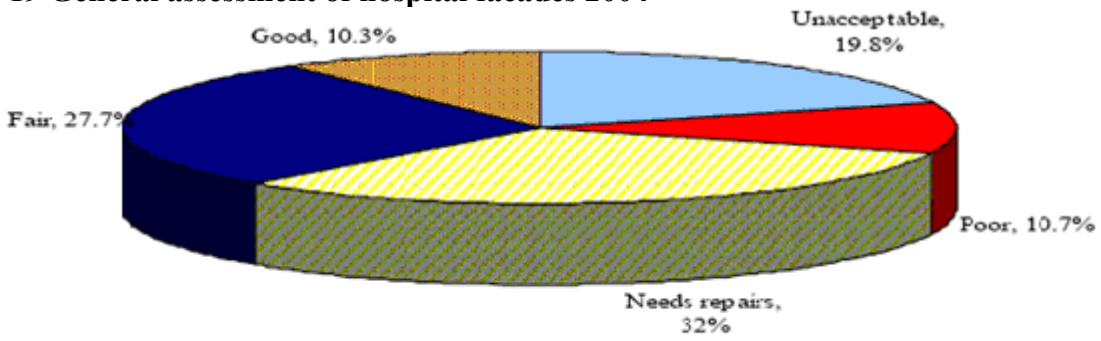
Table 31: Condition of hospital roofs by hospital categories (2004)

Hospital category	Good	Satisfactory	Repairs required	Poor	Unacceptable
Specialised hospitals	24 %	32 %	27%	9 %	8 %
General hospitals	17 %	23 %	26 %	10 %	24 %
All hospitals	20 %	28 %	26 %	10 %	16 %

Source: Analysis of the company Sanigest - Slovak Hospitals Evaluation, 2004

The overall condition of hospital facades (49.5%) was slightly worse than that of hospital roofs (51.5%), but the condition of the facades comes under the partial damage category (i.e. repairs required). About 30% of facades were in an unacceptable or poor condition, while the condition of 38% of them was satisfactory or good.

Chart 19 General assessment of hospital facades 2004



Source: Sanigest International Analysis – Hospital Assessment Slovakia 2004

The key indicator concerning the technical condition of facades is that the differences between hospital categories are much smaller than in the case of roofs. The data shown in the following table confirm that the share of unacceptable or poor facades is about 29% for specialised as well as general hospitals and more than 20% of all facades require repairs.

Table 32: Condition of hospital facades by hospital categories (2004)

Hospital category	Good	Satisfactory	Repairs required	Poor	Unacceptable
Specialised hospitals	11 %	36 %	24 %	10 %	19 %
General hospitals	10 %	28 %	33 %	11 %	19 %
All hospitals	10 %	32 %	29 %	11 %	19 %

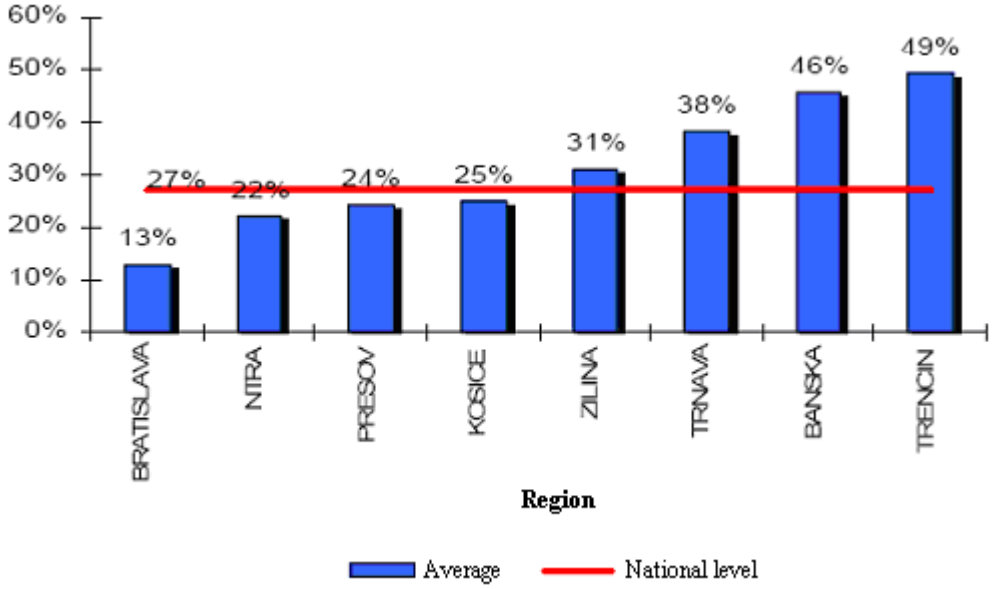
Source: Analysis of the company Sanigest - Slovak Hospitals Evaluation, 2004

Besides the overall condition of buildings, the condition of infrastructure systems for individual operational facilities and constructions is also unacceptable. The infrastructure systems for operational facilities and constructions mean the following: electric installations, high voltage lines, low voltage lines, electric distributors, water installations and facilities, fire protection, heating management, gas management, air supply systems and air-conditioning, medical gases, waste management, and construction parts of buildings.

In total, 27% of infrastructure systems require repair or their condition is poor/unacceptable.

According to regions, Trenčín, Banská Bystrica and Trnava have shown the highest numbers of systems which required at least one repair. On the contrary, Bratislava, Nitra and Prešov had the lowest figures, although the difference between Bratislava and other regions is significant (40% lower than in the case of Nitra, the region with the second lowest value).

Chart 20: Overall condition of systems according to region (requires repair, insufficient, unacceptable)

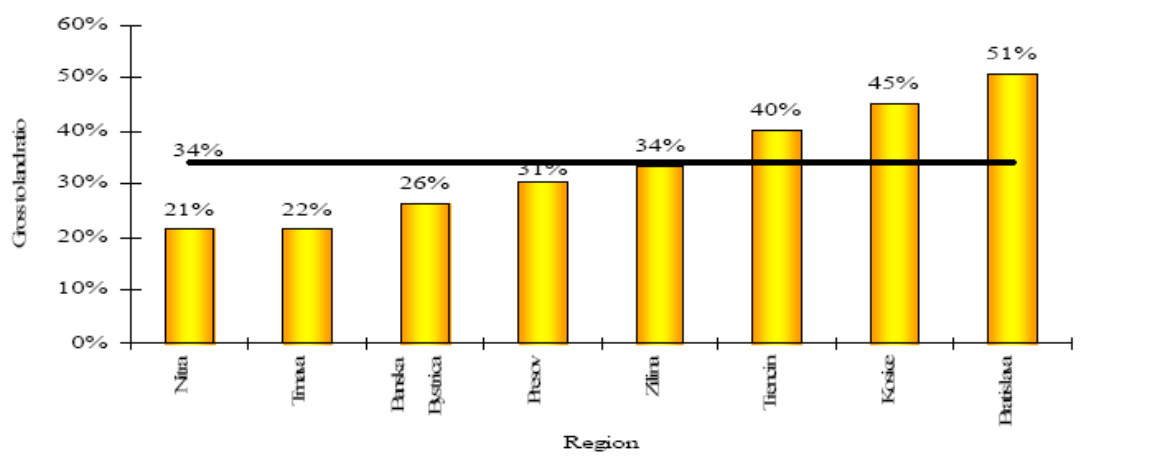


Source: Sanigest International Analysis – Hospital Assessment Slovakia 2004

As far as built-up areas are concerned, we are falling behind international standards. The majority of hospitals own large parcels of land with a number of buildings throughout the Slovak Republic. This is a representative image of a Slovak hospital.

For nearly half of all general teaching hospitals the ratios of total facility area to parcel area are over 70%, but, at the same time, 27% of these hospitals have the coefficients below the national average. According to regions, the average is higher than the international standard only in Bratislava (51%), while in Nitra and Trnava the built-up area constitutes approximately of one fifth of the whole parcel.

Chart 21: Total area to utility area ratio by regions (2004)

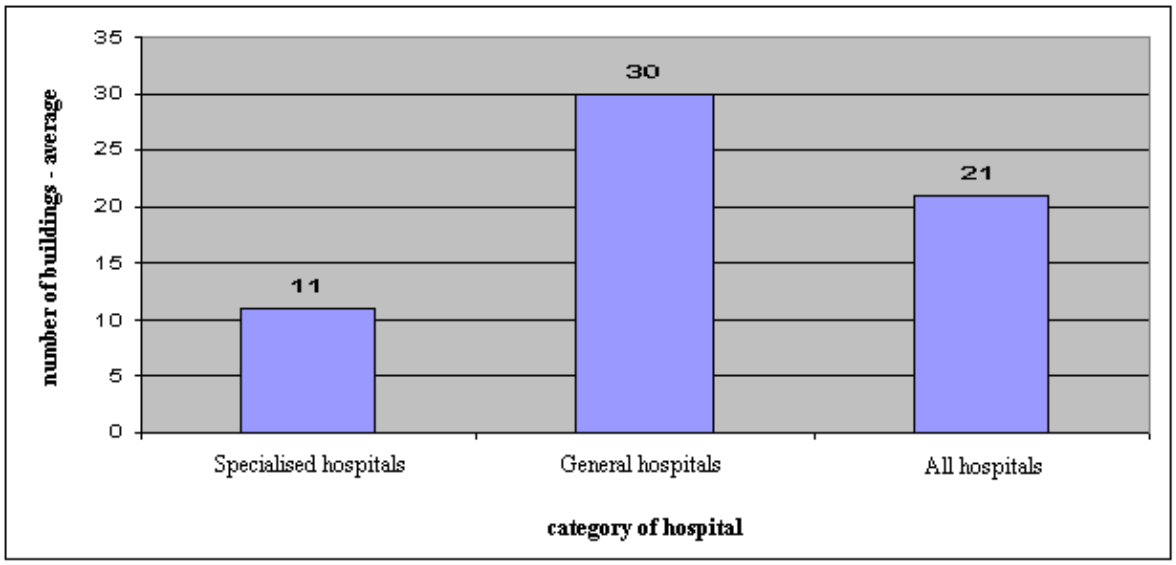


Source: Analysis of the company Sanigest - Slovak Hospitals Evaluation, 2004

In most hospitals, a random positioning of buildings on the premises is a characteristic feature of their layout. For example general hospitals have, on average, 30 buildings per hospital and some facilities even have as many as 81 buildings (e.g. Teaching Hospital of Martin).

The problems that accompany the inconvenient layout of buildings include long distances between individual key clinical departments, dangerous conditions for patients (especially in winter) during their transport from one building to another, and growing maintenance costs for the hospital.

Chart 22: Number of buildings by hospital categories (2004)



Source: Sanigest International Analysis – Hospital Assessment Slovakia 2004

The results of the analysis indicate that the clinical infrastructure of hospitals is unsatisfactory in terms of technological, economical, and operational aspects, it is also obsolete, the layout of many hospital buildings on the hospital premises and related logistics are poor, and the economy of hospitals is excessively costly and inefficient.

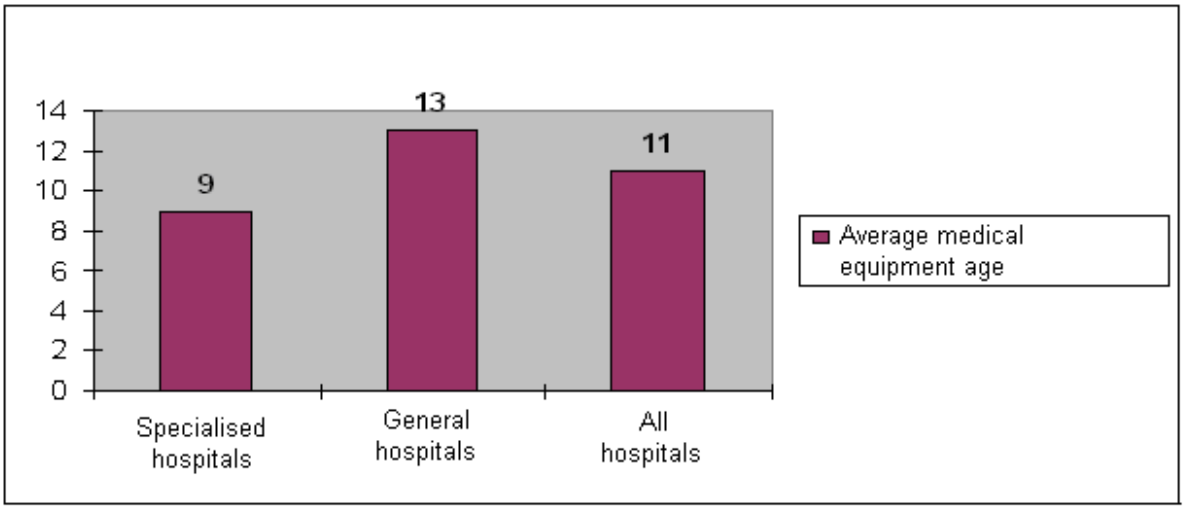
Medical equipment and instruments in hospitals

The assessment of the present condition of medical equipment focuses on its age, functional performance, operational conditions, use, and maintenance.

Medical equipment and instruments in most hospitals are unsatisfactory, often beyond their service life. The necessity for the modernization of medical equipment concerns all regions and its importance especially grows in connection with the emphasis on the provision of quality healthcare.

The average age of medical equipment in Slovakia is 11 years and there are significant differences between the individual hospital categories. Chronic and long-term care centres in specialised hospitals have 4-year old equipment. Medical equipment used by general hospitals is nearly 50% older than that in specialised hospitals as shown in the following chart.

Chart 23 Average medical equipment age according to hospital category, 2004

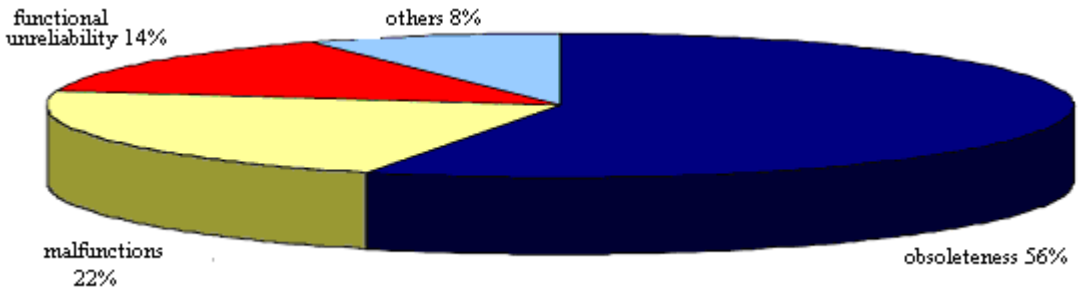


Source: Sanigest International Analysis – Hospital Assessment Slovakia 2004

The present inventory includes mainly medical equipment bought in the 1970s and in the past five years.

The operational reliability of medical equipment depends on its functionality based on its operating parameters. As far as the operational reliability is concerned, three key causes of low performance can be defined: obsoleteness (56%), malfunctions (22%), and functional unreliability (14%) as shown in the following chart.

Chart 24 Operational reliability of hospital equipment, aggregated level 2004



Source: Sanigest International Analysis – Hospital Assessment Slovakia 2004

As far as the individual types of equipment are concerned, the following table summarises medical equipment in terms of obsoleteness, malfunctions or both of these indicators combined.

Table 33: Equipment with the highest level of obsoleteness, frequent malfunctions or both problems present at the same time

Equipment	obsolete	% malfunctions	% both problems	Total %
Surgical Lamp, Ceiling – lighting	0	44	38	82
Linear Accelerator	0	50	25	75
Dental Unit	7	34	32	73
Incubator, Infant	22	19	18	59
Anaesthesia Unit	30	16	13	59
Gamma Camera – a diagnostic system for scanning internal organs using radioactive indicators	2	30	26	58
Operating Table	0	29	29	58
Electrocardiograph	26	13	11	50
Defibrillator / Monitor	31	8	8	47
Sterilizer, Steam	14	16	14	44
X - Ray Unit	14	16	13	43
Ventilator, Neonatal	2	19	19	40
Angiography, Digital Unit (DSA)	0	28	6	34
Slit Lamp – examining the frontal eye structures	4	11	10	25

Table 34 below shows the need for new medical equipment according to regions and types. The regions of Trenčín and Trnava have the highest need for new equipment. A similar classification according to specific equipment for selected diagnoses is given in Annex 10.

Table 34: Needs for new medical equipment by regions (NUTS III) and type of equipment

Equipment	WS			CS		ES		BA	SR
	TT	TN	NR	BB	ZA	PO	KE		
Blood gas analyzer	3	-2	11	10	17	8	19	3	69
Clinical Chemistry analyzer	-6	-71	-25	-35	-29	1	-4	-18	-187
Haematology Analyzer	-1	-23	12	4	-4	-8	19	2	1
Defibrillator / Monitor	-15	-64	22	49	33	86	63	34	208
MRI - Magnetic Resonance Imaging	2	1	-2	2	1	-17	2	1	-10
Incubator, Infant	-1	-55	-13	-1	-2	32	9	9	-22
Mammography Unit	7	3	3	6	3	8	9	3	42
Microscope, Electronic	-18	-34	0	-6	-19	1	1	-16	-91
Patient Monitor	155	122	161	181	183	174	198	180	1354
Refrigerator, Blood Bank	15	9	11	12	9	5	21	4	86
Ventilator, Adult	12	5	61	66	56	103	92	52	447
Ventilator, Paediatric	26	-17	25	35	25	33	40	31	198
X - Ray Fluoroscopic Unit, Image Intents	8	5	8	8	9	8	9	9	64
X - Ray Hemodynamic Unit	8	7	8	9	9	-2	10	10	59
X - Ray Unit	-5	-9	-17	2	-27	13	22	-15	-36
X - Ray Unit, Mobile, Image Intents	25	3	24	18	26	33	35	16	180
CT Scanner	3	0	4	4	0	4	7	2	24
Angiography, Digital Unit (DSA)	-3	0	0	-1	-1	-2	3	1	-3
Linear Accelerator	3	1	3	4	3	-10	5	3	12
Echograph, General Purpose	12	-29	-2	1	0	37	31	11	61

Water Purification System	14	11	13	11	14	17	21	17	118
Angiography, Ophthalmology	5	5	7	9	8	8	10	8	60
Echograph, Mammography	8	3	6	10	9	8	10	10	64
Echograph, Ophthalmologic	4	5	3	7	8	-34	9	9	11
Electrocardiograph	-1	-72	-1	32	14	100	71	-25	118
Electroencephalograph EEG	11	6	5	13	6	13	18	12	84
Electromyograph - EMG	7	-1	2	5	2	7	5	2	29
Endoscope, Flexible	-37	18	37	39	36	51	59	28	231
Endoscopic Unit	12	5	2	16	5	13	20	-4	69
Endoscopy, Video System	-3	-16	4	6	1	8	8	-1	7
Hemodyalisis Unit	106	83	73	140	129	128	142	137	938
Slit Lamp – examining the frontal eye structures	-4	-8	4	11	12	17	15	12	59
Tonometer, Electronic	16	2	16	19	15	-12	20	19	95
Anesthesia Unit	2	-70	17	14	6	67	71	-23	84
Arthroscopy Unit – optical system for examining joints	4	-5	4	7	3	8	8	3	32
Dental Unit	47	43	-11	55	50	52	62	54	352
Extracorporeal Unit / connected to a separate computer	1	0	1	1	1	-1	2	2	7
Gamma Camera – a diagnostic system for scanning internal organs using radioactive indicators	0	1	-1	4	0	2	2	3	11
Incubators, Infant, Intensive Care	34	28	17	38	28	27	43	35	250
Laparoscopy Unit	2	-6	-3	5	-8	6	3	-3	-4
Laser, Surgical	5	-3	6	8	5	8	10	8	47
Lithotriptor, Extracorporal	1	0	-1	0	0	1	1	-1	1
Operating Table	47	20	45	56	54	52	64	60	398
Sterilizer, Ethylene Oxide	7	4	7	6	8	7	10	7	56
Sterilizer, Plasma	7	4	8	9	5	7	10	9	59
Sterilizer, Steam	-22	-42	-9	-15	-40	17	19	-51	-143
Surgical Lamp, lighting	50	14	49	58	56	49	64	61	401
Ventilator, Neonatal	21	14	15	19	19	21	28	21	158

Source: Analysis of the company Sanigest - Slovak Hospitals Evaluation, 2004

The medical equipment analysis indicates its high average age, wear, and technical, moral, and economic obsoleteness. The most critical situation is in general hospitals with medical equipment with average age of 12 – 13 years.

Energy management in inpatient facilities

The results of the analyses of hospitals' energy costs (Analysis of the company Sanigest - Slovak Hospitals Evaluation, 2004) based on the efficiency of energy facilities and their management, indicate an excessive share of energy costs in the total expenses of hospitals. In Slovakia, it is 7% of the total expenses of hospitals. This figure is much higher than similar data in comparative countries, where energy costs account for 1-4% of hospital expenses.
In general, the analyses indicate that energy facilities and system are costly and uneconomical, which is connected with an unsatisfactory technical condition of buildings used by healthcare facilities.

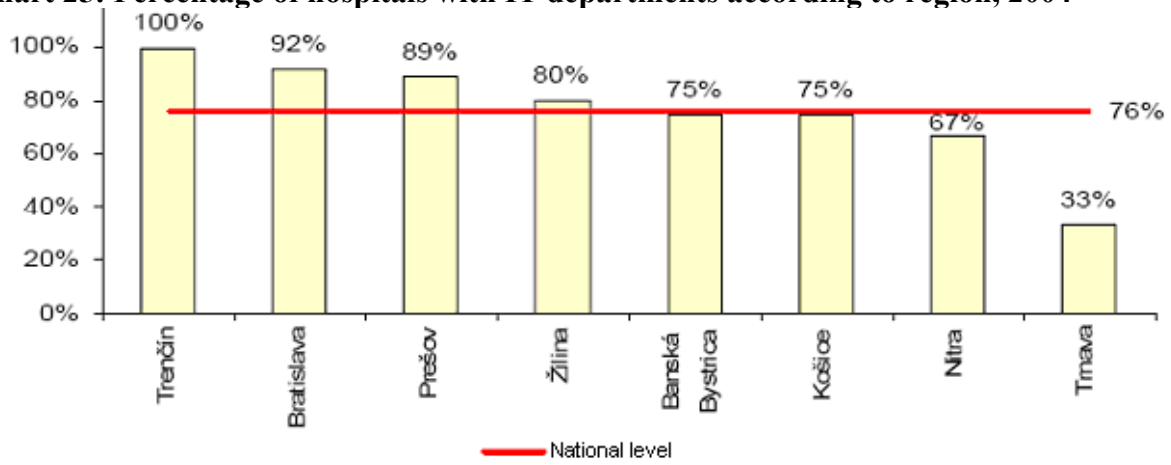
Information systems of inpatient facilities

Information systems represent the baseline of productivity in every organization. Healthcare facilities are no exception in this respect, since these systems represent the primary tool for managing and organizing of day-to-day administrative tasks.

A great majority of inpatient facilities (76%) have an *IT department* as a part of their organizational structure, but its roles are insufficient or not sufficiently used.

From the regional viewpoint, the greatest number of hospitals with IT departments are situated in Trenčín (100%), Bratislava (92%) and Prešov (89%). On the other hand Trnava (33%), Nitra (67%) as well as Košice and Banská Bystrica (75% each) are below the national average (76%).

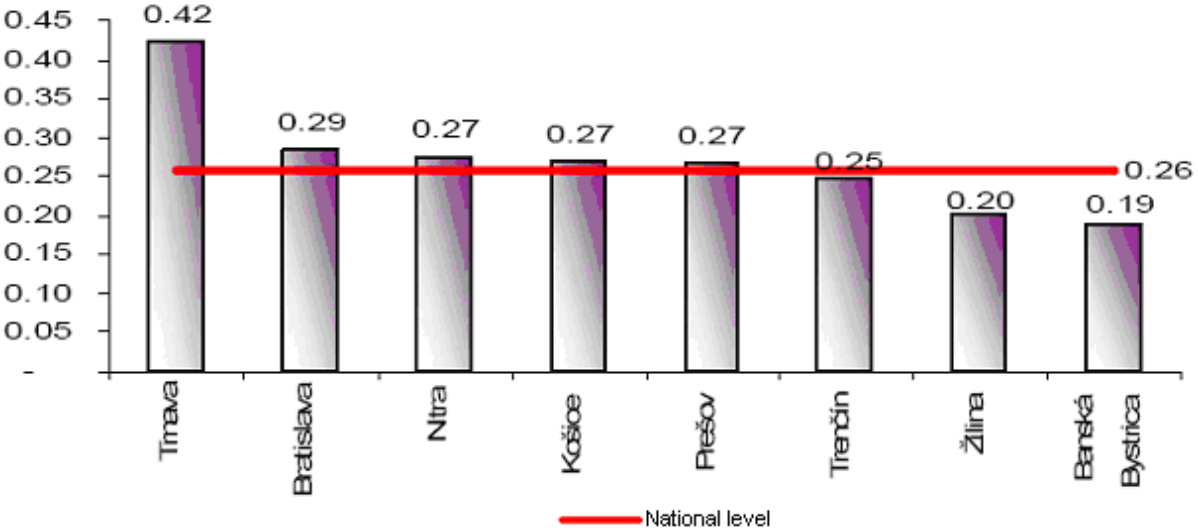
Chart 25: Percentage of hospitals with IT departments according to region, 2004



Source: Sanigest International Analysis – Hospital Assessment Slovakia 2004

In Slovak inpatient facilities, there are four medical workers per one computer. The respective figures for Nitra, Košice, Prešov, and Trenčín are very close to the national average. In hospitals in the region of Trnava, there are two medical workers per one computer. In Banská Bystrica and Žilina the ratio of medical workers and computers is 1:5.

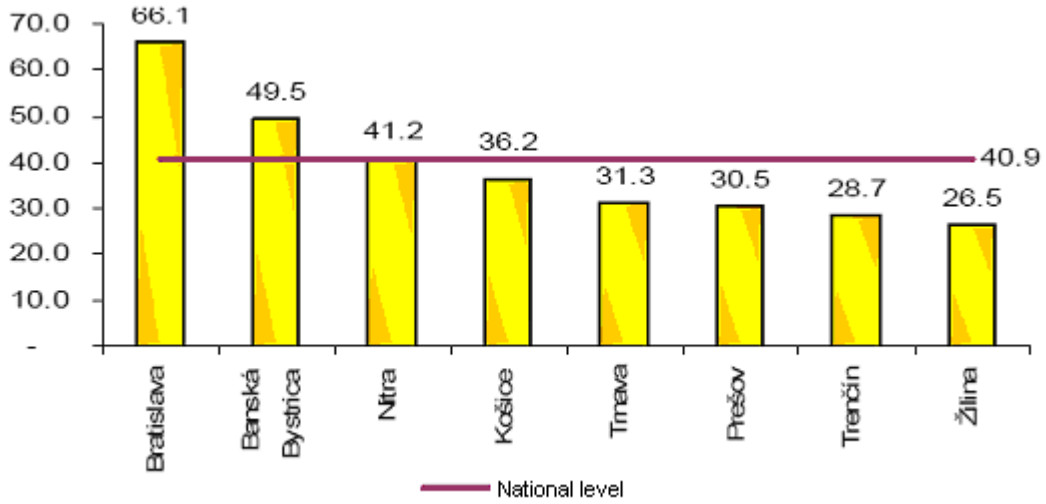
Chart 26: Total number of computers per number of employees according to region



Source: Sanigest International Analysis – Hospital Assessment Slovakia 2004

In 2004, 40.9% of all medical workers in Slovakia had access to the Internet. It is a necessary tool for information exchange, communication, and research. More specifically, 66.1% of workers had access to the Internet in Bratislava, while in Žilina, Trenčín a Prešov it was only 30% of workers.

Chart 27: The percentage of medical workers with access to the Internet according to region 2004



Source: Sanigest International Analysis – Hospital Assessment Slovakia 2004

The analysis of the information systems shows a certain progressive trend in hospital equipment including access to the Internet. A persisting shortcoming is the incompleteness and low compatibility of information systems in general. It is desirable to correct these shortcomings and to provide policy and investment-based support for the informatisation of healthcare providers to ensure a complex and functional interconnection with the Operational Programme on Informatisation of Society including eHealth.

3.4.2 Outpatient Facilities

Technical and operational condition of outpatient facilities

The current technical and operational condition of the outpatient infrastructure such as polyclinics and outpatient medical centres and National transfusion service, including IT systems is as unfavourable as was stated in the analysis of inpatient facilities, section 3.4.1.

Medical equipment in outpatient facilities

The conclusion of the analysis concerning medical equipment in inpatient facilities can also be applied to the analysis of medical equipment used by outpatient facilities.

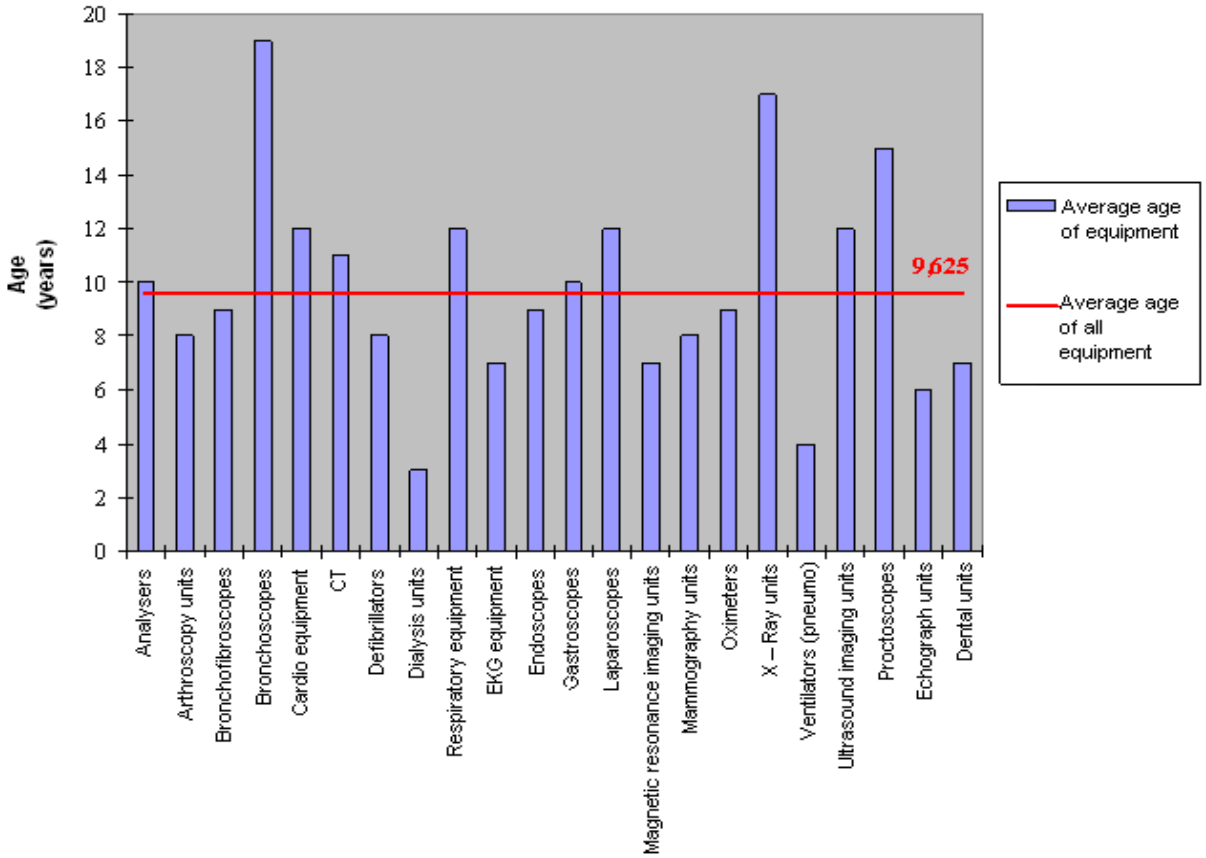
As indicated by Table 35 and Chart 28 concerning selected types of equipment in Slovakia, the average equipment age is about 10 years.

Table 35: Average age of selected types of equipment

Selected types of equipment	Average age of equipment
Blood analysers	14
Arthroscopy units	8
Bronchoscopes	14
Tomographic units	11
Defibrillators	8
Dialysis units	5
ECG units	7
Endoscopes	9
Gastroscopes	10
Laparoscopes	12
Magnetic resonance imaging units	7
Mammography units	8
Oximeters	9
X – Ray units	17
Ultrasound imaging units	12
Proctoscopes	15
Echograph units	6
Dental units	7
Average age of all types of equipment	**10**

Source: NHIC 2006

Chart 28: Average age of selected types of equipment in Slovakia



Source: NHIC 2006

The conclusion of the state of health analysis concerning the Slovak population in chapter 3.3 was that the most frequent cause of death for the Slovak population are circulatory system diseases, carcinomas, digestive and respiratory system diseases, and external causes of diseases and deaths.

For this reason, a survey and analysis were carried out in order to determine the average age of those types of equipment, which are used for diagnosing and treatment of patients especially with these problematic diagnoses. The average age of the equipment specifically used for the "Group 5" diseases is described in Table 36 and Chart 29.

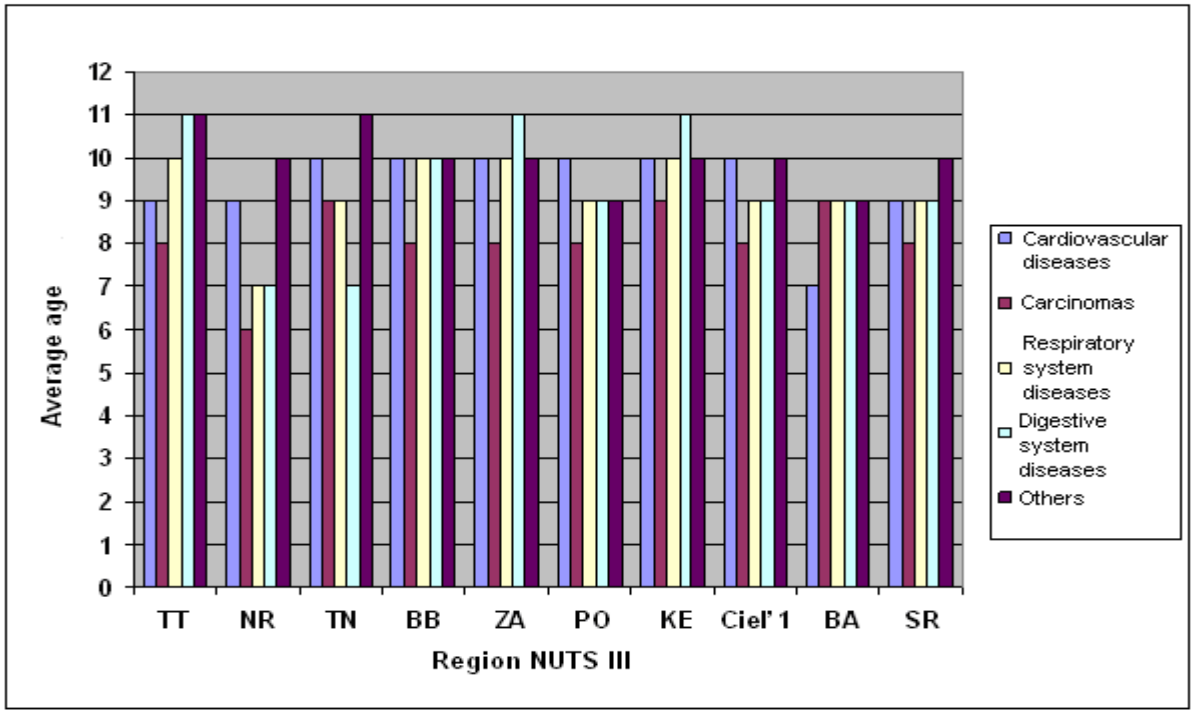
As indicated by the data, the average age of the medical equipment is about 10 years, while the write-off period for these types of equipment is 2 to 8 years. From the technical and economic point of view, the great majority of the equipment is practically written-off.

Table 36: Average age of equipment by regions and use for specific diseases

Use of equipment	WS			CS		ES		"Convergence" objective	BA	SR
	TT	NR	TN	BB	ZA	PO	KE			
Circulatory system diseases	9.33			10		10		**10**	7	**9**
	9	9	10	10	10	10	10			
Carcinomas	7.66			8		8.5		**8**	9	**8**
	8	6	9	8	8	8	9			
Respiratory system diseases	8.66			10		9.5		**9**	9	**9**
	10	7	9	10	10	9	10			
Digestive system diseases	8.33			10.5		10		**9**	9	**9**
	11	7	7	10	11	9	11			
Other	10.66			10		9.5		**10**	9	**10**
	11	10	11	10	10	9	10			

Source: NHIC 2006

Chart 29: Average age of equipment by regions and use for specific kinds of diseases



Source: NHIC 2006

Healthcare equipment of the National Blood Transfusion Service in Slovakia

Average age of own NTS equipment for processing of blood and preparation of blood products is 10 years. The equipment is worn down, its failure rate is high and therefore many repairs are necessary. Its small reliability and regular failures represent the cause of financial problems. Repairs are costly and expenses on maintenance of the NTS equipment in 2007 are, as of 30 June 2007, approximately 4 million SKK.

As a result of lacking financial means for purchasing of its own equipment necessary for its daily work, almost 40% of all NTS equipment are borrowed and the technical state of this equipment is not satisfactory.

3.4.3 Conclusion of the Analysis of Healthcare Infrastructure in the Slovak Republic

The healthcare infrastructure of hospital healthcare providers in the Slovak Republic is to a great extent technologically, morally, and economically obsolete, often unsatisfactory, and does not enable the provision of quality, efficient, accessible, and safe healthcare.

Inpatient facilities

Buildings and operational facilities

In general, the analysis shows that a large portion of facilities is in a condition when they are beyond their service life and can be considered as written-off.

From a regional point of view, the oldest buildings are in the region of Trnava.

Based on the comparison of the age of hospitals, the worst condition of the infrastructure is present in specialised hospitals.

When comparing hospitals on the basis of their technical and operation condition, the situation is critical for both general and specialised hospitals. The technical and operational condition of hospitals has been analysed in detail based on the condition of their facades – cladding, roofs, and infrastructure systems.

The comparison of the total and utility area of hospital premises often indicates insufficient logistic conditions due to the layout of buildings.

Medical equipment

The medical equipment with the average age of 10 years is in a condition when a significant portion of it requires technical restoration as soon as possible. The most critical situation is in general (regional and teaching) hospitals with the medical equipment with average age of 12 – 13 years.

The main reason why equipment is put out of service is its old age and maintenance level.

Outpatient facilities

The conclusions of the analysis concerning constructions and operational facilities – buildings and medical equipment – in inpatient facilities are also applicable in reference to outpatient facilities.

3.5 System evaluation and analyses summary

Currently, in spite of some long-term activities, healthcare system is in a situation when the structure and quality of provided services does not correspond with the needs of inhabitants. **Therefore, one of the top priorities is to improve the quality, effectiveness and accessibility of provided healthcare**.

Analyses of healthcare (including growth poles) and of public state of health in the Slovak Republic clearly showed the immediate necessity to treat diseases of "Group 5" by means of acute general and specialized hospital care together with effective activities in the scope of prevention and health support by means of outpatient healthcare facilities.

The main problems of the healthcare system, which are to be solved simultaneously, include excessive tendency of patient hospitalisation, excessive usage of specialised services, increasing number of hospitals and inadequate relation between primary and specialised care.

From the point of view of capacities, the emphasis is laid on decreasing the amount of hospitalisations and moving the focus of provided healthcare from hospitals to outpatient sector and to one-day and/or home care.

Current European trends in healthcare contain important elements influencing mainly institutional – hospital healthcare. This emphasis is caused by several reasons:

- Hospitals use a large portion of healthcare budget, in some European countries up to 70%.
- Hospitals employ up to 50% of doctors and three quarters of nurses.

3.6 Programming Period 2004 - 2006

3.6.1. Realization results of the Programming Period 2004 – 2006

Support of healthcare sector in the form of technical investments within the shortened Programming Period 2004 – 2006 was primarily implemented in the Operational Programme on Basic Infrastructure (hereinafter OPBI) financed from the ERDF means.

Within the OPBI, healthcare problematic was supported in the scope of the Local Infrastructure priority.

Sub measure 3.1.2. Building and Development of Healthcare Infrastructure is dealing with the support of healthcare infrastructure. Healthcare informatics is a part of measure 3.2. Building and Development of Information Society for Public Sector.

The OPBI was developed to support organizations with public character. MA for the OPBI including priority No. 3 Local Infrastructure was the MCRD SR.

Table 37: Financial allocations for sub measure 3.1.2 Building and Development of Healthcare Infrastructure (EUR)

Term	Total expenses	EU funding (ERDF)	Total national funds	Central funds (SB)	Self-governing region funds
2004 - 2006	25,679,870	20,543,897	5,135,973	3,851,980	1,283,993
2004	6,002,561	4,802,049	1,200,512	900,384	300,128
2005	8,572,768	6,858,215	1,714,553	1,285,915	428,638
2006	11,104,541	8,883,633	2,220,908	1,665,681	555,227

Source: OPBI

Table 38: Financial allocations for measure 3.2. Building and Development of Information Society for Public Sector (EUR)

Term	Total expenses	EU funding (ERDF)	Total national funds	Central funds (SB)	Self-governing region funds
2004 - 2006	13,702,715	10,277,036	3,425,679	2,740,542	685,137
2004	3,202,952	2,402,214	800,738	640,590	160,148
2005	4,574,408	3,430,806	1,143,602	914,881	228,721
2006	5,925,355	4,444,016	1,481,339	1,185,071	296,268

Source: OPBI

Within the financial plan of measure 3.2. allocation for information projects of the health sector was not specified. Allocation was specified at the level of measure. On the level of individual blocks (e.g. national projects), indicative division of financial resources was specified. On the level of individual activities (e.g. Information System for Healthcare Surveillance Authority), the minimum and maximum limits for non-refundable financial contributions for a project were specified.

Table 39: Evaluation demand and absorption to date by measures

OP	Priority		Measure		Allocation 2004-2006 (EUR)	Demand %	Contracting %	Drawing %
Operation Programme – Basic Infrastructure	3	Local Infrastructure	3.1	Building and Development of Civil Infrastructure in Regions	68 055 288	1093,15	92,50	52,72
			3.1.2	Sub measure Building and Development of Health Infrastructure	24 395 877	580,63	70,31	17,53
			3.2	Building and Development of Information Society for Public Sector	13 017 578	286,36	65,71	18,85

Source: MCRD SR (ITMS from 24.8.2007)

Legend:
Demand after measures is expressed as the share of value of accepted requests for NFC on the whole allocation for the measure (i.e. ERDF, SB put together and level of co-financing).
Absorption of measure is expressed as:
- State of contracting is calculated as the share of value of accepted requests for NFC on the whole allocation for the measure.
- State of drawing financial means of a measure is expressed as the share of settled financial means on the whole allocation for the measure.

Table 40: Evaluation of the number of received and supported project objectives

OP	Priority		Measure		Number of received applications for non-refundable financial contribution (NFC)	Number of approved applications for non-refundable financial contribution
Operation Programme – Basic Infrastructure	3.	Local Infrastructure	3.1	Building and Development of Civil Infrastructure in Regions	1393	180
			3.1.2	Sub measure Building and Development of Healthcare Infrastructure	126	29
			3.2	Building and Development of Information Society for Public Sector	143	56

***Source: MCRD SR** (ITMS 24.8.2007)*

From the aforementioned data from the shortened programming period 2004-2006, it results that additional sources from the ERDF and SR state budget are, in the conditions of the Slovak Republic an important measure for lessening of the impact of the long-term underestimation investments in relevant spheres. Analyses of the current state point out the necessity of support for the sphere of civil infrastructure facilities. This is also subsequent to big interest in the aforementioned types of activities in the shortened Programming Period 2004-2006, when the demand after capital investments from the side of founders of civil sphere facilities is several times greater than available means.

Evaluation of reached effectiveness and effect of realized projects

In the scope of single measures of Priority 3 Local Infrastructure OPBI in the programming period 2004-2006, the managing authority observed three levels of indicators – indicators of output, result and impact. For the OPBI programme for each level one indicator was defined. Values of output indicators on the level of single projects are determined on the basis of monitoring reports, which are sent to the managing authority by beneficiaries quarterly. Values of result and impact indicators are gained from final monitoring reports and subsequently in the period of 5 years from the end of the project from monitoring reports. Current implementation phase does not enable to evaluate the fulfilment of result and impact indicators. It shall be possible to evaluate these after the end of the project realization.

Sub Measure 3.1.2 Building and Development of Healthcare Infrastructure

Table 41: Received Projects – sub measure 3.1.2 – OPBI

STU (NUTS III)	Number of received projects	Demand (EUR)
Trnava	14	18,337,457.82
Nitra	17	12,316,061.74
Trenčín	10	14,627,354.36
Banská Bystrica	19	25,064,298.47
Žilina	16	14,287,030.82
Prešov	28	35,522,313.10
Košice	22	21,949,422.76
Bratislava	0	0
TOTAL	**126**	**142,103,939.08**

***Source: MCRD** (ITMS 24.8.2007)*

Table 42: Approved Projects – sub measure 3.1.2 – OPBI

STU (NUTS III)	Number of approved projects	Allocation on approved projects (EUR)
Trnava	3	3,292,578.95
Nitra	5	3,078,712.89
Trenčín	1	442,724.10
Banská Bystrica	4	6,306,631.58
Žilina	6	6,692,789.47
Prešov	6	5,733,286.29
Košice	4	2,292,327.84
Bratislava	0	0
TOTAL	**29**	**27,956,862.03**

Source: MCRD 15.02.07

Since Measure 3.1 is made of 4 sub measures, each of them follows the same indicators, the difference lies only in their stated values. Generally, there are the following indicators:

Table 43: Evaluation of Measure 3.1 OPBI

Type of indicator	Indicator name	Target values of single PD to OPBI					Assumed target values for y. 2008 according to approved projects in the scope of SM				
		3.1.1	3.1.2	3.1.3	3.1.4	3.1	3.1.1	3.1.2	3.1.3	3.1.4	3.1
Output	Number of reconstructed buildings	25	10	10	10	55	86	28	26	40	180
Result	No. of users of supported infrastructure (in thousands)	150	150	75	75	450	N/A	N/A	N/A	N/A	N/A
Impact	Gross/net employment rate	2 %	2 %	2 %	2 %	2 %	N/A	N/A	N/A	N/A	N/A

Source: MVRR SR, 2007

Table 44: Contracted Projects – sub measure 3.1.2 – OPBI

STU (NUTS III)	Number of contracted projects	ccContracting (EUR)
Trnava	2	2 883 800,00
Nitra	1	0,00
Trenčín	1	420 337,90
Banská Bystrica	3	5 602 829,13
Žilina	5	5 595 540,00
Prešov	1	584 026,32
Košice	3	2 065 416,41
Bratislava	0	0
TOTAL	**16**	**17 151 949,76**

Source: MCRD *(ITMS 24.8.2007)*

Measure 3.2 Building and Development of Information Society for Public Sector

Table 45: Accepted projects (healthcare) - Measure 3.2 OPBI

STU (NUTS III)	Number of projects	Demand (EUR)
Nitra	5	1,202,950.55
Prešov	3	584,272.21
Banská Bystrica	4	984,459.79
Trnava	2	493,299.47
Košice	1	234,794.21
Žilina	3	863,727.24
Trenčín	0	0
Bratislava	0	0
National project	2	2,273 957.89
TOTAL	**20**	**6,601,461.37**

Source: MCRD *(24.8.2007)*

Table 46: Approved projects (healthcare) - Measure 3.2 OPBI

STU (NUTS III)	Number of projects	Allocation (EUR)
Nitra	4	992,822.47
Prešov	2	505,061.68
Banská Bystrica	2	523,831.00
Trnava	1	263,157.89
Košice	1	234,794.21
Žilina	1	430,815.79
Trenčín	0	0
Bratislava	0	0
National project	1	741,326.31
TOTAL	**12**	**3,691,809.37**

Source: MCRD *(24.8.2007)*

Table 47: Contracted projects (healthcare) - Measure 3.2 OPBI

STU (NUTS III)	Number of projects	Contracting (EUR)
Nitra	0	0
Prešov	1	252,105.26
Banská Bystrica	0	0
Trnava	1	263,157.89
Košice	0	0
Žilina	1	430,815.79
Trenčín	0	0
Bratislava	0	0
National project	0	0
TOTAL	**3**	**946,078.95**

***Source: MCRD** (24.8.2007)*

Measure 3.2 - Building and Development of Information Society for Public Sector

Table 48: Evaluation of Measure 3.2 OPBI

Type of indicator	Indicator name	Target values according to PD to OPBI	Assumed target values for y. 2008 according to approved projects
Output	Number of public hot spots	10	46
Output	Number of school connected to the Internet	5	12
Output	Number of hospitals connected to the Internet	5	11
Result	No. of users of supported infrastructure (in thousands)	50,000	100,000
Impact	Gross/net employment rate	N/A	N/A

Source: MVRR SR, 2007

Generally, it can be summarized that in the sphere of healthcare infrastructure there was supported approximately one fifth of presented projects (29 of 126). **Contracting status on 15th February 2007 in relative formulation is 28.07 % and drawing according to the ITMS is at 10.08 %.**

On the basis of evaluation process, recommendations and decisions of the Selection Committee for the project selection and sub measure 3.1.2 Building and Development of Health Infrastructure, 29 applications for non-refundable financial contribution handed in were approved as of 15 February 2007. The Managing Authority (The Ministry of Construction and Regional Development of the SR) concluded a contract on providing non-refundable financial contribution (hereinafter "contract on NFC") with 6 applicants of 29 approved applications.

From the 6 contracted projects, 4 were realized. Three of them were focused on thermal insulation and reconstruction of inner infrastructure and one on reconstruction of heath economy. The realization of the last two projects began as well.

On the basis of evaluation process, recommendations and decisions of the Selection Committee for the project selection for sub measure 3.2 Building and Development of Information Society

for Public Sector, 12 applications for non-refundable financial contribution handed in were approved as of 15 February 2007. From 12 approved applications, 2 projects are realized in the sphere of healthcare. Overall sum of the contracted projects is 140,288,756,- SKK.
One of these two projects focuses on improving the effectiveness of the provided healthcare and on improving of the hospital management and economy. The aim of the other project is to achieve a level of effective hospital management that is in concord with the EU standards.

Positive examples from the shortened programming period 2004-2006 (Best practice)

- The OPBI strategy correctly identified priority spheres of support related to underestimated capital financing of civil infrastructure. High interest in receiving of additional resources from the ERDF from the side of local and regional self-governments confirmed that the OPBI was focused on their topical thematic priorities in the sphere of investment financing (the negative side was insufficient effective strategy).
- A large portion of project objectives in the scope of Priority 3 – Local Infrastructure OPBI could not be supported due to amount of allocation. Many intentions of organizations in the jurisdiction sphere of self-governments were, in the interest of receiving support from the SF, processed and readied into the form of particular construction and technical projects. There were issued building permits and from the side of self-governments there was in several cases performed a settlement referring to the rights of property for the particular construction.
- Lessons learned for the programming period 2007-2013
- In spite of their additional character the SF are in many Slovak self-governing regions perceived as the only alternative for the realization of their investment intentions. High demand after supported types of operations on the one side, and additional and restricted character of means from the SF on the other irrevocably create the need of a precise definition of the operational programme strategy.
- One of the most important elements for the increase of implementation quality is a pre-defined division of the allocation of the OPH allocation available for the relevant NUTS 2 regions. The available allocation is one of the most relevant data for all subjects connected with the implementation of the OPH (EC, Managing authority for the OPH, beneficiaries, etc.). Based on experience from the previous programming period it is necessary to regularly and often update information about drawing of funds on the level of single OPH measures and single regions. The most resourceful source of information for the aforementioned subjects are web pages of managing authorities and a common information portal for SF a CF.
- In relation with the need to process a large number of applications for financial contribution, it is necessary to create implementation environment in which information technologies are applied at the greatest scale possible. Improvements in this sphere significantly influence increased transparency and objectivity of processes. The core is to secure a fluent and continuous acceptation and registration of applications for financial contribution and that also in electronic form.
- In the shortened programming period 2004-2006, the evaluation process of projects in the scope of Priority 3 – Local infrastructure OPBI was administratively complicated and time consuming. This fact is related to control mechanisms on several levels, which were the result of a lack of experience from the sphere of SF. The set system of the OPH implementation in the programming period 2007-2012 assumes an objective evaluation of application documentation in the first phases of evaluation by means of a bundle of measurable and yes/no criteria for each thematic sphere of support.

- Decisions on approval of projects are in the final phase made by collective bodies consisting of social-economical partners (so called selection committees). Function of selection committees in the programming period 2004-2006 was based on evaluation of project intentions, which were, on the basis of previous evaluation, qualified into selection process. In relation to the selection process there were identified following insufficiencies:
- Selection committees brought together on the principle of partnership were making decisions on the basis of consensus of all members, what lead to decreasing effectiveness in the cases when a member vetoed the decision of all other members. In the programming period 2007-2013, it is necessary to decide on a functioning mechanism of decision-taking, meanwhile the composition of the selection committee represents (on the basis of partnership) national, regional and local level, level of horizontal priorities etc.
- As the most simple and administratively least complex system for data storage and for following of gained progress seems to be the ITMS system. The ITMS system is adjusted on the basis of lessons learned in the previous programming period and it represents a valuable information source for the process of monitoring and programme evaluation.
- Experience from the years 2004-2006 confirmed that continuous and regular informing of public by means of updated information on gained progress in implementation represents a key factor for a transparent realization of the operational programme. The most spread and most required way of acquiring information is their publication on internet pages of managing authorities and on the common portal for all operational programmes.

3.7 SWOT analysis

The SWOT analysis is based on the description of the current situation and captures the identified key disparities of the sector. The analysis of the Slovak healthcare sector contains an overall evaluation of its strengths and weaknesses, opportunities and threats. It forms the basis for the formulation of aims in the scope of the OPH for 2007 – 2013.

Table 49: SWOT analysis

STRENGHTS	WS	CS	ES
Even coverage of the whole area by inpatient healthcare providers in growth poles	x	x	x
Existence of teaching hospitals and specialized institutions with centralized and specialized healthcare	x	x	x
Developed network of outpatient wards performing prevention of risk factors significant for some specific diseases	x	x	x

WEAKNESSES	WS	CS	ES
Poor state of health of the Slovak population, high morbidity and mortality from circulatory system diseases, tumours, external causes of diseases and deaths, respiratory and digestive system diseases (diseases of group 5)	x	x	x
Lower average life expectancy of Slovak inhabitants in comparison to the EU	x	x	x
Unfavourable state of material and technical basis of infrastructure of healthcare providers	x	x	x
Unfavourable state of healthcare technology of healthcare providers	x	x	x

Uncomplexity of provided outpatient healthcare services due to individualization of healthcare providers	x	x	x
High energy consumption of healthcare infrastructure	x	x	x
Uncomplexity and low compatibility of information system of healthcare providers	x	x	x

OPPORTUNITIES	**WS**	**CS**	**ES**
Creation of an effective and flexible network of providers on the NUTS II level, which can provide accessible available, safe and economically sustainable quality healthcare	x	x	x
Improvement of quality of life by means of improvement of providing inpatient healthcare	x	x	x
Improvement of quality of life by means of improving prevention, diagnosing and modernization of healthcare facilities	x	x	x
Increasing of individual responsibility of citizens for their health condition	x	x	x

THREATS	**WS**	**CS**	**ES**
Citizens' passivity in relation to their own health condition	x	x	x
Ongoing unfavourable social situation of the marginalized Roma communities		x	x
Resistance against restructuring changes	x	x	x
Insufficient financial resources important for an overall and complex restructuring of healthcare providers	x	x	x

Identified strengths and weaknesses, as well as opportunities and threats have a general character reflected on a nation-wide level and at the same time they are common for all regions of the Slovak Republic on the NUTS II level.

3.8 Key Disparities and Factors of Development

Table 50: Key disparities and factors of development with regional projection on the NUTS 2 level

Key Disparities	Regional Projection			Key Factors of Development	Regional Projection		
Priority Axis 1	**WS**	**CS**	**ES**	**Priority Axis 1**	**WS**	**CS**	**ES**
1. Unfavourable state of material and technical basis of infrastructure of healthcare providers	x	x	x	a. Improvement of healthcare facilities infrastructure with the aim to increase quality, effectiveness and accessibility of healthcare with focus on specific types of diseases (1, 2, 3, 4)	x	x	x
2. Insufficient effectiveness of healthcare system	x	x	x				
3. Shortcomings in healthcare provision with negative impact on the quality and security of patients	x	X	x				
4. Poor state of health of the population and mortality from specific types of diseases							
Priority Axis 2	**WS**	**CS**	**ES**	**Priority Axis 2**	**WS**	**CS**	**ES**
5. Insufficient level and old infrastructure of outpatient facilities performing prevention of risk factors of specific diseases	x	X	x	b. Increasing quality of infrastructure of outpatient facilities in order of timely check of risk factors of specific diseases, which have a large share on population mortality (5)	x	x	x

Source: MOH SR

4 Operational Programme strategy

4.1 OPH strategy backgrounds

In the process of defining the scope for the OPH strategy for the period 2007-2013 it is necessary to take into account the following principles:

- background of the NSRF for the OPH;
- strategies on the Community, national, regional and local levels and outputs from the application of the partnership principle;;
- analyses results and backgrounds for thematic and regional intervention concentration.

4.1.1 Backgrounds of the National Strategic Reference Framework for the Operational Programme Health – connection of the OPH with the vision and strategy of the NSRF

The NSRF is a basic framework strategic document of national level, which defines the development of priorities co-financed from the SF and CF in the programming period 2007-2013 in relation to Community Strategic Guidelines defining frameworks for intervention funds on the European level.
The NSRF defines as the first of its strategic priorities the infrastructure and regional accessibility and its global aim is to **"increase the density of infrastructure in regions and increase the effectiveness of public services related to it"**. The aforementioned goal is reached by means of realization of single specific NSRF priorities. The OPH is an operational programme for which the specific priority 1.4 Healthcare Infrastructure is relevant. Its aim is defined as *"Improvement of conditions influencing the state of health of population in productive and post productive age by means of increasing quality of healthcare infrastructure"*. Basis for the NSRF for defining a strategy for the OPH is the fact that the aim of the specific priority 1.4 of the NSRF is achieved mostly by means of OPH implementation.

Table 51: Hierarchic structure of priorities and aims of the NSRF relevant from the point of view of the OPH.

Hierarchy	Objective:
National Strategic Reference Framework	Until 2013, notably increase the competitiveness and effectiveness of regions and of the Slovak economy and the employment rate while respecting the principles of sustainable development.
Strategic priority 1 Infrastructure and regional accessibility	Increasing of density of regional infrastructure and increasing effectiveness of public services related to it
Specific priority 1.4 Healthcare infrastructure	Improvement of conditions influencing the state of health of population in productive and post productive age by means of increasing quality of healthcare infrastructure.

Strategic priorities of the NSRF and their goals on lower levels are defined in specific priorities and aims including key structural indicators for each thematic sphere worked out in the specific priority.

4.1.2 Strategies on the Community, national, regional and local level and outputs from the application of the partnership principle

Evaluation of the current state of regional infrastructure in a single thematic sphere of the OPH support and assumed development in coming years was performed on the basis of conceptual and strategic documents:

Community Strategic Guidelines (CSG) *– The OPH is based on the 3. guideline CSG - "Creating of a greater number of qualitatively better work places"* and in the scope of it, it is oriented on *"Protection of work force health"*.

Lisbon strategy/National development plan (LS/NDP) – The OPH contributes to the improvement of regional competitiveness and attractiveness by means of supporting the healthcare infrastructure development especially in growth poles.

National Sustainable Development Strategy/Sustainable Development Action Plan (NSDS/SDAP) – The OPH, by means of improving quality of life in regions (strengthening of innovation and cohesion growth poles), supports polycentric overall development of the SR, due to which the support of healthcare infrastructure in cohesion growth poles contributes to lowering of interregional disparities.

Concept of territorial development of Slovakia 2001 (CTDS 2001) defines the population structure of the SR, the hierarchy of its centres and crucial areas, which are the basis for defining of innovation and cohesion growth poles as priorities of the territorial concentration for the NSRF.

During the OPH elaboration, the following basic documents and strategies were taken into account:

- Decrees on Structural Funds for 2007 – 2013;
- Community strategic guidelines;
- "Detailing of the Government's 2006 – 2010 Manifesto for the health sector situation";
- Act No. 578/2004 Coll. of 21 October 2004 on healthcare providers, health workers and professional organizations in the health service, and amending and supplementing certain laws, as amended;
- Act No. 576/2004 Coll. of 21 October 2004 on healthcare, healthcare-related services and on the amendment and supplementing of certain laws, as amended;
- Regulation of the Ministry of Health of the Slovak Republic No. 770/2004 Coll. of 20 December 2004, which defines the indicators of single types of healthcare facilities;
- National Development Plan for 2004 – 2006 (approved by Governmental Resolution No 166/2003);
- Operational Programme on Basic Infrastructure for 2004-2006;
- National Strategic Reference Framework of the SR 2007 – 2013 – approved by the Resolution of the Slovak Republic Government No. 1005/2006 of 6 December 2006;
- Strategy for development of the Slovakia's competitiveness by 2010;
- Concept of territorial development of Slovakia 2001 (approved by Governmental Resolution No. 1033/2001);
- Analysis of the company Sanigest International- Slovak Hospitals Evaluation; of 02/2006
- Report on health condition of the population in Slovakia – Resolution of the Slovak Republic Government No. 873 of 18 of October 2006;

- "Amendment to the National Reform Programme of the Slovak Republic 2006 – 2008"- Resolution of the Slovak Republic Government No. 1056/2006 of 13 December 2006;
- Year-book on health statistics of the Slovak Republic 2000-2005; issued in 2007
- "Report on programme of rationalization in the healthcare system of the SR" Resolution of the Slovak Republic Government No. 462/2007 of 23 of May 2007.
- Proposal concept of health development of Prešov self-governing region;
- Concept of health of Žilina self-governing region;
- Development strategy of healthcare services in Banská Bystrica self-governing region for years 2006-2009;
- Development program of Nitra self-governing region 2003-2013, part Health;
- Development plan Slovakia – East (proposal), Developing theme: Healthcare;
- Economic and social development program of Trenčín self-governing region, part Health;
- Economic and social development program of Trnava self-governing region 2004-2013, part Health.

On the preparation and the approval of the OPH participated a broad spectre of social and economical partners, who promoted the projection of approved sector or supporting strategies into the OPH strategy. Conclusions from the application of the partnership principle in the process of the OPH preparation are in Annex 7.

During the programming period 2007-2013, participation of social and economic partners on the preparation and implementation of the OPH is secured by means of activity of a prepared work group by the preparation of the sole operational programme, appeals for single OPH measures, activities in the Monitoring Committee for the OPH, management group for evaluation and co-operation on single activities resulting from the Communication plan by providing of information and publicity of the OPH etc. Participation of the aforementioned partners on the OPH implementation is described in Chapter 2 of the OPH.

4.1.3 Results of analyses in the sphere of the health condition of the Slovak population and healthcare infrastructure of healthcare providers

Results of analyses and bases for thematic and territorial concentration of the OPH intervention, which point out the current situation in healthcare, are in the following parts of the programme document:

- Evaluation of the healthcare provision system in the Slovak Republic;
- Analysis of the population health condition in the SR;
- Analysis of healthcare infrastructure of inpatient and outpatient healthcare providers;
- Evaluation of the shortened programming period 2004-2006;
- SWOT analysis;
- Key disparities and factors of development in healthcare.

From the executed analyses of the population health condition in the SR, the necessity to treat diseases of Group 5 came out:

- circulatory system;
- tumours;
- external causes;
- respiratory system;

- digestive system.

These belong to the main causes of morbidity and mortality of the Slovak population. It is necessary to treat them by means of acute general and specialized hospital care and outpatient healthcare connected with prevention and health support.

Main causes of diseases and deaths and diagnoses of Group 5 caused the focus of the analysis on healthcare infrastructure of inpatient and outpatient healthcare providers. Healthcare infrastructure, on the basis of Article 4 of Regulation (EC) No 1080/2006 of the European Parliament and of the Council of 5 July 2006 repealing Regulation (EC) No 1783/1999, is a part of Priority theme 11 "*investments into healthcare and social infrastructure contribute to regional and local development and increase quality of life*". For determination of the OPH strategy from the analysis of healthcare infrastructure, the following generalized facts arise:

- Unsatisfactory state and quality of material and technical basis and technical-economical level of healthcare infrastructure of healthcare providers.
- Unsatisfactory level of equipment of healthcare providers with healthcare technology.
- Uncomplexity of provided outpatient healthcare services as a result of increased outpatient healthcare providers' individuality, which does not secure sufficient complexity of provided healthcare services of polyclinics and healthcare centres.
- High energy consumption of the healthcare infrastructure.
- Incomplete and incompatible information of healthcare providers.
- From the quantitative point of view, the healthcare infrastructure facilities network of healthcare providers is in Slovakia average quite satisfactory. In the case of some facilities, there are attempts of its restructuring to preserve its financial sustainability.
- An analysis confirmed that the number of facilities and their distribution copy innovation and cohesion growth poles (IGP) and the distribution of population in the real structure of population.
- There exist certain regional differences in the equipment of healthcare infrastructure facilities, especially between more developed western and less developed eastern part of the country.
- Improved active prevention with the aim to decrease mortality of women on breast cancer is possible by means of national project of purchase, delivery and organized function of mobile mammography units in prevention.
- Ongoing problem is lack of material and technical equipment (deficient material and technical baseline), which provides sufficiency and quality of blood and blood products, effective supplying and accessibility for the real needs of healthcare providers.

4.1.4 Summary for thematic concentration of interventions

Based on the aforementioned results of analysis, it is possible to define the following bases for thematic direction of interventions in the scope of single areas of support – measures of healthcare infrastructure:

- Interventions into healthcare infrastructure facilities (general and specialized hospitals, polyclinic outpatient facilities and healthcare centres) direct into building of new hospital facilities, reconstruction, modernization, improvement of construction and technical state of all selected facilities and the modernization of their equipment with healthcare and information technologies; increasing of energetic economy of building. Supported shall be demand projects in order to rationalize the network of healthcare providers.

- Intervention into national project. Its realization shall provide conditions for the state-wide securing of effective solutions for the prevention and treatment of breast tumours of women.
- Intervention into national project, which shall eliminate existing problems by means of a complex solution of material and technical basis of healthcare infrastructure of the national transfusion service.
- In direction of intervention into facilities of healthcare infrastructure of demand and national-oriented projects, exercise selection criteria, which shall provide quality, effectiveness, accessibility and safety of provided healthcare and its long-term sustainability (capacity and economical criteria).

4.1.5 Backgrounds for territorial concentration of interventions

According to the NSRF, from the point of national bases of regional projection of the NSRF strategy, it is an important fact that the Slovak Republic has an evenly developed system of population centres, where there are polarized and agglomerated areas (so called settlement territories) around the greatest centres. These cities and their agglomerations can fulfil the role of development accelerators or, in other words, growth poles of single areas.

For the purposes of territorial concentration in the NSRF, it is recommended to observe the concentration of activities into innovation and cohesion growth poles in concord with the polycentric concept of settlement development.
Innovation and cohesion growth poles were (in the scope of the NSRF preparation) specified on the basis of ahead-determined social and economical, urban criteria and statistical evaluations of all municipalities in the Slovak Republic. Proposal of definition of growth poles in the form of a precise list of municipalities was individually discussed and commented by substantially appropriate specialized divisions of all self-governing regions (i.e. divisions concerned with urban planning and regional development and of self-governing regions). This procedure ensured a more precise final list of municipalities and their classification into growth poles.

Description of the growth poles classification method together with the final list of municipalities categorised according to regions are in Annex 5 of the OPH. On the web page of the Ministry of Construction and Regional Development SR (www.build.gov.sk) there is a precise list of categorised municipalities and graphic representation on the map of the region for each NUTS3 region.

Classification of municipalities into innovation and cohesion growth poles was realized predominantly on the basis of existence of single facilities relating to the civil and economic infrastructure and the impact of these facilities on the surrounding area municipalities. Innovation cycle of these facilities is, on the basis of their long-term character, tens of years, even hundred. Because of these reasons, we do not expect any significant changes in the classification of municipalities in the programming period 2007-2013 and neither its revision. Changes may occur when there is a significant development of economic activity in the municipality, which is not a growth pole (e.g. sudden in-flow of investments). Subsequent economic and social development can require development in the sphere of basic equipment in such a scope, that these facilities shall be more influent than the facilities in neighbourhood falling into the scope of cohesion growth poles. During the programming period 2007-2013, the part of running evaluations on the NSRF level are also: running evaluation of efficiency of the chosen territorial concentration, of the impact of realized interventions and of the overall development of the Slovak economy on the

list of innovation and cohesion growth poles. Considering the need to keep a certain time space for the intervention impact to show, it is possible to think of performing such evaluation in 2010 at soonest. Evaluation results are presented to the National monitoring committee, which on their bases makes a decision concerned with a possible change of the chosen approach to territorial concentration.

Innovation growth poles are created by the most important cities in the sphere of Slovak settlement. As these were specified all cities that secure higher and specific civil equipment and at the same time they function as work centres of regional, above-region and state importance. To these centres were (on the basis of previous and current development) counted current regional capitals and towns with the function of district centres, towns fulfilling the former role of a regional centre and some other important cities, which were added on the basis of regional specifics after individual professional consultations with responsible authorities of self-governing regions. The most important cities, which are specified as innovation growth poles, as a result of their influence, created agglomeration relations with other municipalities and cities near. In the Concept of territorial development of Slovakia 2001 (hereinafter as CTDS 2001), these areas are called main settlement territories. For the purpose of the NSRF in concord with the CTDS 2001, certain interest areas of innovation growth poles were specified, which are directly and strongly influenced by central cities (innovation growth poles) and in which suburban tendencies connected with exhibits of so called concentrated de-concentration show. It means that new economic and social activities are being allocated and together with central cities create one functional unit. In the scope of these areas, there are or could be further innovation growth poles, which are interconnected by means of intensive agglomeration relations, cohesion growth poles and other municipalities, from this point of view further unspecified.

Cohesion growth poles are created by the most important municipalities that fulfil or have the potential to fulfil the criteria for securing of basic service functions equally for the inhabitants of the respective municipality and for the inhabitants living close to it. Innovation growth poles represent also the functions of cohesion growth poles.

Cohesion growth poles are decided on the basis of the following criteria, in which there were followed these indicators:

- Existence of facilities of basic equipment (school facilities and their scope, facilities of social infrastructure);
- position of the municipality from the viewpoint of several public functions (registry Office, common building offices);
- number of inhabitants in the respective municipality in 2004;
- historical development of the municipality and its position in the settlement system (in relation to former central system of settlement present at the territory of Slovakia);
- localisation of the municipality in the region and accessibility of the suggested cohesion growth pole from the surrounding municipalities;
- accessibility of regional centres is in the whole Slovak Republic under the isochrone of 30 minutes.

Table 52: Number of growth poles and share of inhabitants living in growth poles in 2004

Region	Number of all municipalities in region	Number of growth poles in region	Number of innovation growth poles	Number of cohesion growth poles	Number of municipalities, which are not growth poles		Population in the growth poles	% of inhabitants in the growth poles
					In interest area of innovation growth poles	Out of interest area of innovation growth poles		
NUTS 2 Bratislava	**73**	**37**	**4**	**33**	**22**	**14**	**571 811**	**95.1**
Bratislava	73	37	4	33	22	14	571 811	95.1
NUTS 2 West	**881**	**366**	**29**	**337**	**77**	**438**	**1552535**	**83.2**
Trnava	251	106	7	99	26	119	453251	81.9
Trenčín	276	104	12	92	23	149	504801	83.9
Nitra	354	156	10	146	28	170	594483	83.8
NUTS 2 Central	**831**	**264**	**24**	**240**	**148**	**419**	**1107933**	**81.8**
Žilina	315	139	11	128	82	94	602321	86.8
Banská Bystrica	516	125	13	112	66	325	505612	76.8
NUTS 2 East	**1106**	**306**	**25**	**281**	**168**	**632**	**1230376**	**78.5**
Prešov	666	176	13	163	93	397	615371	77.2
Košice	440	130	12	118	75	235	615005	79.8
Objective "Convergence"	**2818**	**936**	**78**	**858**	**393**	**1489**	**3890844**	**81.45**
Aggregate SR	**2891**	**973**	**82**	**891**	**415**	**1503**	**4462655**	**82.87**

Source: Aurex, 2007

Approximately one third of all municipalities in the scope of "Convergence" objective is an innovation or cohesion growth pole. In them live app. 83% of inhabitants of the whole area of "Convergence" objective in the conditions of the Slovak Republic. The smallest share of inhabitants living in the growth poles have the regions of Banská Bystrica and Prešov, what is caused especially by he splintered structure of settlement (large number of small municipalities). The NSRF territorially concentrates thematic priorities, from the point of view of reaching strategic objectives, into the region by means of projects implemented[4]

- in priority manner in innovation and cohesion growth poles;
- in specific cases into territories outside growth poles.

From the aforementioned it results that interventions related to single strategic priorities of the NSRF are directed in the following manner:

- Strategic priority "Infrastructure and regional accessibility" – priority direction is into innovation and cohesion growth poles depending from single types of infrastructure;
- Strategic priority "Information economy" – priority concentration is into innovation growth poles except the sphere of increasing accessibility to broadband Internet, in which there are conditions for the creation and development of most important sources of growth based on the usage of knowledge, increase of effectiveness and impact of deciding economic and social processes influencing the development in the rest of the Slovak Republic.
- Strategic priority "Human Resources" – Interventions shall not be conditioned by the principle of territorial concentration, since the relation of content of education with the needs of work market, acquiring of basic skills and key competences just like improvement of quality of life-long education require a complex and unified approach in the whole Slovak Republic (including the self-governing region of Bratislava).

[4] National strategic reference framework SR for the programming period 2007-2013, Ministry of Construction and Regional Development SR

In the case of especially effective and efficient interventions, considering reaching of objectives defined by the NSRF and its relevant priorities, which are impossible to realize in priority territories, it is purposeful to direct the contributions into territories outside the growth poles. The aforementioned approach can be performed mainly in the case of support of activities with horizontal character such as social inclusion of marginalized Roma communities (segregated and separated Roma settlements); furthermore, in the case of support of civil infrastructure facilities outside the growth poles, which are also important from the point of view of function, type of services in the structure and capacity of the region; in the case of support of selected projects in environment and support of tourism.

The scope of implementing of the territorial concentration principle within each of the OPH priority axes is presented in Chapter 4.1.6 and 4.1.7 of the OPH.

In the conditions of market economy, the concentration principle of development and localisation of economic activities is in concord with concentration tendencies occurring mainly in the production and market services branches. In the conditions of the Slovak Republic, the OPH should represent a balanced concept with elements of concentration and equalisation approach. **Support directed into innovation growth poles contributes to equalisation of inter-regional differences and support directed into cohesion growth poles contributes to equalisation of intra-regional differences.** Support directed into growth poles supports not only equalisation of undesired regional differences, but also the development and sustaining of rural space. By means of support of innovation and cohesion growth poles, basic and higher civil equipment in "territorial manner" is secured, what leads to increasing of service quality in rural space. In this way, rural space becomes equal to urban areas and shall contribute to higher attractiveness of respective urban areas.

Principle of the OPH territorial concentration adheres to the polycentric concept of development of settlement of the Slovak Republic and it is based on the theory of innovation and cohesion growth poles identified already on the NSRF level. Support directed into innovation growth poles contributes to evening of inter-regional differences and support directed into cohesion growth poles contributes to evening of intra-regional differences.

4.1.6 Inpatient Healthcare Facilities and Growth Poles

Table 53 *"Division of individual healthcare facilities according to growth poles, NUTS II and NUTS III"* below introduces the comparison of relations and consequences between the healthcare infrastructure (hospitals) and growth poles based on categorization of **inpatient healthcare facilities** according to the type in the scale of official classification. The result of the table is as follows:

- 172 inpatient healthcare facilities (including Bratislava region) are located on the territory of Slovak Republic.
- 99 (96%) general and specialized hospitals out of 103 general and specialized hospitals (except of Bratislava region) included within „Convergence" objective are in the growth poles, it follows;
  - 62 general hospitals are in the innovation growth poles;
  - 20 specialized hospitals are in the innovation growth poles;

- 1 general hospital out of 2 general hospitals included within the "Convergence" objective is in the cohesion growth poles of the Innovation Growth Poles (IGP) interest area;
- 8 specialized hospitals are in the cohesion growth poles of the Innovation Growth Poles (IGP) interest area;
- 4 general hospitals are in the cohesion growth poles outside of IGP interest area;
- 4 specialized hospitals are in the cohesion growth poles outside of the IGP interest area;

The analysis confirms high logical cohesion and connection between the number of innovation growth poles, the number of cohesion growth poles in the interest area of innovation growth poles and the number of corresponding healthcare infrastructure represented by general hospitals inclusive polyclinics (outpatient part) and specialized hospitals.

All general hospitals in the scope of the "Convergence" objective are (100%) in the growth poles.

From 67 hospitals included within the "Convergence" objective 100% are in the innovation and cohesion growth poles, whereof 40 facilities are general hospitals with polyclinics (outpatient part).

32 specialized hospitals out of 36 specialized hospitals included within the "Convergence" objective are in the innovation and cohesion growth poles, representing 89 %.

The rest of 4 (11%) of specialized hospitals is, with regard to their diagnoses and character of treatment located outside of innovation and cohesion growth poles.

Table 53: ***Division of individual healthcare facilities according to growth poles, NUTS II and NUTS III***

Growth poles	Region NUTS II in the growth poles	WS			CS		ES		Objective "Convergence"	BA	SR
	Number of municipalities in the growth poles	32			33		26		91	6	97
	Population in the growth poles	405,640			597,883		637,787		1,641,310	478,047	2,119,357
	Region NUTS III in the growth poles	TT	TN	NR	ZA	BB	PO	KE	Objective "Convergence"	BA	SR
	Type of healthcare facility	Number of healthcare facilities									
IGR	General hospitals / with polyclinic	6/5	9/6	7/3	5/4	11/8	13/3	11/6	**62/35**	5/2	**67/37**
	Specialized hospitals	2	1	2	1	3	3	8	**20**	15	**35**
	Natural healthcare facilities and spas	1	-	-	1	-	2	-	**4**	-	**4**
	Healthcare facilities	-	-	-	-	1	2	1	**4**	-	**4**
	Hospice	1	1	-	-	1	2	-	**5**	1	**6**
	Nursing care homes	-	-	-	-	-	1	-	**1**	-	**1**
	Bio-medical research facility	-	-	-	-	-	-	-	**0**	1	**1**
CGP in IA IGP	General hospitals/with polyclinic	-	1/1	-	-	-	-	-	**1/1**	1	**2/1**
	Specialized hospitals	1	-	1	1	1	4	-	**8**	1	**9**
	Natural healthcare facilities and spas	-	3	-	2	2	4	-	**11**	-	**11**
	Healthcare facilities	1	-	-	2	-	-	-	**3**	1	**4**

	Hospice	-	-	-	-	-	-	-	-	-	-
	Nursing care homes	-	-	-	-	-	-	-	-	-	-
	Bio-medical research facility	-	-	-	-	-	-	-	-	1	1
CGP outside IGP IA	General hospitals/with polyclinic	-	-	1/1	1/1	2/2	-	-	4/4	-	4/4
	Specialized hospitals	-	-	1	2	1	-	-	4	-	4
	Natural healthcare facilities and spas	-	-	-	-	3	1	1	5	-	5
	Healthcare facilities	-	-	1	-	1	-	2	4	-	4
	Hospice	-	-	-	-	-	-	-	-	-	-
	Nursing care homes	-	-	-	-	-	-	-	-	-	-
	Bio-medical research facility	-	-	-	-	-	-	-	-	-	-
Growth poles total	General hospitals	6/5	10/7	8/4	6/5	13/10	13/3	11/6	67/40	6/2	73/42
	Specialized hospitals	3	1	4	4	5	7	8	32	16	48
	Natural healthcare facilities and spas	1	3	-	3	5	7	1	20	-	20
	Healthcare facilities	1	-	1	2	2	2	3	11	1	12
	Hospice	1	1	-	-	1	2	-	5	1	6
	Nursing care homes	-	-	-	-	-	1	-	1	-	1
	Bio-medical research facility	-	-	-	-	-	-	-	-	2	-
Out of growth poles	General hospitals	-	-	-	-	-	-	-	-	-	-
	Specialized hospitals	-	-	1	-	1	2	-	4	-	4
	Natural healthcare facilities and spas	-	1	-	-	-	-	-	1	-	1
	Healthcare facilities	-	-	-	2	2	-	-	4	1	5
	Hospice	-	-	-	-	-	-	-	-	-	-
	Nursing care homes	-	-	-	-	-	-	-	-	-	-
	Bio-medical research facility	-	-	-	-	-	-	-	-	-	-
Total		**12/5***	**16/7***	**14/4***	**17/5***	**29/10***	**34/3***	**23/6***	**145/40***	**27/2***	**172/72***

Source: MCRD SR 2007, MOH SR 2007
****general hospitals/with polyclinic***

Table 53 legend

*** number of general hospitals with a polyclinic**
WS – Western Slovakia Region NUTS II
CS – Central Slovakia Region NUTS II
ES – Eastern Slovakia Region NUTS II
TT - The Self-Governing Region of Trnava NUTS III
TN – The Self-Governing Region of Trenčín
NR – The Self-Governing Region of Nitra
ZA – The Self-Governing Region of Žilina
BB - The Self-Governing Region of Banská Bystrica
PO – The Self-Governing Region of Prešov
KE – The Self-Governing Region of Košice
Objective – regions under "Convergence" objective
SR – Slovak Republic
IGP – innovation growth poles
CGP in IGP IA – cohesion growth poles in the innovation growth poles interest area
CGP outside IGP IA – cohesion growth poles outside the innovation growth poles interest area
EAFRD (in) – municipalities supported from the EAFRD in the innovation growth poles interest area
EAFRD (outside) – municipalities supported from the EAFRD outside the innovation growth poles interest area

In the tables in Annex 6a Growth Poles/Inpatient Healthcare Facilities – Western Slovakia Region, number 6b Growth Poles/Inpatient Healthcare Facilities – Central Slovakia Region and number 6c Growth poles/Inpatient Healthcare Facilities – Eastern Slovakia Region is together with maps given also the summary of individual inpatient healthcare facilities position according to growth poles and municipalities together with their population.

4.1.7 Outpatient Healthcare Facilities and Growth Poles

Table 54 "Division of individual outpatient healthcare facilities (concentration of 5 and more) according to growth poles, NUTS II and NUTS III" below introduces comparison of relations and consequences between the healthcare infrastructure of **outpatient facilities** (polyclinics and health centres) and growth poles based on categorization of outpatient healthcare facilities according to type in the scale of official classification. The result of the table is as follows:

- 217 outpatient facilities - polyclinics and health centres (including Bratislava region), are located on the territory of Slovak Republic.
- 180 (99%) outpatient facilities (polyclinics and health centres) out of 181 outpatient facilities (polyclinics and health centres) (except of Bratislava region) included within „Convergence" objective are in the growth poles, it follows;
  - 141 polyclinics and health centres are in the innovation growth poles,
  - 14 polyclinics and health centres are in the cohesion growth poles in the innovation growth poles interest area,
  - 25 polyclinics and health centres are in the cohesion growth poles outside the innovation growth poles interest area,

One outpatient healthcare facility in the west slovakia region – Nitra region (Jesenské municipality) is located out of growth poles.

The comparison certifies the logical cohesion and connection between the number of innovation growth poles, the number of cohesion growth poles in the innovation growth poles and the number of correspondent healthcare infrastructure represented by polyclinics and health centres, providing outpatient healthcare, which is line with the valid legislation (Government of the Slovak republic Directive No. 751/2004) on necessary network of outpatient healthcare providers.

Table 54: Division of individual outpatient healthcare facilities (concentration of 5 and more) according to growth poles, NUTS II and NUTS III

Growth poles	NUTS II Region	WS			CS		ES		Objective "Convergence"	BA	SR
	Number of municipalities	35			26		31		92	8	100
	Population	752,728			526,903		748,811		2,028,442	502,164	2,530,606
	NUTS III Region	TT	TN	NR	ZA	BB	PO	KE	Objective "Convergence"	BA	SR
	Type of healthcare facility	Number of facilities / number of outpatient facilities									
IGP	Polyclinics and healthcare centres	9/178	19/180	24/309	18/219	16/174	26/229	29/408	**141/1697**	32/571	**173/2268**
CGP in IA IGP	Polyclinics and healthcare centres	1/9	4/27	1/11	2/31	-	5/37	1/5	**14/120**	4/27	**18/147**
CGP outside IGP IA	Polyclinics and healthcare centres	4/31	3/26	-	6/40	4/40	7/60	1/5	**25/202**	-	**25/202**

Growth poles total		**14/218**	**26/233**	**25/320**	**26/290**	**20/214**	**38/326**	**31/418**	**180/2019**	**36/598**	**216/2617**
Out of growth poles	-	-	1/7	-	-	-	-	**1/7**	-	**1/7**	**1/7**
Total		**14/218**	**26/233**	**26/327**	**26/290**	**20/214**	**38/326**	**31/418**	**181/2026**	**36/598**	**217/2624**

Source: Common Health Insurance Company 2007, MCRD SR 2007, MOH SR 2007
Note: Data have only indicative character

Table 54 legend

WS – Western Slovakia Region NUTS II
CS – Central Slovakia Region NUTS II
ES – Eastern Slovakia Region NUTS II
TT - The Self-Governing Region of Trnava NUTS III
TN – The Self-Governing Region of Trenčín
NR – The Self-Governing Region of Nitra
ZA – The Self-Governing Region of Žilina
BB - The Self-Governing Region of Banská Bystrica
PO – The Self-Governing Region of Prešov
KE – The Self-Governing Region of Košice
Objective – regions under "Convergence" objective
SR – Slovak Republic
IGP – innovation growth poles
CGP in IGP IA – cohesion growth poles in the innovation growth poles interest area
CGP outside IGP IA - cohesion growth poles outside the innovation growth poles interest area
EAFRD (in) – municipalities supported from EAFRD in the innovation growth poles interest area
interest area
EAFRD (outside) – municipalities supported from EAFRD outside the innovation growth poles interest area
interest area

In the tables in annex number 6d Growth Poles/Outpatient Healthcare Facilities – Western Slovakia Region, number 6e Growth Poles/Outpatient Healthcare Facilities – Central Slovakia Region and number 6f Growth poles/Outpatient Healthcare Facilities – Eastern Slovakia Region is together with maps given also the summary on individual outpatient healthcare facilities position according to growth poles and municipalities together with population.

- All 11 (100%) National transfusion workstations are situated in the inovation growth poles.

Table 55:
Division of transfusion facilities according to growth poles, NUTS II and NUTS III

Growth poles	**NUTS II Region**	**WS**			**CS**		**ES**		**Objective "Convergence"**	**BA**	**SR**
	Number of municipalities	**35**			**26**		**31**		**92**	**8**	**100**
	Population	**752728**			**526903**		**748811**		**2028442**	**502164**	**2530606**
	NUTS III Region	**TT**	**TN**	**NR**	**ZA**	**BB**	**PO**	**KE**	**Objective "Convergence"**	**BA**	**SR**
	Type of healthcare facility	**Number of transfusion workstations**									
IGP	**Number of transfusion workstations**	1	1	2	2	1	2	1	**10**	1	**11**

Source: NTS 2007, MoH SR 2007

4.2 Global Aim of the OPH

Pursuant to conclusions for thematic concentration and starting points for territorial concentration of interventions, the global objective of the operational programme is focused on;

the improvement of conditions influencing health condition of the productive-age and unproductive-age population through increasing of the quality, accessibility and effectiveness of healthcare and health support under healthcare infrastructure.

4.3 Strategy for Achieving of the Global Aim of the OPH

In spite of their supplementary and restrictive character, financial resources represent under the conditions in Slovakia an important source of support for the healthcare infrastructure. Their efficient use requires a well-targeted directing of support in such a way as to achieve the biggest possible effect of realized operations, to secure sustainability and accessibility of interventions and to establish a synergy with the support from other operational programmes co-financed from the SF(especially in the field of horizontal priorities) or other development resources.

Global objective of the OPH – the improvement of conditions influencing the health condition of the productive-age and unproductive-age population through increasing the quality, accessibility and effectiveness of healthcare and health support under healthcare infrastructure – can be achieved in the most efficient way by means of a common application of thematic and territorial concentration of interventions.

4.3.1 The OPH Strategy: synthesis of thematic and territorial concentration.

The OPH strategy is based and structuralized pursuant to performed analyses of thematic and territorial concentration of intervention into priority axes and spheres of support - measures of the OPH.

Main problems concerning the health and health condition of the Slovak population are:

- high morbidity of Group 5 diseases and as a result sick leave and decrease of life standard;
- high mortality rate of Group 5 diseases and as its result shorter average life expectancy at birth in comparison to the EU-average.

These crucial problems have society-wide thematic and territorial character and therefore require a global solution in compliance with the objective “Convergence” in order to achieve the global objective of the OPH.

As to achieve the global objective of the OPH as a result of high morbidity and mortality of Group 5 diseases, while respecting trends in rationalization of the network of healthcare providers, there are necessary investments from demand projects into:

- healthcare infrastructure of general and specialized hospitals (providers of curative, acute, and clinical healthcare) – Priority axis 1 “Hospital Healthcare System Modernization”;
- healthcare infrastructure of polyclinics and healthcare centres (providers of complex outpatient healthcare along with prevention) – Priority axis 2 “Health Promotion and Health Risks Prevention”.

And by means of national projects into:

- project “Purchasing and delivery of mobile mammography units” – Priority Axis 2 “Health promotion and health risks prevention”;

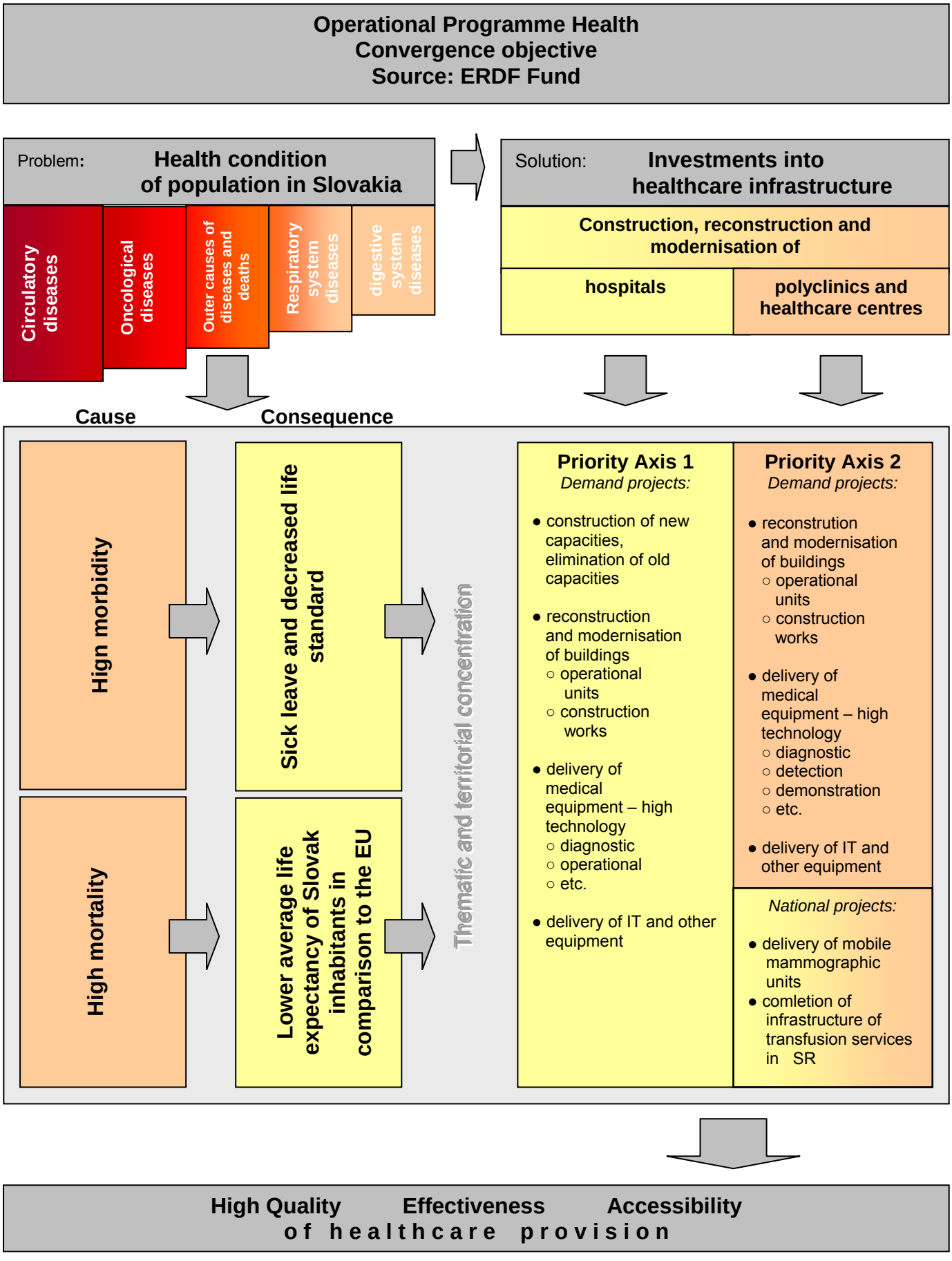
- project “Completion of Infrastructure of the National Transfusion Service of Slovakia“ – Priority Axis 2 “Health promotion and health risks prevention”.

The top position of high-quality hospital healthcare in the system of healthcare is proven by analyses of status and development orientation of healthcare systems in Europe. Policy and practice of running hospitals have a huge mainly socio-economic impact on the entire quality standard of healthcare. [5]

The main financial tool for the achievement of the global objective is the European Regional Development Fund (ERDF) along with the national resources.

Starting points, based on the performed analyses for the achievement of synthesis of thematic and territorial concentration of interventions into population health and healthcare infrastructure in Slovakia, are graphically presented in the scheme below. They result in a distinct and clearly oriented strategy of the OPH.

[5] *Anaysis of the company Sanigest International – Slovak Hospitals Evaluation, 2004*



Source: MoH SR 2007 pd

Healthcare infrastructure

Construction of healthcare facilities in the second half of the 20th century secured an even and accessible location of facilities of healthcare infrastructure in the entire Slovakia. However, a relatively wide network of facilities of inpatient and outpatient healthcare providers is nowadays in a poor construction and technical conditions, dilapidated and out-of-date. The current situation is caused by insufficient capital financing. Changes in the ownership relations and changes in the system of financing of healthcare facilities have also contributed to insufficient maintenance and repairs of buildings used as well as the entire premises. Apart from this fact, construction works and operational units do not meet current construction and technical requirements especially from the aspect of energy economy of buildings and level of informatisation.

Considering the importance of quality, effectiveness and accessibility of healthcare provision and health support under healthcare infrastructure, it is crucial to re-evaluate spatial and capacity provisions of inpatient healthcare facilities.

The OPH strategy in facilities of hospital healthcare (Priority axis 1)

Curative, acute, and clinical healthcare focused on diseases of Group 5 can be provided exclusively in general and specialized hospitals.

From the total number of 103 general and specialized hospitals (situated in regions) are 96 % of them localized in growth poles in the scope of the "Convergence" objective.

Currently, building projects and operational units – building and medical equipment of general and specialized hospitals – are in a very poor technical state, which is a result of lack of financial investments and a long-term undercapitalization.

Interventions in the scope of Priority axis 1 shall be directed into general hospitals (including general hospitals with polyclinic), preferentially into those specialized in treatment of diseases of Group 5, localized in the growth poles and respecting the trends of network rationalization, by means of demand projects.

Priority axis 1 "Hospital Healthcare System Modernization" is, from the substantial point of view, oriented on projects with framework activities:

- construction of new capacities, elimination of old capacities;
- reconstruction, modernization of buildings of:
  - operational units,
  - construction facilities.
- delivery of medical equipment - high technology:
  - diagnostic,
  - surgical,
  - etc.
- delivery of IT and other equipment.

Construction of new capacities, and reconstruction and modernization of existing facilities has to be realized in a way, which would take into account the low energy consumption of buildings, possibility of a complex solution of barrier-free entrance for immobile persons, and other technical and operational norms valid in the Slovak Republic as well as the EU standards.

In the context of analyses and in compliance with the cohesion policy of the EU, the reason for the recovery and improvement of healthcare inpatient facilities infrastructure in the regions of

Slovakia in the scope of the "Convergence" objective is the reduction of inequality in the health sector, overcoming of great regional differences in healthcare, improvement of healthcare accessibility and quality, increasing of safety of provided healthcare and a more efficient management of sources in the health sector. Through a successful implementation of interventions within the inpatient healthcare provision, we shall achieve a decrease of costs for healthcare provision, increase of competitiveness of the regions and through the improvement of population health, prolonged population working life and increased labour productivity.

The OPH strategy in facilities of outpatient healthcare provision (Priority axis 2)

As a consequence of high morbidity and mortality of specific groups of diseases (diseases of Group 5), it is desirable as proven by the analysis, to support curative part of healthcare provision, i.e. when the disease has already occurred, as well as preventive part and an early disease detection in its initial stage, when it is still possible to avoid or slow down the its outbreak, which leads to a difficult and protracted treatment and has in the end an impact on the increase of expenses intended for curative care as well as on the life standard of an individual.

Together with the support of hospitals, it is necessary to specifically direct the investments also into facilities of outpatient healthcare with the character of polyclinics and healthcare centres. In this process the complexity of healthcare provision and starting points of territorial concentration have to be respected, as from the total number of 181 polyclinics and healthcare centres in regions, almost 100% of them are in the scope of the "Convergence" objective localized in the growth poles

Based on the outcomes of analyses, it is required to aim interventions, in the scope of Priority axis 2, by means of demand projects into the infrastructure of outpatient healthcare facilities (polyclinics and healthcare centres), purchase and supply of mobile mammography units and completion of NTS infrastructure.

Priority axis 2 "Health Promotion and Health Risks Prevention" focuses from the objective aspect on projects:

- reconstruction and modernization of buildings of
  - operational units,
  - construction facilities.
- delivery of medical equipment - high technology:
  - diagnostic,
  - detection,
  - demonstration,
  - etc.
- delivery of IT and other equipment.

And national projects:

- "Purchasing and delivery of mobile mammography units" as tools for the improvement of active prevention with the aim to decrease mortality rate of breast cancer of women. National project shall be realized by the East-Slovak Oncological Institute, a.s. (EOI), which is one of specialized institutes focusing on diagnostics and treatment of oncological diseases within the scope of objective "Convergence" in Slovakia. The improvement and accessibility of health adjustment and effective data acquisition (which will be central

evaluated) will be provided by mobile mammography units. The project is unassuming for human resources and effectively solves the problem of deficient human resources in the regions. Purchasing of mammography units shall lead not only to an increase in chances of an early diagnostics and thus a successful treatment and improvement of quality of life, but also to a decrease of treatment expenses in later-stages of the diseases.

- "Completion of Infrastructure of the National Transfusion Service of Slovakia" with the aim to secure self-sufficiency in blood-products productions of the highest possible quality and safety in the conditions of maximized efficiency in the demanded volume in all regions of Slovakia. national project shall be realized by the Slovak National Transfusion Service, which integrates transfusion care and implements national blood policy in Slovakia.

  Integrant part of national project are following activities:

  - reconstruction and modernization of transfusion workstations
    - operational part
    - construction part
  - equipment supply
  - ICT supply (including on-line connection of transfusion workstations)

  Extraordinary feature of complex project with nation - wide activity is that one transfusion workstation of 11 is situated on area of Bratislava region (Bratislava city), which is non eligible for alocation of ERDF by OPH under the „Convergence" objective.

  The first two above mentioned independent function activities and it´s results (for transfusion workstation situated in Bratislava) will be financed as non eligible costs from national sources.

  For the third above mentioned activity of national project (ICT supply), implemented nation - wide, for all transfusion workstations of NTS, will be applying pro-rata principle. On this principle, the part of allocation responding on equivalent citizens of Bratislava region (11,4%), will be financed as non eligible cost from national sources. The rest part of third activity will be financed proportional of ERDF and national sources.

  Implementation of the project shall secure the growth of volume and quality of blood products, their efficient supply and availability for feasible needs in regions, increase of safety of transfusion drugs and the prevention of haemotherapeutic complications.

  Specific % of this national project will be financed from national sources only (not from ERDF) on pro rata principle, which is based on the number of inhabitants of SR in total and number of inhabitants of Bratislava district.

Reconstruction and modernization of existing facilities has to be realized in a way, which would take into account low energy consumption of buildings, possibility of a complex solution of barrier-free entrance for immobile persons, and follow technical and operational norms valid in the Slovak Republic as well as the EU standards.
In the context of these analyses and in compliance with the cohesion policy of the EU, the reason for the support of development of facilities of outpatient healthcare focused on prevention in regions, which fall under the Convergence objective, is an improvement of the population health condition. Result of the high quality, timely and safe outpatient healthcare (which is a key entity for securing of effective prevention and also a result of preventive examinations in selected specializations) is the increase in population participation on the work market, prolonging of the productive age, increasing the labour productivity and decreasing the healthcare costs. By means of successful realization of intervention in the network of outpatient facilities of healthcare

provision and prevention arises space and conditions for redirection of activities and investments from hospitals into outpatient healthcare facilities.

4.3.2 Measuring of Efficiency of Achievement of the Global Aim of the OPH

Efficiency of achievement of the global aim of the OPH is assessed on the basis of system of measurable indicators on the programme level. Indicators are monitored continuously and aggregated from the level of projects through the level of measures and priority axes up to the level of the OP and the NSRF.

Target values of indicators on the programme level were defined in compliance with strategies on the level of thematic territories of support of the OPH and were applied on:

- the principle of territorial concentration (support of innovation and cohesion growth poles);
- the criteria of sustainability (substantial, capacity, economic, etc.).

Table 56: Indicators on the OPH level

Indicator type	Indicator name	Unit of measurement	Initial year	Initial value	Target value for 2015	Definition	Note
Output	Number of supported projects by OPH on the level of Priority axis 1 **Core indicator**	number	2006	0	30	Number of supported projects by OPH focused on the reconstruction and modernization of chosen general and specialized hospitals, preferentially oriented on the treatment of diseases of Group 5	*Assuming the average budget cost of the project is SKK 250 million*
Output	Number of supported projects by OPH on the level of Priority axis 2 **Core indicator**	number	2006	0	28	Number of supported project by OPH focused on the reconstruction and modernization of chosen outpatient facilities, i.e. polyclinics and healthcare centres, preferentially oriented on the prevention of diseases of of Group 5.	*Assuming the average budget cost of the project is SKK 50 million.*
Impact	Number of created work positions together - men - women **Core indicator**	number	2006	0	58 29 29	Overall number of created work positions	
Result	Average decrease of energy requirements of buildings used by supported facilities of healthcare infrastructure	%	2006	0	15	Average percentage of decreased energy requirements for heating of buildings used by supported facilities of healthcare infrastructure	Contributes to improvement of quality of conditions in healthcare infrastructure facilities and also to effectiveness of their function. Source of information is the TIMS system, documentation to project applications and regular after-realization monitoring reports concerning projects.

Source: MOH SR, 2007.

After the operational programmes have been approved by the EC, the Managing Authority for the OPH takes over the responsibility for the preparation of outcome benchmark values and benchmarking. Benchmarks are assessed as a division of financial means allocated for the given measure and the key indicator of output or result pursuant to the OPH.

The NSRF also identifies four horizontal priorities. Their fulfilment is realized by means of contributions from individual operational programmes co-financed from the Structural Funds and Cohesion Funds in the programme period 2007-2013. For more information on the OPH contribution to the fulfilment of mentioned horizontal priorities see chapter 6.

5 Priority Axes

Global objective of the operational programme - the improvement of conditions influencing health condition of the productive-age and unproductive-age population through increasing the quality, accessibility and effectiveness of healthcare and health support under healthcare infrastructure shall be achieved by means of realization of priority axes.

Table 57: OPH segmentation to Priority axes

Operational Programme Health	
Programme priority axes	**Fund**
1 Hospital Healthcare System Modernization	ERDF
2 Health Promotion and Health Risks Prevention	ERDF
3 Technical Assistance	ERDF

Source: MOH SR

5.1 Priority Axis 1 – Hospital Healthcare System Modernization

5.1.1. Specific Objective and Focus of Priority Axis 1

Specific Objective of Priority Axis 1

A specific objective of Priority axis 1 is to provide construction, reconstruction and modernization of the infrastructure of general hospitals and hospitals specialized in treatment of diseases of Group 5.

Table 58: Indicators on the Level of Priority Axis 1

Indicator name	Definition	Information source	Indicator type: *R - result* *O - output* *C - core*	Unit of measurement	Starting and target value for the Slovak Republic	
Number of beds operated within the modernized infrastructure	Number of beds operated within the modernized infrastructure of general and specialised hospitals – diseases of Group 5	MOH SR	R ☐ C..☐ O ☒	number	**2006**	0
					2015	1,250
Area of built and equipped spaces for healthcare provision	Area of built and equipped spaces of general and specialised hospitals for healthcare provision – diseases of Group 5	MOH SR	R ☐ C..☐ O ☒	m^2	**2006**	0
					2015	37,600
Area of reconstructed and furnished spaces of	Area of reconstructed and furnished spaces of general and specialised hospitals	MOH SR	R ☐ C..☐ O ☒	m^2	**2006**	0
					2015	150,200

healthcare provision	for healthcare provision – diseases of Group 5					
Number of hospitalized patients within the modernized infrastructure	Number of hospitalized patients within the modernized infrastructure in general and specialised hospitals – diseases of group 5	MOH SR	R ☒ C..☐ O ☐	number/year	**2006** **2015**	0 56,000
Number of hospitalizations of ambulatory care sensitive diseases	Ambulatory care sensitive diseases are an indicator of effectiveness of healthcare services among primary hospital services	MOH SR	R ☒ C..☐ O ☐	%	**2006** **2015**	12.2 8
Average duration of hospitalization	Average duration of hospitalization in general and specialised hospitals – diseases of Group 5	MOH SR	R ☒ C..☐ O ☐	days	**2006** **2015**	9.5 7.1
Number of created work positions together men women	Number of created work positions on the basis of support of healthcare infrastructure facilities	MOH SR	R ☐ C..☒ O ☐	number	**2006** **2015**	0 0 0 30 15 15
Average decrease of energy requirements of buildings used by supported healthcare infrastructure facilities	Average decrease of energy demands by heating of buildings used by supported healthcare facilities of general and specialised hospitals	MOH SR	R ☒ C..☐ O ☐	%	**2006** **2015**	0 15
Number of supported projects by OPH, priority axis 1	Number of supported projects aimed at reconstruction and modernisation of selected general and specialised hospitals preferably aimed at treatment of diseases of Group 5	MOH SR	R ☐ C☒ O ☒	number	**2006** **2015**	0 30*

Source: MOH SR

****Assuming the average budget cost of the project is SKK 250 million.***

*****Hospitalisation in the scope of ambulatory care sensitive cases are hospitalisations in situations, in which if they are taken care of in timely and appropriate manner, usually do not necessitate hospitalisation of the patient (Institute of Medicine, 1993). They are defined by a gremium of doctors. Ambulatory care sensitive cases represent a healthcare situation: usually these cases are diseases, which require treatment on the level of primary care. They reflect problems in the function of ambulatory healthcare and the network of hospital specialists.***

Focus of Priority Axis 1

Priority axis 1 is based on the outcomes of the analysis of the health condition of the Slovak population and the state of material and technical basis of healthcare infrastructure of constitutional healthcare providers - hospitals. It focuses on the improvement of quality, effectiveness, accessibility, and safety of the provided healthcare by means of support of investment projects of complex restructuring programmes of hospital healthcare providers. Investment projects can focus on the elimination of old capacities and construction of new ones, reconstruction and modernization of healthcare infrastructure of operational units and hospital buildings, and securing of the newest technical, healthcare, diagnostic, surgical, technological, information and other instrumental equipment.

Intervention logic of usage of the Structural Funds within Priority Axis 1 is based on the following principles:

- To support complex changes of providers with the aim to increase productivity.
- To support only those complex changes of providers, which are in compliance with the future demand for services.
- To support only those complex changes of providers, which are economically sustainable and do not result in increased requirements put on the public financial budget.
- Priority focus of general and specialized hospitals in treatment of diseases of Group 5

Support shall be given to those investment projects, in which the applicant (by means of complex restructuring plans) demonstrates the realization of a portfolio of at least medium-term activities (next 5 years), which shall create conditions important for the accomplishment of the priority axis objective. An evaluation methodology shall be elaborated as to evaluate the activities portfolio.

One condition of this support is to prove the provider's **economical sustainability** by means of submission of a medium-term economic plan elaborated for the next 5 years.

Framework Activities of Priority Axis 1 – Hospital Healthcare System Modernization

Priority axis 1 "Hospital Healthcare System Modernization" is from an objective aspect oriented on projects with framework activities:

- construction of new capacities, elimination of old capacities;
- reconstruction, modernization of buildings of:
  - operational units,
  - construction facilities.
- delivery of medical equipment - high technology[6]
  - diagnostic,
  - surgical,
  - etc.
- delivery of IT and other equipment.

Construction of new capacities, and reconstruction and modernization of existing facilities has to be realized in a way, which would take into account the low energy consumption of buildings,

[6] On the recipients level will MO ensured observance of the legislation concerning disposal of out of date healthcare technology.

possibility of a complex solution of barrier-free entrance for immobile persons, and other technical and operational norms valid in the Slovak Republic as well as the EU standards.

Priority axis shall be implemented by means of projects oriented on demand, submitted by the owners of properties.

5.1.2 Localization of Project Realization under Priority Axis 1

Interventions under Priority axis 1 are in the target area of the "Convergence" objective directed:

- into innovation and cohesion growth poles;
- exceptional into ares out of growth poles, regarding of specific high-elevation conditions, inevitable for respiratory diseases treatment

5.1.3 Authorized Recipients within Priority Axis 1

Authorized recipients within Priority axis 1 are the owners of general and specialized hospitals from the public and private sector. The list of authorized recipients localised in the growth poles is published on the web page www.health.gov.sk together with the system of updates.

5.1.4 Reasoning on Priority Axis 1

Priority axis 1 is focused on securing the demanded qualitative and quantitative level of healthcare infrastructure of general and specialized hospital providers of healthcare in the supported area of the “Convergence” objective under conditions in Slovakia.

As implied by the analytical part, hospitals are currently in a poor technical state and state of construction. The current situation is caused by insufficient capital financing. Changes in ownership relations and changes in system of financing of healthcare facilities have also contributed to insufficient maintenance and repairs of buildings used as well as the entire premises. Apart from this fact, construction works and operational units do not meet current construction and technical requirements especially from the aspect of energy economy of buildings and level of informatisation.

Considering the importance of quality, effectiveness, accessibility, and safety of healthcare provision, it is crucial to re-evaluate spatial and capacity provisions of inpatient healthcare facilities.

In the context of analyses and in compliance with the cohesion policy of the EU, the reason for the recovery and improvement of healthcare inpatient facilities infrastructure in the regions of Slovakia in the scope of the “Convergence” objective is the reduction of inequality in the health sector, overcoming of great regional differences in healthcare, improvement of healthcare accessibility and quality, increasing of safety of provided healthcare and a more efficient management of sources in the health sector. By a successful realization of interventions within the inpatient healthcare provision, we have achieved a decrease of costs for healthcare provision, increase of competitiveness of the regions and by improvement of population health, prolonged population working life and increased labour productivity.

Table 59:

Assistance Areas Categorization 2007 – 2013 – for Priority Axis 1:	
Priority topic	76
Form of financial contribution	01
Supported region	01, 05
Supported main economic activities	19

Source: MOH SR

5.2 Priority Axis 2 – Health Promotion and Health Risks Prevention

5.2.1. Specific Objective and Focus of Priority Axis 2

Specific Objective of Priority Axis 2

Specific objective of Priority axis 2 is to secure reconstruction and modernization of the infrastructure of outpatient healthcare with its primary focus on the prevention and health support in the treatment of diseases of Group 5 and securing of adequate equipment.

Table 60: Indicators on the Level of Priority Axis 2

Indicator name	Indicator name	Information source	Indicator type: *R - result* *O - output* *C - core*	Unit of measurement	Starting and target value for the Slovak Republic	
Area of reconstructed and furnished spaces of healthcare provision	Area of reconstructed and furnished spaces of healthcare provision of polyclinics and healthcare centres	MOH SR	R ☐ C..☐ O ☒	m^2	**2006** **2015**	0 66140
Number of patients who were provided with healthcare within the modernized infrastructure	Number of patients who were provided with healthcare within the modernized infrastructure in polyclinics and healthcare centres	MOH SR	R ☒ C..☐ O ☐	number	**2006** **2015**	0 84400 0
Number of preventive examinations	Number of preventive examinations in polyclinics outpatient wards and healthcare centres	MOH SR	R ☒ C..☐ O ☐	number	**2006** **2015**	0 *
Number of preventive procedures – interventions (selected diagnoses)	Number of preventive procedures – interventions in the cases of diseases of Group 5 –in polyclinics outpatient wards and healthcare centres	MOH SR	R ☒ C..☐ O ☐	number	**2006** **2015**	0 *
Number of created work positions together men women	Number of new work positions on the basis of support of healthcare infrastructure polyclinics and healthcare centres	MOH SR	R ☐ C..☒ O ☐	number	**2006** **2015**	0 0 0 28 14 14
Average	Average percentage	MOH SR	R ☒ C..☐	%	**2007**	0

decrease of energy demand of buildings used by supported facilities of healthcare infrastructure	decrease of energy demand on heating of buildings used by supported healthcare infrastructure facilities of polyclinics and healthcare centres		O ☐		**2015**	15
Number of supported projects by OPH, priority axis 2	Number of supported projects aimed at reconstruction and modernisation of selected outpatient wards facilities such as polyclinics and healthcare centres preferably aimed at prevention of diseases of Group 5	MOH SR	R ☐ C☒ O ☒	number	**2007** **2015**	0 28**

Source: MOH SR

Note:

**** The indicators, number of preventive examinations and procedures - interventions (selected diagnoses) have not been monitored and registered (for the time being), therefore it is impossible to competently determine the planned number. From 2007 on, we shall secure the register and evaluation of the preventive examinations and procedures. We expect a continuous growth of these indicators.***

*****Assuming the average budget cost of the project is SKK 50 million. .***

Focus of Priority Axis 2

Priority axis 2 is based on the outcomes of the analysis of the health condition of the population of the Slovak Republic and state of material and technical basis of healthcare inpatient infrastructure. It focuses on the improvement of quality, effectiveness and accessibility of healthcare and health support under healthcare infrastructure along with the support of investment projects of inpatient healthcare providers (polyclinics and healthcare providers). Investments shall be oriented on reconstruction and modernization of hospital buildings and their provision with complex new technical and operational, healthcare diagnostic, informational and other equipment.

Intervention logic of the Structural Funds applied in the scope of Priority Axis 2 is based on the following principles:

- to support changes of processes and infrastructure of outpatient healthcare providers with the aim to improve the productivity in the field of prevention;
- to support of introduction of new methods and technologies – high tech for improvement of health care provision;
- to support specialized programmes focused on tele-diagnostics, which are directly related to the increasing trend of disease occurrence (especially oncological and cardio-vascular diseases) and at the same time secure high effectiveness of prevention, efficiency, and impact on the improvement of the quality of life of the workforce;
- to support only those changes that are economically sustainable and do not cause increased requirements from public financial budget.

Only those investment projects shall be supported, where the applicant (through a development plan) demonstrates the implementation of at least medium-term-horizon activities (next 5 years)

that shall create conditions important for accomplishment of priority axis objective. To evaluate the activities portfolio, the evaluation methodology shall be elaborated.

One condition of this support is to prove the provider's **economical sustainability** by means of submission of a medium-term economic plan elaborated for the next 5 years.

Framework Activities of Priority axis 2 – Health promotion and health risks prevention

Priority axis 2 "Health promotion and health risks prevention" focuses from the substantial point of view on demand projects of:

- reconstruction, modernization of buildings of:
  - operational units,
  - construction facilities.
- delivery of medical equipment - high technology[7]
  - diagnostic,
  - detection,
  - demonstration,
  - etc.
- delivery of IT and other equipment.

And national projects:

- "Purchasing of mobile mammography units". This project presents a distinctive share of solution for prevention and detection of early stages of breast cancer. This disease is among those oncological diseases that are the most frequent causes of death for productive-age women. 2000 new cases appear every year, 10-15% of which are in the III. and IV. stage (i.e. 200-300 women). Still, early treatment is highly successful and considerably improves the quality of life for productive-age women. National project shall be realized by the East-Slovak Oncological Institute, a.s. (EOI), which is one of specialized institutes focusing on diagnostics and treatment of oncological diseases within the scope of objective "Convergence" in Slovakia and has plenty of experience with the diagnosis and treatment of oncologic diseases as proves the certificate ISO 9001 of quality management. EOI shall fulfil the role of a specialised evaluation work place with a digital mammography unit. Mobile screening units shall be placed according the need in the scope of the territory of the "Convergence" objective and they shall secure a higher quality of examinations by a lower radiation amount, together with shortening of the waiting periods and saving of operating expenses. Concentration of specialists in the EOI shall secure diagnosis (guarantee of quality of screening and diagnosis) and following therapy and a central digital archive of examinations. At the same time, there shall be eliminated the occurrence of false examinations from facilities not falling under the scope of specialized facilities of this type (currently the share of false examinations is 15.4%). Professional training of workers, media support, coordination and marketing together with logistic of mobile units and monitoring shall be financed in the form of cross-financing in the scope of the operational programme.

[7] On the recipients level will MO ensured observance of the legislation concerning disposal of out of date healthcare technology.

- „National Transfusion Service of SR Infrastructure Completion“ regarding the trends of rationalisation of the healthcare infrastructure. The project will be executed by National Transfusion Service of SR, contributory institution of the Ministry of Health of SR which represents substantial branch of healthcare provision and inhabitants' health protection. The National Transfusion Service of SR integrates transfusion care and implements the National Haematic Policy in the Slovak Republic. The aim of the project is to guarantee national self-sufficiency of required volume of the blood products production in the top-grade quality and safety under maximum efficiency conditions in all regions of Slovakia. The programme will ensure public health protection and effective infection transmission prevention by blood collection, processing, distribution and use of blood and blood products. Other task will be also launching standards for blood donors' selection, blood collection, testing, processing and clinical use of blood products, establishing quality system and its control, eliminating and solving problems with discrepancy of the haemotherapy. Introduction of new technologies and examination methodologies will be likewise one of the main aims of the project.

The objective of project will be fullfiled through following activities:

- reconstruction and modernization of transfusion workstations
  - operational part
  - construction part
- equipment supply
- ICT supply

Reconstruction and modernization of existing facilities has to be realized in a way, which would take into account the low energy consumption of buildings, possibility of a complex solution of barrier-free entrance for immobile persons, and other technical and operational norms valid in the Slovak Republic as well as the EU standards.

Activities focused on professionals training on operation of new appliances and technical equipment for workers shall be financed from the ESF from the Operational Programme on Education, Priority axis 2. “Further education as an instrument of development of human resources”, measure 2.2 “Support of further education in healthcare".

5.2.2. Localization of Project Realization within Priority Axis 2

Interventions under Priority axis 2 are in the objective area of "Convergence" aimed at:

- innovation and cohesion growth poles;
- besides the support to a large spectrum of OPH activities primarily oriented towards the growth poles, there is an exception under the OPH Priority axis 2, namely the implementation of healthcare infrastructure projects with segregated or separated Roma settlements that may also be carried out by owners of buildings in municipalities outside the growth poles with a high concentration of marginalised Roma communities (according to the updated Atlas of Roma Communities) having attributes of multiple deprivation and attributes of social exclusion from the life of the municipality, and thus having a limited access to public services. The exception concerns precise activities in selected projects of OPH under comprehensive approach to MRK, not the municipalities as the beneficiaries during 2007-2013.

If interventions should be placed outside the growth poles, sustainability has to be proven and all legal conditions for the realization of the project have to be met, especially the fulfilment of the specified OPH indicators.

5.2.3 Authorized Recipients within Priority Axis 2

Authorized recipients within Priority axis 2 are owners of polyclinics and healthcare centres from the public and private sector located in the growth poles. At the same time are authorized the owners of buildings in municipalities with a high concentration of marginalised Roma communities (according to the updated Atlas of Roma Communities) having attributes of multiple deprivation and attributes of social exclusion from the life of the municipality, and thus having a limited access to public services.

Table 61 contains an indicative survey on the number of potential applicants for the provision of non-refundable financial contribution (NFC) based on the distribution of individual types of outpatient healthcare facilities (concentration of outpatient facilities: 5 and above) according to the growth poles, NUTS II, and NUTS III (chapter 4.1.7).

5.2.4 Reasoning on the Priority Axis 2

Priority axis 2 is focused on securing the demanded qualitative and quantitative level of healthcare infrastructure of outpatient healthcare providers (polyclinics and healthcare centres) and on national projects in the supported area of "Convergence" objective under conditions in Slovakia.

As implied by the analytical part, polyclinics and healthcare centres are in a poor technical state and state of construction and are out-of –date. The current situation is caused by insufficient capital financing. Changes in ownership relations and changes in system of financing of healthcare facilities have also contributed to insufficient maintenance and repairs of buildings used. Apart from this fact, construction works and operational units do not meet current construction and technical requirements especially from the aspect of energy economy of buildings and level of informatisation.

Considering the importance of quality, effectiveness, accessibility, and safety of healthcare provision, it is crucial to re-evaluate spatial and capacity provisions of outpatient healthcare facilities.

In the context of analyses and in compliance with the cohesion policy of the EU, the reason for the recovery and improvement of polyclinics and healthcare centres in regions of Slovakia in the scope of the "Convergence" objective is the reduction of inequality in the health sector, overcoming of great regional differences in healthcare, improvement of healthcare accessibility and quality, increasing of safety of provided healthcare and a more efficient management of sources in the health sector. Through a successful realization of intervention into the outpatient healthcare facilities, with the emphasis on prevention, we have achieved a decrease of costs for healthcare provision, increase of competitiveness of regions and by improvement of population health, prolonged population working life and increased labour productivity.

In the context of these analyses and in compliance with the cohesion policy of the EU, the reason for the support of the development of outpatient healthcare facilities focused on prevention in regions that fall under the "Convergence" objective is the improvement of the population health condition. The result of the high quality, timely and safe outpatient healthcare (which is the key entity for securing effective prevention and also a result of preventive examinations in selected specializations) is the increase in population participation on the work market, prolonging of the productive age, and increase in the labour productivity and decrease of healthcare costs. Through

a successful realization of interventions in the network of outpatient facilities of healthcare provision and prevention arises space and conditions for redirection of activities and investments from hospitals into outpatient healthcare facilities.

The purchase of mobile mammography units, which provide a new modern approach to prevention, creates conditions for timely disease detection and improvement of quality of life of women as the number of breast cancer cases increases and there is still a high number of late-stage occurrences. A mobile unit would secure the accessibility of diagnostics in all regions and flexibility of transportation in accordance with the real demand.
Completion of infrastructure of the national transfusion service in Slovakia shall create conditions for a central management structure for activities of transfusion services, unified communication system and unified system of symbols for blood products (this shall enable to monitor the usage of blood products in practice by means of electronic evidence, creation of the National Register of Blood Donors, database on excluded and rare blood donors, and accessibility of information on the state of supplies and demand for blood products). Thanks to a central system it would be possible to make use of equipment, material, and personnel and to implement new analysis technologies (NAT) efficiently. As a result it shall secure the increase in volume and quality of blood products, effective supplements and accessibility for real needs of regions, increased security of transfusion medication and prevention of haemotherapy complications.

Table 61:

Assistance Areas Categorization 2007 – 2013 – for Priority Axis 2:	
Priority topic	76
Form of financial contribution	01
Supported region	01, 05
Supported main economic activities	19

Source: MOH SR

5.3 Priority axis 3 – Technical assistance

5.3.1. Specific Objective and Focus of Priority Axis 3

Specific Objective of Priority Axis 3

A specific objective is on the one hand a successful implementation of the OPH in compliance with the requirements set on the management, implementation, control, auditing, monitoring, and evaluation of the operational programme and requirements set on the administrative structures responsible for the implementation of the operational programme, and on the support for projects preparation. On the other hand the objective is to inform the public, promote, evaluate and exchange experience.

Table 62: Indicators on the Level of Priority Axis 3

Indicator name	Indicator name	-{}-Information source	Indicator type: *R - result* *O - output* *C - core*	Unit of measurement	Starting and target value for the Slovak Republic	
Number of supported projects	Number of projects concerning technical assistance realized by the MA. MA project on stabilisation of administration capacities, preparation, evaluation and selection, implementation, monitoring and auditing of projects. MA project on evaluation and analysis, information and communication. Number of projects that are not a part of indicator of number of OPH level projects.	MOH SR	R ☐ C..☐ O ☒	number	**2006** **2015**	0 2
Number of work positions created	Number of work positions created for preparation, evaluation, implementation, monitoring and auditing of projects and monitoring and management of the programme.	MOH SR	R ☐ C..☐ O ☐	number	**2006** **2015**	0 65

Source: MOH SR

Focus of Priority Axis 3

Technical Assistance is focused on the support of an effective operational programme management, its propagation, support of priority axes and evaluation of selected projects . Technical Assistance shall be also applied within the scope of activities connected with the management, monitoring, control, analysis and providing information including promotion, evaluation and experience exchange. Technical Assistance budget shall be used for financing of supporting IT systems, especially for the needs of the MOH SR as the MA for the OPH, in such a manner that no duplicative financing of IT systems (financed from the OP - Technical Assistance) shall occur. IT monitoring systems (hereinafter ITMS) shall be used uniformly within the operational programmes management and their development costs shall be fully reimbursed from the OP - Technical Assistance.

Framework Activities

Supported activities shall be directed mainly at:

- publicity activities and informing of the MA;
- technical, space and operation equipment of the MA;
- MA employees wages;
- educational activities for the MA;
- securing of functionality of the Monitoring Committee of the OPH;
- evaluation of the OPH defined in General Regulation;
- software products and their maintenance;
- studies, analyses, outsourcing, monitoring;
- further activities in concord with the legislation of the Slovak Republic and the EU.

5.3.2. Reasoning on Priority Axis 3

The objective of this Priority Axis is to support the implementation of the whole OPH and its activities. An effective implementation of the operational programme depends on the ability of the bodies involved to perform their duties in line with the obligations arising from the EC and the SR legislation and guidelines. Technical Assistance is an important tool of the managing authority for the building of adequately knowledgeable human resources, ensuring their professional growth and creation of adequate conditions important for quality decision making. At the same time, Technical Assistance is also an important tool for information coverage and awareness propagation of the operational programme with a direct influence on the improvement of absorption capacity of the applicants. It is also an important tool designed to evaluate the intervention results and impacts in order to make expenditures of finances from the structural funds effective.

Table 63:

Assistance Areas Categorization 2007 – 2013 – for Priority Axis 3:	
Priority topic	85, 86
Form of financial contribution	01
Supported region	00
Supported main economic activities	17

Source: MOH SR

6 Horizontal Priorities

Based on the predicted impact of benefits for the development of the region and individual fields of economic activities, strategy of the National Strategic Reference Framework of the Slovak republic defines priorities, which complementarily influence its goals in four fields:

- marginalized Roma communities;
- equality of opportunities;
- sustainable development;
- information society.

6.1 Character and Scope of Horizontal Priorities

Each of four horizontal priorities has its specific character and needs an individual approach throughout the process of implementation. A specific objective of each individual horizontal priority should be met as the aim stands in a relation to several priorities of the National Strategic Reference Framework of the Slovak Republic and thus cannot be met exclusively by means of one OP. It requires a coordinated approach combining several specific priorities or projects.

Horizontal priorities in compliance with their character are applied in relevant operational programmes according to the table below.

Table 64: Application of horizontal priorities in the OPH

Horizontal priorities	Objective of horizontal priorities	Implementation of horizontal priorities
A. Marginalized Roma communities	Increase of the rate of employment and education level of MRC and improvement of their living standard.	The OPH will be solve a complex approach under priority axis 2.
B. Equal opportunities	Secure equal opportunities for all citizens and prevention of all forms of discrimination.	A principle followed in every project.
C. Sustainable development	Securing of environmental, economic and social sustainability of economic growth.	A principle followed individually in every project.
D. Information society.	Development of inclusive information society.	Integrated approach (interoperability of IT systems of public administration and implementation of e-Health in the OPIS with support of the OPH).

Indicative indicators for horizontal priorities in the scope of the OPH are a part of the national system of indicators elaborated on the level of the National Strategic Reference Framework of the Slovak Republic.

Final indicators of OPH for horizontal priorities on the program level (including quantification) shall be submitted and discussed in the second meeting of Monitoring Committee at latest.

Table 65:Indicative values of indicators of the OPH horizontal priorities

Horizontal priority	Indicator name	Indicator type	Unit of measurement	Initial year	Initial value	Target value for 2015
Marginalized Roma communities (MRC)	Value of projects identified by The Slovak Government Office (SGO) as focused on MRC	result	EUR	2006	0	8,000,000
	Number of projects identified by the SGO as targeted at MRC	result	number	2006	0	8
	Number of created work positions exclusively for MRC	result	number	2006	0	5
Equal Opportunity	Number of created work positions held by men	result	number	2006	0	29
	Number of created work positions held by women	result	number	2006	0	29
Sustainable Development	Average decrease of energy demand of construction works supported by the OPH	impact	%	2006	0	15
	Total number of work positions created	impact	number	2006	0	58
Information Society	Value of project with results or impacts concerning the development of information society	result	EUR	2006	0	7,800,000
	Number of project with results or impacts concerning the development of information society	result	number	2006	0	30

Source: National Strategic Reference Framework of the Slovak republic, 2007

6.1.1 Marginalized Roma Communities

The issue of marginalized groups of population focuses on solution of specific questions of marginalized Roma communities ("MRC"). Its aim is to enforce cooperation, to improve coordination of activities and coordination of financial sources targeted at the improvement of living standards of the MRC. Support of the MRC is focused on four priority fields: education, employment, health, housing and three related problem areas: poverty, discrimination and gender equality.

Based on conclusions of CSF working committee (Community Support Framework) for the development of Roma communities, whose task is to monitor the effects of interventions from the SF targeted at the issues of the MRC and drafting of proposals focused on increasing their efficiency, it is necessary to increase the efficiency of interventions from the SF in this field by means of a complex approach, which would connect several activities or projects into a complex strategy of development of a specific area in a way, which would establish a liaison and contribute to a long-term development of the MRC in the given area. A complex approach puts emphasis on a common interconnection of activities and active participation of the local community on the realization of the project. Making use of complexity when solving problems of the MRC is a necessity, since this shall secure a system solution of problems in such communities. Such an approach shall also enable a long-term strategic planning and the control of the development of the community towards a positive change.

Considering the scope and demands of implementation of a complex approach, for chosen areas/micro-regions[8] with an interest in a complex approach, a help with planning of local strategy of development of Roma communities and preparation of project activities within

[8] Realisation of the project shall be based on already prepared micro-regions and settlements with processed project documentation in the frame of granting scheme PHARE, 14 micro-regions (134 municipalities) were selected and pre-prepared in the scope of the project TA 11400130021 "Capacity building of the Secretariat of the Government Plenipotentiary"

strategy, as to secure the content and time complementarities and a total synergetic effect, is available. A complex approach is applied especially in areas with a high concentration of MRC.

Horizontal priority MRC influences individual strategic, specific priorities and their objectives especially by means of realization of a wide range of measures focused on the integration of the MRC, especially through the improvement of the infrastructure of Roma settlements, employment, education, healthcare, and social services.

The target of a complex approach are settlements, which are enlisted in Sociographic mapping from 2004 and which declare their interest in solving the issues by means of a complex approach and simultaneously prove their eligibility as required and specified in individual calls for submission of applications for non-refundable financial contribution from the EU.

Based on the needs of selected areas/micro regions and expected realization of complex projects, an indicative allocation for realization of complex projects on the level of the NSFR was set at EUR 200 mil. Financing shall be provided by means of an indicative location on the level of OPs relevant for the realization of complex projects (see NSRF). This indicative allocation may be adjusted during the programming period based on the continuous evaluations of usefulness and efficiency of the chosen complex approach. Its revaluation and results of continuous evaluation are subjects to the meetings of the National Monitoring Committee.

Contribution of the OPH to the Horizontal Priority MRC

The health of marginalized Roma communities is dealt with in a separate analysis of the OPH. Support of marginalized Roma communities focuses on the complex provision and accessibility of healthcare. Making use of the complexity also in solving problems of marginalized Roma communities is a necessity, as it shall help to provide system solutions of problems in marginalized Roma communities.

The horizontal priority MRC influences individual priority axis of the OPH by means of realization of measures focused on the integration of marginalized Roma communities through the improvement of infrastructure of healthcare.

Support of the MRC in OPH is executed through the projects. They can be executed like demand orientated projects under priority axis 1 and priority axis 2 and like a part of comprehensive approach in solving problems of MRC under priority axis 2.

6.1.2 Equal Opportunity

Promotion of basic rights, non-discrimination and equal opportunities is one of the basic principles applied in the EU. Equal Opportunity is an integral part of pillars of the European Employment Strategy and European Framework Strategy for Non-discrimination and Equal Opportunities for All. According to these, the horizontal priority of Equal Opportunity supports fight against discrimination on the ground of racial or ethnic origin, religion or belief, disability, age or sexual orientation.

A special emphasis is put on the principle of gender equality (equality of opportunities of women and men). Its fulfilment is one of the basic goals of the European community and as such it is one of the very essential objectives of structural funds. Pursuant to Article 2 of The Treaty of Amsterdam, the key objective of the Community is to achieve gender equality throughout the society and according to Article 3, it is an obligation to eliminate inequalities and promote gender equality in all activities by the method of gender mainstreaming. It is a procedure, in which all, conceptual, strategic, decision-making and evaluating processes in all phases of preparation and realization, are subordinated to the aspect of gender equality. In the context of the SF this has an impact on programming, monitoring and evaluation as it is considered a contribution to the

integration of equal opportunities for all and to the support of a balanced representation of men and women.

Horizontal priority of Equal Opportunities is exercised and monitored in all operational programmes. Horizontal priority of Equal Opportunity influences only those projects, which have a positive or negative impact on equality of opportunities. This principle is not applied in other projects (with no impact on equality of opportunities).

The horizontal priority is applied also in the form of accessibility of the physical environment, public transportation and services for persons with restricted mobility and orientation.

Very often we get a combination of several discriminating factors, which causes a more difficult entry and remaining on the labour market, access to professional education and other life opportunities. This is the reason why, besides respecting the principle of equality when granting all contributions, special priorities of the NSRF focus on the field of equality of opportunities "*Promotion of Growth of Employment and Social Inclusion"* and "*Modern Education for Information Society"*. The specific priority *"Promotion of Growth of Employment and Social Inclusion"* deals with equal opportunities on the labour market and focuses amongst other issues also on the creation of equal opportunities when entering the labour market and integration of disadvantaged groups on the labour market including the support of mechanisms eliminating gender discrimination on the labour market. In the specific priority *"Modern Education for Information Society"*, the equal opportunity is supported by specific activities, which create conditions for an equal access to both formal and informal education for all throughout their entire lives. We pay special attention to the issue of disadvantaged groups of population.

Contribution of the OPH to the Implementation of Equal Opportunity

Realization of investment projects with the emphasis on elimination of barriers and other adjustments, which would enhance the access of handicapped people to reconstructed, modernized, or newly build healthcare infrastructure facilities, or facilities under reconstruction. The objective is to create an enhanced access to all forms of medical equipment and facilities.

6.1.3 Sustainable Development

Sustainable development means that the needs of the current generation should be satisfied in such a way as not to endanger the ability of the next generations to satisfy their needs. This is one of the essential objectives of the EU and it is heeded by all policies and activities. It focuses on the constant improvement of quality of life and welfare of the current and next generations on the Earth. As to achieve this, it supports a dynamic economy with a full employment, high level of upbringing, education, protection of health, social and territorial integrity, as well as a high-level environmental protection. A change in behaviour and views of citizens and politicians in favour of respect of the principles and objectives of sustainable development is a key and long-term task for the entire society.

Sustainable development as one of the key principles of the NSRF is contained in the strategic objective of the NSFR, which defines respect of sustainable development as one of the key conditions for the increase of competitiveness and performance of regions and economy of Slovakia in the period 2007-2013. Accomplishment of the long-term vision of the NSRF, i.e. the process of convergence of Slovak economy toward the average of the EU15, has to take place in the conditions of sustainable development.

Objective of the horizontal priority Sustainable Development is to secure, that the end effect of all interventions financed in the scope of the NSRF, shall synergically support the sustainable development in all its components, i.e. in environmental, economic and social component in compliance with the objectives and indicators of the EU policy of Sustainable Development Strategy. With regard to the fact that interventions into the three components, as mentioned above,

are implemented by means of several OPs, monitoring and evaluation of the aim accomplishment shall be determined by means of an evaluation of the NSRF strategic objective, which contains the principle of sustainable development.

Contribution of the OPH to the Implementation of the Horizontal Priority Sustainable Development

Individual evaluation of all investment projects supported in the scope of the OPH from the viewpoint of impacts on the environment.

Increasing of energy performance of buildings used by facilities of healthcare infrastructure, which results in a decrease of economic demand.

Implementation of principles of territorial and thematic concentration oriented toward prospects and sustainability of interventions.

6.1.4 Information Society

Currently, when building information society, in the world the traditional understanding of it in the context of knowledge triangle (education, research, innovation) transforms into a knowledge quadrangle (fourth side added - informatisation). Introduction of information communication technologies (ICT) and increase in efficiency of processes by making use of them significantly contributes to a much higher efficiency of implementation of components of knowledge-based society.

The objective of the horizontal priority is the support of bigger efficiency, transparency and quality of implementation of the NSRF priorities as a result of implementation and usage of ICT.

The field of building of information society is supported by the NSRF in two ways; as part of the Operational Programme on Informatisation of Society (OPIS) and by means of informatisation projects implemented in other OPs. In this context, the implementation of the horizontal priority Information Society requires an integrated approach to the implementation of projects in the field of informatisation in operational programmes other than the OPIS, based on a close cooperation of managing and intermediary bodies of such programmes with managing and intermediary bodies for the OPIS.

The OPIS strategy concentrates on the creation of technological, application and process environment for the implementation of efficient electronic services provided by public administration; and on increase of their accessibility via broadband connection. The OPIS focuses on the project of eGovernment including eHealth, eCulture and broadband connection, which provide high-quality environment for the development of infrastructure and eServices in thematically specific fields, which are in competence of other managing and intermediary bodies.

On the horizontal level, the development of information society is supported by projects of informatisation implemented by other operational programmes than the OPIS. In this context, horizontal priority Information Society focuses on the optimization of specific service processes provided by central body of state administration and on integration of technological and application infrastructure owned by: MoE SR, MoEn SR, Ministry of Labour, Social Affairs, and Family SR, MoEd SR, Ministry of Transport, Post and Telecommunications of SR, and MCRD SR. Activities in the field of purchase and operation of technological and application infrastructure, local and specialized networks and development of electronic services in specific fields are supported within the implementation of this horizontal priority. Interventions in this horizontal priority require support of the introduction of such services of eGovernment as e.g. eContent, eLearning, eTransport, eInclusion, eBusiness, eTourism, eSkills etc. as these represent parts of sector strategies of individual operational programmes. Projects of these topics are

financed from their own resources allocated in the operational programmes focused on the given topic.

Programmes of informatisation of society, implemented in these operational programmes are follow-ups of activities of the OPIS, which creates integrated, methodical, process, technological, and application environment for a coordinated development of such projects.

The OPIS focuses on the implementation of efficient electronic services provided for public by public administration by means of technological and application environment with the usage of broadband.

The OPIS creates conditions for the MOH SR for implementation of the approved concept of electronisation and informatisation of healthcare in those fields concerning the provision of information to public.

The OPIS shall create a central portal of public administration. National health portal shall be connected to it containing project concerning :

- national health registries;
- national data centre of National Centre for Health Information;
- publishing public health information.

Contribution of the OPH to the Implementation of Informatisation of Society

Interventions into all facilities of healthcare infrastructure, which shall enable procurement of ICT equipment as well as realization of building and technical adjustments for the ICT infrastructure.

6.2 Coordination of Horizontal Priorities

Government of the SR Resolution No 1005/2006 of 6 December 2006 designated horizontal priorities coordinators, namely the Office of the Government of the SR for MRC, sustainable development and information society, and the Ministry of Labour, Social Affairs and Family of the SR for the horizontal priority of equal opportunities.

The framework of the coordination of the horizontal priorities implementation is described already on the NSRF level. The implementation systems of respective horizontal priorities are detailed in the system of horizontal priorities coordination that is separately elaborated for each horizontal priority and approved by the Central Coordination Body and operational programmes Managing Authorities. The aforementioned description is enclosed to the System of Management of the Structural Funds and the Cohesion Fund for 2007-2013.

Monitoring of the respective horizontal priorities is ensured via a set of indicators that is part of the National system of indicators for priority axes of individual operational programmes. The horizontal priorities implementation is monitored separately by annual reports of the operational programmes in line with the horizontal priorities nature, as well as by the NSRF annual report including the monitoring reports elaborated by the coordinator of a respective horizontal priority, indicating also the regional reflection of implemented activities.

During the programming period, continuous evaluations are carried out, focusing on success rate and efficiency of a selected way of implementation of each horizontal priority, on assessment of outputs and results of the projects implemented in the frame of the horizontal priorities, and on assessment of achievement of the horizontal priorities. When the programming period is over, an evaluation of the impact of projects implemented in the horizontal priorities framework is performed. All accomplished evaluations are discussed at meetings of the National Monitoring Committee and relevant work groups involved in implementation of a given horizontal priority,

and published through the communication channels of the Central Communication Authority, and thus accessible by the large public.

6.2.1. Marginalised Roma Communities

Through the MRC horizontal priority, the NSRF would like to create room for an efficient impact of the SF assistance on the MRC-related problems resolution. On the political level, the MRC horizontal priority comes under the responsibility of the Vice-Prime Minister for the knowledge society, European affairs, human rights and minorities. The MRC horizontal priority is coordinated by the Office of the Slovak Government Plenipotentiary for Roma Communities (hereinafter referred to as "OSGPRC") that establishes a department for MRC horizontal priority coordination in order to perform activities related to the administrative and methodological implementation of the MRC horizontal priority9.

The ambition is to use the SF for enlargement, completion and better combination of programmes already existing on the national level. On the basis of the SR governmental strategy for integration of economically and socially excluded Roma communities carried out during several years and of inclusion tools verified by the practice, it is possible to use the 2007-2013 period to achieve a synergic and sustainable effect. This will be based on the governmental policy based on balancing measures, ministerial conceptions for education (preschool preparation, assistants for teachers, support to Roma language, integrated training), regional development and housing (construction of renting flats and infrastructure), support to health (medical assistants), community development and employment (community social workers, community centres, social business), and more. A network of institutions represents also a positive factor, built either via public institutions (OSGPRC regional agencies, UTU departments, regional agencies of the Slovak National Centre for Human Rights, and so on), or via the non-governmental and civic sector. This network represents a qualified human potential. In order to have a comprehensive solution and a better coordination especially on the regional level, the OSGPRC elaborate in 2006 Regional conceptions for Roma communities development in the areas of marginalised groups high concentration (Košice, Prešov and Banská Bystrica regions). They were elaborated by large partnerships and consulted and accepted on the level of self-governing bodies as well.

Suggested tools ensuring the impact and coordination are as follows:

- comprehensive approach in solving the MRC problems that is used in the ROP, OP on Employment and Social Inclusion, OP on Education, OP on Environment, OP on Competitiveness and Economic Growth and OP on Healthcare;
- individual projects (demand-oriented projects) likely to apply to all operational programmes.

The OSGPRC tasks and cooperation with managing authorities, and the scope and precise conditions of implementation of the described tools providing for MRC horizontal priority in the framework of concrete operational programmes are subject to a binding agreement on cooperation between the OSGPRC and each managing authority or intermediary authority under the managing one.

The comprehensive approach is provided for as follows:

- submission of local strategies of comprehensive approach (hereinafter referred to as “CA”) by the municipality or the micro-region (in relation to the content of regional conceptions of socioeconomic inclusion of the MRC initiated by the OSGPRC in 2006 in case of

[9] In concord with the document „Analysis of administrative capacities for the programming period 2007-2013“ approved by Government Resolution No. 396 from 2 May 2007

Košice, Prešov and Banská Bystrica regions and necessitating participation of a large partnership in a given locality);

- assessment and approval of local strategies of comprehensive approach;
- elaboration of projects under the adopted local strategies of comprehensive approach;
- adoption and implementation of projects in the framework of the operational programmes;
- continuous monitoring and evaluation of fulfilment of the local strategies goals through individual projects;
- assessment of comprehensive projects contribution to the fulfilment of the horizontal priority objective.

The OSGPRC competencies in relation to the comprehensive approach implementation result from an assignment by the Vice-Prime Minister of the Slovak Government for the knowledge society, European affairs, human rights and minorities who is informed regularly by the OSGPRC on coordination of the MRC horizontal priority:

- with respective managing authorities and intermediary authorities under the managing ones, the OSGPRC concludes contracts on mutual cooperation and coordination in achieving the MRC horizontal priority, which are to be signed by the Head of the Office of the Slovak Government as a statutory representative of the Office of the Slovak Government;
- it cooperates with managing authorities on preparation of project appeals in the frame of CA;
- it publishes appeals for CA local strategies proposals;
- it constitutes a CA selection committee and coordinates its activity in order to adopt CA local strategies;
- it cooperates with municipalities/micro-regions obtaining/using the consulting based on a successful CA local strategy;
- it cooperates with managing authorities and intermediary authorities under the managing ones in selection, evaluation and monitoring of projects submitted under CA and clearly identified by an indication put directly in the application for non-repayable financial contribution;
- it coordinates the activity of the CA monitoring group that has to monitor on-site the implementation of a comprehensive project and to resolve potential identified problems related to implementation by means of direct communication and cooperation with the managing authorities of respective operational programmes;
- it cooperates with the MRC Work Group in monitoring and evaluation of SF impact on the MRC during 2007-2013;
- it provides for a specific monitoring and evaluation focusing on global fulfilment of the adopted CA local strategies.

Competencies of managing and intermediary authorities under the managing ones in relation to the comprehensive approach implementation:

- they are members of an inter-ministerial committee for evaluation and selection of the CA projects;
- they assign an indicative allocation of resources designed for comprehensive projects implementation under the OP;
- they launch CA project appeals, while a continuous appeal system is to be used, i. e. the project submission is allowed in any moment during the OP implementation, which

secures conditions for fluent implementation of all comprehensive project components in line with the time table for implementation of the adopted CA local strategy;

- they assess and select individual projects submitted under CA;
- they secure the monitoring and control of accepted projects submitted under CA;
- they cooperate with the OSGPRC in providing for the material and technical equipment of CA project appeals;
- on a regular basis, they provide the OSGPRC with necessary information for performance of monitoring and evaluation of the SF impact on the MRC.

Individual projects having impact on the MRC shall be implemented as follows:

- in a separate application for non-repayable financial contribution, the applicant shall clearly indicate that the project focuses on the MRC;
- the expected real impact of the project on the MRC horizontal priority identified by the applicant shall be assessed by the OSGPRC in the process of evaluation of projects focusing on the MRC;
- the projects considered by the OSGPRC as the ones having an important impact on the MRC shall obtain more points (except for the operational programmes dealing with the MRC HP be means of a separate measure or a group of activities);
- the OSGPRC shall monitor the projects focusing on the MRC using a sample defined by the managing authority or intermediary authority under the managing one.

Information and promotion, as important parts of creating an atmosphere of cooperation and successful solution to the MRC situation, shall be provided for by the following activities performed by the OSGPRC:

- on a regular basis in cooperation with the managing authorities and intermediary authorities under the managing ones, it shall inform the Central Coordination Body and the Vice-Prime Minister of the Slovak Government for the knowledge society, European affairs, human rights and minorities on the MRC horizontal priority fulfilment;
- it shall secure the implementation of a MRC horizontal priority communication plan aiming at improving the awareness of the MRC as well as of the large public regarding the possibilities of support provision and the results of MRC horizontal priority implementation.

In the interest of involving the beneficiaries and other actors and securing a larger platform for communication on the MRC horizontal priority implementation in the NSRF, and in the interest of further monitoring and evaluating of the implemented projects influence on the MRC in close cooperation with the MRC HP Coordination Department to the OSGPRC, there is a CSF Working Commission for Roma communities development (called Working Commission for Roma Communities Development), whose activity in the programming period 2004-2006 turned out to be a good example of SF implementation.

6.2.2 Equal opportunities

The minister of labour, social affairs and family of the SR is coordinator of implementation of the "Equal Opportunities" NSRF horizontal priority. The Equal Opportunities horizontal priority is monitored in all operational programmes in the frame of the NSRF.

An examination of the project impact on the achievement of the Equal Opportunities horizontal priority is mandatory for all SF and CF applicants. The achievement is monitored in a project

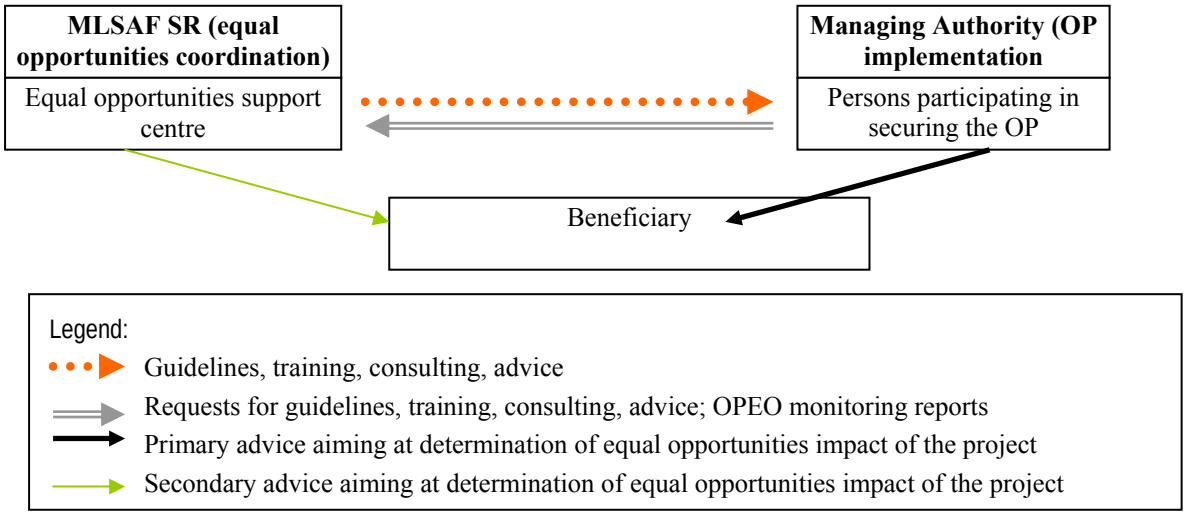
application where the applicant shall assess whether the project has an impact on equal opportunities. If the project has an impact on equal opportunities, this impact shall be assessed as a positive or negative one and the equal opportunities relation shall be added to evaluation criteria. If the project has no impact on equal opportunities, the equal opportunities relation shall not be added to evaluation criteria.

The evaluation criteria for the equal opportunities impact of the projects shall be elaborated by the Ministry of Labour, Social Affairs and Family of the SR (hereinafter referred to as "MLSAF SR"), which shall provide guidelines to all managing authorities and train their staff in this area. The project indicators of such a project shall also include the indicators monitoring the equal opportunities impact.

The MLSAF SR shall establish a support centre providing the beneficiaries with assistance in examining the equal opportunities impact of the projects. At he respective operational programmes managing authorities, the focal points (contact persons) shall be established, whose task consist in cooperating with the MLSAF SR support centre, providing the beneficiaries with advice in determination of the project relationship to the Equal Opportunities horizontal priority as well as in project evaluation in the process of their selection and implementation/monitoring.

Those activities shall be coordinated by the MLSAF SR. The MLSAF SR in cooperation with the Central Coordination Body shall provide for an adequate awareness aiming at strengthening the positive influence of supported activities on equal opportunities, as per the OP on Technical Assistance and OP on Employment and Social Inclusion funds.

Coordination scheme for implementation of the "Equal Opportunities" horizontal priority



Source: MLSAF SR, 2007

6.2.3 Sustainable Development

On the political level, the implementation of the Sustainable Development (hereinafter referred to as "SD") horizontal priority is coordinated by the Vice-Prime Minister for the knowledge society, European affairs, human rights and minorities. He/she shall fulfil this task related to sustainable development as the Chairman of the Government Council for Sustainable Development. On a working level, the horizontal priority shall be coordinated by the Office of the Slovak Government (hereinafter referred to as "OSG"). The OSG shall secure effective management and implementation of the horizontal priority in relation to all operational programmes and their priority axes, and monitor and evaluate fulfilment of the horizontal priority objectives on the NSRF level.

For this purpose, the OSG created a work group for SD horizontal priority, including representatives of all relevant managing authorities, Central Coordination Body and

representatives of socioeconomic partners (representatives of regional and local self-governing bodies, academics, research institutions, entrepreneur associations and trade unions, associations of interest and civil society).

The Government Council for SD of the SR is advisory and coordinating body of the Slovak Government in the field of SD principles implementation. Besides other tasks, it shall give its opinion on documents submitted by the Work Group for SD horizontal priority. The cooperating and advisory bodies of the Council are experts from universities, institutions of science, representatives of self-governing bodies, entrepreneur associations, trade unions and representatives of State administration bodies, as per the examination of solutions to some sustainable development-related problems.

Key means managing the interventions so as to achieve the SD horizontal priority are integration tools resulting from the conceptual, legal and institutional SD frame:

- policy and programming documents, conceptions in the field of sustainable development;
- sustainable development principles, priorities, objectives and indicators.

One of the areas with a SD significant contribution is energy and energetic effectiveness sector that will be supported not only by the OP on Competitiveness and Economic Growth, but also under the Regional Operational Programme activities and the OP on Environment (in the field of renewable resources use), OP on Healthcare, OP on Research end Development, OP on Bratislava Self-Governing Region and Rural Development Programme of the SR financed from the EAFRD. The coordination of the support to energy sector is horizontally performed by the Ministry of Economics of the SR that is in charge of energetic policy10, carries out the SR tasks resulting from the EU regulations, directives and policy documents, and at the same time is obliged to inform the EC on performance of these commitments according to the Competency Law2.

In cooperation with the managing authorities of the aforementioned operational programmes, the Ministry of Economy of the SR shall provide for the participation of competent representatives in the evaluation committee for project selection concerning the measures where the renewable resources are used or energetic effectiveness is secured. Besides the project evaluation, the role of the aforementioned person is to approve the indicators of the proposed project so as to allow the monitoring of the project contribution to securing the energetic effectiveness.

By means of the intermediary authority under the managing one for the OP on Competitiveness and Economic Growth (Slovak Energy Agency – SEA), the Ministry of Economy of the SR shall also provide for the collection of data in the energetic field from the respective managing authorities so as to their overall value for all relevant operational programmes is centrally monitored and assessed at the Ministry of Economy of the SR.

6.2.4 Information Society

On the political level, the implementation of the Information Society horizontal priority is coordinated by the Vice-Prime Minister for the knowledge society, European affairs, human rights and minorities. On the working level, the horizontal priority is coordinated by the OSG. On the conceptual and material level, the horizontal management and implementation of all Society Informatization projects is a responsibility of the MoF SR, which is the central state administration body in the field of informatization according to Act No 275/2006 Coll. on public administration information systems and on amendment and supplementing of certain laws.

The OSG shall secure effective management and implementation of this horizontal priority in relation to all operational programmes and their priority axes, and monitor and evaluate fulfilment of the horizontal priority objectives on the NSRF level. For this purpose, the OSG

[10] Act No. 575/2001 Coll. on the organisation of the activities of the Government and on the organisation of the central state administration

created a work group for Information Society horizontal priority, including representatives of all relevant managing authorities, Central Coordination Body, MoF SR and socioeconomic partners (representatives of regional and local self-governing bodies, academics, research institutions, entrepreneur associations and trade unions, associations of interest and civil society). There is also creation of the Office of the Government Plenipotentiary for Society Informatization under way, which is a part of the work group on information society and has an advisory function in this group according to its by-law.

Key means managing the interventions so as to achieve the Information Society horizontal priority are integration tools resulting from the conceptual, legal and regulatory frame of the society informatization, which are the responsibility of the MoF SR as the central state administration body in the field of informatization pursuant to Act No 275/2006 Coll. on public administration information systems and on amendment and supplementing of certain laws:

- policy documents, action plans in the field of society informatization;
- national conception of public administration informatization and resulting conceptions of development of public administration information systems as per obliged entities which are public administration institutions;
- national projects implemented in the frame of the OPSI;
- data standards, technology standards and security standards;
- methodological instructions, guidelines, manuals for applicants, or project appeals.

In the stage of implementation on the basis of the use of integration tools, the implementation of the Information Society horizontal priority is performed as follows:

- in the stage of operational programmes implementation, the fulfilment of the Information Society horizontal priority is carried out by the means of defining a uniform context discussed with the Ministry of Finance of the SR for all managing authorities or intermediary authorities under the managing one in the framework of a manual for beneficiaries stating that an applicant for non-repayable financial contribution has to clearly define in his/her project whether and how he/she desires to support the information society development by the project;
- in the stage of implementation, the fulfilment of the Information Society horizontal priority is also secured by setting the project evaluation criteria in line with the objectives of the Information Society horizontal priority; the respective managing authorities or intermediary authorities under the managing ones shall send the OSG a proposal of project evaluation criteria for the Information Society horizontal priority;
- in concurrence with the MoF SR, the OSG shall examine the proposal of project evaluation criteria according to the aforementioned integration tools.

7 Concord of the strategy with policies, documents and objectives

Strategic documents of the EU and SR build together a basic frame for the OPH strategy to reach a global aim – by means of greater effectiveness in health support; and increasing quality, effectiveness and access to healthcare services contribute to a better health condition of the population as a workforce, which is the basis for a competitive economy. Concerned are mainly documents of strategic value such as the Community Strategic Guidelines, Lisbon Strategy for the Slovak Republic, National Reform Programme of the Slovak Republic 2006 – 2008, National Sustainable Development Strategy, Concept of Territorial Development in Slovakia 2001, etc.

7.1 Concord with policy documents and policies of the EU

7.1.1 Communitarian programme in the sphere of public health

By Decision of the European parliament and the Council No. 1786/2002/EK from 23rd September 2002 the Communitarian programme in the sphere of Public health for 2002-2008 was passed. The programme introduces Community policy in the sphere of healthcare. It is based on commitments defined in the Agreement, which requires a high level of health protection by definition and implementation of all policies and Community activities. At the same time it strengthens close cooperation between international organizations in the sphere of healthcare such as the World Health Organization (hereinafter WHO) and the Organization for Economic Co-Operation and Development (hereinafter OECD).

The aim of this programme is the protection of health and support of public health. The OPH is interlocked with the aforementioned aim with its activities, which shall contribute to the improvement of the national health condition by means of a better healthcare system and preventive measures, and by increasing awareness of the public concerning the healthcare system and prevention.

7.1.2 Community Strategic Guidelines

The OPH is fully compatible with chapter 1.3.5 Protection of Workforce Health, Community Guidelines, related to the protection of the workforce health.

Considering the EU demographic structure, aging population and in all likelihood a decrease in the workforce, it is inevitable to make measures to increase the number of years, in which the workforce can participate in the work process in a good health condition. Investments into healthcare support and prevention of diseases contribute to preservation of participation of the active part of population in the social and economical life, which has a direct influence on productivity and competitiveness. Between the individual regions of the EU, great differences exist in the population health condition and the access to healthcare. Therefore, it is important that the cohesion policy contributes to the support of healthcare facilities, which shall help by increasing of working years during which the workforce can participate in the working process in a good health condition. Quality healthcare results in a larger participation on the work market, longer productive age, greater productivity, lower expenses on healthcare and lower social expenses.

Member States should contribute with their cohesion policy to increasing of effectiveness in their respective healthcare systems by means of investments into information and communication technologies, knowledge and innovations. It is necessary to pay attention to the following factors:

- **prevention of health risks** in the form of general information campaigns about health, by means of securing of knowledge transfer and technologies; by making sure that healthcare services are provided with necessary qualification, products and equipment for preventing risks and decreasing of possible resulting damage;
- **diminishing of differences in the healthcare infrastructure** and support of an effective healthcare provision, in cases, where there has been affected the economical development in regions justified in the scope of the "Convergence" objective; This measure must be based on a detailed analysis of an optimal level of service provision and adequate technologies (such as telemedicine) and the possibility to save expenses by means of providing electronic healthcare services.

7.1.3 Lisbon Strategy and Goteborg Strategy

Lisbon Strategy

The Lisbon Strategy has proclaimed as its aim to "make Europe, by 2010, the most competitive and the most dynamic knowledge-based economy in the world". Based on the Lisbon Strategy, government of the Slovak republic worked out and passed the Competitiveness Strategy for the Slovak republic until 2010 (Lisbon Strategy for Slovakia).

The main goal of the strategy is to secure that the Slovak republic reaches the standard of living of the more developed EU countries. Good state policy in the sphere of healthcare and pension security is an inevitable requisite for securing of an individual's full-fledged life at every age. With a generally low birth rate and a growing life expectancy in Europe, including Slovakia, the expenses on quality healthcare and pension system are going to grow significantly. Reforms implemented in this sphere enable that despite the facts, adequate healthcare and adequate pensions are going to be secured in a long-term and justified manner for all citizens of Slovakia. Any kind of change in the sphere of healthcare and pension system must be in concord with two basic principles:

- *sustain a balanced combination of securing of basic human rights and dignity and of the principle of merits*
- *not endanger the long-term economic sustainability of the healthcare and pension system*

The OPH shall fulfil the policy in the sphere of healthcare in such manner that shall secure providing of quality, accessible and effective healthcare in order to secure a standard of living similar to the EU states.

Goteborg Strategy

Proposal of a sustainable development strategy: A Sustainable Europe for a Better World (presented to the Council of Europe in June 2001 in Goteborg) claims as its sphere of interest climatic changes and negative influences on the population health condition, using of natural sources, dynamics of population development and environment pollution. To the dominant spheres belongs, among others, also the theme of transport.

Aim of the OPH is contribute to fulfilling of the global aim, such as improving of the health condition of the population as a representative of the workforce, which is the basis of any competitive economy, in concord with the principles of the sustainable development. **Reaching** this goal shall secure the growth of quality, accessibility and effectiveness of healthcare-related services.

At the same time, activities focusing on purchasing the mobile mammography units will have a significant influence on improving the quality of women as the workforce and reaching the

Lisbon Strategy objectives related to the achievement of women participation on the labour market.

7.1.4 Legislation of the EC in the sphere of competition

The OP on Healthcare is in concord with principles of competition – Council Regulation (EC) No. 1/2003 on the implementation of the rules on competition laid down in Article 81 and 82 of the EC Treaty.

Supervision over the sphere of protection and support of competition in the SR is held by the Anti-Trust office of the SR as a central body of the state administration.

As an EU Member State, the Slovak Republic, has fully transposed to its legislation the EC regulations in the field of state assistance, which is currently governed by Act 231/2001 Coll. on state aid as amended. The Managing Authority – MoH SR – shall secure that the state aid provided to those operational programmes is implemented in line with applicable processes and procedures implemented in the moment of the state aid provision.

7.1.5 Legislation of the EC in the sphere of public procurement

Main principles of public procurement are based on the Treaty establishing the European Community and on Regulations of the EC concerning public procurement. Concerned are the principles of transparency, equal treatment, anti-discrimination, mutual recognition and proportionality in keeping principles of economical use of expenditures.

Problems of public procurement and the awarding of public procurement contracts are ensured by the approximated legislation through Act 25/2006 Coll. on public procurement, and on the amendment and supplementing of certain laws, as amended by Act No. 282/2006 Coll., introducing a public procurement system with respect to the obligations of the Slovak Republic as an EU member. This act regulates the process of public procurement of offerings on goods, building works, service providing, license for building works, design competitions and management in public procurement.

Implementation of this act leads to a higher transparency of public procurement and greater competition, therefore to the development of a greater economic competition and in general of the business environment. It contributes to a greater effectiveness of control by spending of public means and to a decrease of the possibility of corruption.

Central body of the state administration for the sphere of public procurement is the Public procurement office.

Activities and actions, which are not influenced by the act on public procurement, are realized on the basis of the Commercial Code by means of a public procurement competition.

7.1.6 Legislation of the EC concerning the principles of environmental protection and care

By the creation of the OP on Healthcare an environmental evaluation has been concluded, pursuant to Act No. 24/2006 on environmental impact assessment and on amendment and supplementation of certain acts, as amended by Council Directive No. 2001/42/EC on the assessment of the effects of certain plans and programmes on the environment and is applied by assessing of policy documents.

Preparation and selection of the projects in the process of operational programme implementation are carried out with respect to principles of environment protection and amelioration according to Act No 543/2002 Coll. on protection of nature and landscape as amended.

The OPH implementation also preparation and selection of the projects respect the EC legislation in the field of rules of environment protection and amelioration and the recmmendations of strategic environmental assessment, which is reflected by:

- Implementation of principles of diminishing the energetic consumption of buildings in realisation of projects in the frame of all OPH priority axes;
- Individual examination of separate project intentions supported via the OPH in line with the applicable Slovak legislation (e. g. under the construction procedure process)
- Heeding of Act No. 24/2006 Coll. on Environmental Impact Assessment and on the amendment and supplementing of certain acts; and that within the scope of project implementation
- Consistent evaluation of the sustainability of the supported activity, after the co-financing has been cut off, and the ratio of long and short lasting effects, when selecting the projects.
- Consideration of the balance of local, regional and supra-regional effects of the projects when selecting the projects; preferred shall be projects with cumulative and synergic effects on the regional level.
- When selecting the projects, integration of financial means on the horizontal and vertical level shall be supported
- Focus on the support of solutions of acute problems
- Ensuring transparency and access to information throughout the entire process of declaration of appeals, selection and allocation of sources, project monitoring and evaluation of projects, individual priority axes and programme on respecting the competition protection

In the frame of the OPH, construction site interventions (healthcare infrastructure facilities) are carried out with respect to the environmental aspects consisting in diminishing the energetic consumption and increasing the economic efficiency of the buildings. Energy savings in the construction of new buildings or reconstruction of existing ones applies on the basis of EP and Council Directive No 2002/91/EC of 16 December 2002 on the energy performance of buildings (OJ EC L 001. 4.1.2003) that is transposed to Act No 555/2005 Coll. on the energy performance of buildings and on the amendment and supplementing of certain laws, which has been in force since the 1 January 2006. This act governs obligatory energetic certification of the new and renewed buildings, setting the minimal requirements for their energy performance. The “average reduction of energy consumption of buildings” indicator is applied (in per cents) that refines the average rate of reduction in energy needs for heating of healthcare infrastructure buildings supported via priority axes 1 and 2. The sustainability is also conditioned by implementation and use of renewable energy sources, reconstruction and modernisation of existing sources of energy and heat, and increase of energetic efficiency.

7.1.7 Legislation of the EC concerning the equality of opportunities, gender equality and anti-discrimination

Activities by the implementation shall be secured in concord with the EC legislation in the sphere of abiding principles of equal opportunities, gender equality and anti-discrimination.

Basic human rights and freedoms in the Slovak republic are secured by the Constitution of the SR. At the same time the Slovak republic is bound by international treaties and the state legislation,

which attempts to introduce the equality of opportunities into practice. In connection with the implementation of the European anti-discrimination legislation into the Slovak legislation, in 2004 Act No. 365/2004 Coll. on equal treatment in some spheres and protection against discrimination and amendments of some acts (antidiscrimination act) was passed.

The aim of the anti-discrimination act is to secure the subjects a form of protection against all forms of discrimination, which shall secure the victims the possibility to seek an adequate and effective court protection, including a compensation for damages and immaterial harm. Law specifies the content of regulations concerning equality and anti-discrimination based in the Constitution of the SR and in some international treaties.

Since already before passing of the antidiscrimination law, several acts in force withheld so called antidiscrimination regulations, in order to avoid duplicity, together with passing of the antidiscrimination act, novelisation of the connected regulations were passed, which strengthen the equality by handling of genders.

As an active measure for preventing of all forms of intolerance, government of the SR regularly passed a systematic instrument fight against discrimination since 2000 - "Action plan to prevent all forms of discrimination, racism, xenophobia, anti-Semitism and other forms of intolerance." (Action plan for the period 2006-2008 is already the fourth since 2000). The aim of the action plan is to contribute to the creation of a systematic and permanent attention to the problems concerning human rights and prevention of discrimination in the frame of individual resorts, development of resort co-operation with individual non-governmental organizations and other subjects.

7.2 Concord with strategic documents and policies of the SR

7.2.1 NSRF and operational programmes

National Strategic Reference Framework

The aim of the NSRF 2007-2013 is to reach a strategic goal defined in the following way: **"Until 2013, notably increase competitiveness and effectiveness of the regions and of the Slovak economy and the employment rate while respecting the principles of sustainable development."**

One of the measurable strategic goals is formulated as reaching of GDP per capita in the purchase power parity in relation to the EU 15 to more than 60% of the EU 15. The NSRF strategy is fulfilled by means of a hierarchic system of strategic and specific priorities and it consists of the following three strategic priorities:

1. Infrastructure and regional accessibility, 2. Knowledge-based economy and 3. Human resources.

By means of the OPH strategy implementation, the strategic priority 1 of the NSFR shall be supported. The synergies of measures taken under the NSRF, as well as under other operational programmes will be achieved in the OPH through the creation of better conditions for attaining and preserving the health of citizens, which is one of the essential pre-conditions for a quality work force, a decisive factor for competitiveness of the economy.

In order to secure the sectional solutions to the healthcare-related topics between the operational programmes with the aim of support to their coordination and synergy, a specialised work group has been created at the MoH SR including the concerned managing authorities. In cooperation with the CCB, the coordination of horizontal administrative capacities shall be used to a maximum possible extent for supporting these activities under the programme evaluation. OPH

relationships with other OPs is stated bellow. Definition of these demarcation lines will secure a synergy effect and avoid the mixing of the separate OP activities.

Operational Programme Education

According to a Government of the SR Resolution, the MoH SR is the intermediary authority under the managing one in the support area 2.2 Support to further education in the healthcare system in the OP Education. Healthcare infrastructure regulated by the OPH and financed from the ERDF means shall create a material and technical basis. In its frame there shall be created conditions for practical education of healthcare experts, theoretically educated through OPV (specialized, certificated and permanent education of experts in healthcare) which is financed by ESF.

Operational Programme Environment

In the Priority Axis 3 Air Protection, the Operational Programme Environment will support a change in fuel basis of the sources of energy used for production of heat and hot water to the use of renewable resources, and in the Priority Axis 4 Waste Economy, it will support the disposal of selected types of dangerous waste (including the hospital one). These activities are complementary to the other investment restructuring activities that will be implemented under the OPH, priority axes 1 and 2.

Operational Programme Employment and Social Inclusion

In the Priority Axes 1 and 2, the OPH will support the projects focusing especially on securing the renewal and development of the healthcare infrastructure of the healthcare (HC) providers, underlining the prevention and health support as well as provision of adequate appliance equipment. Doing this, the access of all SR inhabitants to healthcare will be improved, including the increase in prevention of marginalised groups, which creates positive conditions for an increase of employment rate of the members of those communities and thus an effect of synergy with the activities under the Priority Axis 2 of the OPESI, in the frame of which there will be support to specific tools reflecting the needs of marginalised groups of population (including the Roma marginalised groups) financed from the ESF.

A synergy of the OPH and OPESI is also expected while securing the connection of the modernisation of material and technical healthcare infrastructure with the human resources development in the healthcare system, with respect of the demarcation lines between the OP on Education and OPESI

The programme activity focusing on purchasing the mobile mammography units will have a direct influence on improving the quality of women's life in relation to the labour market as well, which creates a direct connection to the activities focusing on improving the women's situation on the labour market that are implemented through the OPESI.

Operational Programme Research and Development

The Operational Programme Research and Development shall support, in the scope of Priority Axis 3, the infrastructure of high schools and universities, including the schools with medical direction. The OPH shall create conditions for further practical and theoretical education of graduates from these schools in a modernized network of healthcare providers.

Regional Operational Programme

Renewal and development of the healthcare infrastructure of general and specialised hospitals and outpatient healthcare facilities via the Operational Programme Health (OPH) is indirectly linked to the support to secondary schools of medicine in the framework of the support to the secondary schools infrastructure via the Regional Operational Programme (ROP). Both programmes will significantly contribute to the achievement of the “Convergence” and “Competitiveness” objectives by increasing the level of the material and technical basis, OPH

healthcare infrastructure and ROP education infrastructure – schools, and setting the conditions for the healthcare provision (OPH) and for the human resources education in the field of healthcare (ROP).

As per the support to infrastructure of non-commercial rescue services, the ROP focuses on the support to entities that do not directly perform the medical rescue services (Firemen and Rescue Corps, municipal firemen corps, mountain rescue services, and more).

Operational Programme Society Informatization

The OPSI focuses on implementation of effective electronic services provided to the public by the public administration through a technology and application environment using the broadband connection.

The OPSI will set conditions allowing the MoH SR to implement the adopted conception of electronization and informatization of healthcare, in its components concerning the provision of information services to the public.

The OPSI will create a central portal of public administration to which the national healthcare portal will be connected including the following projects:

- national health registries;
- national data centre NHIC;
- publication of public health information.

The OPH will also support the informatization of the healthcare providers in relation to the internal informatization of the selected healthcare providers.

Operational Programme Competitiveness and Economic growth

Priority Axis 1 of the Operational Programme Competitiveness and Economic Growth shall support the development of firms and services mainly by means of innovation. The priority axis shall not support healthcare providers (including outpatient healthcare). Support of these subjects shall proceed only within the OPH.

7.2.2 Competitiveness Strategy for the Slovak Republic until 2010

The Competitiveness Development Strategy for the Slovak Republic until 2010 is based on the basic philosophy of the EU Lisbon strategy, which aim is to develop economical competition by means of two basic activities:

- far-reaching reforms (so called structural reforms) and
- adequate development of policies.

Among structural reforms, it is necessary to mention mainly the changes in the pension and healthcare system. Changes in the healthcare system have been directed to reach the most effective expenditure of public means just like an increase in the quality of provided services. It is assumed that by finishing of the pension and healthcare reforms, many problems connected with the aging of population that would occur in Slovakia in the future, should be solved.

In this time, it is necessary to concentrate on finishing and especially on a precise implementation of all reforms, so they could bring expected results.

7.2.3 National Sustainable Development Strategy

The National Sustainable Development Strategy (NSDS) is based on several areas: cultural, social, economic, environmental, institutional and regional conditions. The starting position in securing of sustainable development in the SR (SD), in the scope of social conditions and point of views, is determined (among other factors), especially by the development and state of quality

and life expectancy, population development, population education level, health condition and at the same time the level of healthcare.

The SD social aspect is based on the basic principle that the real treasure of a society is in its people. The goal of the SD strategy should be to create an environment, which enables the people a long, healthy, full-fledged and creative life. The idea of the SD SR is based on the assumption that the local, regional societies and the whole society as such are interested in effective using of human resources in the presence, but also in a near and far future; and therefore, one of the basic aims should be to improve the quality of life.

A good health condition is one of the basic determiners of the quality of life. The Statistical office of the Slovak republic determined that the population health condition is not favourable. It is influenced by an unhealthy way of living, situation in healthcare, worse quality of living environment in some regions, unemployment rate and bad flat conditions occurring by a part of the population. Among other factors that negatively influence the population health condition there is also a lower education level, character of economic development and an insufficient integration of the Roma community.

Through its priorities, the OPH reflects the NSDS needs and focuses on aspects of improving the healthcare infrastructure, implementing the tolls of efficiency and quality, supporting the preventive measures that will contribute to the provision of quality healthcare, and thus improving the quality of citizens' life in the end. Further, it is oriented on enforcing of a whole-society all-level responsibility for the health condition, especially in support and health protection and securing of information penetration.

7.2.4 Concept of territorial development in Slovakia

The Concept of territorial development in Slovakia (CTDS) concentrates in its analytical parts on the conditions and factors, which are necessary for the development of the economic and social sphere of the society in concord with the requirements of the sustainable development. Among the explicitly mentioned factors, there is also health condition and population health protection. It is stated, that Slovak population health condition is not favourable. The current situation is influenced by an unhealthy way of living and the state of healthcare organization and unfavourable conditions of its financing, partially worsened quality of the living environment in some regions, unemployment rate and unfavourable flat conditions occurring by a part of population. More details are in the part State of Environment Protection, in which there are described individual elements such as air, waste management etc, which in great measure influence the population health condition.

The aim of the OPH is to contribute by means of its instruments to the creation of conditions, which shall eliminate negative impacts on the health condition and at the same time create good requisites for quality and effective healthcare.

7.2.5 Other national and sector strategic and analytic materials

The strategy of modernizing healthcare is based on the following documents:

- Analysis of the company Sanigest International- Slovak Hospitals Evaluation; of 02/2006
- Report on health condition of the population in Slovakia – Resolution of the Slovak Republic Government No. 873 of 18 of October 2006;
- "Amendment to the National Reform Programme of the Slovak Republic 2006 – 2008"- Resolution of the Slovak Republic Government No. 1056/2006 of 13 December 2006;
- Year-book on health statistics of the Slovak Republic 2000-2005; issued in 2007

- "Report on programme of rationalization in the healthcare system of the SR" Resolution of the Slovak Republic Government No. 462/2007 of 23 of May 2007.

7.2.6 Regional strategic documents

The strategy of healthcare modernization is based on the accessible strategic documents of the individual UTUs in the sphere of healthcare:

- Proposal concept of health development of Prešov self-governing region;
- Concept of health of Žilina self-governing region;
- Development strategy of healthcare services in Banská Bystrica self-governing region for years 2006-2009;
- Development program of Nitra self-governing region 2003-2013, part Health;
- Development plan Slovakia – East (proposal), Developing theme: Healthcare;
- Economic and social development program of Trenčín self-governing region, part Health;
- Economic and social development program of Trnava self-governing region 2004-2013, part Health.

7.3. Connection with other EU financial tools

Seeing the nature and orientation of the OPH activities, the OPH Managing Authority in cooperation with the MoF SR examines during the OPH implementation actively and continuously possibilities of the use of innovative financial tools.

Seeing the nature and orientation of the OPH activities, the OPH Managing Authority examines actively how to involve innovative activities resulting from the "Regions for Economic Change" initiative in the OPH, also by allowing the participation and creating the room for a network representative in the OPH Monitoring Committee.

7.3.1 Synergy, Complementarity with Programmes Financed from the EAFRD and EFF

Within the programming period 2007-2013, direct support to the countryside is performed through the Rural Development Programme of the SR (hereinafter referred to as "RDP") co-financed by the European Agricultural Fund for Rural Development (hereinafter referred to as "EAFRD"). Global objective of the RDP is "Multifunctional agriculture, food-processing industry, forestry and sustainable rural development". The RDP is managed by the Ministry of Agriculture of the SR. The RDP is carried out through four axes:

1. Strengthening competitiveness of agriculture and forestry;
2. Improving environment of the country;
3. Quality of life in rural regions and diversification of rural economy;
4. Leader.

The content of the RDP axis 3 "Quality of life in rural regions and diversification of rural economy" is focuses on:

- Diversification of non agricultural activities;

- Support to tourism activities;
- Reconstruction and development of municipalities;
- Vocational training;
- Acquiring skills and activation.

Synergy, complementarity and together division line of both programmes – RDP and OPH in 2007 – 2013, on behalf of strengthening of convergence, socio-economical development and competitiveness of rural areas of SR, is in common support and complexity repletion of material infrastructure of municipalities, namely in growth poles and in some inevitable valid cases – out of growth poles too.

The content of RDP through axis 3 "Quality of life in rural regions and diversification of rural economy" and concrete activities – restoration and development of municipalities focused on support of material infrastructure of municipalities, but healthcare infrastructure is not solved.

OPH – for completion and securing complexity of material infrastructure of municpalities, is solving through content of the priority axis 2 "Health promotion and health risks prevention" healthcare infrastructure of municipalities, in the growth poles, including of exception, which represents realisation of projects of healthcare infrastructure with separated and segregated Roma settlements (according to the updated Atlas of Roma Communities) having attributes of multiple deprivation and attributes of social exclusion from the life of the municipality, and thus having a limited access to public services. The exception concerns precise activities under OPH within concrete projects of the beneficiaries during 2007-2013.

7.3.2 Complementarity and Synergy with Operational Programmes under the European Territorial Cooperation Objective

The cross-border cooperation programmes for 2007-2013 take into account provisions of the fundamental EU policy and programming documents, particularly in the field of defining objectives and scope of priorities. In accordance with the General Regulation, the programme provides for cohesion of the support obtained from the ERDF and the measures, policies and priorities of the Community. The activities suggested in the cross-border cooperation programmes are in accordance with the Community policies and policy documents.

The support area focuses especially on support to socioeconomic development of cross-border regions, and development of the cross-border transport information infrastructure and environment.

Under the cross-border cooperation programmes, the individual projects are implemented in the frontier regions of the SR. On the territory of the "Convergence" objective, the cooperation of Slovak regions with the Czech, Austrian, Polish and Hungarian ones is concerned. The projects develop the cross-border cooperation, the cooperation being of supranational nature.
Following two cross-border cooperation programmes are focused also on cooperation in healthcare area.

Cross-Border Cooperation Programme Slovakia – Austria
Cross-Border Cooperation Programme Slovakia – Austria 2007-2013 was elaborated under the European Territorial Cooperation objective with Austrian counterpart cooperation. It covers Convergence objective concerning Trnava Self-governing Region.

Priority 1 – Learning Region and Economic Competitiveness is focused also on the development of the cooperation in the healthcare area and is complementary with OPH that is focused on improvement of healthcare quality, effectiveness and availability and health support in the healthcare infrastructure framework.

Hungary – Slovakia Cross-Border Cooperation Programme 2007-2013
Hungary – Slovakia Cross-Border Cooperation Programme 2007-2012013 was elaborated under the European Territorial Cooperation objective with Hungarian counterpart cooperation. This programme is inter alia focused on the development of the cooperation in the healthcare area in the priority 1 – Economy and Society. Hungary – Slovakia Cross-Border Cooperation Programme covers by the means of projects development of border regions and in this way also synergy effect by achieving of the aims of OPH in Košice, Banská Bystrica, Nitra and Trnava regions analogous to other programmes focused on cross-border cooperation.

The nature of the supported activities under both programmes guarantees clear demarcation lines between the operational programmes under the European Territorial Cooperation objective and the OPH so as to avoid the double co-financing of the same development activities in the framework of both programmes. Mechanism avoiding double support of the same operations or their parts consists of the use of the ITMS system that registers all projects carried out under the OPH up to the level of separate operations, and in an exchange of information between both managing authorities involved.

8 Financial Plan

8.1 OPH Financial Plan – Annual Obligations

Table 66: OPH Financial Plan – annual obligations (in EUR, in current prices)

Year	ERDF Structural Funds (1)	Cohesion Fund (2)	Total (3)=(1)+(2)
2007	35,556,323	0	35,556,323
2008	34,599,224	0	34,599,224
2009	33,296,268	0	33,296,268
2010	30,717,394	0	30,717,394
2011	33,076,047	0	33,076,047
2012	36,494,036	0	36,494,036
2013	46,260,708	0	46,260,708
Total 2007-2013	**250,000,000**	**0**	**250,000,000**

Source: MOH SR, 2007.

8.2 OPH Financial Plan for the Entire Programming Period according to priority axes

In accordance with Government of the SR Resolution of 8 October 2006 concerning the Strategy of financing the Structural Funds and the Cohesion Fund during the programming period 2007-2013, the proportion of the ERDF assistance is to be expressed in relation to the total eligible public expenses pursuant to Art. 53 Subs. 1b) of Council Regulation (EC) No 1083/2006 of 11 July 2006 laying down general provisions on the European Regional Development Fund, the European Social Fund and the Cohesion Fund and repealing Regulation (EC) No 1260/1999.

Table 67: OPH Financial Plan (in EUR, in current prices)

	EU sources a)	National funds b)	Total (c)=(a)+(b)	Co-financing rate (d)=(a)/(c)	For information (indicative)	
					EIB contribution	Other funds –
Priority Axis 1 Hospitals Healthcare System Modernisation	193,075,000	34,072,059	**227,147,059**	85 %	0	9,653,750
Priority axis 2 Health promotion and health risks prevention	49,100,000	8,664,706	**57,764,706**	85 %	0	245,500
Priority axis 3 Technical assistance	7,825,000	1,380,882	**9,205,882**	85 %	0	0
Total	**250,000,000**	**44,117,647**	**294,117,647**	**85 %**	**0**	**9,899,250**

Source: MOH SR, 2007.

The financial plan for distribution of available funds to individual priority axes was elaborated on the basis of an identification of expected needs in respective areas in the Slovak conditions. It takes into account the global objective of the programme as well as the definition of priority axes and their orientation stated in the Chapter 5 of the present Operational Programme. Larger amounts shall support the projects aiming at the change of the structure and quality of the economically sustainable offer of healthcare services through comprehensive restructuring projects **of hospital healthcare providers**.

8.3 Division of Funds Benefit into the Assistance Category on the OPH Level

Table 68: Informative division of benefit from EU funds to categories of the dimension "Priority Theme" (EUR)

Code of the category	Name of the category	Indicative amount of resources within the category	%
76	Healthcare infrastructure	242,175,000	96.87
85	Preparation, performance, monitoring and control	6,651,250	2.66
86	Evaluation and studies; information and communication	1,173,750	0.47
Total		**250,000,000**	**100.00**

Source: MOH SR, 2007.

Table 69: Informative division of benefit from EU funds to categories of the dimension "Form of Financial Benefit" (EUR)

Code of the category	Name of the category	Indicative amount of resources within the category	%
01	Non-refundable financial contribution	250,000,000	100.00
Total		**250,000,000**	**100.00**

Source: MOH SR, 2007.

Table 70: Informative division of benefit from EU funds to categories of the dimension "Supported Territories" (EUR)

Code of the category	Name of the category	Indicative amount of resources within the category	%
01	Urban regions	200,000,000	80.00
05	Rural regions - other	50,000,000	20.00
Total		**250,000,000**	**100.00**

Source: MOH SR, 2007.

8.4 OPH Regional Financial Allocations

Indicative regional financial allocations for Priority Axis 1 were calculated based on the number of beds in inpatient healthcare facilities (hospitals) in respective self-governing regions (NUTS III). Table 72 resumes them on the NUTS II level.

Table 71: Indicative Regional Financial Plans – Priority Axis 1

NUTS II Region	EU funds (EUR)	%
WS	67,576,250	35.00
CS	57,922,500	30.00
ES	67,576,250	35.00
Total	**193,075,000**	**100.00**

Source: MOH SR

Indicative regional financial allocations for Priority Axis 2 were calculated based on statistical data on the number of inhabitants in respective self-governing regions (NUTS III). Table 73 resumes them on the NUTS II level.

Table 72: Indicative Regional Financial Plans – Priority Axis 2

NUTS II Region	EU funds (EUR)	%
WS	19 101 225	38,90
CS	13 858 372	28,22
ES	16 140 403	32,88
Total	**49,100,000**	**100.00**

Source: MA SR ,MoH SR

Table 74 contains a summary of the data included in the tables 72 and 73.

Table 73: Indicative Regional Financial Plans for the OPH – Priority Axes 1 and 2

NUTS II Region	EU funds (EUR)	%
WS	86 677 475	35,79
CS	71 780 872	29,64
ES	83 716 653	34,57
Total	**242,175,000**	**100.00**

Source: ŠÚ SR, MZ SR

8.5 State Assistance Scheme

The OPH MA shall guarantee that any state assistance including potential de minimis schemes under the OPH shall be provided in accordance with procedural and material state assistance rules applying in the moment of provision of public funds support.

8.6 Cross Financing

The OPH provides for the complementary financing of actions coming within the ESF remit only for Priority Axis 2 "Health promotion and health risks prevention" in the amount of 2% of the priority axis.

In the frame of the OPH, the cross financing shall be employed e. g. for the purposes of promotion and education related to the operation of mobile diagnostics units (mammography equipment).

Table 74: Cross financing

Priority Axis	Foreseen cross financing [%]
1. Hospitals Healthcare System Modernisation	0
2. Health Support and Prevention of Health Risks	2

Source: MOH SR

9 Implementation System

Chapter 9 describes the implementation system of the OPH that is in line with General Regulation and with the SF and CF Management System for the programming period 2007 – 2013.

9.1 Bodies Involved in Management and Programme Implementation

9.1.1 Central Coordination Body

On the basis of General Regulation No. 832 from October 8, 2006 the Ministry of Construction and Regional Development of the Slovak Republic as the Central Coordination Body for the operational programmes within the National Strategic Reference Framework of SR for 2007 – 2013 (hereinafter "CCB") ensures the strategic level of the NSFR management system. In this regard, in the field of assistance management from the SF and CF the CCB performs the following functions:

- ensures the programming, monitoring, evaluation, publicity, public awareness and administration capacities education in these areas on the level of the NSFR;
- ensures the coordination of managing processes and operational programme implementation in accordance with the SF and CF Management System;
- methodologically guides the entities involved in operational programmes management and implementation;
- has the responsibility for the ITMS development, operation and maintenance;
- fulfils the function of MA important for the OP Technical Assistance.

9.1.2 Managing Authority

Managing Authority of the operational programme (hereinafter “MA”) represents the operational level of the NSRF managing system. Managing Authority appointed by the member state and based on Article 59(1) of the General Regulation is responsible for programme managing and fulfilment in accordance with the EU and SR regulations. When managing the operational programme, MA proceeds in accordance with CCB methodological directives and methodological directives of certification authority and audit authority in respective areas.

On the basis of General Regulation No. 832 of October 8, 2006 the OPH Managing Authority is the Ministry of Health of the Slovak Republic.

In line with Article 60 of the General Regulation, the MA is responsible for OP managing and fulfilment and especially for:

- operational programme and programme manual elaboration;
- co-financing of operational programme from the state budget;
- direction of beneficiaries;
- operational programme monitoring and evaluation;
- MC management for the OPH and elaboration of annual and final report on implementation, reports submission to the Monitoring Committee and European Commission;

- publicity on help from the EU and informing the public about the EU funds in line with Article 69 of the General Regulation;
- collection and recording of data required for financial management, monitoring, control, audits and evaluation in electronic form;
- archiving and accessibility of documents in line with Article 90 of the General Regulation;
- declaration of appeals, acceptance, selection and approval of beneficiaries' projects in line with the evaluation criteria and with projects selection approved by the Monitoring committee;
- concluding contracts with beneficiaries on the provision of non-refundable financial contribution;
- verification of individual projects co-financing from the beneficiary's funds and other national funds;
- verification of tasks performance, goods supply and services provision financed in the project framework, and verification of real expenditures;
- securing the management of independent accounting system by beneficiaries and other bodies involved in implementation;
- control in line with Article 60b RG.

In line with Article 71 of the General Regulation, the inner structure and division (delegacy) of MA responsibility for the OPH shall be described in the system management and control description. This description shall be submitted by the Member State to the EC prior to the submission of the first request for interim instalment, or at least within 12 months from the OP approval.

9.1.3 Involvement of Regional and Local Self-governments Bodies

Regions (UTU) entered into the preparation and implementation of the OPH at several levels:

1. In the process of OPH preparation, the UTU (except for Bratislava region that does not fall under the "Convergence" objective) and ASTV (Association of Slovak Towns and Villages) representatives were a part of a work group for the Operational Programme preparation.

2. In the process of preparation, the regional UTU strategies concerning the health sector were taken into consideration.

3. In the process of preparation of the OPH criteria, one of the basic criteria for support to the healthcare providers shall be the one of meeting requirements of thematic and territorial concentration by the submitted project.

4. In the process of assessment and selection of projects, the participation of UTU and ASTV representatives in evaluation commissions is provided for.

In the process of programme monitoring, the participation of UTU and ASTV representatives in the OPH Monitoring Committee is provided for.

9.1.4 Monitoring Committees

OPH Monitoring Committee

In line with Article 63 of the General Regulation the Monitoring Committee (hereinafter "MC") for each OP must be established within three months from its approval by the European Commission. Aim of the Monitoring Committee is to check the efficiency and quality of the programme implementation.

MC chairman for the OPH is the Minister of Health of the SR as a representative of Managing Authority for the OPH. Function of the MC secretary is operated by the MA OPH. MC members are appointed by the Minister of Health of the SR. In line with Article 11 of General Regulation, the composition of the Monitoring Committee is based on the partnership principle – besides the relevant ministries, the MC members include as well representatives of the regional and local self-governing bodies, third sector and other socioeconomic partners (Public Healthcare Authority of the SR, Healthcare Supervision Authority, Slovak Medical Chamber, Association of Slovak Hospitals, Association of Private Doctors of the SR, Association of Slovak Towns and Villages, Union of Slovak Towns, Trnava Self-governing Region, Nitra Self-governing Region, Trenčín Self-governing Region, Banská Bystrica Self-governing Region, Žilina Self-governing Region, Prešov Self-governing Region, Košice Self-governing Region), and as for the Marginalised Roma Communities horizontal priority, also the Office of the Slovak Government Plenipotentiary for Roma Communities, which are concerned by the content of the given operational programme, while a balanced participation of the partners needs to be ensured. Member of the MC is also a representative of the CCB, certification authority and audit authority. The representative of the European Commission is involved in the MC sessions as an observer and advisor. The MC composition might be further examined and enlarged in order to ensure a sufficient representativeness and partnership.

The Monitoring Committee meets two times a year, potentially in cases when it is necessary to discuss the matters for which the agreement of the MC is crucial (e. g. a proposal for operational programme revision), the Monitoring Committee shall meet upon suggestion of the MA or a MC member more frequently.

Competency and activity of the MC are governed by the bylaws and procedural rules adopted by the MC during its first meeting.

Main tasks of the Monitoring Committee in line with Article 65 of the General Regulation are:

- approval of criteria for projects selection (within a period of 6 months from the OP approval) and their possible revision;
- review and approval of proposals for change and contents amendment of the operational programme;
- regular examination of the results of programme implementation, mainly the operational programme objectives achievement and evaluations provided for by Article 48(3) of RG;
- review and approval of annual and final reports on programme implementation before they are sent to the European Commission;
- receipt of information about annual control report or about a part of it concerning the OP, and the information about important comments that might be raised by the Commission after its examination;
- any moment make a proposal to the Managing Authority to execute any revision or examination of the OP, which would lead to achieving of the relevant fund's aims or to an improvement of the OP management (including financial management).

9.2 Monitoring

In line with the SF and CF Management System, monitoring represents the activity that systematically deals with data collection, classification, aggregating and imposing for the needs of the evaluation and managing processes control. The main aim of monitoring to regularly study the realization of the NSRF, OP and projects aims using indicators.

Outputs from monitoring ensure for the Managing Authority the inputs for decision-making, with the aim of improving the implementation of the OP, the elaboration of annual reports and the final report on the OP implementation and the documents necessary for decision-making of monitoring committees (e.g. in connection with any revision to the OP).

Monitoring process is based on a structured management model on the level of the NSFR, OP and projects. Monitoring and evaluation is ensured by all subjects involved in the SF and CF management in the scope of defined tasks and responsibilities and subjects that draw financial resources from funds.

MA tasks for the OPH in the area of monitoring:

- It operates in line with the CCB methodology within the area of monitoring;
- When necessary, it submits to the CCB proposals for changes or amendments of the national system of indicators;
- It is responsible for data collection and analysing on the programme level in the monitoring area by means of a system of indicators as well as in the monitoring area on the level of assistance categories;
- It is responsible for elaboration of annual and final reports on OP performance that are submitted for their approval to the Ministry of Interior for the given OP, and consequently to the European Commission.

Monitoring (and consequently the evaluation) runs in two ways – using the indicators system and assistance categories from the SF. Monitoring of indicators mentioned in chapter 5 will be ensured on individual projects level and consequently will be evaluated on whole strategic programme document level.

Monitoring through indicators system

The aims of the NSRF and individual operational programmes are defined and consequently quantified in the process of programming performed through the system of physical and financial indicators (national indicators system for the NSRF). Indicators shall be obligatory for all subjects and they shall be a part of the ITMS. The most important tool for monitoring and evaluation of the operational programmes and achievement of the NSRF objectives is the fulfilment of defined indicators.

Operational programme indicators are listed in Chapter 5 of this document.

The monitoring process begins on the lowest level – the level of project. For the monitoring purposes, the project is the basic unit analyzed through the relevant collected data. In the agreement on help received from funds the beneficiary must undertake to provide data for the monitoring and project reporting purposes. Physical and financial projects indicators obtained from beneficiaries through uniform monitoring reports are reflected into the ITMS and aggregated towards the level of measure, priority axis, operational programme, the NSRF.

Monitoring using the assistance categories from the SF
In line with Article 9 of the General Regulation and with Annex II of the implementation regulation, the funds expenses shall be monitored according to the following categories:

- priority theme;
- form of financing;
- type of region;
- dimension of economical activity;
- dimension of help placement.

Within the first three categories every OP contains an indicative, planned funds benefit division on the level of programme. Within the OP category "priority themes", indicative funds benefit is assigned to those activities that focus on the competitiveness support and on the creation of new jobs ("Lisbon Activities"). During the programme implementation and after its termination the above mentioned facts allow monitoring and evaluating of the operational programmes' benefit with the aim to fulfil the aims of the Lisbon Strategy and the National Reform Program.

Within the process of monitoring through the assistance category from the SF, the following steps are applied: during the project approval the data is recorded to the ITMS and after the project termination the real value reached in the given category is recorded. Through the ITMS, the data for categorisation from the level of individual projects are aggregated into the higher levels of programme structure and are included within the Annual reports.

9.3 Evaluation

In line with the SF and CF Management System, the evaluation represents a process that systematically investigates the contribution of the programmes realizations and their compliance with the aims determined by the OP and NSRF. Moreover, evaluation analyzes the realisation processes and setup suitability of individual programs and measures and prepares recommendations for efficiency improvement.

In line with Article 47 of the General Regulation, the evaluation can be of strategic character (examination of programme/programme groups development in respect to the national priorities and priorities of the Community) or of operational character (with the aim to support the operational programme development). This evaluation is performed prior to the programming period launch (interim evaluation), during the period (continuous evaluation) and after the programming period termination (final evaluation).

Evaluation is carried out within the scope of responsibility of the Member State (CCB, MA) or the Commission, in line with the proportionality principle. Results are published in compliance with regulations on access to information in force.

CCB tasks within the area of evaluation:

- It ensures the interim evaluation of the main policy document for the programming period until 2013;
- It ensures continuous and thematic evaluation on the central level;
- It coordinates and methodically directs managing authorities in the sphere of evaluation.

MA tasks for the OPH in the area of evaluation:

- It operates in line with the CCB methodology within the area of evaluation;
- It ensures the interim and continuous OP evaluation and submission of the results of continuous evaluation to the OPH Monitoring Committee and Commission;
- It ensures the communication with the EC and inputs for subsequent OP evaluation and possible strategic evaluation performed by the EC.

The evaluation identifies and defines generally applicable facts and suggests possible ways of solutions to findings. While the monitoring may be considered as a set of immediate information activities, the evaluation employs the selected documents, reports and information for analytic activities.
Evaluation focuses on improving the management and implementation of the operational programmes. It is based on monitoring activities providing the necessary information. Based on the monitoring results, it performs assessment of the provided assistance.

Pursuant to Article 37 (1) g) of Council Regulation (EC) No 1083/2006, the operational programmes shall contain implementing provisions for the operational programme, including a description of the monitoring and evaluation systems.

Ex-ante evaluation

The EU Member States have to perform an ex-ante evaluation. Under the individual objectives of the EU regional policy, the OPH MA has chosen the possibility to perform the ex-ante evaluation of the entire OPH for the "Convergence" objective financed by the European Regional Development Fund. The ex-ante evaluation performance is the responsibility of the body in charge of the elaboration of programming documents.

The ex-ante evaluation has to identify and assess disparities, gaps and potential of development, objectives to be achieved, expected results, quantified aims, strategy coherence proposed for the region (if relevant), added value of the Community, scope of the Community priorities consideration, experiences from the previous programming period, quality of procedures and obstacles to implementation, monitoring, evaluation and financial management.

The interim evaluation aims at optimising the allocation of budget funds under the operational programme and at improving the programming quality. The evaluation shall determine and examine differences, gaps and potential of development, objectives to be achieved, expected results, quantified aims, accordance of the strategy proposed for the region, and if necessary, added value of the Community, scope of the Community priorities consideration, experiences from the previous programming period, and quality of procedures of implementation, monitoring, evaluation and financial management.

The OPH ex-ante evaluation process is detailed in chapter 2.2.

Continuous evaluation

Legal basis and content of continuous evaluation

Pursuant to Article 48 (3) of Council Regulation (EC) No 1083/2006, during the programming period, the Member States shall carry out evaluations linked to the monitoring of operational programmes in particular, where that monitoring reveals a significant departure from the goals initially set or where proposals are made for the revision of operational programmes, as referred to in Article 33. The results shall be sent to the monitoring committee for the operational programme and to the Commission.

The continuous evaluation may be of operative or strategic nature. **Operative evaluation** (aimed at supporting the operational programme operation) focuses on macroeconomic impact of the SF assistance, well-grounding and consistency of strategies on the national and programme level, specific themes of fundamental importance for the OP (e. g. innovations, information society), horizontal priorities. This evaluation may fix recommendations for an OP revision or provide information for strategic reports of a Member State or the EC. **Strategic evaluation** (examination of a programme or group of programs evolution in relation to the Community priorities and national priorities) focuses on quality and relevance of the quantified objectives, financial progress analysis, recommendations for improvement of the OP performance, ways to achieve some of the socioeconomic goals, assessment of functionality of the administrative structure and of quality of the implementation mechanisms.

Experience from the 2004-2006 programming period showed the need to create a tighter link between the OP monitoring and evaluation. The monitoring shall provide the operative information (achieved outputs and results, financial absorption, quality of implementation mechanisms) that could be a basis for evaluation, e. g. when real or potential problems occur. On the other hand, the information on certain strategic aspects, e. g. socioeconomic impact or changes in the Community, national or regional priorities concerning the OP, cannot be furnished by the monitoring system; they have to be subject of a regular evaluation.

Continuous evaluation of the OPH

Continuous evaluation of the OPH shall be carried out and determined on the basis of internal requirements and needs of the Slovak Republic. Continuous evaluation of the OPH will be carried out in accordance with elaborated, adequate system of implementation, supplying filling of article 48 (3) of Council regulation No. 1083/2006. Based on the real or possible problems (or other information) revealed by the monitoring system, the OP continuous evaluation shall be carried out. The continuous evaluation shall also be performed in the case there is a revision of socioeconomic impacts or other strategic aspects.

According to the aforementioned, the OPH MA shall ensure:

- a strong binding between the monitoring and evaluation system;
- periodicity or regularity of the monitoring and evaluation operations;
- an evaluation plan.

Based on the monitoring outputs, the MA shall decide whether the continuous evaluation will be performed on the level of priority axes, measures, framework activities, national projects or other.

The OPH MA shall carry out continuous evaluation in the following cases:

- if the aforementioned monitoring reveals a significant departure from the initially fixed goals;
- if there is a proposal for an operational programme revision;
- other.

Grounds for an OP revision may be following:

- fundamental socioeconomic changes;
- fundamental changes in the Community, national or regional priorities;
- implementation-related problems/difficulties;
- if the monitoring reveals a significant departure from the initially fixed goals (e. g. lack of monitoring system data, risky area known in advance – MRC, and more).

In all such cases, the OP revision had to be preceded by an evaluation; i. e. the OP revision has to be based on a regular monitoring process and/or a regular continuous evaluation that determines specific OP modifications.

The European Commission shall receive all the results of a continuous evaluation, including of proposals for an OP revision involve the following fundamental changes:

- financial modifications – e. g. financial reallocations between various priority axes, where an EC approval is needed;
- modifications of content – e. g. revision of goals on the OP level or priority axes level;
- implementation modifications – e. g. application of new implementation procedures or fundamental changes in existing ones.

Evaluation plan of the OPH

Pursuant to Article 48 (1) of Council Regulation (EC) No 1083/2006, a Member State may draw up under the "Convergence" objective, in accordance with the principle of proportionality, an evaluation plan presenting the indicative evaluation activities which it intends to carry out in the different phases of the implementation. The EC recommends to elaborate an evaluation plan on the national level, and where appropriate (in accordance with the principle of proportionality) on the programme level as well.

The evaluation of the OPH plan shall be drawn up by the Managing Authority during the first year of the OP implementation, and it shall include the following components:

1. **Coordination** – this chapter shall contain a proposal and an explanation of the overall coordination of the continuous evaluation process, i. e. link to the monitoring system, creation of a work group for evaluation, distribution of human resources, mechanisms for potential revision of the evaluation plan, vocational trainings for evaluators;
2. **Specific evaluation activities** – this chapter shall contain the following parts:
   a) Indicative list of evaluations planned during the programming period;
   b) Content of each evaluation activity:
      - Strategic or operative evaluation;
      - Level of the OP, group of the OP, specific subject and so on;
      - Possible areas of risk identified on the basis of past experience in the specific area of assistance;
   c) Principal question to be answered in the process of evaluation;
   d) Use of the evaluation results (publication and accessibility of evaluation reports, presentation of evaluation results, monitoring of recommendations consideration);
   e) Indicative time schedule;
   f) External or internal evaluation;
   g) Finance planned for respective evaluations;
   h) Management structure (including the work group for evaluation, consultations with social partners, and partners on the regional and local level).

Continuous evaluation management

The OPH MA has the final responsibility for the continuous evaluation process, i. e. in cooperation with the work group for evaluation, it decides on the structure and content of the evaluation plan, and provides for an administrative basis for its implementation.

In the process of continuous evaluation, the OPH MA shall carry out the following tasks:

- providing for collection and accessibility of the monitoring indicators;
- guaranteeing of the respect of evaluation goals and preservation of its quality standards;
- providing for the technical assistance funds necessary for performance of evaluation;
- submission of evaluation results to the Monitoring Committee for the OPH and to the EC.

To carry out the continuous evaluation, the OPH MA shall use external evaluators on the basis of a written framework contract/agreement. The continuous evaluation shall be performed by independent evaluators selected in a public procurement. The framework contract concluded between the internal evaluators and the OPH MA shall cover the entire programming period. The framework contract may in no case substitute the Managing Authority responsibility for evaluation performance in the OP implementation.

By the framework contract, the independent external evaluators shall commit themselves to closely cooperate with the internal MA capacities in the scheduling and performing of the evaluation processes.

The OPH Monitoring Committee shall also actively participate in the analysis of the evaluation results and recommendations.

Continuous evaluation principles

1. Proportionality – the MA shall provide for respect of the principle of proportionality while determining the amount and content of individual evaluations during the evaluation plan preparation;
2. Independence – the MA shall provide for performance of the continuous evaluation by experts independent from the MA, CO and OA;
3. Partnership – the MA shall provide for performance of the planning, preparing and carrying out of the continuous evaluation in cooperation with all relevant partners;
4. Transparency – the MA shall provide for publication of all evaluation reports and continuous evaluation results and recommendations, e. g. on its web, in accordance with raising a public debate on the evaluation findings.

Ex-post evaluation

Pursuant to Article 49 (3) of Council Regulation (EC) No 1083/2006, the EC shall carry out an ex post evaluation for each objective in close cooperation with the Member State and managing authority. The ex-post evaluation aim is to examine the extent of fund use, the effectiveness and efficiency of the programming and socioeconomic impact.

It shall be carried out for each of the objectives and shall aim to draw conclusions for the policy on economic and social cohesion.

It shall identify the factors contributing to the success or failure of the implementation of operational programmes and identify good practice.

Ex-post evaluation shall be completed by 31 December 2015.

Source of information for evaluation

A system of indicators is the main source of information on which the evaluation is based. Indicators are fixed on every level, i. e. on the programme level, for individual priority axes and support areas. They take into account the methodology, list of indicator examples and categorisation of areas of action determined by the Commission, that are bound to a specific

nature of assistance, its goals and socioeconomic, structural and ecologic situation of the given State and its regions.

On the level of a support area, this information allows describing the ways to achieve the objectives (involved organisations and structures, connection with other support areas, selection of goals and tools depending on the needs and priorities, quality of provided services, appropriateness of resources mobilised for implementation). This qualitative information contributes also to the identification of factors of success and/or obstacles resulting from the examination of effectiveness, efficiency and importance of the support area. They treat questions such as "cream gathering effect".

This information shall help to complete the causality analysis and relativise it in the frame of its context.

Besides the indicators, the qualitative information needs also to be gathered. It is a part of evaluation of the "process" that is of special importance while examining the implementation conditions and political context of intervention. The qualitative information represents an important component of the evaluation work (surveys, interviews, key groups, and more).

Disclosure of evaluation results

the evaluation results shall be published according to the applicable rules on access to documents..Evaluation reports have to be approved by the Monitoring Committee.

The evaluation reports are structured so as to allow using the evaluation results for the following purposes:

- Passing the information on the results of programme evaluation to the Managing Authority, Monitoring Committee and EC;
- Giving recommendations for the next programming period as per the programme management, implementation and monitoring;
- Formulating conclusions and recommendations for the national employment policy;
- Analysing and creating a container of good examples and practice.

An important element of evaluation is also represented by spreading the evaluation results aimed at improvement of effectiveness of the programme itself and informing the large public on the SF resources use. The MA is responsible for spreading the results.

9.4 IT Monitoring System for the SF and CF

IT Monitoring System for the SF and CF (hereinafter "ITMS") is a central information system and serves for evidence, processing, export and monitoring of data about programming, project and financial management, control and audit of the SF and CF. The ITMS consist of two subsystems working in parallel for the periods of 2004-2006 and 2007-2013. Subsystems desired for these two programming periods closely cooperate; they use a common database and evidence of objects within this database.

The ITMS is used by all operational programmes to the same degree. The task of a common monitoring system is to ensure a unified and compatible system of monitoring, management and financial management of programs financed by the SF and CF.

The system is divided into three main sections:

1. Non-public section of the ITMS ensures the program, project and financial management, control and audit in interconnection with the accounting system FAIS or via this accounting system with the State Treasury and budgetary information system.
2. Summary section of the ITMS ensures the development of static and dynamic data export.
3. Public section ensures the communication with beneficiaries, information system of the European Commission SFC2007 and with monitoring systems of neighbouring countries needed for programs of cross-border co-operation.

All subjects able to submit an application for funds benefit can become authorised users of the ITMS public section (following an application). Communication between the applicants/beneficiaries and ITMS public section is ensured by SSL protocol. The CCB shall develop a manual for the use of the ITMS public section. Through the ITMS public section the applicants/beneficiaries can perform the following activities:

- electronic submission and reception of applications for funds benefit;
- acquisition of clearly arranged information about project processes including the payment/reimbursement of costs;
- additional possibilities (beneficiary data update, electronic reception of the request for payment, electronic reception of monitoring sheets).

The ITMS and applicant communication processes for a funds contribution on the level of a project are following:

- account setting, subscription of agreement on using between MA and applicant, account activation;
- entering data into electronic forms and placement of these data into the ITMS public section, sending a certified paper form to applicants, administrator and user of the non-public section of the ITMS;
- electronic and paper form data concordance verification by a user of the ITMS non-public section;
- additional requests processing after the control and correction of potential discrepancies among the electronic and paper form.

CCB tasks in relation to the ITMS:

- to bear responsibility for the development, operation and system maintenance that ensures the operation of all ITMS sections;
- to manage the commission, where each managing authority has its own representative; this commission proposes the development orientation, communicates the MA requests with the CCB, manages and guides the system users according to the CCB instructions and guidelines and it is responsible for initialisation system data;
- to develop the guidelines for the ITMS use;
- to maintain the initialisation data on the level of the current NSRF state.

MA tasks for the OPH in relation to the ITMS:

- to maintain the initialisation data of its programme in an updated state;
- to bear responsibility for program, project and subordinate structure data entering according to the CCB guidelines for the ITMS use;
- to bear responsibility for assigning user roles according to internal manuals;
- to provide the first level support for users of the ITMS public and non-public section.

9.5 Electronic Data Exchange with the EC

Pursuant to the implementation order appointed in Section 7, electronic communication between a member state and the database of the European Commission (SFC 2007) is obligatory.

The following forms of electronic communication are possible:

- web interface SFC2007;
- integration of the member state monitoring systems with SFC2007.

For the conditions in the Slovak Republic, the second option was chosen: Integration of ITMS II with SFC 2007. ITMS II shall secure data collection and communication with SFC 2007. Usage of web interface SFC 2007 is enabled for individual MA. However, using ITMS II shall secure data integrity of both systems and thus save time, which would be needed for entering the data. In case of a malfunction of the interface or ITMS, with the agreement of the CCB it shall be possible to use the web interface for data input into the SFC 2007 system; however, the person entering the data is responsible for the data concordance in both systems.

Web interfaces ITMS II and SFC2007:

- import of the breakdown of the sum allocated from the Structural Funds and the Cohesion Funds according to the goals in stable prices in 2004 and usual prices;
- export of the National Strategic Reference Framework;
- export of the operational programme and priority axes;
- export of large projects;
- export of the OP TA;
- import of the EC decisions concerning the operational programme;
- breakdown of the EU funds categorisation;
- export of the expected expenses assessment;
- requests to the EC for a payment;
- declaration about a partial termination of the programme;
- export of the management and control system description;
- export of annual reports;
- export of final reports;
- export of the final payment;
- settlement according to the n+2, (n+3) rule;

- export of unstructured data: National Strategic Reference Framework
- import of unstructured data: The EC decisions concerning the National Strategic Reference Framework of the Slovak Republic and the operational programme.

Securing of the communication between ITMS II and SFC2007 on the system level shall be handled by means of a warranted electronic signature issued for ITMS II.

For identification of users and client systems in the frame of SFC2007, "MS Liaison" shall be held responsible, like in every member state. The task of MS Liaison for the ERDF, ESF and CF funds in the SR shall be held by a responsible employee of the CCB. All requests for access to the SFC2007 web interface and changes of access rights shall be sent to the CCB. After a formal and content check of the requests, MS Liaison shall communicate by the creation and activation of a user account with the European Commission. Access passwords from the European Commission shall be sent in two parts, the first part shall be sent directly to the user and the second one to MS Liaison.

9.6 Informing and Publicity

Pursuant to Article 69 of General Regulation, the member state and the managing authority shall secure informing of citizens and beneficiaries and the publicity part concerning co-financed programs with the goal of emphasizing the role of the Community, and secure transparency of the help received from the funds.

For information and publicity coverage, the managing authority shall provide a communication action plan (CAP) for the corresponding operational programme. The plan shall be presented to the EC within four months from passing of the operational programme. When implementing the CAP, the MA shall secure the execution of all measures concerning informing and publicity pursuant to Articles 5 to 7 of the implementation order.

CCB tasks in the sphere of informing and publicity:

- working out and implementation of the Central communication action plan for the SF and CF (hereinafter as CCAP), including supporting activities for all operational programmes;
- co-ordination and methodical guidance of managing authorities with regard to information provision and publicity;
- holding the position of a contact authority for the EC and communication networks of the Community and providing information to the managing authorities.

MA tasks for the OPH in the sphere of informing and publicity:

- working out of a communication action plan for the operational programme;
- by the elaboration of the communication action plan and by any other activities concerning informing and publicity, its actions shall be in concord with the methodology provided by the CCB;
- within 4 months from the passing of the operational programme, it shall present a communication plan to the EC;
- it shall include the sphere of publicity and informing into the annual and final report on the operational programme;

- it shall inform the OP monitoring committee about the progress of communication plan implementation, accomplished and planned activities;
- it shall secure abiding of regulations in Article 8 of the implementation order by the beneficiary (duty to inform the public about the help provided from the funds), by naming these matters in the agreement with the beneficiary;
- pursuant to Article 5(3) of the implementation order, it shall secure involvement of other bodies into informing and publicity.

Informing policy measures:

MA – MOH SR shall be held responsible for exercising national informing activities. If necessary bodies on regional and local level shall be involved in activities connected with publicity and informing.
Information strategy is an expression of the way, in which the MA shall put the CAP into practise. This is a strategy and a volume of measures for the sphere of informing and publicity, which shall be approved by the MA, intended for potential beneficiaries and general public, concerning the added value of help of the Community on the state, regional and local level. Informing policy measures include:

- securing transparency for potential beneficiaries and beneficiaries;
- informing general public.

Media and Internet

MA shall make sure that media shall be informed about activities, which are co-financed by the EU from the SF means, in the most proper way. In compliance with this aim, information measures shall be implemented and that especially through regional media (press, radio, and television). These principles apply e.g. to promotional events, such as press releases or promotion communiqué.

As to improve the general public awareness, articles in newspapers and magazines shall be published. At the beginning of the programming period, articles on individual programming documents, their priorities and measures shall be published. These articles shall summarize activities financed from the SF and their results.

The Ministry of Health SR shall maintain and update a separate information section with a detailed and clear documentation for general public on www.health.gov.sk. This section shall include a part Frequently Asked Questions (FAQ). For maintenance and update of this web page, the manager of informing and publicity is held responsible.

Information Policy Activities

During the programming period, various occasional activities shall take place. They should serve the purpose of promotion of the SF objectives by means such as usage of stalls, poster publishing, and participation in trade fairs as to create and promote a positive picture of the SF assistance.

Promoters of information campaigns such as conferences, seminars, fair trades, exhibitions, etc. connected with the realization of operations partially financed from the SF, have to make all the efforts as to explicitly declare participation of the EU (e.g. displaying EU flags in conference rooms, printing the EU and OP/SF logo on documents).

Seminars shall provide information on the basic SF topics, chosen according to the priorities of human resources development policy. These seminars might have a form of regional seminars contributing to the encouragement and support of the SF on the regional level. The objective of these seminars is to provide information and promote the possibility of assistance from the SF.

Communication plan obliges to organizing various seminars with various aims and in various forms for various target groups.

Information Materials

Publications on programmes or similar measures financed or co-financed from the SF shall bear a visible set of symbols declaring the EU participation, including the EU flag and OP/SF logo on the title page positioned in the same place as the state or regional symbol. Principles as stated above shall be followed in the same way in the case of audiovisual records.

Leaflets – publications easily accessible to general public. They are easy to use and inform on potential assistance from the SF. They contain text with information sectionalized into individual blocks.

Posters - MA shall secure the hanging of the posters declaring the EU contribution or assistance from the SF on the buildings of institutions, which exercise the measures financed from the SF. Poster shall show the SF logo.

Announcement for recipients – all announcements on assistance for recipients sent by the respective authority have to quote that they are being co-financed by the European Union (or they might quote the exact amount or percentage of the financial assistance).

Scientific Publications

Manual for Applicants - manual for those, who would like to learn more about assistance provided from the SF. This manual shall contain information on the programming document, legal sources and regulations, contacts information for respective managers and way of filling-in the application for NFC, and way of project financing. The manual shall be published on the web page of the Ministry of Health www.health.gov.sk.

Each document, subject or report produced with assistance from the SF has to be provided with the EU and OP logo and has to declare, that the given activity was co-financed by the ERDF.

Further information on the possibilities of obtaining a non-refundable financial contribution from the SF as well as the full wording of programming documents and programme complements are accessible on the web page of the Ministry of Health www.health.gov.sk.

Evaluation of Publicity

For evaluation of information and publication activities as per Council Regulation (EC) No 1083/2006, monitoring committees, which shall keep informing the media on the development of assistance usage, are held responsible. Monitoring committees will consider and approve annual and final reports on the performance pursuant to Article 65 of Commission Regulation No 1083/2006. These in compliance with Article 67 of the regulation concerned shall contain approved measures for provision of information on operational programme and its publicity.

9.7 Project Types

The OPH shall be implemented by means of demand-oriented and national projects.

One of the national projects shall be purchasing of mobile mammography units. This project presents a distinctive share of solution for prevention and detection of early stages of breast cancer.

Another national project shall be the project of "Completion of Infrastructure of the National Transfusion Service of Slovakia", which shall be implemented by the National Transfusion Service SR, a contributory organisation of the MoH SR, which represents a distinctive share of securing the healthcare provision and population health protection.

9.8 Financial Management, Control and Auditing

System of financial management for the Structural funds and Cohesion fund includes a complex of intertwined and interlocked sub-systems and actions by means of which the following tasks shall be secured: effective financial planning, budget setting, accounting, financial reporting, payments to beneficiaries, and observation of financial flows, financial control and auditing by the realization of help from the EC.

The following subjects shall be involved in the system of financial management of the operational programme:

- managing authority;
- certification body;
- payment unit;
- auditing authority.

Tasks of the **managing authority** are stated within 9.1.2.

Tasks of the **certification authority** shall be fulfilled by the Ministry of Finance of the Slovak Republic. The certification authority shall secure mainly:

- coordination and methodical directing in relation to the financial management of the Structural funds and Cohesion fund, including the coordination of payment unit;
- writing and sending of requests and continuous payments and the final payment for the EC;
- preliminary financial control of summary requests for payment made by payment units;
- certification verification on all levels of the financial management including the beneficiary of the assistance, with the goal of checking the procedure of the managing body, intermediary body subordinated the managing body and payment units;
- certification of the EC expenditure report;
- accepting of the EU means on individual non-budget accounts of the Ministry of Finance of the SR;
- transfer of financial means of the EU to the assistance receiver by means of a payment unit;
- creation and presentation of the expected expenditures for the corresponding and the following year to the European Commission every year until the end of April;
- keeping of the book of debtors;
- creation and presentation of a sums report up to 31 December of the preceding year, which should be returned divided in units according to the beginning of proceedings until 31 March;
- financial corrections of EU means based on requirements from the European Commission;
- returning of illegitimately used or unused financial means to the European Commission, including default interests;
- implementation of a single accounting system for the certification authority and payment units (funds accounting information system – FAIS);
- conducting of accounting, reports and archiving of documents.

Tasks of the **payment unit** shall be fulfilled by the Department of Financing and Project Payment of the Financing Section of the Ministry of Health SR The payment unit shall secure mainly:

- assessment of beneficiaries' applications for payments received from the managing body;
- transfer of EU means and state budget for co-financing to beneficiaries;
- filling in and presentation of summary payment requests and partial financial reports on expenditures to the certification authority;
- conducting of accounting, reports and archiving of documents;
- conducting of the partial book of debtors.

The Ministry of Health SR is endued with separate functionally not interconnected bodies within the Financing Section, which shall cover the functions of e managing authority a payment unit.

The tasks of the **auditing authority** shall be covered by the Ministry of Finance SR. The auditing authority covers following tasks:

a) elaboration of result report on implementation of systems pursuant to section 2 Article 71 of Council Regulation (EC) No 1083/2006;

b) securing that auditing is being conducted with the goal to control the effectiveness of the management system and to check the operational programme;

c) securing that the auditing is being conducted on a suitable sample, so the declared expenditures are checked;

d) presentation of an audit strategy to the EC within 9 months from passing the operational programme, which shall deal with the subjects handling auditing mentioned in a) b) and c), used method, choice of a selection method of a sample for an operation auditing and a preliminary auditing plan with the goal to ensure that the major subjects shall be subjected to auditing and the audits shall be distributed evenly throughout the whole programming period. If a common system is used for several operational programs, a single auditing strategy can be used.

e) until 31 December of each year from 2008 to 2015 is responsible for:

i) presentation of an annual report to the Commission, which shall contain the results of auditing concluded during the last 12-month span, which shall end on 30 June of the touched year, in concord with the auditing strategy of the operational programme. It shall mention defects in the management and programme control system. The first report shall be presented until 31 December 2008 and shall cover the time span from 1 January 2007 to 30 June 2008. Information concerning auditing concluded after 1 July 2015 shall be concluded in the final control report, which serves as a background document for declaration of termination pursuant to letter f);

ii) based on controls and auditing, which were concluded under its supervision, the authority shall issue a statement whether the management system and control system functions efficiently enough to offer sufficient guarantee, that the expenditures reports presented to the Commission are correct, and based on these, also a sufficient guarantee that the corresponding transactions were concluded in a legal and correct manner;

iii) presentation in the cases pursuant to Article 88, declarations on partial termination, which is used to determine legality and correctness of the corresponding expenditures. If several operational programmes use a common system, the information included in (i) can be joined into one report, and statement and declaration issued pursuant to (ii) and (iii) can include all corresponding operational programmes**;**

f) presenting a declaration of termination to the Commission until 31 March 2017, which shall determine the validity of the request for the final payment and legal and correct manner of all

corresponding transactions included in the final expenditures report, which shall be supplied with the final control report.

Bodies present at the Ministry of Health SR with no interconnections in terms of organisation shall cover these tasks. Tasks of the certification authority are covered by the Section for European and International Affairs of the Ministry of Finance SR, which is in the terms of organisation subordinated to the first state secretary. The tasks of auditing are fulfilled by the Section of Auditing and Supervision of International Financial Sources of the Ministry of Finance of the Slovak Republic, whose general director is in the direct managing competence of the MoF SR.

The Ministry of Finance SR, as the body covering the tasks of auditing authority, prepared Procedures for Auditing of the Structural Funds, the Cohesion Funds, and the European Fisheries Fund for years 2007-2013 and shall in connection to this documentation sign contracts with individual ministries containing specification of the subject of audit activity, which shall be secured by individual impendent bodies on ministries and the Financial Control Authority. These bodies shall perform auditing activities as authorities acting on behalf of the Auditing Authority and shall follow methods defined by the Ministry of Finance of the Slovak Republic.

Bodies have to be independent from the bodies connected to any kind of activities connected with managing, implementing, or monitoring the Structural Funds, the Cohesion Funds, and European Fisheries Fund for years 2007-2013. This shall be declared also in the description of systems especially applying to organisation and procedures of auditing authority and all other authorities, which perform auditing under its supervision as requested in Regulation (EC) No 1083/2006. Government of the Slovak Republic shall adopt procedures for auditing of the Structural Funds, Cohesion Funds, and European Fisheries Fund for the period 2007-2013 at latest until 31 November 2007.

Financial Flow System

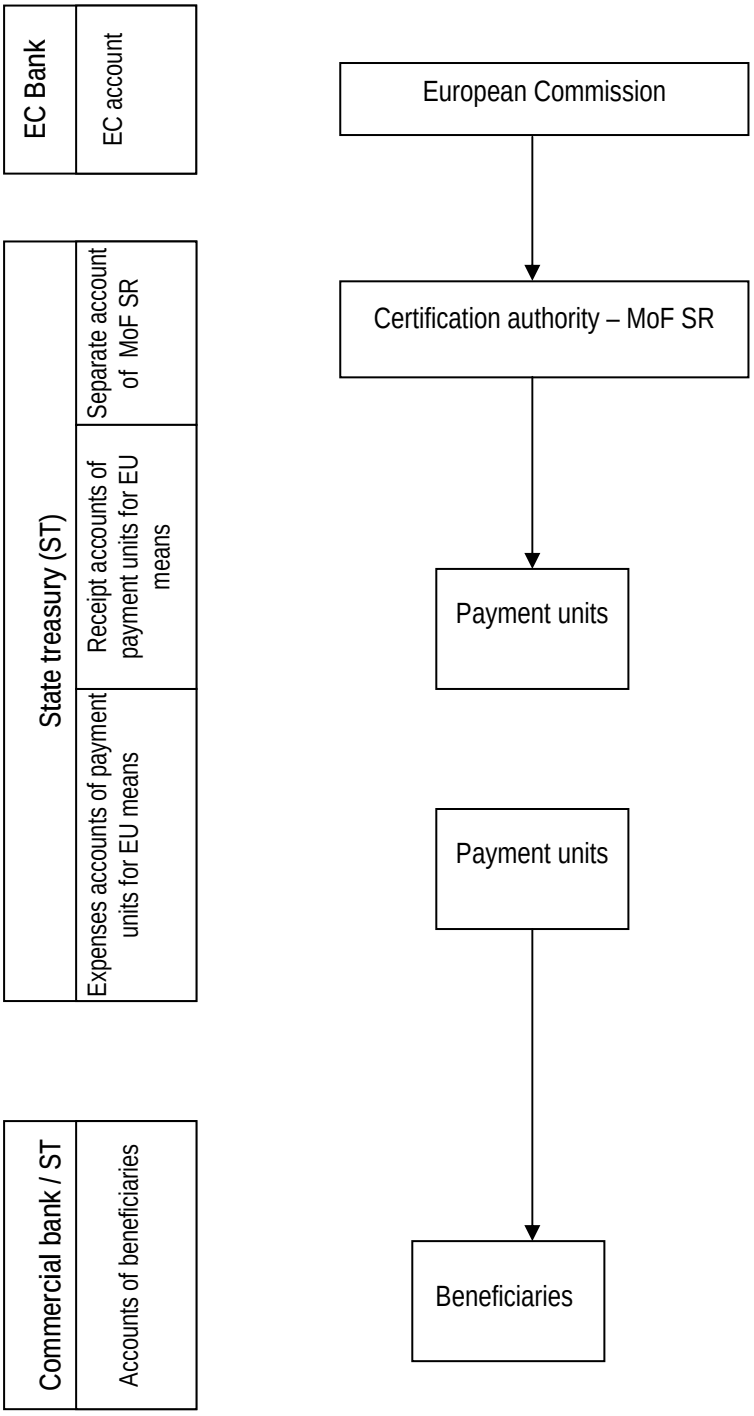
Payments of the EU financial means shall be transferred from the European Commission to a separate account of the certification authority of the Ministry of Finance SR in the National Fund Department in compliance with the commitment passed by the European Commission. Payments of the ERDF financial means to the beneficiaries shall be concluded by means of the state budget.

The EU financial means and means of the state budget earmarked for co-financing are paid to the beneficiaries by means of a payment unit based on the agreement on providing non-refundable financial contribution in a ratio stated in the project.

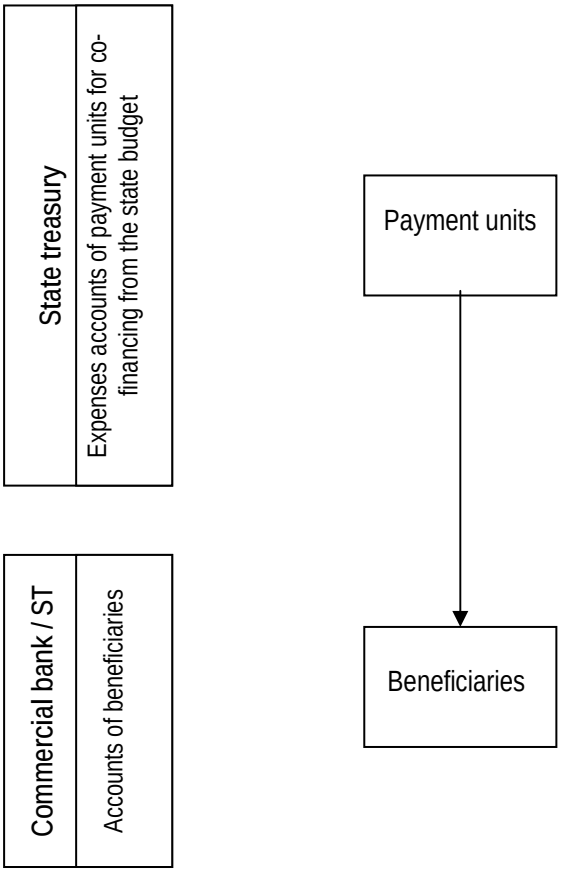
Payments of the EU financial means and co-financing means from the state budget for beneficiaries are performed by the payment unit in the amount confirmed by certification authority based on the summary application for payment in case of reimbursement. In case of the system of upfront payments, or upfront financing, payments shall be realized by the payment unit in the amount of approved application for upfront payments, or upfront financing, without the preceding approval of the certification body.

A detailed description of the financial management is stated in the System of financial management of the Structural Funds and the Cohesion Fund for the Programming period 2007-2013, passed by Governmental Resolution of the Slovak republic No 835/2006 of 8 October 2006 and published on *www.finance.gov.sk*.

Picture 3: Scheme of the Financial Flow of the Means from the Structural Funds and Cohesion Funds



Picture 4: Scheme of the Financial Flow of National Co-financing from the State Budget



10. Annexes:

Annex 1

List of shortenings

ACSC	Ambulatory Care Sensitive Condition
ERDF	European Regional Development Funds
EC	European Communities
ESF	European Social Fund
EU	European Union
GDP	Gross Domestic Product
IBRD	International Bank for Reconstruction and Development
ICT	Information Communication Technologies
ITMS	IT Monitoring System
CF	Cohesion Fund
MDP	Medical Doctor Position
HR	Human Resources
MOF SR	Ministry of Finance of the Slovak Republic
MOE SR	Ministry of Economy of the Slovak Republic
MLSAF SR	Ministry of Labor and Social Affairs of the Slovak Republic
MCRD SR	Ministry of Construction and Regional Development of the Slovak Republic
MOH SR	Ministry of Health of the Slovak Republic
NSRF	National Strategic Reference Framework
NUTS	Nomenclature des Unitées Territoriales Statistiques – classification system
NHIC	National Health Information Centre

OP	Operational Program
OPH	Operational Program on Healthcare
POC	Primary Outpatient Care
I&S	Industry and Services
SL	Sick Leave
HP	Healthcare Provider
MIS	Managing Information System
MA	Managing authority
SEA	Strategic Environmental Assessment
NP	Nurse Position
SOP	Sector Operational Program
SR	Slovak Republic
SWOT	Strengths, Weaknesses, Opportunities and Threats Analysis
SOC	Specialized Outpatient Care
SF	Structural Funds
SD	Sustainable Development
HCSA	Health Care Surveillance Authority
SRGO	The Slovak Republic Government Office
STU	Superior Territorial Unit
HS	Healthcare Service
WHO	World Health Organisation

Annex 2 Members of Work Group

1. Ministry of Health of the SR
2. Ministry of Finance of the SR
3. Ministry of Construction and Regional Development of the SR
4. Public Health Authority of the Slovak Republic
5. Health Care Surveillance Authority
6. Medical rescue service operating centre of the SR
7. Slovak Medical University
8. Slovak Medical Chamber
9. Slovak Chamber of Nurses and Midwives
10. Slovak Chamber of miscellaneous medical workers, assistants, laboratory workers and technicians
11. Slovak Hospital Association
12. Association for the defence of patients' rights in Slovakia
13. Alliance of Organizations of Disabled People in Slovakia
14. Association of Independent Clinics in Slovakia
15. Private Physician's Association in Slovakia
16. Teaching Hospital Association in Slovakia
17. Association of Slovak Towns and Communities
18. Union of Towns and Cities of Slovakia
19. Superior Territorial Unit of Nitra
20. Superior Territorial Unit of Trnava
21. Superior Territorial Unit of Trenčín
22. Superior Territorial Unit of Banská Bystrica
23. Superior Territorial Unit of Žilina
24. Superior Territorial Unit of Košice
25. Superior Territorial Unit of Prešov

Annex 3

OPERATIONAL PROGRAMME HEALTH

S T A T E M E N T
(No.: 1839/07-3.4/gn)
Issued by the Ministry of Environment SR pursuant to § 17, subsection 12 of Act No. 24/2006 Coll. on Environmental Impact Assessment and on Amendment and Supplementation of Certain Acts

I. BASIC INFORMATION ABOUT THE PROCURING AUTHORITY

1. **Title:**
   The Ministry of Health of the Slovak Republic

2. **Identification No.:**
   165565

3. **Registered seat:**
   Limbová 2, P.O. Box 52, 837 52 Bratislava 37

4. **Name, surname, address, phone number and other contact information of a legal representative of the procuring authority:**
   Ing. Iveta Klimová, general manager of the Department of Payment of the Ministry of Health SR, Limbová 2, P.O. Box 52, 837 52 Bratislava 37, phone.:02 59373 121, fax: 02 54 777 465.

II. BASIC INFORMATION ABOUT STRATEGIC DOCUMENT WITH IMPACT AT NATIONAL LEVEL

1. **Title:**
   Operational Programme Health

2. **Character:**

The Operational Programme Health (hereinafter "OPH") is a strategic programming medium-term document for years 2007-2013. It defines global aims, priority axes, measures and frame activities that shall be supported on territories falling under the scope of the Convergence objectives in the given time span. From the geographical point of view, the impact of all OPH measures shall be on the whole territory of the Slovak Republic with the exception of the Bratislava self-governing region.

3. **Main objectives:**

The main objective of the OPH is as follows: "Improvement of conditions influencing population health condition in productive age and unproductive age by means of the improvement of quality, effectiveness and accessibility of healthcare and health promotion." The basis of the strategy is contributing to the fulfilment of the Goteborg and Lisbon Strategy by means of projects.

4. Brief description of the strategic document with impact at national level:

The Operational Programme Health (hereinafter "OPH") is a programming document of the Slovak Republic for drawing assistance from funds of the European Union (hereinafter

"EU") for the healthcare sector for the 2007 – 2013 period. It contains the strategy, aims and also defines years-long measures to attain them, which are to be carried out with the help of national funds and the European Regional Development Fund (hereinafter "ERDF"). On the basis of Government Resolution of the SR No. 832/2006 of 8 October 2006, the Managing Authority for the OPH is the Ministry of Health of the Slovak Republic.

The OPH has been elaborated on the basis of Council Regulation (EC) No. 1083/2006 laying down general provisions on the ERDF, the European Social Fund (hereinafter "ESF") and the Cohesion Fund (hereinafter "CF") and repealing Regulation (EC) No. 1260/1999, and Regulation (EC) No. 1080/2006 of the European Parliament and of the Council on the ERDF and repealing Regulation (EC) No. 1783/1999.

The introductory part of the document briefly describes the process of document preparation, partnership principle implementation, results of ex-ante evaluation and of the strategic environmental assessment.

The analytical part of the document provides information about the population health condition in the Slovak Republic, healthcare system (hereinafter "HCS"), health infrastructure, material-technical base and equipment of inpatient and outpatient healthcare providers in the Slovak Republic. Results of analyses together with experiences from the programming period 2004 – 2006, the SWOT analyses, definition of the main disparities and development factors serve as the background for identification, specification of needs and strategic directing of investments from the ERDF.

The strategic part follows the results of the complex analysis, defines regional focus in the context of innovation and cohesion growth poles and thematic focus of intervention into the inpatient and outpatient health infrastructure. The OPH strategy focuses mainly on the development of conditions necessary for the improvement of quality of the provided healthcare through the modernisation of healthcare infrastructure with the aim to improve its economic effectiveness, strengthen the economic and social cohesion and achieve a harmonised, balanced and sustainable development. Fulfilment of this programme context shall bring benefits in the form of diminishing economic, social and regional differences, which arose in the past and are connected with the ongoing economic and social restructuring and with aging of population.

The Operational Programme is based on three priority axes:

Priority Axis 1 – Hospital healthcare system modernisation

Priority Axis 2 – Health promotion and health risks prevention

Priority Axis 3 – Technical assistance

The text of the OPH specifies the focus and justification of priority axes through which the OPH shall be implemented, objectives and framework activities together with the indicators on the OPH and individual priority axis level.

Specific objective of Priority Axis 1 is to provide building, reconstruction and modernization of healthcare infrastructure in general and specialised hospitals with the preference of facilities specialising in the treatment of diseases of "Group 5" (circulatory system diseases, tumours, external causes of diseases and deaths, respiratory system and digestive system diseases).

Specific aim of Priority Axis 2 is to secure reconstruction and modernisation of out-patient healthcare infrastructure with the preference of facilities specialised in health prevention and promotion of the diseases of "Group 5" (circulatory system diseases, tumours, external causes of diseases and deaths, respiratory system and digestive system diseases) and on providing of adequate equipment.

Specific objective of Priority Axis 3 is on the one hand a successful implementation of the OPH in compliance with the requirements set on the management, implementation,

control, auditing, monitoring, and evaluation of the operational programme and requirements set on the administrative structures responsible for the implementation of the operational programme, and on the support for projects preparation. On the other hand the objective is to inform the public, promote, evaluate and exchange experience.

5. Relation to other strategic documents:

The OPH is fully compatible with chapter 1.3.5 Protection of Workforce Health of Community Guidelines, related to the protection of the workforce health. Execution of Priority Axes shall contribute to the implementation of the Goteborg and Lisbon Strategies. The Lisbon Strategy has proclaimed as its aim to “make Europe the most competitive and the most dynamic knowledge-based economy in the world by 2010”. Based on the Lisbon Strategy, government of the Slovak Republic elaborated and passed the Competitiveness development Strategy for the Slovak Republic until 2010 (Lisbon Strategy for Slovakia).

The main goal of the strategy is to ensure the Slovak Republic reaches the standard of living of the more developed EU countries. Good state policy in the sphere of healthcare and pension insurance is a vital requirement for this objective, since the improvement in population health condition is going to lead to the quality improvement in work force, which is the basis for economic competition. Reaching this objective shall secure the growth of quality, accessibility and effectiveness of healthcare-related services. Realization of the OPH shall also fulfil the NSRF strategy for 2007-2013, more precisely the priorities Infrastructure and regional accessibility and human resources. Realization of the operational programme shall secure the improvement of healthcare infrastructure and healthcare. This shall consequentially lead to the improvement of quality of life and human resources. The OPH is in concordance with the National Sustainable Development Strategy. The National Sustainable Development Strategy (hereinafter "NSDS”) is based on several areas: cultural, social, economic, environmental, institutional and regional conditions. The starting point in providing the sustainable development in the SR (hereinafter “SD”), in the scope of social conditions and point of views, is determined (among other factors), especially by the development and state of quality and life expectancy, population development, population education level, health condition and on the same time the level of healthcare.

The SD social aspect is based on the basic principle that the real treasure of a society is in its people. The goal of the SD strategy shall therefore be the creation of an environment, which enables people a long, healthy, full-fledged and creative life. The idea of the NSDS SR is based on the assumption that the local, regional communities and the whole society as such, are interested in effective utilization of human resources in the presence, but also in near and far future; and therefore, one of the basic objectives should be to improve the quality of life. Through its priorities, the OPH reflects the NSDS needs and focuses on the aspects of improving the healthcare infrastructure, implementing the tolls of efficiency and quality, supporting preventive measures that will contribute to the provision of quality healthcare, and thus improving the quality of citizens' life in the end. Further, it is oriented on enforcing of a whole-society all-level responsibility for the health condition, especially in support and health protection and of information provision.

Similarly, this programme is in compliance with other strategic documents of national and regional importance - The Concept of Territorial Development of Slovakia, individual operational programmes, and especially the operational programme on regional development and the operational programme on environment, since the OPH implementation shall contribute to the elimination of several sources of environmental pollution, and strengthening and improvement of healthcare infrastructure in individual regions.

III. DESCRIPTION OF PREPARATION AND EVALUATION OF IMPACTS OF THE STRATEGIC DOCUMENT WITH IMPACT ON THE ENVIRONMENT AT NATIONAL LEVEL

Impact Assessment of the strategic document at national was provided by the Ministry of Health SR in co-operation with the Ministry of Environment SR. The evaluation was performed pursuant to Directive No. 2001/42/EC of the European Parliament and of the Council of 27 June 2001 on the Assessment of the Effects of Certain Plans and Programmes on Environment (hereinafter "SEA Directive") pursuant to Act No. 24/2006 Coll. on Environmental Impact Assessment and on change and amendment of certain acts (hereinafter "Act").

1. Time and practical timetable of preparation and environmental impact assessment

The partnership principle has been respected already during the process of preparation of the “Modernisation of Healthcare Infrastructure” specific priority in the frame of the NSRF, namely in form of working groups, work meetings and bilateral meetings related to this document. For the specific priority purposes, a working group was established at the MOH SR consisting of the relevant ministerial sections representatives, a National Health Information Centre representative and a Public Health Authority of the SR representative. The representatives of higher territorial units, health insurance companies and professional community (e. g. Slovak Chamber of Physicians) were also participating in the OPH elaboration. While formulating the specific priority, the MOH SR was communicating with the Ministry of Construction and Regional Development SR (hereinafter “MCRR SR”) and the Office of the Government's Plenipotentiary for Roma Communities as well. In the next stage, the NSRF, including the specific priority “Modernization of Healthcare Infrastructure”, was a subject to inter-ministerial commenting proceedings involving not only the ministries, but also higher territorial units, non-governmental organisations, representatives of involved governmental agencies, Association of Towns and Communities of Slovakia, Union of Towns and Cities of Slovakia, and more.

While specifying individual areas of the OPH, the MOH SR based its work on the documents available and strategic materials related to higher territorial units.

Pursuant to the decision of the Slovak Government from 8 October 2006 on updating the NSRF, due to the elaboration of technical revisions of the European Commission and the definition of priorities in the Slovak Government Manifesto 2006 – 2010, with the aim to update the OPH, a smaller working group with relevant institutions in the health sector and representatives of socio-economic partners was established. While composing the work group consisting of 25 subjects were taken into account several factors: specific character of the sector, influence on the environment and co-operation with the Ministry of Environment SR by the evaluation of the environmental impact of the strategic document OPH and equal opportunities among men and women (this dimension is in the healthcare department fully respected).

Due to the character of this strategic document as well as its processing according to the partnership principle, the proposal of the OPH was processed in one variant as a result of an agreement between individual members of the partnership and the Government, when incorporating of a majority of emerged comments.

Notification on document preparation was elaborated by Ing. Zuzana Pikulová and Ing. Richard Krchňák from the MOH SR on 20 November 2006. Publishing of the notification on elaboration of the strategic document OPH was provided by the MOH SR and MOE SR on 21 November 2006 on web pages www.health.gov.sk, www.enviroportal.sk and in the daily newspaper Hospodárske noviny (Economic News) on 24 November 2006.

The MOH SR in co-operation with the MOE SR, with regard to the character of the strategic document, which is not mentioned in Annex 4 of the Act, but creates the frame for the assessment of suggested activities assessed pursuant to this Act, published on 9 January 2007 a decision from screening proceeding carried out pursuant to § 7 of the Act

with the decision that the aforementioned strategic document shall not be assessed pursuant to this Act. The assessment took into account the criteria of the screening proceeding mentioned in Annex 3 of the Act, character and possible impacts of the strategic document on environment, including impact on the population health condition.

Based on the request of the MOH SR to carry out the whole assessment process of this strategic document pursuant to the Act despite the aforementioned facts, the entire scoping of the OPH was discussed at the beginning of August 2007 and approved on 13 August 2007.

Presented scoping of the strategic document OPH dealt especially with the following requirements:

1. Draft of content, main objectives of the OPH and its relation to other relevant strategic documents (e.g. the scope in which the strategic document influences other plans and programmes), importance of the strategic document for the integration of environmental considerations especially with regard to the support of sustainable development and for execution of legal regulations in the sphere of environment and protection of public health.
2. The scope in which the OPH defines the frame for projects and other activities with regard to place, character, scope and operational conditions or resources allocation.
3. Important aspects of the current state of environment and their probable development without performing the OPH.
4. Environmental characteristics of areas and the issue of public health, which are going to be most likely deeply influenced by the realization of the OPH.
5. All existing environmental problems, which are relevant for the proposed OPH including and especially considering those, which are related to areas of special environmental importance, i.e. areas defined in Directives No. 79/409/EEC and 92/43/EEC.
6. Objectives of environmental protection defined at international and national level, and the EU level, which are relevant to the proposed OPH and manner, in which these objectives and other considerations about environmental aspects were regarded by its preparation.
7. Expected important impacts of the proposed OPH on the environment including the probability, duration and frequency of influences, their cumulative character, transboundary character, risk for human resources and environment, influence on biodiversity, animals, plants, soil, water, air, climate factors, matter founds, cultural heritage, including architectonic and archaeological heritage, influence on the country and separate protected territories and inter-relations of the aforementioned factors.
8. Measures aimed at prevention, lessening and the greatest possible compensation of each important negative influence on the environment resulting from the realization of the proposed OPH.
9. Draft of reasons for the choice of an alternative and a description of the way in which the assessment was performed, including all difficulties and problems (such as technical deficiency or lack of know-how), which occurred in the course of accumulation of the requested information.
10. Description of monitoring measures pursuant to § 16 of the Act.
11. A thorough written analysis of all opinions related to the notification about the strategic document OPH.

The MOH SR published the scoping of the strategic document OPH on the web page www.enviroportal.sk on 15 August 2007.

The Environmental Report of the strategic document OPH was submitted at the MOE SR on 13 September 2006 under the condition that the procuring authority shall ensure its publishing on the web page www.health.gov.sk on 12 September 2007 and in the daily

Hospodárske noviny on 14 September 2007. The MOE SR published on the website www.enviroportal.sk on 13 September 2007.

The MOH SR ensured publishing of the notification on the term of public hearing concerning the Environmental Report of the Strategic Document OPH on the web page www.health.gov.sk on 19 September 2007 and in the daily Pravda on 21 September 2007.

2. Authority competent for the adoption of the strategic document

Government of the SR and the European Council

3. Type of adoption, decision:

Adoption by the Government of the SR and the European Council

4. Elaboration of the Environmental Report:

The Environmental Report of the strategic document was elaborated by the company Environment, a. s., Centrum bioštatistiky a environmentalistiky, Dlhá 108, 949 07 Nitra, contact person: Ing. Mária Letkovičová, CSc., Chairperson of the board in September 2007, pursuant to § 17, subsection 5 and 6 and Annex 4 of the Act and in compliance with Article No. 5 and Annex 1 of the SEA Directive.

5. Assessment of the Environmental Report:

Pursuant to § 17, subsection 11 of the Act, the MOE SR provided the elaboration of a professional assessment for the OPH and the Environmental Report (letter No. 1839/07-3.4/gn of 21 September 2007). Person responsible for elaboration of the professional assessment is RNDr. Zita Izakovičová from the Institue of Landscape Ecology from the Slovak Academy of Sciences, included on the list of professionally competent experts for the evaluation of influences on the environment under the number 99/96-OPV.

RNDr. Izakovičová stated that the Report basically fulfilled the requirements pursuant to Act and the Scoping defined by the MOE SR. The analysis is based on information stated in the Report on the State of the Environment in the SR and on the basis sector database, especially of the Statistics Office.

With regard to the character of the document and accessibility of information stated in the submitted report and on the basis of information provided by the authority procuring the strategic document for the elaboration of the assessment, it is possible to state that the realization of the strategic document shall not have any considerable, negative influences on the environment or public health, that are not possible to eliminate. It is possible to state that positive effects of the project realization are clearly prevalent and sustainable. It is possible to decrease, eliminate, or compensate negative effects within the suggested measures and conditions for their elimination or mitigation.

At the end the author of the assessment recommends to publish a positive opinion of the assessment authority for the strategic document OPH.

The assessment was elaborated on 3 October 2007.

6. Opinions and their evaluation:

No comments were delivered to the MOH SR or MOE SR in the time span pursuant to the Act set for sending of opinions concerning the OPH and the Environmental Report.

7. Public hearing concerning the Environmental Report and strategic document with national reach and its conclusions:

Public hearing about the Environmental Report of Environmental Influences for the Operational Programme Health and the draft version Of Operational Programme Health, was concluded on 1 October 2007 on the premises of the Ministry of Health SR. As stated in the memorandum from the public hearing concerning the Environmental Report of Environmental

Influences there were no questions or comments raised. Similarly, no comments concerning the report published on the Internet came.

IV. OVERALL ENVIRONMENTAL IMPACT ASSESSMENT OF THE STRATEGIC DOCUMENT WITH NATIONAL REACH

The main objective of the operational programme is as follows: Improvement of conditions influencing health condition of the productive-age and unproductive-age population by means of increasing the quality, accessibility and effectiveness of healthcare and health support.

The result of aforementioned comments is that the programme is focused on protection, development and improvement of human potential quality and improvement of life quality. Priority Axis 1 and 2, which are aimed at the reconstruction of healthcare facilities, shall contribute to the elimination of current sources of environment pollution, since many healthcare facilities are not only medium, but also large sources of air pollution, and at the same time they also contribute to water pollution and waste production (often of dangerous nature).

Reconstructions of the buildings contribute to solving of high energy consumption of selected objects and increase the utilization of alternative energy resources. Realization of the operational programme shall be a contribution also from the point of view of culture and history, since many objects are often situated in historic buildings, which are a part of protected territories or the sole buildings have high historical value. By renovation of these buildings, while respecting the conditions set by responsible authorities, the value of aforementioned objects multiplies. Reconstruction of other buildings and their suitable architectonic condition contribute to livening up of aesthetic hygiene of not only living, but also work environment.

Realization of the programme shall also contribute to increasing of the employment rate and to creating of new work positions.

The improvement of healthcare quality is gradually going to mirror in decreasing of morbidity, mortality and shall indirectly influence the socio-economic situation by the improvement of work force of the Slovak population. As a contribution to the socio-economic sphere may also be considered the lowering of sickness expenses and generally diminishing of the need of healthcare services.

Negative impacts include impacts that shall arise after the reconstruction and modernisation of buildings, application of new technologies and changes of aging equipment, etc. They are comparable as by other similar building projects and reconstructions. They include mainly noise, dust emissions, waste production, etc. However, their character is only short-timed and temporary. By means of suitable work technology and discipline, many of these negative influences may be eliminated.

Risk ensuing from the realization of the Operational Programme Health is represented in the increased number of production of other and dangerous waste. This concerns mainly the change of old and often non-functional healthcare equipment. Added to it there ensues other non-usable waste falling into the category of other and dangerous waste produced in the course of buildings reconstruction. To dangerous waste belong old roofs with asbestos roof coverage, building waste polluted by dangerous materials, old unused chemicals, etc. The realization of these activities shall be evaluated pursuant to Act No. 24/2006 Coll. on Environmental Impact Assessment

In certain cases, direct or indirect negative influences on fauna, flora, biotops, NATURA objects and protected areas can occur, since in the areas of respective healthcare facilities or in their close proximity (hospitals, polyclinics, etc.) there are protected areas, parks or rare species of flora and fauna. The reconstruction works in these areas must be

performed with uttermost care so the impacts on these rare biotops are decreased. In the case of inevitable impacts or other endangering it is necessary to provide substitute biotops.

As a conclusion we can state that objectives of the Operational Programme Health give rise to pre-requisites and create conditions necessary for the improvement of quality of life not only of current, but also future generations and create necessary pre-requisites for securing of the SD, since the OPH contributes:

- to the modernization of healthcare facilities and the improvement of healthcare services.
- to the elimination of old facilities incompatible with the requirements of the current legislation and building of new facilities compatible with them.
- to the deployment of the newest technical-operating, sophisticated diagnostic, technological, information and instrumental equipment.
- to solving of high energy consumption of healthcare facilities and prefers the usage of renewable energy sources.
- to improve the process of disposal of single types of dangerous wastes in concordance with the Operational Programme on Environment.
- to the improvement of public health condition and consequently to the development and improvement of human potential.
- to secure more effective functioning of healthcare services and improvement of competitiveness of the Slovak healthcare system.
- to the elimination of current sources of pollution and contributes to general protection and creation of individual elements of the environment.

Proposed priorities, objectives and supported activities that are in concordance with superior strategic objectives defined in European and national strategic documents, which are in line with the objective of optimisation of long-term influences on the social, cultural, economic and environmental aspects.

The OPH is based on a detailed analysis of problem situation in the sphere of healthcare and healthcare services and reflects the need to solve current problems in this sphere and it this way secures that its realization shall not hinder further society development in the future.

The OPH with its character indirectly contributes to the development of democratic, institutional tools of management and with its transparency of directing institutions and monitoring it guarantees access to information from the media but also public, and guarantees the same rights of participation of all inhabitants on supported activities, regardless of their national or social status, religion, orientation or gender.

The OPH with its focus, but also with individual priorities, predominantly ensures the principle of solidarity between generations and in the scope of generations.

V OVERALL ENVIRONMENTAL IMPACT ASSESSMENT EVALUATION OF THE INFLUENCE OF STRATEGIC DOCUMENT WITH NATIONAL REACH ON THE PROPOSED PROTECTED BIRD AREAS, AREAS OF EUROPEAN IMPORTANCE AND CONTINUOUS EUROPEAN SYSTEM OF PROTECTED AREAS (NATURA 2000)

From the character of the strategic document it is clear that the document has no direct impact on the proposed bird protected areas of European importance or on the continuous European system of protected areas (NATURA 2000). As assumed in the proposal of the Operation Programme, most investment intentions will be realized within built-up urbanized areas. Emphasis will be put on reconstruction of buildings already constructed; i.e. activities of the Operational Programme will not include any significant negative interventions into the protected areas of European importance. As a matter of fact,

often there are protected territories and areas around certain types of healthcare facilities. These are mostly parks surrounding these facilities. Special attention should be paid to the evaluation of the impact of buildings in question on the environment pursuant to the Act.

VI SUMMARY

1. Outcome of the Environmental Impact Assessment for the Strategic Document with National Reach

The impacts of the OPH on the environment were carefully evaluated pursuant to the Act (e.g. evaluation of the state of use of the area, level of the impacts on the environment, range of the expected impacts of the OPH on the environment, protected areas and public health from the point of view of probability, scope and duration). Emphasis was put on synchronisation with other transboundary, national, regional and local strategic documents, quality of the notification elaborated, opinions on notification, defined volume of the evaluation and timetable, quality of the Environmental Report and the OPH, outcomes of the public hearing on the Environmental Report of the OPH, conclusions of the expert report and consultations, and the current state of knowledge. Based on the outcomes of assessment of these criteria we

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approving the strategic document "**Operational Programme Health**" with national reach. However, conditions set in part VI "SUMMARY", section 3 of this statement, should be met; i.e. if projects supported from the OPH shall fulfil all criteria pursuant to the Act, it will be necessary to perform the evaluation of the impacts on the environment in compliance with the Act, before their approval, under special regulations.

2. Recommended alternative

Recommendations to adapt the version of "Operational Programme Health", which was evaluated from the aspect of its impact on the environment pursuant to the Act.

3. Recommendations on reviewing, amending and editing the proposal of the strategic document.

From the outcomes of the evaluation process on the impacts on the environment of the OPH, notification, opinions on the notification, defined volume of the evaluation and timetable for the Environmental Report and the OPH, public hearing on the Environmental Report and the OPH, expert report and consultations it is clear that no reviewing, amending or editing of the proposal of the strategic document is necessary. However, it is necessary to implement following recommendations into the OPH :

1. Heeding of Act No. 24/2006 Coll. on Environmental Impact Assessment and on the amendment and supplementing of certain acts; and that within the scope of project implementation.
2. Consistent evaluation of the sustainability of the supported activity, after the co-financing has been cut off, and the ratio of long and short lasting effects, when selecting the projects.
3. Consideration of the balance of local, regional and supra-regional effects of the projects when selecting the projects; preferred shall be projects with cumulative and synergic effects on the regional level.
4. When selecting the projects, integration of financial means on the horizontal and vertical level shall be supported.
5. Focus on the support of solutions of acute problems.

6. Ensuring transparency and access to information throughout the entire process of declaration of appeals, selection and allocation of sources, project monitoring and evaluation of projects, individual priority axes and programme on respecting the competition protection.

4. Justification of the Statement on the Environmental Impact Assessment of the Strategic Document with National Reach

The Statement was elaborated pursuant to § 17 subsection 12 of the Act on the basis of notification, opinions on notification, defined volume of evaluation and timetable for the Environmental Report, Environmental Report and the OPH, public hearing on the Environmental Report and the OPH, expert review and consultations.

Evaluation of the documentation and opinion elaboration followed provisions of the Act and requirements of the SEA Directive.

Recommendations of the OPH were preceded by a careful consideration of environmental, social influences and influences on economy on the transboundary, national, regional and local levels, influences on the ground, relief, mineral resources, geodynamic and geomorphic phenomena, soil, local climate, atmosphere, surface and sub-surface waters, noise, other physical and biological features (e.g. vibrations, radioactive and electromagnetic radiation, light-technical conditions, heat and smell), genetic resources, biodiversity, biota, ecological stability, protected trees, protected areas pursuant to Act No. 543/2002 Coll. on Protection of Nature and Landscape as amended, landscape, its structure and utilization, landscape scenery, territory system of ecological stability, population and its health, waste management, health risks, social and economic consequences and relations, violation of life comfort and quality, and their vulnerability, urban facilities and utilization of grounds, on cultural and historical monument, paleontological and archaeological excavation sites, structure of settlements, architecture, buildings, cultural values, on agricultural and industrial production, forestry, transportation, construction activities, infrastructure, services, vacation and tourism.

From the outcomes of the environmental impact assessment is clear that the version of the OPH, which was evaluated from the aspect of its impact on the environment, is in the context of general (negative and positive) impacts on the environment acceptable.

Environmental Report of the strategic document and expert review of professionally competent person have clearly shown the potential of positive influences of the strategy on the environment and development of human resources. They have also shown that there is a possibility to eliminate or to minimize potentially negative environmental impacts when implementing the OPH in compliance with approved indicators (e.g. Average Reduction of Energy Consumption of Buildings within health infrastructure, Number of Created Work Positions).

If recommendations are accepted and met, and their heeding is monitored consistently, it is possible to minimize the prevalent part of negative impacts of the OPH implementation on environment and also to provide prevalence of positive OPH's impacts.

The Environmental Report specified, described, assessed and classified all important OPH's impacts on the environment and public health, including cumulative ones.

Pursuant to the strategy of sustainable development, impacts of the OPH on economic, social and environmental field were specified and their potential impacts on the environment and public health were assessed.

Current state of legislature covers identification and ensuring of the elimination of all possible negative impacts of the OPH on the environment. Act and the trend towards stricter legislature actively take part in elimination of all negative impacts of the OPH on the environment and population health.

5. Proposal on monitoring

A Monitoring Committee (hereinafter "MC") for each OP must be established within three months from the OP's approval by the European Commission. Aim of the MC is to check the efficiency and quality of the programme implementation. Chairperson of the MC for OPIS is the Vice-Prime Minister of the Slovak Government for the knowledge society, European affairs, human rights and minorities. Members of the MC are representatives of the IBMA, CO and, in compliance with the partnership principle, also representatives of state administration, National Audit Office of the Slovak Republic, representatives of regional and local self-governments, and representatives of business and non-profit sector. Representatives of the EC might participate as advisory members of the MC. Members of the MC are appointed by the Vice-Prime Minister of the Slovak Government for the knowledge society, European affairs, human rights and minorities. Authority, activities, composition and structure of the MC are defined in the statute and standing order approved by the MC. Main tasks of the MC in line with Article 65 of the General Regulation are:

- to approve the criteria for selection of the projects (within six months from the approval of the OP) and any revision thereof;
- to review and approve the proposals for change and contents amendment of operational programme;
- to check on the results of programme implementation on a regular basis - especially the operational programme aims achievement and evaluations;
- to review and approve annual and final reports on programme implementation before they are sent to the EC;
- to receive information on annual inspection report or on the part of the report concerning the OP and information on important comments, which could be raised by the EC after its examination;
- to propose to the Managing Authority whenever necessary any kind of revision or OP examination, which could enable reaching the aims of particular fund or improvement of the OP management (including financial management).

MA tasks for the OPH in the area of evaluation:

- it operates in line with the CCB methodology within the area of evaluation;
- it ensures the preliminary and progress OP evaluation and horizontal priority Informatisation of Society evaluation, and submission of the results of progress evaluation to the OPH Monitoring Committee and Commission;
- it ensures the communication with the EC and inputs for subsequent OP evaluation and possible strategic evaluation performed by the EC,
- It elaborates an evaluation plan for the OP, which will include approximate evaluation activities planned in individual stages of the OP implementation.
- it is responsible for elaboration of annual, thematic and final evaluation reports on the achievement of the OP and its priority axis that are submitted for approval to the MA for the given OP, to MC and to the EC.

As per § 16 of the Act, the procurer and sector body are obliged to secure the monitoring and evaluation of impacts of the approved OPH on the environment or to make use of an already existing monitoring, as to prevent double monitoring. Monitoring and evaluation of the impacts of the ROP on environment includes a systematic monitoring and evaluation of its impacts, evaluation of its effectiveness and obtaining of an expert

comparative evaluation on the expected effects, defined in the Environmental Report, and the real state.

If the procurer finds out, that real impacts of the OPH on the environment, evaluated pursuant valid Acts, are worse than it was stated in the Environmental Report, the procurer is obliged to meet conciliation measures and to make sure the OPH will be changed, adjusted or reviewed.

The Ministry of Health of the Slovak Republic (the OPH managing authority) and the OPH Monitoring Committee – as an evaluator - have to, as to secure the monitoring process and the evaluation process of the impacts of the Operational Programme Health for 2007-2013, make sure:

a) to propose and approve criteria for project selection, evaluation of their progress and level of the aim achievement in projects, which implement strategic document. These criteria should be defined in such a way, as to achieve a priority evaluation of long-term and synergic effects of the project realization and the principle of effectiveness;

b) to evaluate regularly the progress of concrete OP objections in the overall context and in the context of individual priority axes and specific objectives;

c) to monitor the impacts on environment by means of the defined indicator – energy consumption on the priority-axis level;

d) to monitor social and economic realization activities of the OP by means of the defined indicator – the number of created job positions;

e) to process and publish monitoring reports. We distinguish progress, annual and final monitoring reports. These reports are the main information resource for the Monitoring Committee, the EC and general public as well.

f) to perform monitoring on the project level by means of measurable indicators. These shall be described in the Guide for Applicants for Non-refundable Financial Contribution. Assistance recipients provide indicator information in the form of monitoring reports from the very beginning of the project realization. Periodicity of the submission of monitoring reports to the Managing Authority can be specified in the contract on the provision of non-repayable cash benefit.

g) to ensure within the scope of project evaluation also evaluation of the impacts on the sustainable development horizontal axis.

VII. AUTHENTICATION OF DATA ACCURACY

1. Statement prepared by

Ministry of Environment SR
Department for Environmental Impact Assessment

2. Verified by

Ing. Viera H u s k o v á
Directress of the Department for Environmental Impact Assessment
Ministry of Environment SR

3. Date and place of issue:

5 October, 2007, Bratislava

Annex 4:
Network of inpatient healthcare facilities – hospitals in the Slovak Republic

Type of healthcare facility	Name of healthcare facility	Town
Region of Bratislava		
General hospital	Nemocničná a.s. Malacky	MALACKY
General hospital	Nemocnica Modra n.o.	MODRA
General hospital	Fakultná nemocnica s poliklinikou Bratislava (including facilities Staré Mesto, Kramáre, Petržalka, Ružinov)	BRATISLAVA
General hospital	Detská fakultná nemocnica s poliklinikou	BRATISLAVA
General hospital	Fakultná nemocnica s poliklinikou Milosrdní bratia, spol. s r.o.	BRATISLAVA
Specialised hospital	Centrum pre liečbu drogových závislostí Bratislava	BRATISLAVA
Specialised hospital	Sanatórium AT, s.r.o.	BRATISLAVA
Specialised hospital	Nemocnica Podunajské Biskupice	BRATISLAVA
Specialised hospital	Národný onkologický ústav	BRATISLAVA
Specialised hospital	Národný ústav srdcových a cievnych chorôb a.s.	BRATISLAVA
Specialised hospital	Detské kardiocentrum SR Bratislava	BRATISLAVA
Specialised hospital	Onkologický ústav sv. Alžbety s.r.o.	BRATISLAVA
Specialised hospital	TETIS, s.r.o.	DUNAJSKÁ LUŽNÁ
Specialised hospital	Psychiatrická nemocnica Philippa Pinela Pezinok	PEZINOK
General hospital	TOP-MED všeobecná nemocnica a.s.	BRATISLAVA
Specialised hospital	LOGMAN a.s.	BRATISLAVA
Specialised hospital	Nemocnica Ministerstva obrany SR, a.s.	BRATISLAVA
Specialised hospital	Nemocnica s poliklinikou Ministerstva vnútra SR a.s. Bratislava	BRATISLAVA
Specialised hospital	Špecializovaná nemocnica pre ortopedickú protetiku Bratislava, n.o.	BRATISLAVA
Specialised hospital (general hospital permission)	NOVAPHARM, s.r.o.	BRATISLAVA
Specialised hospital	NEURÓN PLUS s.r.o.	BRATISLAVA
Specialised hospital	Sanatórium Koch - MEDILINE s.r.o.	BRATISLAVA
Sanatorium	Sanatórium Karpatia, s.r.o. Limbach	LIMBACH
Sanatorium	DO Biela Skala, spol. s r.o.	ČASTÁ
Hospice	MEDIKA-R, a.s.	BRATISLAVA
Biomedical research facility	VULM, a.s. Modra	MODRA
Biomedical research facility	SZU – UPKM	BRATISLAVA
Region of Trnava		
General hospital	Nemocnica s poliklinikou Dunajská Streda	DUNAJSKÁ LUŽNÁ
General hospital	Nemocnica s poliklinikou Svätého Lukáša Galanta	GALANTA
General hospital	Nemocnica s poliklinikou Dunajská Streda	HLOHOVEC
General hospital	Nemocnica Alexandra Wintera, n.o. Piešťany	PIEŠŤANY
General hospital	NsP Skalica	SKALICA
General hospital	Fakultná nemocnica Trnava	TRNAVA
Specialised hospital	FMC-dialyzačné služby s.r.o.	PIEŠŤANY
Specialised hospital	Národný ústav reumatických chorôb Piešťany	PIEŠŤANY
Specialised hospital	MERKATOR SPOL. s r.o.	ŠAMORÍN
Hospice	Zdravotno-sociálne centrum sv. Alžbety, n.o. Trstice	GALANTA
Sanatorium	VITALITA n.o. Lehnice	LEHNICE
Natural therapeutic spa	Slovenské liečebné kúpele a.s.	PIEŠŤANY
Region of Nitra		
Specialised hospital	Centrum pre liečbu drogových závislostí Nové Zámky	NOVÉ ZÁMKY

Annex 4:
Network of inpatient healthcare facilities – hospitals in the Slovak Republic

Specialised hospital	Psychiatrická nemocnica	HRONOVCE
Specialised hospital	Špecializovaná nemocnica sv.Svorada Zobor, n.o. Nitra	NITRA
Specialised hospital	Odborný detský liečebný ústav Trávnica	TRÁVNICA
Specialised hospital	Psychiatrická nemocnica	VEĽKÉ ZÁLUŽIE
General hospital	FORLIFE n.o. Komárno	KOMÁRNO
General hospital	FORLIFE n.o. Šaľa	ŠAĽA
General hospital	Nemocnica s poliklinikou n.o.	LEVICE
General hospital	Fakultná nemocnica Nitra	NITRA
General hospital	Fakultná nemocnica s poliklinikou Nové Zámky	NOVÉ ZÁMKY
General hospital	Všeobecná nemocnica s poliklinikou Šahy, n.o.	ŠAHY
General hospital	Nemocnica Topoľčany n.o.	TOPOĽČANY
General hospital	Mestská nemocnica s poliklinikou Zlaté Moravce	ZLATÉ MORAVCE
Sanatorium	WESPA, s.r.o.	ŽELIEZOVCE
Region of Trenčín		
General hospital	Fakultná nemocnica Trenčín	TRENČÍN
General hospital	NEMOCNICA Bánovce nad Bebravou, s.r.o.	BÁNOVCE
General hospital	Nemocnica s poliklinikou Prievidza so sídlom v Bojniciach	BOJNICE
General hospital	NEMOCNICA Handlová, s.r.o.	HANDLOVÁ
General hospital	Nemocnica s poliklinikou Ilava, nezisková organizácia	ILAVA
General hospital	Nemocnica s poliklinikou MYJAVA	MYJAVA
General hospital	Nemocnica s poliklinikou Nové Mesto nad Váhom, n.o.	NOVÉ MESTO NAD VÁHOM
General hospital	Nemocnica s poliklinikou Partizánske, n.o.	PARTIZÁNSKE
General hospital	Nemocnica s poliklinikou Považská Bystrica	POVAŽSKÁ BYSTRICA
General hospital	Nemocnica Zdravie, s.r.o.	PÚCHOV
Natural therapeutic spa	Kúpele Bojnice a.s.	BOJNICE
Natural therapeutic spa	Slovenské liečebné kúpele a.s.	TRENČIANSKE TEPLICE
Natural therapeutic spa	Kúpele Nimnica a.s.	NIMNICA
Natural therapeutic spa	Kúpele Brusno a.s.	BRUSNO
Specialised hospital	Nemocnica pre obvinených a odsúdených a Ústav na výkon trestu odňatia slobody	TRENČÍN
Hospice	REFUGIUM, o.z.	TRENČÍN
Region of Banská Bystrica		
General hospital	Fakultná nemocnica s poliklinikou F.D.Roosevelta Banská Bystrica	BANSKÁ BYSTRICA
General hospital	Detská fakultná nemocnica s poliklinikou Banská Bystrica	BANSKÁ BYSTRICA
General hospital	Regionálna nemocnica Banská Štiavnica, n.o.	BANSKÁ ŠTIAVNICA
General hospital	Nemocnica s poliklinikou Brezno, n.o.	BREZNO
General hospital	Nemocnica s poliklinikou Hnúšťa n.o.	HNÚŠŤA
General hospital	Mestská nemocnica s poliklinikou Krupina n.o.	KRUPINA
General hospital	Všeobecná nemocnica s poliklinikou Lučenec n.o.	LUČENEC
General hospital	Nemocnicka s poliklinikou Nová Baňa, n.o.	NOVÁ BAŇA
General hospital	Revúcka medicínsko-humanitná, n.o., Nemocnica s poliklinikou Revúca	REVÚCA
General hospital	Všeobecná nemocnica s poliklinikou, n.o., Veľký Krtíš	VEĽKÝ KRTÍŠ
General hospital	Nemocnica s Poliklinikou -VAŠE ZDRAVIE n.o.	ZVOLEN
General hospital	Nemocnica s poliklinikou Žiar n/H.	ŽIAR NAD HRONOM
General hospital	Nemocnica s poliklinikou Rimavská Sobota	RIMAVSKÁ SOBOTA
Specialised hospital	Centrum pre liečbu drogových závislostí B.Bystrica	BANSKÁ BYSTRICA
Specialised hospital	Odborný liečebný ústav psychiatrický n.o.	MURÁNSKA HUTA
Specialised hospital	Stredoslovenský ústav srdcových a cievnych chorôb a.s. Banská Bystrica	BANSKÁ BYSTRICA
Specialised hospital	Národné rehabilitačné centrum	KOVÁČOVÁ
Specialised hospital	Psychiatrická nemocnica	KREMNICA

Annex 4:
Network of inpatient healthcare facilities – hospitals in the Slovak Republic

Specialised hospital	OFTAL s.r.o.	ZVOLEN
Natural therapeutic spa	Kúpele Dudince a.s.	DUDINCE
Natural therapeutic spa	Prírodné jódové kúpele a.s.	ČÍŽ
Natural therapeutic spa	WELLNESS Kováčová s.r.o.	KOVÁČOVÁ
Natural therapeutic spa	Kúpele Sliač a.s.	SLIAČ
Natural therapeutic spa	Liečebné termálne kúpele a.s.	SKLENÉ TEPLICE
Natural therapeutic spa	Fatranské liečebné kúpele a.s	KORYTNICA
Sanatorium	POLIKLINIKA - LDCH, s.r.o.	DETVA
Sanatorium	Detská ozdravovňa Kremnické Bane	KREMNICKÉ BANE
Sanatorium	GEMERMED s.r.o.	TORNAĽA
Hospice	PRO VITAE o.z.	LUČENEC
Region of Žilina		
General hospital	Nemocnica s poliklinikou Čadca	ČADCA
General hospital	Nemocnica s poliklinikou D. Kubín	DOLNÝ KUBÍN
General hospital	Nemocnica s poliklinikou Liptovský Mikuláš	LIPTOVSKÝ MIKULÁŠ
General hospital	Martinská fakultná nemocnica Martin	MARTIN
General hospital	Nemocnica s poliklinikou Trstená	TRSTENÁ
General hospital	Nemocnica s poliklinikou Žilina	ŽILINA
Specialised hospital	Slovdom Trstená (CPLDZ)	TRSTENÁ
Specialised hospital	Národný endokrinologický a diabetologický ústav n.o. Ľubochňa	ĽUBOCHŇA
Specialised hospital	Ústredná vojenská nemocnica SNP	RUŽOMBEROK
Specialised hospital	Centrum pre liečbu drogových závislostí s.r.o.	POVAŽSKÝ CHLMEC
Natural therapeutic spa	Liptovské liečebné kúpele a.s.	LÚČKY
Natural therapeutic spa	Slovenské liečebné kúpele a.s.	TURČIANSKE TEPLICE
Natural therapeutic spa	Slovenské liečebné kúpele a.s.	RAJECKÉ TEPLICE
Sanatorium	Psychiatrická liečebňa Sučany	SUČANY
Sanatorium	Detská ozdravovňa Železnô	PARTIZÁNSKA ĽUPČA
Sanatorium	Liečebňa pre dlhodobo chorých	ŠTIAVNIČKA
Sanatorium	Rieka, s.r.o.	ŠÚTOVO
Region of Prešov		
General hospital	NsP Sv. Jakuba, n.o., Bardejov	BARDEJOV
General hospital	Nemocnica Andreja Leňa, n.o.	HUMENNÉ
General hospital	M.V.Medicínske centrum spol. s r.o.	HUMENNÉ
General hospital	Nemocnica Dr. Vojtecha Alexandra v Kežmarok n.o.	KEŽMAROK
General hospital	Všeobecná nemocnica s poliklinikou Levoča, a.s.	LEVOČA
General hospital	Nemocnica s poliklinikou Medzilaborce, n.o.	MEDZILABORCE
General hospital	Nemocnica Poprad, a.s.	POPRAD
General hospital	Fakultná nemocnica s poliklinikou J.A.Reimana Prešov	PREŠOV
General hospital	Nemocnica Snina, s.r.o.	SNINA
General hospital	Ľubovnianska nemocnica, n. o.	STARÁ ĽUBOVŇA
General hospital	Nemocnica Stropkov, s.r.o.	STROPKOV
General hospital	Nemocnica s poliklinikou arm. generála Ludvíka Svobodu	SVIDNÍK
General hospital	Vranovská nemocnica n.o.	VRANOV NAD TOPĽOU
Specialised hospital	Šrobárov ústav detskej tuberkulózy a respiračných chorôb, n.o. vysokošpecializovaný odborný ústav Dolná Smokovec	DOLNÝ SMOKOVEC
Specialised hospital	Ústav tuberkulózy a respiračných chorôb Poprad - Kvetnica, n.o.	POPRAD
Specialised hospital	MINERAL-SLOVAKIA, s.r.o.	PREŠOV
Specialised hospital	Vysokošpecializovaný ústav pre pľúcne choroby - Nová Polianka	NOVÁ POLIANKA – VYSOKÉ TATRY
Specialised hospital	Sanatórium Tatranská Kotlina, n.o. Tatranská Polianka	TATRANSKÁ KOTLINA

Annex 4:
Network of inpatient healthcare facilities – hospitals in the Slovak Republic

Specialised hospital	Sanatórium Dr. GUHRA n.o.	TATRANSKÁ POLIANKA
	ORL Humenné s.r.o.	HUMENNÉ
Specialised hospital	Vojenský vysokošpecializovaný ústav pre choroby pľúcne	NOVÁ POLIANKA
Specialised hospital	Ústav tuberkulózy, pľúcnych chorôb a hrudníkovej chirurgie	VYŠNÉ HÁGY
Sanatorium	MEDICAL-CARE, s.r.o.	PREŠOV
Sanatorium	OZAC s.r.o.	PREŠOV
Natural therapeutic spa	Kúpele Horný Smokovec s.r.o.	STARÝ SMOKOVEC
Natural therapeutic spa	Kúpele Štrbské Pleso a.s.	ŠTRBSKÉ PLESO
Natural therapeutic spa	Kúpele Lučivná a.s.	LUČIVNÁ
Natural therapeutic spa	Kúpele Nový Smokovec a.s.	NOVÝ SMOKOVEC
Natural therapeutic spa	TATRASAN, s.r.o.	NOVÝ SMOKOVEC
Natural therapeutic spa	Kúpele Vyšné Ružbachy a.s.	VYŠNÉ RUŽBACHY
Natural therapeutic spa	Bardejovské Kúpele a.s.	BARDEJOVSKÉ KÚPELE
Nursing care home	Ošetrovateľské centrum, s.r.o.	HUMENNÉ
Hospice	Spišská katolícka charita - Hospic sv. Alžbety	KEŽMAROK
Hospice	Arcidiecézna charita Košice - Hospic sv. Terezy	BARDEJOV
Region of Košice		
General hospital	PRO VITAE n.o.	GELNICA
General hospital	Detská fakultná nemocnica Košice	KOŠICE
General hospital	Fakultná nemocnica L.Pasteura Košice	KOŠICE
General hospital	Nemocnica Košice - Šaca a.s. 1. súkromná nemocnica	KOŠICE
General hospital	Nemocnica s poliklinikou Kráľovský Chlmec n.o.	KRÁĽOVSKÝ CHLMEC
General hospital	Nemocnica Krompachy spol. s r.o.	KROMPACHY
General hospital	Nemocnica s poliklinikou Štefana Kukuru v Michalovciach, n.o.	MICHALOVCE
General hospital	Nemocnica s poliklinikou sv. Barbory Rožňava, a.s.	ROŽŇAVA
General hospital	Regionálna nemocnica s poliklinikou Sobrance	SOBRANCE
General hospital	Nemocnica s poliklinikou Spišská Nová Ves, a.s.	SPIŠSKÁ NOVÁ VES
General hospital	Nemocnica s poliklinikou Trebišov, a.s.	TREBIŠOV
Specialised hospital	Vysokošpecializovaný odborný ústav geriatrický sv. Lukáša v Košiciach n.o.	KOŠICE
Specialised hospital	Inštitút nukleárnej a molekulárnej medicíny Košice	KOŠICE
Specialised hospital	Východoslovenský ústav srdcových a cievnych chorôb Košice, a.s.	KOŠICE
Specialised hospital	Východoslovenský onkologický ústav, a.s. Košice	KOŠICE
Specialised hospital	Psychiatrická nemocnica Michalovce, n.o.	MICHALOVCE
Specialised hospital (general hospital permission)	Železničné zdravotníctvo Košice, s.r.o.	KOŠICE
Specialised hospital	Letecká vojenská nemocnica, a.s.	KOŠICE
Specialised hospital	Centrum pre liečbu drogových závislostí Košice	KOŠICE
Sanatorium	Detská psychiatrická liečebňa n.o. Hraň	HRAŇ
Sanatorium	Psychiatrická liečebňa S. Bluma	PLEŠIVEC
Sanatorium	Geria, s.r.o.	TREBIŠOV
Natural therapeutic spa	Kúpele Štós a.s.	ŠTÓS

METHODICAL APPROACH AND CRITERIA FOR THE SELECTION OF INNOVATION AND COHESION GROWTH POLES

Contents

1. Approach

Theoretical approach to the selection of innovation and cohesion growth poles was presented to regional representatives and other workgroup members by its authors at a meeting of the workgroup for ROP preparation in the Ministry of Construction and Regional Development on 17 January 2007.

The new proposal of settlement structure of Slovakia for the purpose of the NSRF was prepared during January – February 2007. The first draft list of the settlement structure was prepared from statistical data and the criteria listed below.

The following input data was used:

- Population number as at 31.12.2004 – Statistical Office of the Slovak Republic,
- Data concerning schools for academic year 2005/2006 – Institute of School Information and Prognosis,
- Slovak Spatial Development Perspective 2001, Environment Ministry, AUREX, s.r.o.,
- Information on existing joint municipal authorities (building authorities) – Ministry of Construction and Regional Development of the Slovak Republic,
- Information on municipalities intended for joint municipal authorities – ZMOS 2002,
- Birth, deaths and marriages registers – Decree of the Ministry of Interior of the Slovak Republic No. 529/2001 Coll., as amended,
- Organisation of settlement of the Slovak Socialist Republic – URBANITA No. 51, February 1985.

The first draft list of settlement structure provided foundation for further negotiations and details between the Regional Development Ministry and the self-governing regions.

Beginning March 2007, the new draft settlement structure by regions was sent by the Regional Development Ministry to all self-governing regions (except for the Bratislava self-governing region) for commenting and taking position. The self-governing regions and the Regional Development Ministry commented on the draft and submitted their proposed amendments. All comments and proposals were assessed by the authors of the proposed growth poles.

In common working meetings with representatives of self-governing regions, all proposals and recommendations made were discussed on an individual basis. In working meetings, the regional representatives and the delegated authors in the Regional Development Ministry agreed on modifications and amendments in the regional lists of growth poles.

2. Methodology and criteria for the selection of innovation and cohesion growth poles

2.1. Groups of municipalities

Municipalities were listed by their significance and location within the settlement system. Innovation growth poles were specified, interest areas of the innovation growth poles and the cohesion growth poles. When determining the innovation growth poles, the national spatial development documentation called Slovak Spatial Development Perspective 2001 and the administrative structure of Slovakia were used as foundation. The total number of Slovak municipalities assessed was 2891. The total number of municipalities assessed outside the Bratislava region was 2818.

1. **Innovation growth poles** are divided by hierarchy into:
   - Settlement centre of national to international significance (regional capital),
   - Settlement centre of regional significance within a core zone of the 1st level core of settlement,
   - Settlement centre of regional significance within a suburban zone of the 1st level core of settlement,
   - Settlement centre of regional to supra-regional significance within a core zone of the 2nd level core of settlement,
   - Settlement centre of regional significance.
2. **Territories of interest of an innovation growth pole** have been outlined on the basis of Slovak Spatial Development Perspective 2001 which defines and outlines the cores of settlement. The territories of interest of the innovation growth poles have been outlined around settlement centres of national to international significance (regional capital) and around centres of regional to supra-regional significance which make cores of the 2nd level cores of settlement. The territory of interest of an innovation growth pole consists of cadastre areas of the core and suburban zones of the 1st level cores of settlement and the 2nd level cores of settlement;
3. **Cohesion growth poles** are divided by hierarchy – depending on their location within the system of settlement – into:
   - Micro-regional centre situated within the area of interest of an innovation growth pole outlined by the core zone of the 1st level core of settlement;
   - Micro-regional centre situated within the area of interest of an innovation growth pole outlined by the suburban zone of the 1st level core of settlement;
   - Micro-regional centre situated within the area of interest of an innovation growth pole outlined by the 2nd level core of settlement;
   - Micro-regional centre situated outside the area of interest of innovation growth poles.

4. **Municipalities outside innovation and cohesion growth poles** are divided – depending on their location within the system of settlement – into:
   - Municipality of the area of interest of an innovation growth pole outlined by the core zone of the 1st level core of settlement;
   - Municipality of the area of interest of an innovation growth pole outlined by the suburban zone of the 1st level core of settlement;
   - Municipality of the area of interest of an innovation growth pole by the core zone of the 2nd level core of settlement;
   - Municipality of the remaining area.

2.2. Criteria for the selection of growth poles

The municipalities proposed to become innovation and cohesion growth poles have been selected on the basis of input data and the following criteria:

2.2.1. Innovation growth poles:

- Capital city
- Town with a district seat
- Town with a former district seat

Altogether, 72 innovation growth poles have been outlined in Slovakia and when abstracting from the Bratislava region, they were 68 in total. The list of innovation growth poles was completed on request of self-governing regions and thus, 82 growth poles have been outlined including the Bratislava region and 78 innovation growth poles excluding the Bratislava region.

2.2.2. Cohesion growth poles:

- Municipalities with a births, deaths and marriages register, joint municipal authority, basic school of type 3 at the same time, which used to be a settlement centre of local significance considered by ZMOS to be seats of joint municipal authorities (92 municipalities in total);
- Municipalities with a basic school of type 3 with more than 100 pupils (774 municipalities in total);
- Municipalities without basic schools of type 3 but with a secondary school (9 municipalities in total);
- Municipalities which do not comply with the above criteria and have a population over 1500 in the Prešov and Košice regions (17 municipalities in total).

By overlapping the above criteria in the first draft, in total 802 cohesion growth poles have been outlined in Slovakia including the Bratislava region. The number of cohesion growth

poles outlined in that way outside the Bratislava region was 769 municipalities in total. As requested by self-governing regions, the list of cohesion growth poles was amended and in total, 891 cohesion growth poles were outlined including the Bratislava region and 858 cohesion growth poles excluding the Bratislava region.

2.2.3. The territories of interest of innovation growth poles are made by:

- Municipalities located within the territory of the core and suburban zones of the 1st level cores of settlement;
- Municipalities located in the territories of the 2nd level cores of settlement.

In total, the initial list outlined 412 municipalities in Slovakia which are located in the territories of interest of innovation growth poles and which are neither innovation nor cohesion growth poles. There are 390 municipalities of that kind outside the Bratislava region. In agreement with self-governing regions, the list was extended into 415 Slovak municipalities located in the territory of innovation growth poles. Outside the Bratislava region, 393 municipalities located in the territories of interest of innovation growth poles were outlined. There are in total 207 cohesion growth poles located in the territories of interest of innovation growth poles (outside the Bratislava region). Altogether, there are 600 municipalities located in the territories of interest of innovation growth poles (outside the Bratislava region).

2.2.4. Municipalities outside innovation and cohesion growth poles

Municipalities which are neither innovation nor cohesion growth poles and are not located in the territories of interest of innovation growth poles are 1503 in total. There are 1489 such municipalities outside the Bratislava region.

Municipalities which are neither innovation nor cohesion growth poles, regardless of their location (including those located in the territories of interest of innovation growth poles) are altogether 1918 in Slovakia and there are in total 1882 such municipalities outside the Bratislava region.

(Note: There are altogether 1946 municipalities with a population under 1000 and they are altogether 1922 outside the Bratislava region).

2.2.5. Summary overview

An overview of population and municipalities numbers and their shares by their position in the structure of settlements in Slovakia is contained in the tables below.

	Slovak Republic total	Population		Municipalities
	Year	2001	2004	
1	Innovation growth poles	2 673 296	2 642 677	82
2	Cohesion growth poles	1 794 183	1 819 978	891
	Innovation and cohesion growth poles total (1+2)	4 467 479	4 462 655	973
3	Municipalities in the territories of interest of innovation growth poles	257 153	266 413	415
4	Municipalities outside growth poles and territories of interest	654 823	655 754	1 503
	Total	5 379 455	5 384 822	2 891

	Slovak Republic excl. Bratislava region	Population		Municipalities
	year	2001	2004	
1	Innovation growth poles	2 191 096	2 163 324	78
2	Cohesion growth poles	1 705 047	1 727 520	858
	Innovation and cohesion growth poles total (1+2)	3 896 143	3 890 844	936
3	Municipalities in the territories of interest of innovation growth poles	238 813	246 562	393
4	Municipalities outside growth poles and territories of interest	645 484	646 284	1 489
	Total	4 780 440	4 783 690	2 818

	Slovak Republic total	Population share		Share of
	Year	2001	2004	municipalities
1	Innovation growth poles	49,7	49,1	2,8
2	Cohesion growth poles	33,4	33,8	30,8
	Innovation and cohesion growth poles total (1+2)	83,0	82,9	33,7
3	Municipalities in the territories of interest of innovation growth poles	4,8	4,9	14,4
4	Municipalities outside growth poles and territories of interest	12,2	12,2	52,0
	Total	100,0	100,0	100,0

	Slovak Republic excl. Bratislava region	Population share		Share of
	year	2001	2004	municipalities
1	Innovation growth poles	45,8	45,2	2,8
2	Cohesion growth poles	35,7	36,1	30,4
	Innovation and cohesion growth poles total (1+2)	81,5	81,3	33,2
3	Municipalities in the territories of interest of innovation growth poles	5,0	5,2	13,9
4	Municipalities outside growth poles and territories of interest	13,5	13,5	52,8
	Total	100,0	100,0	100,0

Annex 6a: Growth poles – Inpatient facilities

Region of Western Slovakia – NUTS II (WS): Upper territorial unit (UTU) – Trnava, Trenčín, Nitra

Region of Western Slovakia – NUTS II (WS)

Growth poles – Inpatient facilities

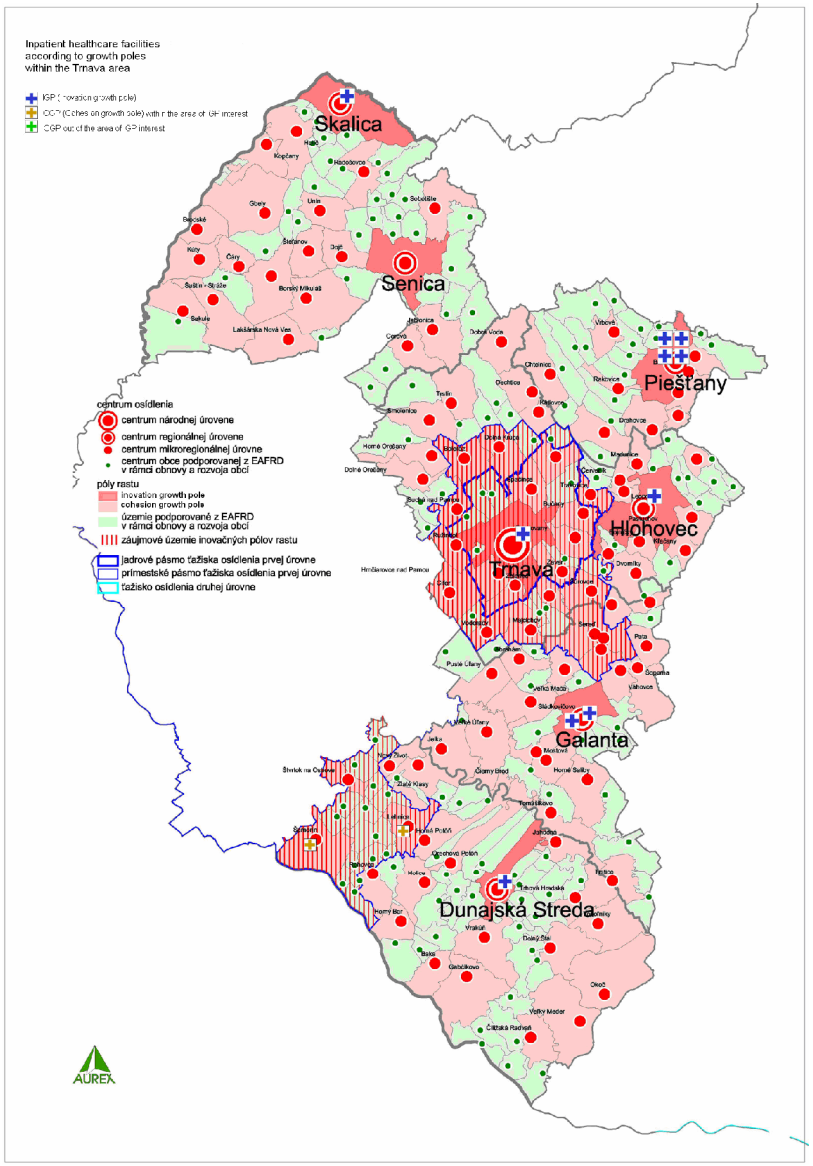
Upper territorial unit (UTU) Trnava

Growth poles	**Type of healthcare facility**	**Town:**	TT	DS	GA	HC	PE	Skalica		Lehnice	Šamorín	**Total population**
		Population:	69140	23562	16000	23151	29957	14984		2432	12339	191565
			Number									
IGP	General hospitals		1*	1*	1*	1*	1	1*	In IGP IA	-	-	
	Specialised hospitals		-	-	-	-	2	-		-	1	
	Natural therapeutic spas		-	-	-	-	1	-		-	-	
	Sanatoria		-	-	-	-	-	-		1	-	
	Hospice		-	-	1	-	-	-		-	-	

* - with polyclinic

Annex 6a: Growth poles – Inpatient facilities

Region of Western Slovakia – NUTS II (WS): Upper territorial unit (UTU) – Trnava, Trenčín, Nitra



Annex 6a: Growth poles – Inpatient facilities

Region of Western Slovakia – NUTS II (WS): Upper territorial unit (UTU) – Trnava, Trenčín, Nitra

Region of Western Slovakia – NUTS II (WS)

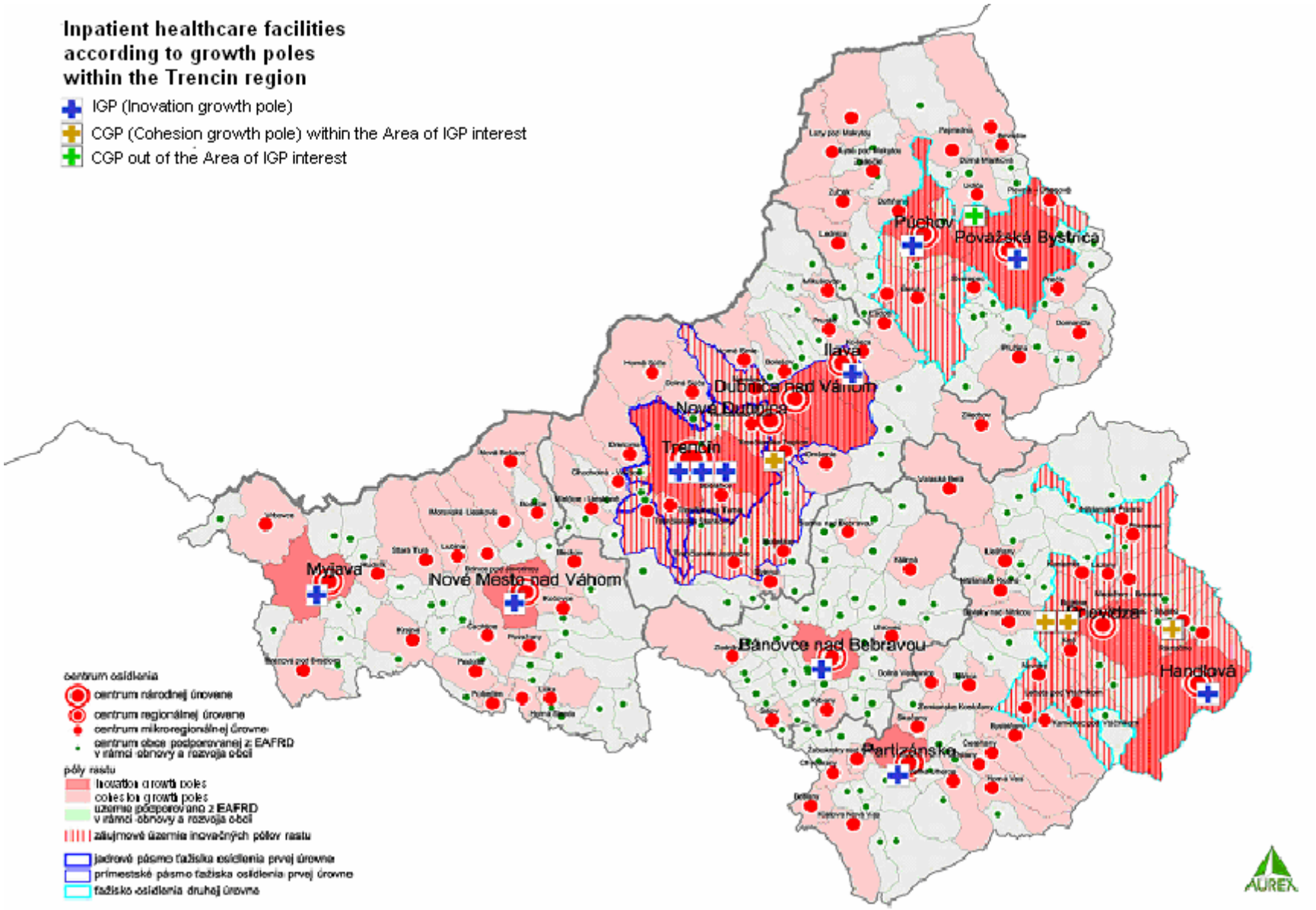
Growth poles – Inpatient facilities

Upper territorial unit (UTU) Trenčín																		
Growth poles	**Type of healthcare facility**	**Town:**	**Trenčín**	**Ilava**	**PB**	**Handlová**	**Púchov**	**Bánovce nad Bebravou**	**Myjava**	**Nové mesto nad Váhom**	**Partizánske**		**Trenčianske Teplice**	**Bojnice**	**Chrenovec**		**Nimnica**	**Total population**
		Population:	56850	5451	42320	17805	18675	20725	12884	20827	24581		4297	4996	1335		670	90315
			Number															
IGP	General hospitals		1*	1*	1*	1	1	1	1*	1*	1*	in IGP IA	-	1*	-	Outside IGP IA	-	
	Specialised hospitals		1	-	-	-	-	-	-	-	-		-	-	-		-	
	Natural therapeutic spas		-	-	-	-	-	-	-	-	-		1	1	1		1	
	Sanatoria		-	-	-	-	-	-	-	-	-		-	-	-		-	
	Hospice		1	-	-	-	-	-	-	-	-		-	-	-		-	

* - with polyclinic

Annex 6a: Growth poles – Inpatient facilities

Region of Western Slovakia – NUTS II (WS): Upper territorial unit (UTU) – Trnava, Trenčín, Nitra



Annex 6a: Growth poles – Inpatient facilities

Region of Western Slovakia – NUTS II (WS): Upper territorial unit (UTU) – Trnava, Trenčín, Nitra

Region of Western Slovakia – NUTS II (WS)

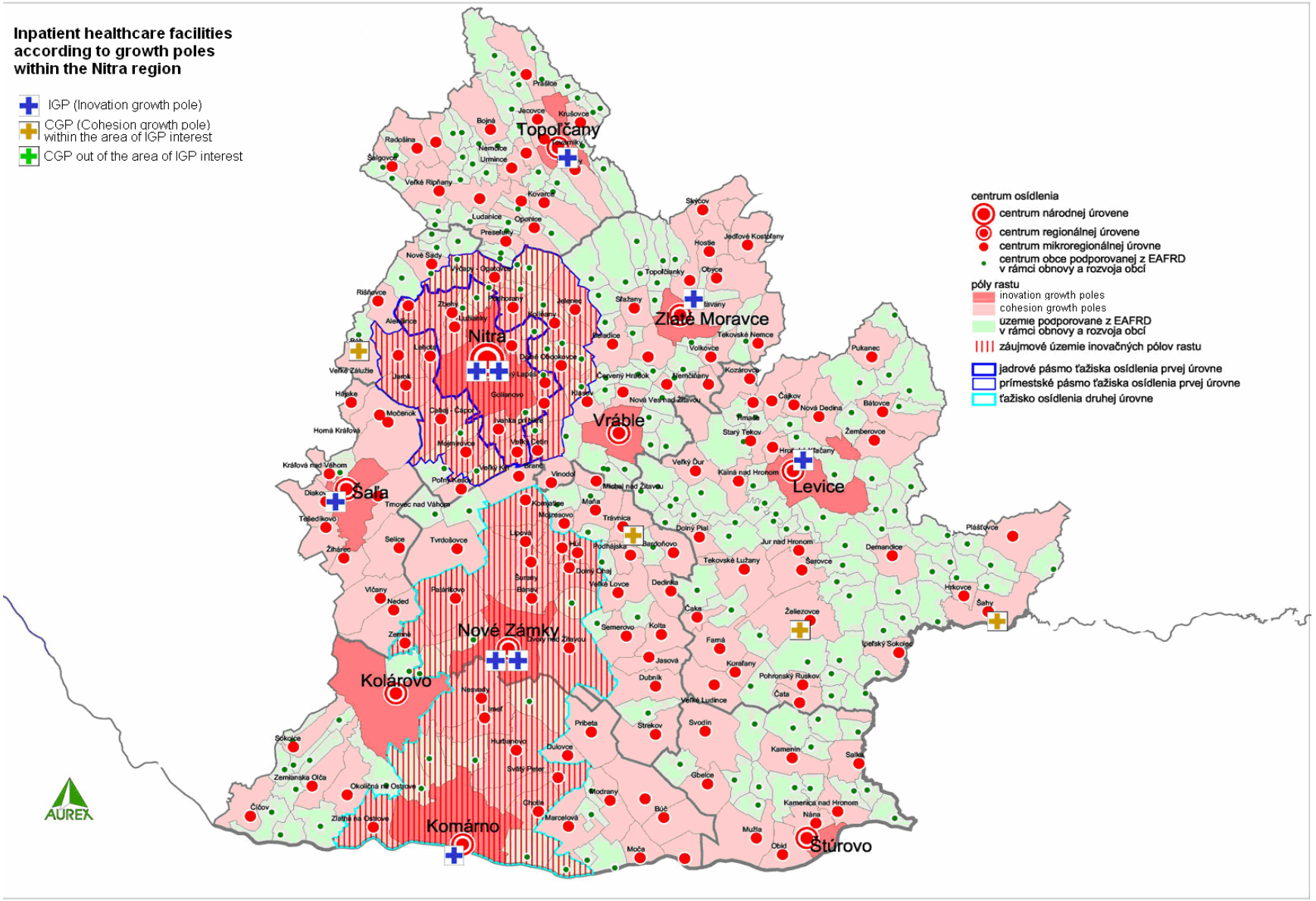
Growth poles – Inpatient facilities

	Higher territorial unit (VÚC) Nitra														
Growth poles	**Type of healthcare facility**	**Town:**	NR	Komárno	NZ	Levice	Šala	TO	Zlaté Moravce		Veľké Záluzie	Šahy	Želiezovce	Trávnica	**Total population**
		Population:	85742	36731	41469	36310	24506	28728	13554		3974	7971	7522	1195	123760
			Number												
IGP	General hospitals		1	1	1*	1*	1	1	1*	in IGP IA	-	1*	-	-	
	Specialised hospitals		1	-	1	-	-	-	-		1	-	-	1	
	Natural therapeutic spas		-	-	-	-	-	-	-		-	-	-	-	
	Sanatoria		-	-	-	-	-	-	-		-	-	1	-	
	Hospice		-	-	-	-	-	-	-		-	-	-	-	

* - with polyclinic

Annex 6a: Growth poles – Inpatient facilities

Region of Western Slovakia – NUTS II (WS): Upper territorial unit (UTU) – Trnava, Trenčín, Nitra



Annex 6b: Growth poles – Inpatient facilities
Region of Central Slovakia – NUTS II (CS): Upper territorial unit (UTU) Banská Bystrica, Žilina

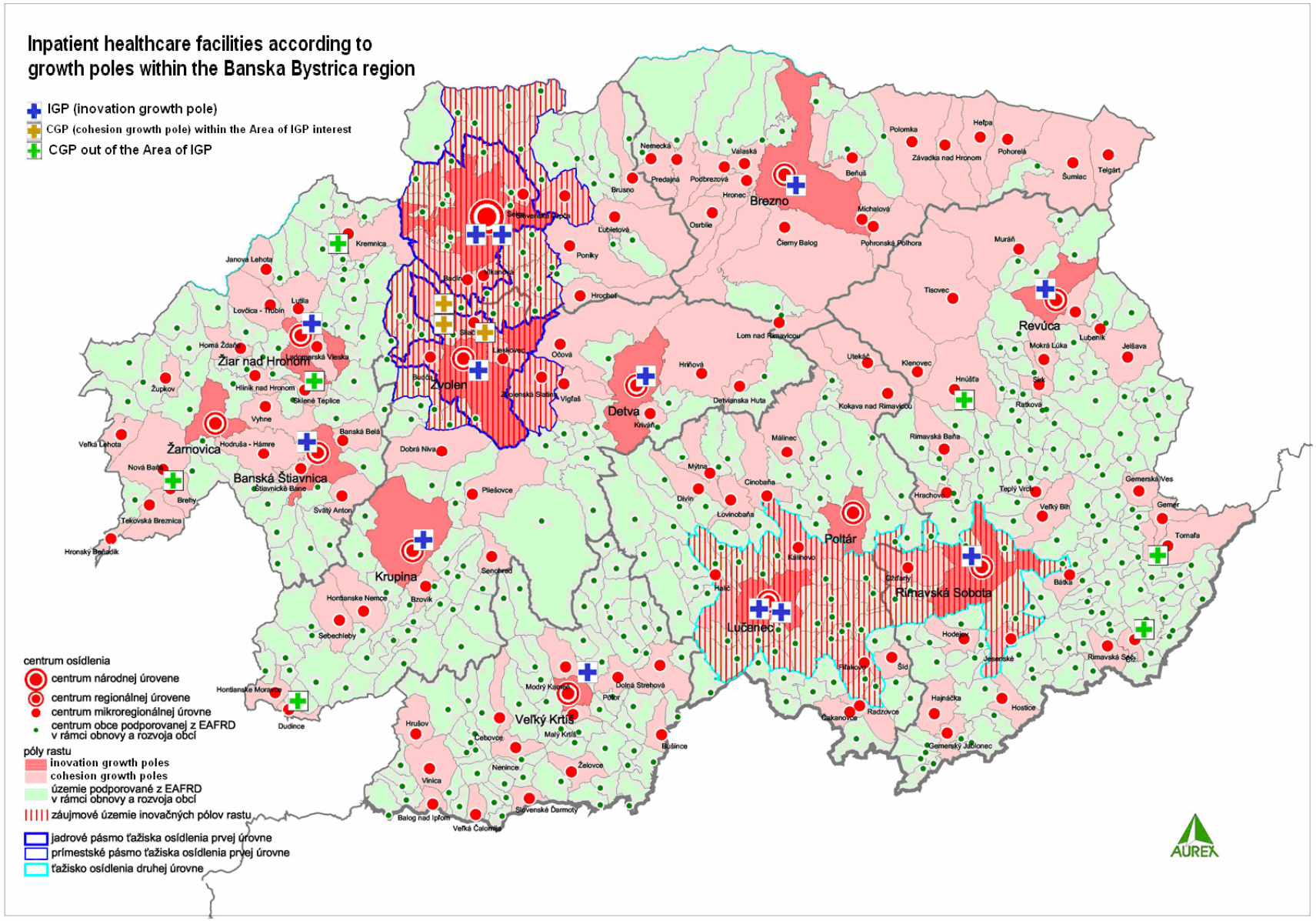
Region of Central Slovakia – NUTS II (CS)
Growth poles – Inpatient facilities

Upper territorial unit (UTU Banská Bystrica																								
Growth poles	**Type of healthcare facility**	**Town:**	**BB**	**LC**	**RS**	**ZV**	**BŠ**	**BR**	**DV**	**Krupina**	**Revúca**	**Veľký Krtíš**	**Žiar nad Hronom**		**Sliač**	**Kováčová**		**Dudince**	**Tornaľa**	**Číž**	**Hnúšťa**	**Nová baňa**	**Kremnica**	**Sklenné Teplice**	**Total population**
		Population:	81704	28039	24520	43272	10814	22417	15043	7857	13147	13932	19718		4853	1439		1521	8016	707	7558	7485	5649	435	318126
			Number																						
IGP	General hospitals		2 / 2*	1*	1*	1*	1	1*	-	1*	1	1*	1*	In IGP IA	-	-	outside IGP IA	-	-	-	1*	1*	-	-	
	Specialised hospitals		-	-	-	1	-	-	-	-	-	-	-		-	1		-	-	-	-	-	1	-	
	Natural therapeutic spas		-	-	-	-	-	-	-	-	-	-	-		1	1		1	-	1	-	-	-	1	
	Sanatoria		-	-	-	-	-	-	1	-	-	-	-		-	-		-	1	-	-	-	-	-	
	Hospice		-	1	-	-	-	-	-	-	-	-	-		-	-		-	-	-	-	-	-	-	

* - with polyclinic

Annex 6b: Growth poles – Inpatient facilities

Region of Central Slovakia – NUTS II (CS): Upper territorial unit (UTU) Banská Bystrica, Žilina



Annex 6b: Growth poles – Inpatient facilities

Region of Central Slovakia – NUTS II (CS): Upper territorial unit (UTU) Banská Bystrica, Žilina

Region of Central Slovakia – NUTS II (CS)

Growth poles – Inpatient facilities

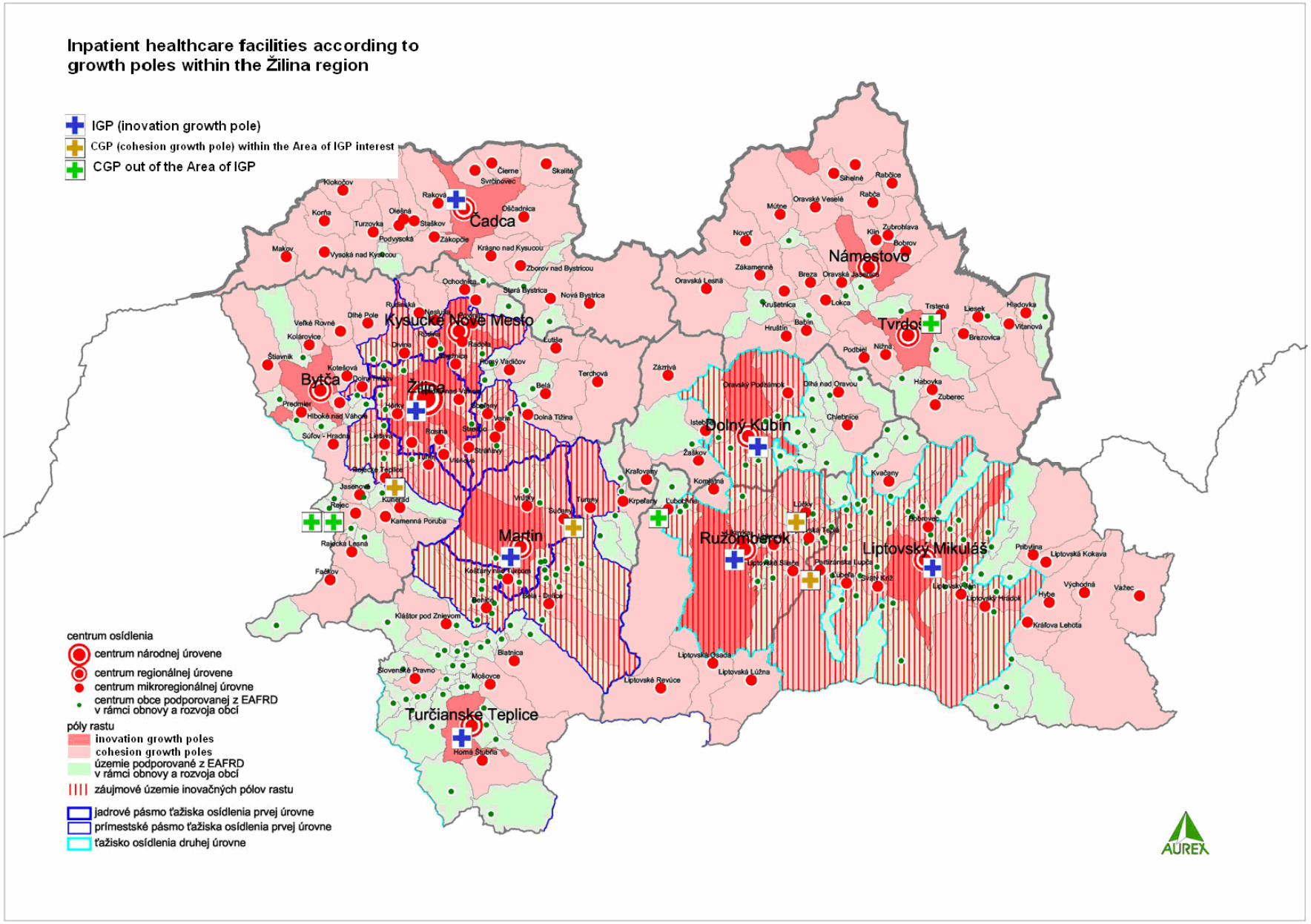
Upper territorial unit (UTU) Žilina

Growth poles	Type of healthcare facility	Town:	ZA	DK	LM	RK	MT	CA	Turčianske Teplice		Sučany	Rajecké Teplice	Lúčky	Partizánska Ľupča		Lubochňa	Trstená	Total population
		Population:	85268	19883	32930	30058	59449	26269	6929		4644	2728	1736	1242		1042	7579	279757
			Number															
IGP	General hospitals		1*	1*	1*	-	1	1*	-	In IGP IA	-	-	-	-	outside IGP IA	-	1*	
	Specialised hospitals		-	-	-	1	-	-	-		-	-	-	-		1	1	
	Natural therapeutic spas		-	-	-	-	-	-	1		-	1	1	1		-	-	
	Sanatoria		-	-	-	-	-	-	-		1	-	-	-		-	-	
	Hospice		-	-	-	-	-	-	-		-	-	-	-		-	-	

* - with polyclinic

Annex 6b: Growth poles – Inpatient facilities

Region of Central Slovakia – NUTS II (CS): Upper territorial unit (UTU) Banská Bystrica, Žilina



Annex 6c: Growth poles – Inpatient facilities

Region of Eastern Slovakia – NUTS II (ES): Upper territorial unit (UTU) – Prešov, Košice

Region of Eastern Slovakia – NUTS II (ES)

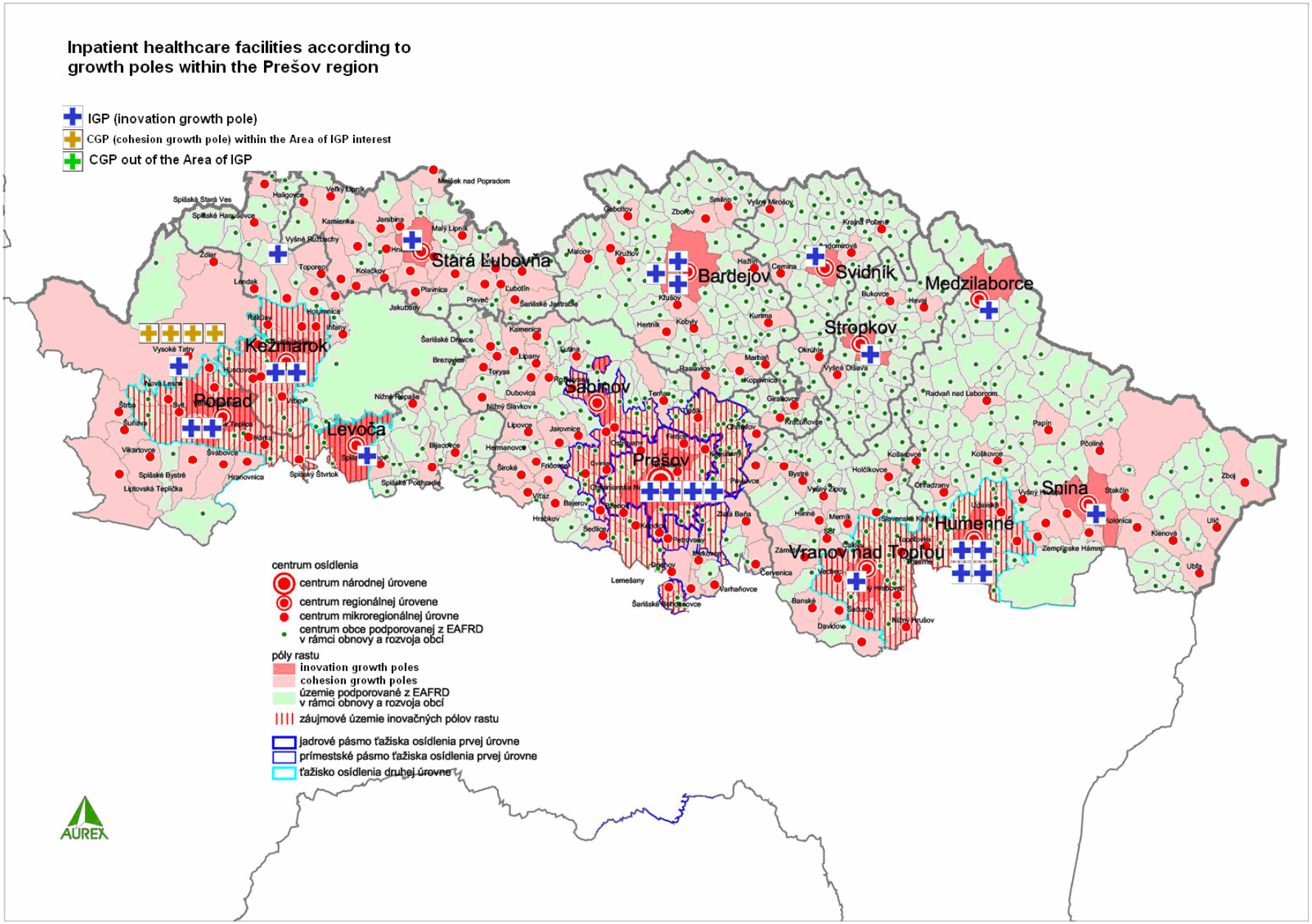
Growth poles – Inpatient facilities

	Upper territorial unit (UTU) Prešov																	
Growth poles	**Type of healthcare facility**	**Town:**	**PO**	**Humenné**	**PD**	**Kežmarok**	**Levoča**	**Vranov nad Topľou**	**Bardejov**	**Medzilaborce**	**Snina**	**Stará Ľubovňa**	**Stropkov**	**Svidník**	**Vysoké Tatry**		**Vyšné Ružbachy**	**Total population**
		Population:	91767	35008	55404	12740	14604	23036	33400	6665	21328	16348	10822	12354	4953		1296	247958
			Number															
IGP	General hospitals		1	2 / 1*	1	1	1*	1	1*	1	1	1	1	1*	-	outside IGP IA	-	
	Specialised hospitals		1	1	1	-	-	-	-	-	-	-	-	-	-		-	
	Natural therapeutic spas		-	-	-	-	-	-	1	-	-	-	-	-	1		1	
	Sanatoria		2	-	-	-	-	-	-	-	-	-	-	-	-		-	
	Hospice		-	-	-	1	-	-	1	-	-	-	-	-	-		-	
	Nursing care home		-	1	-	-	-	-	-	-	-	-	-	-	-		-	
in IGP IA	General hospitals														-			
	Specialised hospitals														4			
	Natural therapeutic spas														4			
	Sanatoria														-			
	Hospice														-			

* - with polyclinic

Annex 6c: Growth poles – Inpatient facilities

Region of Eastern Slovakia – NUTS II (ES): Upper territorial unit (UTU) – Prešov, Košice



Annex 6c: Growth poles – Inpatient facilities

Region of Eastern Slovakia – NUTS II (ES): Upper territorial unit (UTU) – Prešov, Košice

Region of Eastern Slovakia – NUTS II (ES)

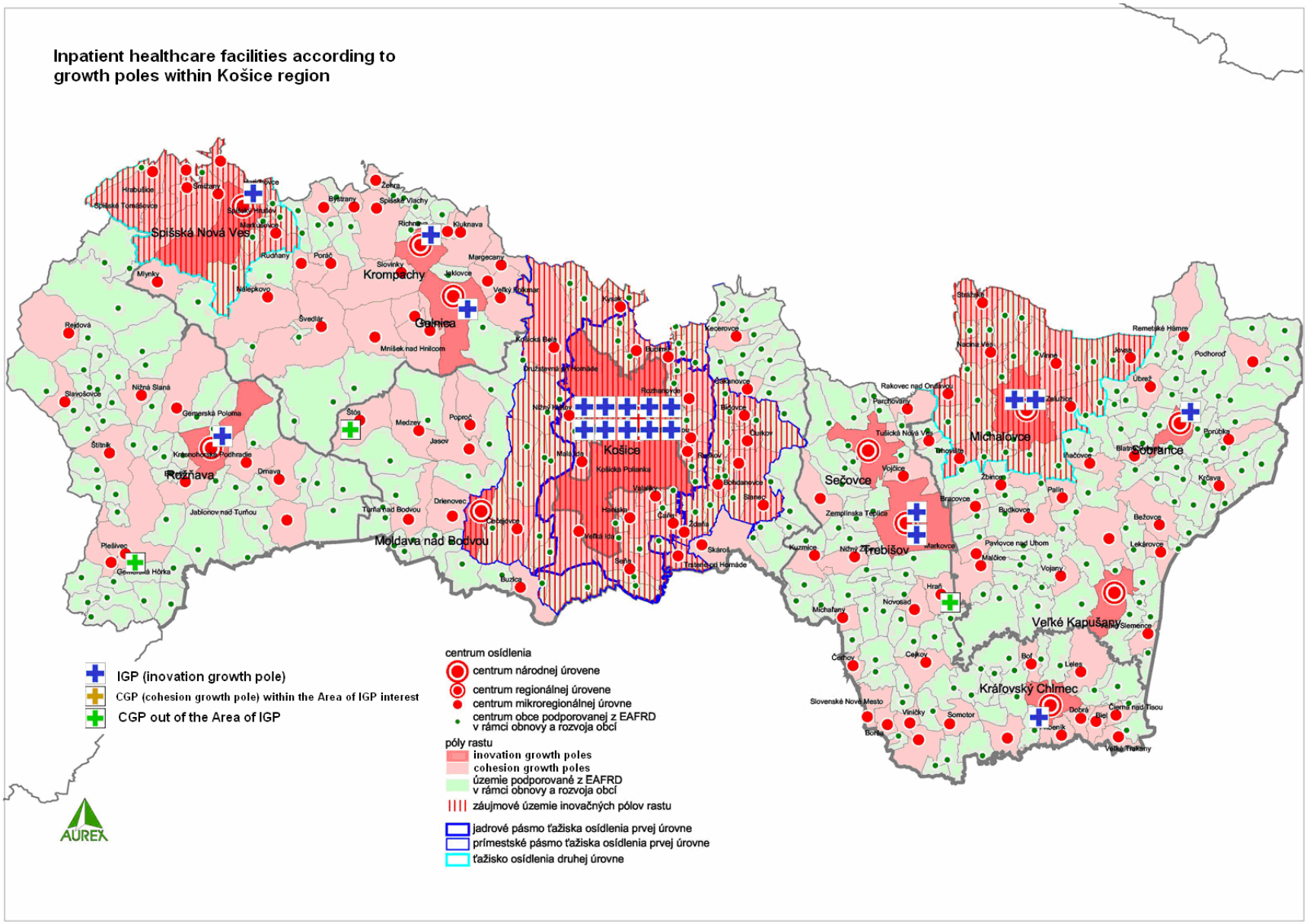
Growth poles – Inpatient facilities

		Upper territorial unit (UTU) Košice													
Growth poles	**Type of healthcare facility**	**Town:**	**KE**	**Michalovce**	**Spišská Nová Ves**	**Gelnica**	**Rožňava**	**Sobrance**	**Krompachy**	**Trebišov**	**Kráľovský Chlmec**		**Štós**	**Plešivec**	**Hraň**	**Total population**
		Population:	235006	39842	38727	6213	19226	6296	8870	22934	7966		766	2417	1566	389829
			Number													
IGP	General hospitals		3	1*	1*	1	1*	1*	1	1*	1*	outside IGP IA	-	-	-	
	Specialised hospitals		7	1	-	-	-	-	-	-	-		-	-	-	
	Natural therapeutic spas		-	-	-	-	-	-	-	-	-		1	-	-	
	Sanatoria		-	-	-	-	-	-	-	1	-		-	1	1	
	Hospice		-	-	-	-	-	-	-	-	-		-	-	-	

* - with polyclinic

Annex 6c: Growth poles – Inpatient facilities

Region of Eastern Slovakia – NUTS II (ES): Upper territorial unit (UTU) – Prešov, Košice



Annex 6d: Growth poles – Outpatient facilities

Region of Western Slovakia – NUTS II (WS): Upper territorial unit (UTU) – Trnava, Trenčín, Nitra

Region of Western Slovakia – NUTS II (WS)

Growth poles – Outpatient facilities

Upper territorial unit (UTU) Trnava

Growth poles	Type of healthcare facility	Town:	TT	DS	GA	HC	PE	SE	SI		Sereď	Šamorín		Banka	Dolný Štál	Holíč	Trhová Hradská	Trstice	Unín	Veľký Meder	Total population
		Population:	69140	23562	16000	23151	29957	21028	14984		17286	12339		2173	1942	11617	2176	3746	1180	8933	**259214**
			Number																		
IGP	Polyclinic, outpatient medical centre		12	8	3	1	4	7	1	in IGP IA	1	2	outside IGP IA	1	1	2	1	1	1	1	

Upper territorial unit (UTU) Trenčín

Growth poles	Type of healthcare facility	Town:	TN	PB	BN	DN	NM	PE	PD		Teplice		Podolie	Total population
		Population:	56850	42320	20725	25734	20827	24581	51596		4297		2056	**248986**
			Number											
IGP	Polyclinic, outpatient medical centre		5	1	1	2	4	1	3	in IGP IA	1	outside IGP IA	1	

Upper territorial unit (UTU) Nitra

Growth poles	Type of healthcare facility	Town:	NR	Komárno	NZ	Levice	Šala	TO	Zlaté Moravce	Štúrovo		Šurany		Demandice	Tekovské Lužany	Total population
		Population:	85742	36731	41469	36310	24506	28728	13554	11290		10426		1001	2937	**292694**
			Number													
IGP	Polyclinic, outpatient medical centre		5	1	3	3	1	6	2	1	in IGP IA	2	outside IGP IA	1	1	

Annex 6e: Growth poles – Outpatient facilities
Region of Central Slovakia – NUTS II (CS): Upper territorial unit (UTU) Banská Bystrica, Žilina

Region of Central Slovakia – NUTS II (CS)
Growth poles – Outpatient facilities

Upper territorial unit (UTU) Banská Bystrica

Growth poles	Type of healthcare facility	Town:	BB	LC	RS	ZV	Žarnovica	BR	DV	Revúca	Veľký Krtíš	Žiar nad Hronom		Sliač	Slovenská Ľupča	Fiľakovo		Nová baňa	Pohorelá	Kremnica	Tornaľa	Total population
		Population:	81704	28039	24520	43272	6522	22417	15043	13147	13932	19718		4853	3130	110329		7485	2552	5649	8016	**410328**
			Number																			
IGP	Polyclinic, outpatient medical centre		5	5	1	6	1	2	2	1	6	2	in IGP IA	1	1	4	outside IGP IA	1	1	1	1	

Upper territorial unit (UTU) Žilina

Growth poles	Type of healthcare facility	Town:	ZA	DK	LM	RK	NO	MT	CA	Turčianske Teplice	Kysucké Nové Mesto	Bytča		Liptovská Teplá	Liptovský Hrádok	Varín	Vrútky		Belá	Skalité	Turzovka	Krásno nad Kysucou	Zuberec	Total population
		Population:	85268	19883	32930	30058	8111	59449	26269	6929	16501	11506		903	8019	3747	7275		3346	5065	7792	7038	1814	**341903**
			Number																					
IGP	Polyclinic, outpatient medical centre		16	2	1	3	2	9	9	1	1	1	in IPGIA	1	1	1	1	outside IGP IA	1	1	1	1	1	

Annex 6f: Growth poles – Outpatient facilities
Region of Eastern Slovakia – NUTS II (ES): Upper territorial unit (UTU) – Prešov, Košice

Region of Eastern Slovakia – NUTS II (ES)
Growth poles – Outpatient facilities

Upper territorial unit (UTU) Prešov

Growth poles	Type of healthcare facility	Town:	PO	Humenné	Svidník	Sabinov		Lipany nad Torysou	Vysoké Tatry	Giraltovce	Total population
		Population:	91767	35008	12354	12 366		6302	4953	4186	166936
			Number								
IGP	Polyclinics, outpatient medical centre		5	2	1	1	outside IGP IA	1	1	1	

Upper territorial unit (UTU) Košice

Growth poles	Type of healthcare facility	Town:	KE	MI	SN	GL	RV	SO	Krompachy	TV	Moldava nad Bodvou	Sečovce	Veľké Kapušany		Trhovište		Bežovce	Nálepkovo	Palín	Porúbka	Streda nad Bodrogom	Veľký Horeš	Total population
		Population:	235006	39842	38727	6213	19226	6296	8870	22934	9807	7882	9536		1816		1007	2786	894	460	2430	960	**414692**
			Number																				
IGP	Polyclinics, outpatient medical centre		21	6	10	1	1	1	2	7	1	1	1	in IGP IA	1	outside IGP IA	1	1	1	1	2	1	

Annex 7:
Comments given by partners concerning the Operational Programme Healthcare

No.	Partner name	Comment text	Assessment	Justification
1.	**Ministry of Construction and regional development**	Chapter 1, page 4, the OPH (Operational Programme on Healthcare) global objective is not in accordance with the OP global objective defined in the National Strategy of Regional Development (NSRD) or the global objective which the Ministry of Health (MoH SR) requested in its comments to the NSRD. We request that this is harmonised and recommend that it is placed within quotes. (also apply to chapter 4.2)	A	Text modified.
2.	**Ministry of Construction and regional development**	The aim of Chapter 3.1 is to describe the current situation, not to specify what the government plans to do during its electoral term as this is a general document for the following 7 years, thus going beyond the current electoral term.	A	The present text is going to be deleted and amended.
3.	**Ministry of Construction and regional development**	The analytical parts should include a regional overview at least at the NUTS 2 level.	A	The regional overview is going to be included.
4.	**Ministry of Construction and regional development**	Chapter 3.3 – based on recommendations, it should include a regional overview at least at the NUTS 2 level.	A	The regional overview is going to be included.
5.	**Ministry of Construction and regional development**	In chapter 7.2.2 we request the description of complementarity not only with the OP on Education, but also the ROP, as interventions concerning secondary medical schools shall be carried out within the ROP (activities: reconstruction, extension, modernisation of buildings and procurement of equipment). As the description of the division lines and complementarity is described at the level of the priority axes in chapters 5.1 and 5.2, it should be described only at the OP level in this chapter.	A	Text amended.
6.	**Slovak Medical Chamber**	The scope of the Operational Programme description is extensive with general formulations concerning the specification and allocation of funds. Part 3 presents the data including the intentions of the Slovak government and the MoH SR rationalisation objectives. The inclusion of this information is not related to the rest of the OPH, it is not clear what funds shall be used for their implementation or whether the OPH funds should be used for these purposes.	A	The allocation of the OP funds is going to be narrowed with regard to the identified most frequent causes of death and growth poles.
7.	**Slovak Medical Chamber**	The content does not make it clear to what extent the OPH is related to previous the activities carried out in connection with using support funds in the past.	A	Text modified.
8.	**Slovak Medical Chamber**	As healthcare providers and health insurance companies paying for healthcare have all significant statistical and factual data concerning healthcare recipients and healthcare provision costs, relevant data can be analysed at least for the period between 2002 and 2005, providing clear development trends. On their basis, essential tasks can be defined to ensure	N	The analyses were based on officially available data.

Annex 7:
Comments given by partners concerning the Operational Programme Healthcare

		that the potentially available funds are used efficiently for improving the population health condition.		
9.	**Slovak Medical Chamber**	Given the relatively low amount of funds, we think that the scope of recipients should be narrowed. The main focus should clearly be on modernisation, restructuring, and extension of healthcare facilities in close connection with changes in the present structure of healthcare facilities, i.e. university hospitals, over-regional hospitals. The OPH should clearly define the use of these funds. It is also important to ensure that the system provides these funds directly without intermediaries.	N	Based on the analyses, the funds are targeted at growth poles and the diseases that are the most frequent causes of deaths.
10.	**Slovak Medical Chamber**	Cross-financing up to 10% is mentioned in part 5.1. An indicative list of activities given further in the text has a broad and unspecific scope. The total of EUR 19.3 million would be allocated for these OPH activities according to the financial allocation proposal. This amount seems too high.	N	Cross-financing is going to be used only in Priority Axis 2 for promotional activities in national projects.
11.	**Slovak Medical Chamber**	The list of beneficiaries is divided into the public and private sector. We do not consider this division appropriate as the criteria for beneficiaries at this priority axis level should not be based on the type of ownership. Associations, foundations, non-investment funds etc. should be beneficiaries at the Priority 2 level, not Priority 1, and it is necessary to consider, if these need to be taken into consideration at all due to the reduction of beneficiaries.	N	We do not want to restrict any beneficiary. The scope can be given in a specific call.
12.	**Slovak Medical Chamber**	The total sum of EUR 193 million only accounts for 77.2 %. Technical assistance – its provision specified in the OPH is going to require the allocation of EUR 7.9 million. In our opinion it would be appropriate to consider using existing capacities at the level of central authorities given the amount of funds (which is even more accentuated by their division for individual years).	N	The financial allocation for technical assistance is provided.
13.	**Slovak Medical Chamber**	A key question in this respect is the share of project co-funding by the state. Given the low total amount of funds, it seems necessary to ensure that this share is as high as possible. In this respect, the intended level of 15% is a minimal share.	N	Project co-funding is specified on the basis of the government-approved document "Strategy of Funding for the Structural Funds and the Cohesion Fund for the 2007 – 2013 programming period."
14.	**Slovak Medical Chamber**	The nearly even allocation of yearly spending for all years from 2007 to 2013 seems inefficient. As far as effectiveness is concerned, a more successful approach could be to increase spending for the nearest years especially for the modernisation of healthcare facilities under priority hospitals (why is the greatest percentage of allocated funds to be drawn in the last year? – see Table 21, page 48, chapter 8.1.).	N	The yearly allocation of spending is specified on the basis of the government-approved document "Strategy of Funding for the Structural Funds and the Cohesion Fund for the 2007 – 2013 programming period."
15.	**Slovak Medical Chamber**	A time schedule with the specification of financial costs would be necessary for implementation. It is important to ensure that the funds used in this way are going to lead to an early and efficient functioning of	N	The OPH structure does not require such detailed information.

Annex 7:
Comments given by partners concerning the Operational Programme Healthcare

		the system from 2007.		
16.	**Slovak Medical Chamber**	Section 9.6 also includes a possibility to submit national projects, it would be necessary to specify under which priority.	A	Text amended.
17.	**Slovak Medical Chamber**	Add an assessment of the present demand and adsorption of measures and an assessment of the number of adopted and supported intentions, and supplemented data in Sub-measure 3.1.2 Building and Development of Healthcare Infrastructure.	A	Text modified.
18.	**ANS**	As the government considers health and equality in the provision of healthcare and its accessibility to be a fundamental right, maintaining accessibility in terms of time and geography is of paramount importance. It cannot be said that only teaching hospitals and over-regional hospitals are the primary elements in the provision of healthcare, as initial diagnosis and differential diagnosis are carried out at general hospital levels.	A	General hospitals are not excluded; Priority Axis 1 focuses on general hospitals.
19.	**ANS**	With the aim of supporting the quality of healthcare, emphasis should be placed on implementing international standards for diagnostics and treatment.	N	Beyond the scope of the OPH The standards shall be implemented.
20.	**ANS**	The ANS requests a change in the financial plan as the allocated funds are low: Priority Axis 1. EUR 193 million..... EUR 220 million Priority Axis 2. EUR 49.1 million ..... EUR 25 million Technical assistance EUR 7.59 million ..... EUR 5 million	N	The division of allocations is based on the results of analyses.
21.	**ANS**	The ANS requests that the ANS representatives should participate in the preparation and implementation of the OP and the evaluation process.	A	The information concerning the participation of partners during implementation shall be added.
22.	**ANS**	The ANS also request that an ANS representative should be present in the monitoring committee.	A	The information concerning the participation of partners during implementation shall be added.
23.	**Self-governing region of Trnava**	We suggest an amendment to the priority axis to include support for healthcare facilities with the aim of increasing their functionality and energy efficiency, with the following framework activities: ▪ Investments in structural modifications of healthcare facilities, which increase the quality, functionality, and energy efficiency of buildings; ▪ Investments in the technical infrastructure of healthcare facilities; ▪ Investments in related inputs/support in the form of equipment, material, and technology.	Partially accepted	The energy efficiency area was explicitly included in Priority Axis 1.
24.	**Self-governing region of Trnava**	We suggest that upper territorial units should be added as beneficiaries at the Priority 3 level.	N	Technical assistance funds are only allocated for the managing authority (Ministry of Health).
25.	**Self-**	In the whole text of the OP the expression	N	The horizontal priority stated in

Annex 7:
Comments given by partners concerning the Operational Programme Healthcare

	governing region of Trnava	"Marginalized Roma communities" should be deleted and replaced with "Marginalized communities" as this wording is not in compliance with the Equality of Opportunities activity within the horizontal priorities.		the NSDR by the Slovak government" is "Marginalised Roma communities", not "Marginalised communities"
26.	**Office of the self-governing region of Žilina**	Add an assessment of the number of adopted and supported project intentions under Sub-measure 3.1.2 "Building and Development of Healthcare Infrastructure"	A	Text amended.
27.	**Office of the self-governing region of Žilina**	The proposed activities for Priority Axis 1 are redundantly interconnected with educational activities and the informatization of society, we therefore suggest the allocation of funds for educational purposes through the EST and ERDG (to ensure the percentage share of 90:10 for cross-funding)	A	Educational activities shall be dealt with in the OP on Education.
28.	**Office of the self-governing region of Žilina**	The changes of intra-organisational and inter-organisational processes should be implemented by means of the state budget. The EU funds should be primarily used for investments in inputs (the infrastructure, medical equipment purchase), which has a direct impact on the quality of the service provided to the final beneficiary – the citizen.	A	The OP funds shall be targeted at the healthcare infrastructure.
29.	**Office of the self-governing region of Žilina**	Give a more specific description of intended investments in the technical infrastructure for educational purposes (construction or reconstruction of education facilities).	N	It is within the scope of another OP (Education).
30.	**Office of the self-governing region of Žilina**	As far as beneficiaries from the private sector are concerned – include only those institutions with a registered activity in the healthcare area, which have been performing it for at least two years.	N	Such information can be given in the programme manual.
31.	**Office of the self-governing region of Žilina**	To ensure the equal treatment in the provision of finance for state, public, and non-state facilities.	N	The OPH does not specify allocations for state, public, and non-state facilities.

Annex 8

Description of particular diagnosis according to chapter ICD - 10

IX. Choroby obehovej sústavy (I00 – I99)	*Diseases of circulatory system*
I10 – I15 Hypertenzné choroby	*Hypertensive diseases*
I10 Esenciálna (primárna) hypertenzia	*Essential (primary) hypertension*
I20 – I25 Ischemické choroby srdca	*Ischaemic heart diseases*
I20 Angina pectoris – hrudníková angína	*Angina pectoris*
I21 Akútny infarkt myokardu	*Acute myocardial infarction*
I22 Ďalší infarkt myokardu	*Subsequent myocardial infarction*
I25 Chronická ischemická choroba srdca	*Chronic ischaemic heart disease*
I48 Predsieňová fibrilácia a flater	*Atrial fibrillation and flutter*
I50 Srdcové zlyhanie	*Heart failure*
I60 – I69 Cievne choroby mozgu	*Cerebrovascular diseases*
I63 Mozgový infarkt	*Cerebral infarction*
I64 Porážka – apoplexia – nešpecifikovaná ako krvácanie alebo infarkt	*Stroke, not specified as haemorrhage or infarction*
I70 Ateroskleróza	*Atherosclerosis*
II. Nádory (C00 – D48)	*(Neoplasms)*
C00 – C97 Zhubné nádory	*Malignant tumours*
C00 Zhubný nádor pery	*Malignant neoplasm of lip*
C01 Zhubný nádor koreňa jazyka	*Malignant neoplasm of base of tongue*
C02 Zhubný nádor iných a nešpecifikovaných častí jazyka	*Malignant neoplasm of other and unspecified parts of tongue*
C03 Zhubný nádor ďasna	*Malignant neoplasm of gum*

Annex 8

Description of particular diagnosis according to chapter ICD - 10

C04 Zhubný nádor ústnej spodiny *Malignant neoplasm of floor of mouth*

C05 Zhubný nádor podnebia *Malignant neoplasm of palate*

C06 Zhubný nádor iných a nešpecifikovaných častí úst

Malignant neoplasm of other and unspecified parts of mouth

C07 Zhubný nádor príušnej žľazy *Malignant neoplasm of parotid gland*

C08 Zhubný nádor iných a nešpecifikovaných veľkých slinných žliaz

Malignant neoplasm of other and unspecified major salivary glands

C09 Zhubný nádor mandlí *Malignant neoplasm of tonsil*

C10 Zhubný nádor ústnej časti hltana (orofaryngu)

Malignant neoplasm of oropharynx

C11 Zhubný nádor nosohltana (nazofaryngu) *Malignant neoplasm of nasopharynx*

C12 Zhubný nádor hruškovitého zálivu (sinus pyriformis)

Malignant neoplasm of pyriform sinus

C13 Zhubný nádor hrtanovej časti hltana (hypofaryngu)

Malignant neoplasm of hypopharynx

C14 Zhubný nádor iných a nepresne určených lokalizácií v oblasti pery, ústnej dutiny a hltana

Malignant neoplasm of other and ill-defined sites in the lip, oral cavity and pharynx

C15 Zhubný nádor pažeráka *Malignant neoplasm of oesophagus*

C16 Zhubný nádor žalúdka *Malignant neoplasm of stomach*

C17 Zhubný nádor tenkého čreva *Malignant neoplasm of small intestine*

C18 Zhubný nádor hrubého čreva *Malignant neoplasm of colon*

C19 Zhubný nádor rektosigmoidového spojenia *Malignant neoplasm of rectosigmoid junction*

Annex 8

Description of particular diagnosis according to chapter ICD - 10

C20 Zhubný nádor konečníka	*Malignant neoplasm of rectum*
C21 Zhubný nádor anusu a análneho kanála	*Malignant neoplasm of anus and anal canal*
C22 Zhubný nádor pečene a vnútropečeňových žlčových ciest	*Malignant neoplasm of liver and intrahepatic bile ducts*
C23 Zhubný nádor žlčníka	*Malignant neoplasm of gallbladder*
C24 Zhubný nádor iných a nešpecifikovaných častí žlčových vývodov	*Malignant neoplasm of other and unspecified parts of biliary tract*
C25 Zhubný nádor podžalúdkovej žľazy	*Malignant neoplasm of pancreas*
C26 Zhubný nádor iných a nepresne určených častí tráviacich orgánov	*Malignant neoplasm of other and ill-defined digestive organs*
C30 Zhubný nádor nosovej dutiny a stredného ucha	*Malignant neoplasm of nasal cavity and middle ear*
C31 Zhubný nádor prinosových dutín	*Malignant neoplasm of accessory sinuses*
C32 Zhubný nádor hrtana	*Malignant neoplasm of larynx*
C33 Zhubný nádor priedušnice	*Malignant neoplasm of trachea*
C34 Zhubný nádor priedušiek a pľúc	*Malignant neoplasm of bronchus and lung*
C37 Zhubný nádor týmusu	*Malignant neoplasm of thymus*
C38 Zhubný nádor srdca, medzipľúcia (mediastína) a pohrudnice	*Malignant neoplasm of heart, mediastinum and pleura*
C39 Zhubný nádor iných a nepresne určených miest dýchacej sústavy a vnútrohrudníkových orgánov	

Annex 8

Description of particular diagnosis according to chapter ICD - 10

Malignant neoplasm of other and ill-defined sites in the respiratory system and intrathoracic organs

C40 Zhubný nádor kosti a kĺbovej chrupky končatín

Malignant neoplasm of bone and articular cartilage of limbs

C41 Zhubný nádor kosti a kĺbovej chrupky iných a nešpecifikovaných lokalizácií

Malignant neoplasm of bone and articular cartilage of other and unspecified sites

C43 Malígny melanóm kože *Malignant melanoma of skin*

C44 Iné zhubné nádory kože *Other malignant neoplasms of skin*

C45 Mezotelióm *Mesothelioma*
C46 Kaposiho sarkóm *Kaposi´s sarcoma*

C47 Zhubný nádor periférnych nervov a autonómneho nervového systému

Malignant neoplasm of peripheral nerves and autonomic nervous system

C48 Zhubný nádor retroperitonea a peritonea

Malignant neoplasm of retroperitoneum and peritoneum

C49 Zhubný nádor iného spojivového a mäkkého tkaniva

Malignant neoplasm of other connective and soft tissue

C50 Zhubný nádor prsníka *Malignant neoplasm of breast*

C51 Zhubný nádor vulvy *Malignant neoplasm of vulva*
C52 Zhubný nádor pošvy *Malignant neoplasm of vagina*

C53 Zhubný nádor krčka maternice *Malignant neoplasm of cervix uteri*

C54 Zhubný nádor tela maternice *Malignant neoplasm of corpus uteri*

C55 Zhubný nádor neurčenej časti maternice

Malignant neoplasm of uterus, part unspecified

C56 Zhubný nádor vaječníka *Malignant neoplasm of ovary*

Annex 8

Description of particular diagnosis according to chapter ICD - 10

C57 Zhubný nádor iných a nešpecifikovaných ženských pohlavných orgánov

Malignant neoplasm of other and unspecified female genital organs

C58 Zhubný nádor placenty (postieľky) *Malignant neoplasm of placenta*

C60 Zhubný nádor penisu *Malignant neoplasm of penis*

C61 Zhubný nádor predstojnice (prostaty) *Malignant neoplasm of prostate*

C62 Zhubný nádor semenníkov *Malignant neoplasm of testis*

C63 Zhubný nádor iných a nešpecifikovaných mužských pohlavných orgánov

Malignant neoplasm of other and unspecified male genital organs

C64 Zhubný nádor obličky okrem obličkovej panvičky

Malignant neoplasm of kidney, except renal pelvis

C65 Zhubný nádor obličkovej panvičky *Malignant neoplasm of renal pelvis*

C66 Zhubný nádor močovodu *Malignant neoplasm of ureter*

C67 Zhubný nádor močového mechúra *Malignant neoplasm of bladder*

C68 Zhubný nádor iných a nešpecifikovaných močových orgánov

Malignant neoplasm of other and unspecified urinary organs

C69 Zhubný nádor oka a očných adnexov *Malignant neoplasm of eye and adnexa*

C70 Zhubný nádor mozgových plien (meningov) *Malignant neoplasm of meninges*

C71 Zhubný nádor mozgu *Malignant neoplasm of brain*

C72 Zhubný nádor miechy, hlavových nervov a iných častí centrálneho nervového systému

Malignant neoplasm of spinal cord, cranial nerves and other parts of central nervous system

C73 Zhubný nádor štítnej žľazy *Malignant neoplasm of thyroid gland*

C74 Zhubný nádor nadobličky *Malignant neoplasm of adrenal gland*

C75 Zhubný nádor iných žliaz s vnútorným vylučovaním a blízkych štruktúr

Annex 8

Description of particular diagnosis according to chapter ICD - 10

	Malignant neoplasm of other endocrine glands and related structures
C76 Zhubný nádor inej a bližšie neurčenej lokalizácie	
	Malignant neoplasm of other and ill-defined sites
C77 Sekundárny a nešpecifikovaný zhubný nádor lymfatických uzlín	
	Secondary and unspecified malignant neoplasm of lymph nodes
C78 Sekundárny zhubný nádor dýchacích a tráviacich orgánov	
	Secondary malignant neoplasm respiratory and digestive organs
C79 Sekundárny zhubný nádor na iných miestach	
	Secondary malignant neoplasm on other places
C80 Zhubný nádor bez určenia lokalizácie	*Malignant neoplasm without specification of site*
C81 Hodgkinova choroba	*Hodgkin‘s disease*
C82 Folikulárny [nodulárny] non-Hodgkinov lymfóm	
	Follicular [nodular] non-Hodgkin’s Lymphoma
C83 Difúzny non-Hodgkinov lymfóm	*Diffuse non-Hodgkin‘s lymphoma*
C84 Periférne a kožné T-bunkové lymfómy	*Peripheral and cutaneous T-cell lymphomas*
C85 Iné a nešpecifikované typy non-Hodgkinovho lymfómu	
	Other and unspecified types of non-Hodgkin’s lymphoma
C88 Zhubné imunoproliferačné choroby	*Malignant immunoproliferative diseases*
C90 Mnohonásobný myelóm (plazmocytóm) a zhubné nádory z plazmatických buniek	
	Multiple myeloma and malignant plasma cell neoplasms

Annex 8

Description of particular diagnosis according to chapter ICD - 10

C91 Lymfatická leukémia	*Lymphoid leukaemia*
C92 Myeloická leukémia	*Myeloid leukaemia*
C93 Monocytová leukémia	*Monocytic leukaemia*
C94 Iné leukémie so špecifikovaným typom buniek	*Other leukaemias of specified cell type*
C95 Leukémia nešpecifikovaného bunkového typu	*Leukaemia of unspecified cell type*
C96 Iné a nešpecifikované zhubné nádory lymfatického, krvotvorného a príbuzného tkaniva	*Other and unspecified malignant neoplasms of lymphoid, haematopoietic and related tissue*
C97 Zhubné nádory s viacnásobným primárnym výskytom na rozličných miestach	*Malignant tumours of multiple primary occurrence at different places*
D00 Carcinoma in situ ústnej dutiny, pažeráka a žalúdka	*Carcinoma in situ of oral cavity, oesophagus and stomach*
D01 Carcinoma in situ iných a nešpecifikovaných tráviacich orgánov	*Carcinoma in situ of other and unspecified digestive organs*
D02 Carcinoma in situ stredného ucha a dýchacej sústavy	*Carcinoma in situ of middle ear and respiratory system*
D03 Melanóm in situ	*Melanoma in situ*
D04 Carcinoma in situ kože	*Carcinoma in situ of skin*
D05 Carcinoma in situ prsníka	*Carcinoma in situ of breast*
D06 Carcinoma in situ krčka maternice	*Carcinoma in situ of cervix uteri*
D07 Carcinoma in situ iných a nešpecifikovaných pohlavných orgánov	

Annex 8

Description of particular diagnosis according to chapter ICD - 10

	Carcinoma in situ of other and unspecified genital organs
D09 Carcinoma in situ iných a nešpecifikovaných lokalizácií	
	Carcinoma in situ of other and unspecified sites
D25 Leiomyóm maternice	*Leiomyoma of uterus*

XX. Vonkajšie príčiny chorobnosti a úmrtnosti (V01 – Y98)
External causes of morbidity and mortalit

V01 – V99 Dopravné nehody	*Transport accidents*
W75 – W84 Iné náhodné udusenia	*Other accidental threats to breathing*

XIX. Poranenia, otravy a niektoré iné následky vonkajších príčin (S00 – T98)
Injury, poisoning and certain other consequences of external causes

S06 Vnútrolebkové poranenie	*Intracranial injury*
S72 Zlomenina stehnovej kosti	*Fracture of femur*
S82 Zlomenina predkolenia vrátane členka	*Fracture of lower leg, including ankle*

X. Choroby dýchacej sústavy (J00 – J99) *Diseases of the respiratory system*

J10 Chrípka vyvolaná identifikovaným vírusom chrípky	
	Influenza due to identified influenza virus
J12 – J18 Zápal pľúc	*Pneumonia*
J18 Zápal pľúc vyvolaný nešpecifikovaným mikroorganizmom	
	Pneumonia, organism unspecified
J20 Akútny zápal priedušiek –	bronchitis acuta *Acute bronchitis*

Annex 8

Description of particular diagnosis according to chapter ICD - 10

J30 Vazomotorická a alergická nádcha (rinitída) *Vasomotor and allergic rhinitis*

J35 Chronické choroby mandlí a adenoidného tkaniva

Chronic diseases of tonsils and adenoids

J45 Astma – záduch *Asthma*

XI. Choroby tráviacej sústavy (K00 – K93) *Diseases of the digestive system*

K30 Dyspepsia *Dyspepsia*

K35 Akútny zápal červovitého prívesku – appendicitis acuta *Acute appendicitis*

K40 Slabinová prietrž – hernia inguinalis *Inguinal hernia*

K70 – K77 Choroby pečene *Diseases of liver*

K80 Žlčové kamene – cholelithiasis *Cholelithiasis*

K90 Črevná malabsorpcia *Intestinal malabsorption*

Annex 9:

Number of hospitalisations for the Slovak population according to gender and the ICD-10 between 2000 and 2005

Number of hospitalisations according to the ICD –10 chapter in 2000

Diagnosis	Men		Women		Slovak population	
	number	%	number	%	number	%
Circulatory system diseases	74,685	16.47	77,017	12.62	151,702	14.26
Carcinomas	44,002	9.70	53,261	8.73	97,263	9.14
External causes of diseases and deaths	53,416	11.78	29,934	4.91	83,350	7.84
Respiratory system diseases	45,465	10.03	37,085	6.08	82,550	7.76
Digestive system diseases	57,019	12.58	57,032	9.35	114,051	10.72
Total for selected diagnoses	274,587	60.56	254,329	41.68	528,916	49.73
All hospitalisations	453,430	100.00	610,181	100.00	1,063,611	100.00

Source: Medical Yearbook, Slovakia 2005

Number of hospitalisations according to the ICD –10 chapter in 2001

Diagnosis	Men		Women		Slovak population	
	number	%	number	%	number	%
Circulatory system diseases	78,514	16.76	81,496	13.15	160,010	14.70
Carcinomas	44,706	9.54	53,995	8.71	98,701	9.07
External causes of diseases and deaths	54,348	11.60	30,075	4.85	84,423	7.76
Respiratory system diseases	45,728	9.76	36,303	5.86	82,031	7.54
Digestive system diseases	58,465	12.48	58,366	9.42	116,831	10.74
Total for selected diagnoses	281,761	60.14	260,235	41.99	541,996	49.81
All hospitalisations	468,477	100.00	619,703	100.00	1,088,180	100.00

Source: Medical Yearbook, Slovakia 2005

Number of hospitalisations according to the ICD –10 chapter in 2002

Diagnosis	Men		Women		Slovak population	
	number	%	number	%	number	%
Circulatory system diseases	75,562	17.00	79,489	13.35	155,051	14.91
Carcinomas	42,008	9.45	50,014	8.40	92,022	8.85
External causes of diseases and deaths	51,878	11.67	30,023	5.04	81,901	7.87
Respiratory system diseases	42,670	9.60	34,250	5.75	76,920	7.40
Digestive system diseases	56,187	12.64	55,778	9.37	111,965	10.76
Total for selected diagnoses	268,305	60.35	249,554	41.90	517,859	49.79
All hospitalisations	444,564	100.00	595,589	100.00	1,040,153	100.00

Source: Medical Yearbook, Slovakia 2005

Annex 9:

Number of hospitalisations for the Slovak population according to gender and the ICD-10 between 2000 and 2005

Number of hospitalisations according to the ICD –10 chapter in 2003

Diagnosis	Men		Women		Slovak population	
	number	%	number	%	number	%
Circulatory system diseases	74,094	17.24	77,885	13.40	151,979	15.04
Carcinomas	40,205	9.36	49,022	8.44	89,227	8.83
External causes of diseases and deaths	51,925	12.08	30,380	5.23	82,305	8.14
Respiratory system diseases	40,935	9.53	33,134	5.70	74,069	7.33
Digestive system diseases	54,080	12.58	53,446	9.20	107,526	10.64
Total for selected diagnoses	261,239	60.79	243,867	41.97	505,106	49.97
All hospitalisations	429,759	100.00	581,046	100.00	1,010,805	100.00

Source: Medical Yearbook, Slovakia 2005

Number of hospitalisations according to the ICD –10 chapter in 2004

Diagnosis	Men		Women		Slovak population	
	number	%	number	%	number	%
Circulatory system diseases	77,122	17.78	80,386	13.70	157,508	15.43
Carcinomas	41,999	9.68	49,625	8.46	91,624	8.98
External causes of diseases and deaths	52,941	12.21	31,759	5.41	84,700	8.30
Respiratory system diseases	41,100	9.48	33,875	5.77	74,975	7.35
Digestive system diseases	51,086	11.78	51,346	8.75	102,432	10.04
Total for selected diagnoses	264,248	60.93	246,991	42.08	511,239	50.09
All hospitalisations	433,685	100.00	586,902	100.00	1,020,587	100.00

Source: Medical Yearbook, Slovakia 2005

Number of hospitalisations according to the ICD –10 chapter in 2005

Diagnosis	Men		Women		Slovak population	
	number	%	number	%	number	%
Circulatory system diseases	79,478	17.41	85,062	13.86	164,540	15.37
Carcinomas	44,033	9.65	51,001	8.31	95,034	8.88
External causes of diseases and deaths	54,696	11.98	34,112	5.56	88,808	8.30
Respiratory system diseases	48,050	10.53	41,396	6.74	89,446	8.36
Digestive system diseases	51,607	11.31	50,151	8.17	101,758	9.51
Total for selected diagnoses	277,864	60.88	261,722	42.64	539,586	50.42
All diagnoses	456,447	100.00	613,821	100.00	1,070,268	100.00

Source: Medical Yearbook, Slovakia 2005

Annex 10

Requierements on new health equipment according to region and equipment focus on selected diagnosis

Circulatory diseases									
Equipment	**TT**	**TN**	**NR**	**BB**	**ZA**	**PO**	**KE**	**BA**	**SR**
Blood gas analyzer Analyzátor krvných plynov	19	8	10	3	3	17	11	-2	70
Clinical Chemistry analyzer Analyzátor chem.prvkov	-4	1	-35	-6	-18	-29	-25	-71	-186
Hematology Analyzer Prístroj na analýzu krvného obrazu	19	-8	4	-1	2	-4	12	-23	2
Defibrillator / Monitor Defibrilátor -Defibrilátor s monitorom	63	86	49	-15	34	33	22	-64	210
MRI - Magnetic Resonance Imaging -Prístroj na magnetickú rezonanciu	2	-17	2	2	1	1	-2	1	-10
Patient Monitor- Prístroj na monitorovanie pacienta	198	174	181	155	180	183	161	122	1353
Refrigerator, Blood Bank-Zariadenie na získanie veľmi nízkych teplôt, Krvná banka	21	5	12	15	4	9	11	9	87
Ventilator, Adult - Umelá ventilácia - dospelí	92	103	66	12	52	56	61	5	446
Ventilator, Pediatric- Umelá ventilácia - deti	40	33	35	26	31	25	25	-17	199
X - Ray Hemodynamic Unit- RTG	10	-2	9	8	10	9	8	7	60
X - Ray Unit- RTG prístroj	22	13	2	-5	-15	-27	-17	-9	-34
X - Ray Unit, Mobile, Image Intens- Mobilný RTG prístroj	35	33	18	25	16	26	24	3	181
CT Scanner - CT-skener	7	4	4	3	2	0	4	0	23
Angiography, Digital Unit (DSA)- Digitálny prístroj na angiografiu-vyšetrenie ciev	3	-2	-1	-3	1	-1	0	0	-3
Echograph, General Purpose - Sonograf, Všeobecné použitie	31	37	1	12	11	0	-2	-29	60
Electrocardiograph - EKG	71	100	32	-1	-25	14	-1	-72	117
Tonometer, Electronic - Elektronický tlakomer	20	-12	19	16	19	15	16	2	96
Anesthesia Unit- Prístroj na celkovú anestéziu	71	67	14	2	-23	6	17	-70	83
Extracorporeal Unit - Mimotelová jednotka / pripojená k samostatnému počítaču	2	-1	1	1	2	1	1	0	8
Operating Table- Operačný stôl	64	52	56	47	60	54	45	20	399
Surgical Lamp, Ceiling - Chirurgická lampa - osvetlenie	64	49	58	50	61	56	49	14	402
X - Ray Fluoroscopic Unit, Image Intents - RTG so zníženými dávkami žiarenia	9	8	8	8	9	9	8	5	65
Sterilizer, Ethylene Oxide Sterilizátor na etylénoxyd	10	7	6	7	7	8	7	4	57
Sterilizer, Plasma Plazmový sterilizátor	10	7	9	7	9	5	8	4	60
Sterilizer, Steam Parný sterilizátor- Autokláv	19	17	-15	-22	-51	-40	-9	-42	-142

Tumors									
Equipment	**TT**	**TN**	**NR**	**BB**	**ZA**	**PO**	**KE**	**BA**	**SR**
Hematology Analyzer Prístroj na analýzu krvného obrazu	19	-8	4	-1	2	-4	12	-23	2
MRI - Magnetic Resonance Imaging -Prístroj na magnetickú rezonanciu	2	-17	2	2	1	1	-2	1	-10
Mammography Unit - Prístroj na mamografiu/vyšetr.prsníkov	9	8	6	7	3	3	3	3	43
Microscope, Electronic - Elektrónový mikroskop (na histologické vyšetrenie)	1	1	-6	-18	-16	-19	0	-34	-94
X - Ray Unit- RTG prístroj	22	13	2	-5	-15	-27	-17	-9	-34
X - Ray Unit, Mobile, Image Intens- Mobilný RTG prístroj	35	33	18	25	16	26	24	3	181
CT Scanner - CT-skener	7	4	4	3	2	0	4	0	23
Linear Accelerator Lineárny urýchlovač	5	-10	4	3	3	3	3	1	12
Echograph, General Purpose - Sonograf, Všeobecné použitie	31	37	1	12	11	0	-2	-29	60

Annex 10

Requierements on new health equipment according to region and equipment focus on selected diagnosis

Ecograph, Mammography - Prístroj na mamografiu- sono	10	8	10	8	10	9	6	3	65
Electroencephalograph EEG- elektropencefalograf- možno aj nádory...	18	13	13	11	12	6	5	6	85
Anesthesia Unit- Prístroj na celkovú anestéziu	71	67	14	2	-23	6	17	-70	83
Gamma Camera - Gama kamera - diagnostický systém na snímanie vnútorných orgánov pomocou rádioaktívnych indikátorov	2	2	4	0	3	0	-1	1	11
Laser, Surgical - Chirurgický Laser	10	8	8	5	8	5	6	-3	48
Operating Table- Operačný stôl	64	52	56	47	60	54	45	20	399
Surgical Lamp, Ceiling - Chirurgická lampa - osvetlenie	64	49	58	50	61	56	49	14	402
X - Ray Fluoroscopic Unit, Image Intents - RTG so zníženými dávkami žiarenia	9	8	8	8	9	9	8	5	65
Sterilizer, Ethylene Oxide Sterilizátor na etylénoxyd	10	7	6	7	7	8	7	4	57
Sterilizer, Plasma Plazmový sterilizátor	10	7	9	7	9	5	8	4	60
Sterilizer, Steam Parný sterilizátor- Autokláv	19	17	-15	-22	-51	-40	-9	-42	-142

External cause of diseases and deaths									
Equipment	**TT**	**TN**	**NR**	**BB**	**ZA**	**PO**	**KE**	**BA**	**SR**
Hematology Analyzer Prístroj na analýzu krvného obrazu	19	-8	4	-1	2	-4	12	-23	2
MRI - Magnetic Resonance Imaging -Prístroj na magnetickú rezonanciu	2	-17	2	2	1	1	-2	1	-10
X - Ray Unit- RTG prístroj	22	13	2	-5	-15	-27	-17	-9	-34
X - Ray Unit, Mobile, Image Intens- Mobilný RTG prístroj	35	33	18	25	16	26	24	3	181
CT Scanner - CT-skener	7	4	4	3	2	0	4	0	23
Echograph, General Purpose - Sonograf, Všeobecné použitie	31	37	1	12	11	0	-2	-29	60
Anesthesia Unit- Prístroj na celkovú anestéziu	71	67	14	2	-23	6	17	-70	83
Operating Table- Operačný stôl	64	52	56	47	60	54	45	20	399
Surgical Lamp, Ceiling - Chirurgická lampa - osvetlenie	64	49	58	50	61	56	49	14	402
X - Ray Fluoroscopic Unit, Image Intents - RTG so zníženými dávkami žiarenia	9	8	8	8	9	9	8	5	65
Sterilizer, Ethylene Oxide Sterilizátor na etylénoxyd	10	7	6	7	7	8	7	4	57
Sterilizer, Plasma Plazmový sterilizátor	10	7	9	7	9	5	8	4	60
Sterilizer, Steam Parný sterilizátor- Autokláv	19	17	-15	-22	-51	-40	-9	-42	-142

Respiratory system diseases									
Equipment	**TT**	**TN**	**NR**	**BB**	**ZA**	**PO**	**KE**	**BA**	**SR**
Blood gas analyzer Analyzátor krvných plynov	19	8	10	3	3	17	11	-2	70
Clinical Chemistry analyzer Analyzátor chem.prvkov	-4	1	-35	-6	-18	-29	-25	-71	-186
Hematology Analyzer Prístroj na analýzu krvného obrazu	19	-8	4	-1	2	-4	12	-23	2
MRI - Magnetic Resonance Imaging -Prístroj na magnetickú rezonanciu	2	-17	2	2	1	1	-2	1	-10
Patient Monitor- Prístroj na monitorovanie pacienta	198	174	181	155	180	183	161	122	1353
Ventilator, Adult - Umelá ventilácia - dospelí	92	103	66	12	52	56	61	5	446
Ventilator, Pediatric- Umelá ventilácia - deti	40	33	35	26	31	25	25	-17	199
X - Ray Unit- RTG prístroj	22	13	2	-5	-15	-27	-17	-9	-34
X - Ray Unit, Mobile, Image Intens- Mobilný RTG prístroj	35	33	18	25	16	26	24	3	181
CT Scanner - CT-skener	7	4	4	3	2	0	4	0	23

Annex 10

Requierements on new health equipment according to region and equipment focus on selected diagnosis

Echograph, General Purpose - Sonograf, Všeobecné použitie	31	37	1	12	11	0	-2	-29	60
Endoscopic Unit Prístroj na endoskopiu - pojem je to všeobecný- ale endoskopiu čoho?	20	13	16	12	-4	5	2	5	70
Endoscopy, Video System- Videosystém pre endoskopiu	8	8	6	-3	-1	1	4	-16	8
Tonometer, Electronic - Elektronický tlakomer	20	-12	19	16	19	15	16	2	96
Anesthesia Unit- Prístroj na celkovú anestéziu	71	67	14	2	-23	6	17	-70	83
Extracorporeal Unit - Mimotelová jednotka / pripojená k samostatnému počítaču	2	-1	1	1	2	1	1	0	8
Operating Table- Operačný stôl	64	52	56	47	60	54	45	20	399
Surgical Lamp, Ceiling - Chirurgická lampa - osvetlenie	64	49	58	50	61	56	49	14	402
X - Ray Fluoroscopic Unit, Image Intents - RTG so zníženými dávkami žiarenia	9	8	8	8	9	9	8	5	65
Sterilizer, Ethylene Oxide Sterilizátor na etylénoxyd	10	7	6	7	7	8	7	4	57
Sterilizer, Plasma Plazmový sterilizátor	10	7	9	7	9	5	8	4	60
Sterilizer, Steam Parný sterilizátor- Autokláv	19	17	-15	-22	-51	-40	-9	-42	-142

Digestive system diseases									
Equipment	**TT**	**TN**	**NR**	**BB**	**ZA**	**PO**	**KE**	**BA**	**SR**
Clinical Chemistry analyzer Analyzátor chem.prvkov	-4	1	-35	-6	-18	-29	-25	-71	-186
Hematology Analyzer Prístroj na analýzu krvného obrazu	19	-8	4	-1	2	-4	12	-23	2
MRI - Magnetic Resonance Imaging -Prístroj na magnetickú rezonanciu	2	-17	2	2	1	1	-2	1	-10
X - Ray Unit- RTG prístroj	22	13	2	-5	-15	-27	-17	-9	-34
X - Ray Unit, Mobile, Image Intens- Mobilný RTG prístroj	35	33	18	25	16	26	24	3	181
CT Scanner - CT-skener	7	4	4	3	2	0	4	0	23
Echograph, General Purpose - Sonograf, Všeobecné použitie	31	37	1	12	11	0	-2	-29	60
Endoscope, Flexible - Fibroskopický prístroj - vyšetrenie zažívacieho traktu	59	51	39	-37	28	36	37	18	231
Endoscopic Unit Prístroj na endoskopiu - pojem je to všeobecný- ale endoskopiu čoho?	20	13	16	12	-4	5	2	5	70
Endoscopy, Video System- Videosystém pre endoskopiu	8	8	6	-3	-1	1	4	-16	8
Anesthesia Unit- Prístroj na celkovú anestéziu	71	67	14	2	-23	6	17	-70	83
Laparoscopy Unit - Laparoskop	3	6	5	2	-3	-8	-3	-6	-3
Lithotriptor, Extracorporal-Extrakorporeálny / mimo tela/ Litotriptor-odstaň.žlč.,močov. Kameňov	1	1	0	1	-1	0	-1	0	-2
Operating Table- Operačný stôl	64	52	56	47	60	54	45	20	399
Surgical Lamp, Ceiling - Chirurgická lampa - osvetlenie	64	49	58	50	61	56	49	14	402
X - Ray Fluoroscopic Unit, Image Intents - RTG so zníženými dávkami žiarenia	9	8	8	8	9	9	8	5	65
Sterilizer, Ethylene Oxide Sterilizátor na etylénoxyd	10	7	6	7	7	8	7	4	57
Sterilizer, Plasma Plazmový sterilizátor	10	7	9	7	9	5	8	4	60
Sterilizer, Steam Parný sterilizátor- Autokláv	19	17	-15	-22	-51	-40	-9	-42	-142

Annex 10

Requierements on new health equipment according to region and equipment focus on selected diagnosis

Other diseases									
Equipment	**TT**	**TN**	**NR**	**BB**	**ZA**	**PO**	**KE**	**BA**	**SR**
Incubator, Infant Inkubátor pre deti	9	32	-1	-1	9	-2	-13	-55	-24
Water Purification System Systém na čistenie vody	21	17	11	14	17	14	13	11	119
Angiography, Opthalmology - Prístroj pre angiologickú oftalmológiu /vyšetrenie ciev oka/	10	8	9	5	8	8	7	5	61
Ecograph, Opthalmologic- Prístroj sonografický pre očné lekárstvo/oftalmológia/	9	-34	7	4	9	8	3	5	12
Electromyograph - EMG - elektromyograf/ vyšetrenie svalstva/	5	7	5	7	2	2	2	-1	30
Hemodyalisis Unit - Prístroj na hemodialýzu	142	128	140	106	137	129	73	83	940
Slit Lamp - Štrbinová lampa - pozorujú sa predné štruktúry oka	15	17	11	-4	12	12	4	-8	60
Arthroscopy Unit - Arthroskop - prístroj na vyšetrenie kĺbov optickým systémom	8	8	7	4	3	3	4	-5	33
Dental Unit - Stomatologická súprava	62	52	55	47	54	50	-11	43	352
Incubators, Infant, Intensive Care- Detský inkubátor- stály monitoring pacienta/myslím,že sú to aj "Detské ostrovy"/	43	27	38	34	35	28	17	28	251
Ventilator, Neonatal - Novorodenecký ventilátor? Neviem presný výraz...prístroj na cirkuláciu vzduchu v inkubátore	28	21	19	21	21	19	15	14	160