

Vol. 4 No. 3 2002

European
Observatory
on Health Care Systems



Vol. 4 No. 3 2002

Health Care Systems in Transition

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Written by

**Tit Albreht, Marjan Cesen, Don Hindle,
Elke Jakubowski, Boris Kramberger,
Vesna Kerstin Petric, Marjan Premik
and Martin Toth**

Edited by

Elke Jakubowski

Slovenia

2002



The European Observatory on Health Care Systems is a partnership between the World Health Organization Regional Office for Europe, the Government of Greece, the Government of Norway, the Government of Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

Keywords

DELIVERY OF HEALTH CARE
EVALUATION STUDIES
FINANCING, HEALTH
HEALTH CARE REFORM
HEALTH SYSTEM PLANS – organization and administration
SLOVENIA

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Foreword

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Care Systems.

The Observatory is a unique undertaking that brings together the WHO Regional Office for Europe, the Governments of Greece, Norway and Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.

The aim of the HiT initiative is to provide relevant comparative information to support policy-makers and analysts in the development of health care systems and reforms in the countries of Europe and beyond. The HiT profiles are building blocks that can be used to:

- learn in detail about different approaches to the financing, organization and delivery of health care services;
- describe accurately the process and content of health care reform programmes and their implementation;
- highlight common challenges and areas that require more in-depth analysis;
- provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in the different countries of the European Region.

The HiT profiles are produced by country experts in collaboration with the research directors and staff of the European Observatory on Health Care Systems. In order to maximize comparability between countries, a standard template and questionnaire have been used. These provide detailed guidelines

and specific questions, definitions and examples to assist in the process of developing a HiT. Quantitative data on health services are based on a number of different sources in particular the WHO Regional Office for Europe health for all database, Organisation for Economic Cooperation and Development (OECD) health data and the World Bank.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health care system and the impact of reforms. Most of the information in the HiTs is based on material submitted by individual experts in the respective countries, which is externally reviewed by experts in the field. Nonetheless, some statements and judgements may be coloured by personal interpretation. In addition, the absence of a single agreed terminology to cover the wide diversity of systems in the European Region means that variations in understanding and interpretation may occur. A set of common definitions has been developed in an attempt to overcome this, but some discrepancies may persist. These problems are inherent in any attempt to study health care systems on a comparative basis.

The HiT profiles provide a source of descriptive, up-to-date and comparative information on health care systems, which it is hoped will enable policy-makers to learn from key experiences relevant to their own national situation. They also constitute a comprehensive information source on which to base more in-depth comparative analysis of reforms. This series is an ongoing initiative. It is being extended to cover all the countries of Europe and material will be updated at regular intervals, allowing reforms to be monitored in the longer term. HiTs are also available on the Observatory's website at <http://www.observatory.dk>.

Acknowledgements

The Health Care System in Transition (HiT) profile on Slovenia was written by Tit Albreht (Institute of Public Health, Slovenia), Marjan Cesen (Undersecretary of State, Ministry of Health, Slovenia), Don Hindle (Health System Management Project, Ministry of Health), Elke Jakubowski (European Observatory on Health Care Systems), Boris Kramberger (Health Insurance Institute of Slovenia), Vesna Kerstin Petric (WHO Liaison Office in Slovenia), Marjan Premik (Institute of Social Medicine, Slovenia) and Martin Toth (Health Insurance Institute of Slovenia). The input of Andrej Robida (Ministry of Health), Mladen Markota (Institute of Public Health), Zvonka Zupanic Slavec (Institute of History of Medicine, Medical Faculty, University of Ljubljana, Slovenia) and Stanislav Primožic (Office for Medicinal Products, Ministry of Health, Slovenia) is gratefully acknowledged. The HiT was edited by Elke Jakubowski (European Observatory on Health Care Systems).

The European Observatory on Health Care Systems is grateful to Simon Blair (World Bank) and to Serge Heinen (SenS Consult), a health sector specialist in Health Sector Management Project of the Government of Slovenia, for reviewing the HiT. We are also grateful to the Slovenian Ministry of Health for its support and in particular to the Minister of Health, Professor Dusan Keber, and state secretaries Dorjan Marusic, Simon Vrhunec and Jozica Maucec Zakotnik, for their input on recent developments and for thoroughly reviewing the final draft.

The current series of Health Care Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Care Systems.

The European Observatory on Health Care Systems is a partnership between the WHO Regional Office for Europe, the Governments of Greece, Norway and Spain, the European Investment Bank, the Open Society Institute, the World

Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. The Observatory team working on the HiT profiles is led by Josep Figueras, Head of the Secretariat, and research directors Martin McKee, Elias Mossialos and Richard Saltman. Technical coordination is by Suszy Lessof. The research director for the Slovenian HiT was Josep Figueras.

Administrative support for preparing the HiT on Slovenia has been undertaken by a team led by Myriam Andersen, and comprising Uta Lorenz, Anna Maresso, Caroline White and Wendy Wisbaum. Design, production and copy-editing were managed by Jeffrey V. Lazarus, with the support of Shirley and Johannes Frederiksen and David Breuer. Special thanks are extended to the WHO Regional Office for Europe health for all database, from which data on health services were extracted; to the OECD for the data on health services in western Europe, and to the World Bank for the data on health expenditure in central and eastern European countries. Thanks are also due to national statistical offices that have provided national data.

Introduction and historical background

Introductory overview

Slovenia is a small country located between the Alps, the Pannonian Plain, the Mediterranean Sea and the Balkans. It borders Austria and Hungary in the north, Italy in the west and Croatia in the southeast. Formerly a constituent part of Yugoslavia, Slovenia declared independence on 25 June 1991. Slovenia is mountainous with heavily forested areas and covers 20 273 km². The climate is mixed, with a sub-Mediterranean climate on the coast, an alpine climate in the northwest and a continental climate with mild to hot summers and cold winters in the plateaus and valleys to the east. The population in mid-1998 was estimated at 1 978 334; 65% live in urban areas. The capital is Ljubljana, with 270 481 inhabitants.

Slovenes are a Slavic ethnic group and comprise about 88% of the population (1991 census). Hungarians and Italians are considered indigenous minorities with rights protected under the Constitution. Other ethnic groups are Croats, Serbs, Bosnians (Muslims), Yugoslavs, Macedonians, Montenegrins and Albanians. Between 250 000 and 400 000 Slovenes (depending on whether second and subsequent generations are counted) live outside Slovenia, mostly on other continents and in European Union (EU) countries. There are Slovene indigenous minorities in Austria, Hungary and Italy. The official language is Slovene, a South Slavonic language. It is written in the Roman alphabet and has many dialects. In ethnically mixed regions, the official languages are also Italian and Hungarian. Most of the population is Roman Catholic, although there are some small communities of Protestant Christians, Muslims and Jews.

Fig. 1. Map of Slovenia¹ (1)

Government administration

National government

Slovenia has a democratic political system with a parliamentary form of state power. The system is based on a tripartite division of powers between the legislative, executive and judicial branches. Its 1991 constitution guarantees universal suffrage for all Slovenians over 18 years of age, freedom of religion, freedom of the press and other civil rights. Political parties represented in the National Assembly with 90 members (the parliament also has a National Council with 40 members) after the elections of 15 October 2000 are: the Liberal Democracy of Slovenia (LDS); the Social Democratic Party of Slovenia (SDS); the United List of Social Democrats (ZLSD); the Slovene People's Party (SLS/SKD); New Slovenia – Christian People's Party (NIS); the Democratic Party of Pensioners of Slovenia (DeSUS); the Slovene National Party (SNS) and the Party of the Slovene Youth (SMS). The National Assembly also has one

¹ The maps presented in this document do not imply the expression of any opinion whatsoever on the part of the Secretariat of the European Observatory on Health Care Systems or its partners concerning the legal status of any country, territory, city or area or of its authorities or concerning the delimitations of its frontiers or boundaries.

representative of the Hungarian minority and one of the Italian minority. The National Assembly adopts laws and the National Council proposes laws or requests reconsideration in the National Assembly. National Assembly members serve 4-year terms and are elected directly by secret ballot according to a proportional voting system. The National Council members are representatives of social, economic, professional and local interest groups and are elected for 5 years by the elected representatives of special-interest organizations and local communities.

The Government of the Republic of Slovenia is the executive body and the supreme body of state administration and is approved by the National Assembly. The executive function involves mainly preparing legislation, proposing the national budget and national programmes and implementing laws passed by the National Assembly. The government consists of the Prime Minister, the head of government who is elected by the National Assembly for a 4-year term, and the 15-member Cabinet of Ministers. The ministers are appointed for the following areas: finance; internal affairs; foreign affairs; justice; defence; labour, family and social affairs; economy; agriculture, forestry and food; culture; the environment and spatial planning; transport; education, science and sport; health; and information society. A minister without portfolio is responsible for European affairs.

The government must generally endorse all health care reforms before they are implemented. Judicial authority is exercised by judges, who are appointed for life. The Supreme Court is the highest court in the judicial system. There are district and circuit courts; the high courts are appeal courts. The Constitutional Court has been strengthened since the new constitution was introduced in 1992. The President of the Republic represents the Republic of Slovenia and is the supreme commander of its armed forces. The President is elected for a maximum of two 5-year terms by direct elections. The human rights ombudsman is responsible for protecting human rights and fundamental freedoms in relation to state bodies, local administrative bodies and all those with public jurisdiction. The ombudsman is proposed by the president and elected by the National Assembly for a period of 6 years.

Local governments

When Slovenia gained independence, a new constitution gave municipalities the right to a form of self-governance and anticipated the possibility of integrating individual municipalities into larger, self-governing communities.²

² In this document, *self-governing communities* is used to define both single municipalities and units of several municipalities that have been merged to form actual self-governing communities. Strictly speaking, only 30% of all communities are actually operating as self-governing communities.

The activities of any larger self-governing communities are financed by the municipalities that created these communities. The constitution explicitly transfers the mandate for taking on responsibility for local matters to municipalities, and when all municipalities agree, a given responsibility of the state may be transferred to them if the state provides the financial means.

Pursuant to the Act on the Establishment of Municipalities and Determination of their Territory in 1994, Slovenia was divided into 147 municipalities. The number of municipalities increased to 192 in 1998. The highest decision-making body in a municipality is the municipal council, the members of which are directly elected. A mayor is also directly elected. To date, Slovenia has no intermediate level of government between the municipality and the state. The Act on Regions is expected to define the regions.

Socioeconomic development

Slovenia's industry makes up 40.7% of the GDP, with agriculture contributing only 3.2% (2). The main industries include manufacturing of food and beverages, electronics, electrical machinery, metal processing and metallurgy and motor vehicles. The agricultural sector is dominated by dairy farming and stock breeding. The main crops are corn, barley and wheat. With its natural beauty, varied climate and geographical and cultural diversity, Slovenia has great potential for tourism. Slovenia's natural resources include brown coal and lignite in abundant quantities as well as lead, zinc, mercury, uranium, silver, natural gas and petroleum. Following independence, Slovenia adopted a number of economic reforms including a bank reform, market reform and privatization. A reform of the pension system has been introduced to adapt to demographic, economic and social circumstances and to be able to provide long-term social security. The balance of trade (2000) is US \$8732 million for exports and US \$10 115 million for imports. A total of about 64% of exports are sent to EU countries and about 70% of imports come from EU countries. Slovenia exports intermediate goods (48.9%), consumption goods (12.8%) and capital goods (38.2%) (2).

In 1991 a new currency, the tolar, was introduced at a fixed exchange rate to the German mark (224 tolar were equal to 1 euro in April 2002). Slovenia joined the International Monetary Fund (IMF) in 1993, and in 1995 the tolar became convertible in accordance with IMF standards. Slovenia has created solid foreign-exchange reserves in recent years. Since 1992, Slovenia's gross domestic product (GDP) has increased steadily, and the growth rate was 6% in 2000 (2). In 2000, the GDP per capita was US \$9105.

The standardized unemployment rate increased after 1992 but has been stagnant since 1994. In 2000, the standard unemployment rate amounted to 7.2% (7.0% for men and 7.4% for women). The economic and social position of the regions is imbalanced. The Statistical Office of Slovenia calculated various social and economic indicators between 1995 and 1997. These indicators show a favourable picture for the Ljubljana urban region, which was above the national average according to nearly all indicators, whereas some other regions of Slovenia fall significantly behind the EU average (the GDP purchasing power parity per capita equalled 57% of the EU average). This is also reflected in a wide variation in unemployment rates between regions. The highest unemployment rate in 2000 was registered in the Podravje region, amounting to 19.2%, compared with 9.5% in central Slovenia in the same year (3). The Human Development Index for Slovenia in 1998 was 0.864, and Slovenia ranked number 28 in the world.

Demographic trends and health status

The main demographic characteristics in Slovenia are a low birth rate, a low fertility rate and a low rate of population growth.

Slovenia's population is ageing (Table 1). The birth rate decreased from 13.1 per 1000 population in 1985 to 8.8 in 1999. The total fertility rate of 1.2 in 1999 was below the replacement level. Natural population growth has been negative since 1997, -0.7 per 1000 population per year. The crude death rate of 9.5 in 1999 increased only slightly during the transition compared with other countries in economic transition and quickly recovered its relatively low level (2). The main characteristics of the falling birth rate are a decreasing number of women with three or more children; decreasing differences in the number of children within different social classes; and changes in the spacing of births.

Life expectancy at birth in Slovenia in 1999 was estimated to be 71.3 years for males and 78.8 years for females (2). Healthy life expectancy, measured by the disability-adjusted life expectancy index, is about 7 years less. The difference from the EU average was 2.5 years in 1997.

Table 1. Composition of the population by age group, 1985-1999 (%)

Age (years)	1985	1987	1989	1991	1993	1995	1997	1999	2001 (estimate)
0-14	22.0	21.4	20.9	20.0	19.1	17.9	17.2	16.1	16.5
15-64	68.0	68.2	68.4	68.8	69.2	69.5	69.3	70.0	69.4
65 and above	10.0	10.2	10.6	11.0	11.7	12.5	13.1	13.9	14.1

Source: Statistical Office of the Republic of Slovenia.

Life expectancy, morbidity and mortality data show disparities between regions that correspond to indices of relative poverty. The difference in life expectancy between least developed regions and central Slovenia is 3 years. The correlation coefficient between income and life expectancy across Slovenian municipalities is 0.7, indicating a strong correlation. The correlation between life expectancy and education is slightly lower but still statistically significant (3).

The morbidity and mortality data show that Slovenia experiences the same morbidity and mortality characteristics as other European countries in western and central Europe. Diseases of the cardiovascular system are the most common cause of death in Slovenia, causing almost half of all deaths. These are followed by cancer, injuries, poisoning, respiratory diseases, diseases of the digestive system and others.

Mortality by age and sex groups shows a pattern similar to the EU average. The infant mortality rate fell to below 10 per 1000 live births in 1988 for the first time and was 4.5 per 1000 live births in 1999 (2).

The most frequent diseases are diseases of the respiratory system, followed by mental disorders, musculoskeletal disorders and digestive system disorders. In men, the most common type of cancer is lung cancer, followed by cancer of the colon and rectum; skin cancer; and cancer of the larynx, pharynx and mouth. In women the most common type of cancer is breast cancer. Communicable diseases in Slovenia are not a prominent cause of morbidity. In recent years in Slovenia there have been no registered cases of diphtheria, acute poliomyelitis, neonatal tetanus, tetanus or congenital rubella among people younger than 50 years of age. Because immunization coverage has traditionally been good, the incidence of vaccine-preventable diseases, such as measles, mumps and pertussis, has been low and has decreased further recently. Malaria has been eradicated in Slovenia, and thus only isolated cases of malaria imported from African or Asian countries are registered (nine cases in 1999). The incidence of syphilis has continued to decline since 1975 except from 1994 to 1998 (from 0.9 per 100 000 in 1992 to 2.77 in 1995). The incidence in 1999 was 0.2 per 100 000 (4). From 1986 to 1999, the annual reported incidence rate of acquired immunodeficiency syndrome (AIDS) varied between 0.05 and 0.7 per 100 000 population. A cumulative total of 84 AIDS cases, 73 in males and 11 in females, had been reported by 31 December 1999. In addition to AIDS cases, a cumulative total of 71 cases of human immunodeficiency virus (HIV) infection without developed AIDS, 55 in males and 16 in females, had been reported by 31 December 1999 (4).

Slovenia's suicide rate has been among the highest in the world for over two decades: about 30 per 100 000 inhabitants per year. National data have

shown for years that suicide is most common in the marginalized parts of society. This takes into account the specific suicide rates for individual population categories: workers with only primary education, (semi-) skilled workers, unemployed people and alcoholics. This trend shows that the population most at risk is the segment living in social poverty (5).

External causes of injuries and poisonings are also a major public health problem in Slovenia. Injury and poisoning are the leading causes of death after the age of one and represent the main causes of death until about 45 years of age. Even though the number of deaths caused by injury or poisoning decreased slightly from 105 per 100 000 population in 1986 to 63 in 1997, Slovenia still has one of the highest rates of this kind of mortality in Europe, exceeding the EU average by 100% (6). This is also true for the death rate from chronic liver diseases and cirrhosis among men and women. Slovenia has more than 30 deaths per 100 000 population per year from liver diseases. Alcohol consumption in Slovenia is among the highest in Europe (10.38 litres pure alcohol per person per year in 1998) (6).

Oral health has improved, as assessed by the average number of decayed, missing and filled teeth at the age of 12 (DMFT index), with a decline from 5.1 in 1987 to 1.8 in 1998, which places Slovenia among the European countries with the lowest caries prevalence (7).

Historical background

The period from 1899 to 1945

Prior to the First World War, Slovenia was a constituent part of the Austro-Hungarian Empire. The provision of health care services and the epidemiological situation were comparable to those of other parts of the Empire. Health care was delivered on the basis of private practice. The first development towards a health insurance system was at the time of the adoption of the Miners Act in 1854, which enacted fraternal funds providing compulsory insurance to miners and foundry workers. In 1858, insurance covering illness was extended to railway workers, and in 1869 their insurance was enhanced through insurance against injury. Compulsory insurance against injury was enacted in the Austrian part of the Hapsburg monarchy through an act adopted in 1887, which followed the Bismarck model. In 1888, the insurance scheme was extended to incorporate health insurance. Two thirds of the health insurance funding was contributed by workers and one third by their employers.

The first actual sickness fund for compulsory health insurance was established in Ljubljana in 1889. The first district fund was established in Ljubljana in line with the German social insurance model, followed by similar funds established in Slovenian towns across the country. They continued operating until the Austro-Hungarian monarchy collapsed at the end of the First World War. Social insurance for workers was reinstated in 1918, and an association of the health insurance funds on Slovenian territory was founded in 1919.

From 1918 to 1945, Slovenia was a member state of the Kingdom of Yugoslavia. During this period, steps were taken toward the development of social medicine through the establishment of a regional social hygiene institute for prevention, primary care centres and a central institute for hygiene and medicine. Both a Medical Chamber of Slovenia and a Slovene Medical Association existed at that time (the latter dating back to the previous century). In 1937, pension and disability insurance programmes were established.

The period from 1945 to 1991

In 1945, Slovenia became a part of the Socialist Federal Republic of Yugoslavia. Until 1954, the model of social insurance had prevailed as a system for health care funding. In social health insurance, all workers and pensioners together with their family members were included in the obligatory scheme. At that time farmers, self-employed people, craft workers and other professional groups had no coverage.

This social insurance combined pension and disability insurance, health insurance and maternity insurance. It was carried out by regional social insurance branches financed by the contributions of employers and employees; the public budget contributed only funds for the coverage of soldiers and war veterans. It was administered by the state or by regional peoples committees. Because of economic and demographic differences between the regions, reinsurance was introduced between regional social insurance institutes to cover above-average risks and was implemented at the level of the republic.

The basic system of social health insurance has changed gradually because of political changes. The development of a socialist political framework influenced how the health care system was managed. Health care facilities became state-owned. Private practice was not allowed and all physicians became salaried employees of the state. Primary health care was delivered through state-owned health centres, which included general practice, paediatrics, health

programmes for schoolchildren and adolescents, occupational medicine, pulmonary care, gynaecology, dentistry and other services.

Specialist outpatient and hospital activities were carried out in hospitals, which were all public. Hospitals that were under-equipped or outdated were renovated. Regional hospitals were established as were some other health care services, such as physical therapy in spas. This lasted into the 1970s, with the funds being provided partly by the republic budget and partly (in later years) by the providers of health insurance. On the regional level, an institution for social medicine and hygiene monitored the epidemiological situation. Large-scale prevention programmes were prepared, and the national Institute of Public Health carried out public health disease-prevention measures. All professional chambers were abolished, including the Medical Chamber of Slovenia.

Following reforms in 1954 and 1955, health insurance was separated from social security. Separate types of insurance were established for workers, public employees, craft workers and self-employed people, and later also for farmers, who acquired some minimal insurance coverage (such as coverage for emergency treatment in hospitals, treatment of infectious diseases and preventive health care). The providers of these health insurance policies were community health insurance institutes, administered by the representatives of employers and insured people. Contribution rates were different for individual types of insurance (workers, craft workers and farmers). Slovenia had 15 insurance institutes in 1965.

In 1972, a referendum was held that resulted in full equality in the insurance rights of workers and farmers, which provided the conditions for universal insurance of the whole population. According to the federal constitution of 1974, newly adopted health insurance legislation made “self-managing communities of interest in health” the main source of funding. In addition, health centres were introduced at the regional level, encompassing hospitals, primary health centres, pharmacies and the respective regional institutes of public health. These centres were to provide a full range of preventive and curative services. Although this principle was appealing in theory, the centres came to be associated with loss of cost control and an ever-growing bureaucratisation of health care.

In 1991, Slovenia became an independent state and began the process of economic transition to a market economy. The reform of the health care system since 1991 is covered in the section on health care reforms.

Organizational structure and management

Organizational structure of the health care system

The main organizational features of the Slovenian health care system, the key actors and their relationships are derived from the historical development of the system and are further based on legislation introduced in 1992 (Fig. 2).

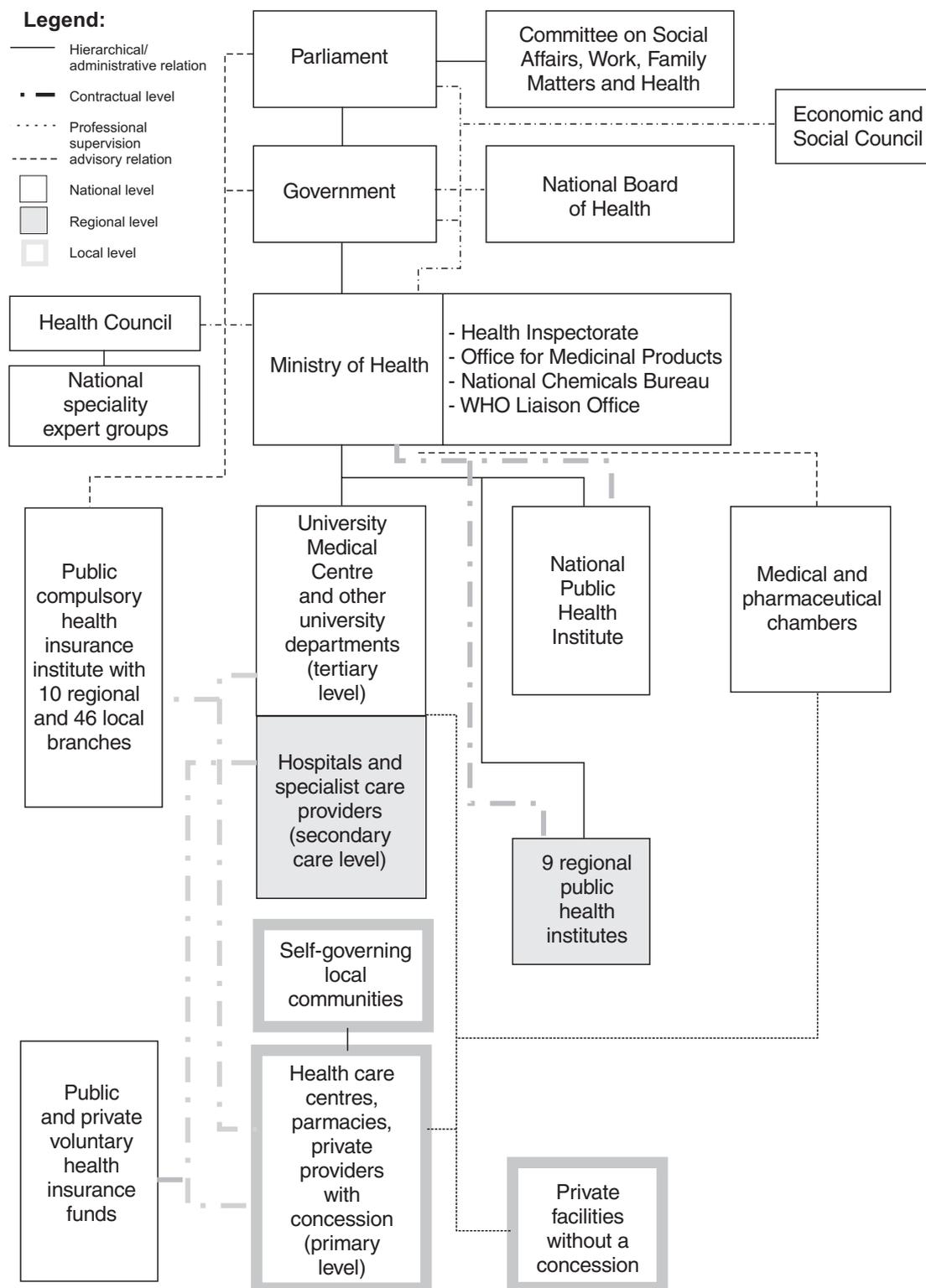
The Law on Health Care and Health Insurance (8) laid the basis for the present system of compulsory and voluntary health insurance, permitted the privatization of health care and transferred some administrative functions to the professional chambers. The state and its legislative and executive bodies (ministries, state agencies and offices) have administrative and regulatory functions. These are carried out by preparing and passing laws, by-laws, standards and other acts. The state is also responsible for the development of national health policy and for the development and implementation of disease prevention and health promotion programmes. Further, the state owns and administers public health facilities at the secondary and tertiary level.

National Board of Health

The National Board of Health is an advisory body to the government and has been responsible for maintaining health on the agenda in government and parliamentary procedures.

As defined by the Law on Health Care and Health Insurance from 1992 (8), the Board's role is to promote health policy by monitoring the effects of the social and physical environment on health; it assesses development plans and legislative drafts to assess their potential effects on health.

Fig. 2. Organization of the health care system



The functioning of the Board is currently being reviewed owing to the need to clarify its accountability. According to the National Health Care Programme of the Republic of Slovenia – health for all by 2004 (9), the Board will coordinate intersectoral investment in health and will coordinate government activities that affect public health, including determining tax policy, defence and food policy, defining sports and cultural programmes, introducing new technologies, promoting road traffic safety and protecting health at work. Herein it has only an advisory role: that is, it can only indicate problems but has no decision-making power.

Parliamentary Committee on Social Affairs, Work, Family Matters and Health

The Parliamentary Committee on Social Affairs, Work, Family Matters and Health prepares legislative proposals for parliamentary hearings.

Ministry of Health

The tasks of the Ministry of Health are to prepare legislation for health care and health protection and to ensure regulation and supervision of the implementation of legislation. The activities of the Ministry relate to health care at the primary, secondary and tertiary levels, including the financing thereof. The Ministry furthermore monitors public health, prepares and implements health promotion programmes and ensures the conditions for people's health education. Activities further focus on supervising the production, trade and supply of medicines and medicinal products and the manufacture of and trade in illicit drugs. The Ministry is in charge of implementing international agreements on social security and of developing national health policies related to health care financing, health insurance benefits, quality assurance and planning of public health care facilities. The Ministry is responsible for establishing hospitals and public health facilities at the national level.

The Ministry has four offices: the Health Inspectorate, the WHO Liaison Office, the Office for Medicinal Products and the National Chemicals Bureau. The Health Inspectorate controls the implementation of legislation and acts regulating sanitation and hygiene. It monitors environmental health and supervises the ecological protection of public health. The Office for Medicinal Products implements the national policy on drugs and medical devices, issues permits for the manufacture of medicinal products and medical devices and approves market authorization for medicinal products. The National Chemicals Bureau, established in 1999, enforces the legislation on chemicals and prepares and implements laws and regulations relating to chemicals. Its further activities

are: maintaining a list of chemicals; regulating the use and the manufacturing conditions of chemicals; trade in and use of chemicals; activities related to classifying, labelling and packing chemicals; and monitoring the implementation of the Convention on Chemical Weapons and the Law on Chemical Weapons.

Health Council

The Health Council is the highest coordinating expert body of health care, advising the Minister and formulating contents of health programmes with regard to their feasibility, the regular development of all medical specialties and access to health care services. The Health Council cooperates with the national specialty expert groups. The expert groups are the highest professional bodies formed within every medical specialty and have full autonomy on professional matters. They also have an impact on the implementation of national policy. The Health Council is based at the Ministry of Health and consists of representatives of the health professions, academicians and other relevant experts dealing with health care, health economics and health care system organization.

The composition, method of nomination and manner of work of the Health Council is defined by the Minister of Health. The Government of the Republic of Slovenia gives its consent to the nomination of members of the Health Council. The members of the national specialty expert groups are nominated by professional institutions such as university medical departments at hospitals, professional chambers and the medical association.

Other ministries

Other ministries directly influence the financing and organization of health services:

- The Ministry of Finance reviews and approves the budget of the Ministry of Health. The Ministry of Finance and the parliament approve the basic principles and the shares of the state budget, budgets of local authorities, mandatory health insurance and mandatory pension and disability insurance through a budget memorandum each year.
- The Ministry of Education, Science and Sport supervises activities related to medical and health professional education and some health promotion programmes. It is also responsible for matters related to basic research and technological development and for university and postgraduate education of junior researchers. In its internal cooperation activities, the Ministry is working on participating fully in EU research activities related to health.

- The Ministry of Labour, Family and Social Affairs together with the Ministry of Health coordinates the provision of homes for elderly and handicapped people.
- The Ministry of Environment and Spatial Planning cooperates with the Ministry of Health in the field of environment and health.
- The Ministry of Internal Affairs, Ministry of Defence and Ministry of Justice pay for health care for police and military personnel while on active duty and for prisoners.

The Health Insurance Institute of Slovenia

Following the 1992 health care reform legislation (the Law on Health Care and Health Insurance), the Health Insurance Institute of Slovenia (HIIS) was created as a public and not-for-profit entity strictly supervised by the state and bound by statute to provide compulsory health insurance to the population.

The statute of the HIIS is subject to approval by the Ministry of Health. The HIIS is the sole organization responsible for providing compulsory health insurance and the only provider of compulsory insurance. Its tasks include: providing compulsory insurance; concluding contracts with health care providers and suppliers of technical appliances; supervisory and administrative tasks; providing legal and other professional assistance to insured people; maintaining a database and statistics on health insurance; and proposing contribution rates.

The HIIS is governed by an assembly made up of representatives of employers and those insured. The director of the HIIS is nominated by the assembly and appointed with the agreement of the parliament. The HIIS has 56 branch offices altogether, including 10 at the regional level and 46 at the local level. Regional councils in the regional branches of the HIIS have more of an advisory role in relation to the central level and do not have decision-making rights concerning health insurance.

Institute of Public Health

The Institute of Public Health of the Republic of Slovenia (IPH) has nine regional public health institutes and was founded in December 1992 by a government decree to cover the fields of social medicine, hygiene, environmental health, epidemiology, informatics and research activities. The most important activities of the national IPH are to implement the national programme of prevention, to collect and analyse data on the health of the population and health care services and, based on reliable data, to prepare health policy documents and suggest measures to improve and protect health.

Health care delivery system

The health care delivery system is defined by the Law on Medical Services (10). Apart from public health care institutions (health care centres and hospitals), some private health care institutions are also part of the public health network, having a contract with HIIS. Health care capacity is structured at three levels: primary, secondary and tertiary. At the primary level, health care centres provide health care to the population of one or several communities. Specialist care at the secondary level is organized in regional general hospitals, hospitals covering specific specialties and specialist outpatient practice organized within hospitals or health care centres or as independent practices (private specialist practices – see above). The tertiary level includes university hospitals and institutes, performing highly specialized services, education, research, transfer of knowledge and development. Tertiary care services are generally organized at the national level.

Local governments

Local governments of self-governing communities have not yet begun to play as active a role in decision-making in the health care system as envisioned by the health care reform legislation of 1992. They are currently mainly responsible for granting concessions to private health care providers who wish to work within the publicly operated primary health care system. They are in theory also responsible for planning, establishing and managing primary health care facilities, which is in part reflected in their responsibility for capital investment in public primary health care facilities and pharmacies. However, despite the target population coverage of at least 8000 inhabitants per self-governing community, many have a smaller population coverage (up to a population of 450), so that, in early 2001, only about 30% of them were self-sufficient in capital investment in primary health care facilities.

Unions and professional associations

The Medical Chamber of Slovenia and the Slovenian Chamber of Pharmacy are responsible for specialization, licensing, developing and issuing a code of medical ethics and supervising professional practice. The Nursing Chamber of Slovenia was established more recently. Membership of professional chambers is compulsory for all professionals in direct contact with patients. There are also proposals to establish new chambers for other health professions.

The Slovene Medical Association, a voluntary nongovernmental association of physicians, discusses expert issues and advises the Medical Chamber of

Slovenia. The Association publishes a monthly medical scientific journal on medical issues in Slovenia (*Zdravniski Vestnik*).

Several trade unions represent the interests of health professionals, covering one or several professions (FIDES – the Slovenian Union of Physicians and Dentists; the Slovenian Health Service and Social Service Union; the Federation of Slovenian Free Unions; and the Union of Health Care Workers of Slovenia).

Public health institutions are members of the Society of Health Institutions of Slovenia, which individuals may also join. This society is one of the partners that represents the interests of health providers in negotiations with the payers of services.

Voluntary organizations

The role of nongovernmental organizations in health care is beginning to emerge in Slovenia. Nongovernmental organizations can implement the role of public participation in proposing changes and calling attention to anomalies. A nongovernmental organization can secure a small share of public financing from the state budget if it meets certain budgetary requirements. The Law on Organizations, passed in 1995, introduced certain conditions for such organizations of public interest. The respective ministries are authorized to determine the criteria that must be met by the organization if it is to obtain the status of a public interest organization.

Slovenia has several self-help groups. The most prominent are alcoholics anonymous groups and self-help groups for people with chronic diseases such as diabetes, cardiovascular diseases and osteoporosis.

The Slovene Consumers' Association has several projects related to out-of-court reconciliation, including for health-related issues.

Parallel health services

The Ministry of Defence owns and employs its own health care facilities within its military premises. A military physician salaried by the Ministry of Defence usually provides first aid care. For more complex primary health services, a general practitioner under contract with the public health insurance fund is often consulted. All specialist care is provided within the public health care network. Services for conscripts are paid through the state budget. Health care for military professionals is covered by the national insurance scheme.

Planning, regulation and management

Similar to most systems in Europe, the Slovene health care system has characteristics of both the integrated and the contract model of health care systems. Services performed are paid by the HIIS based on the contract between HIIS and the health care institution. In addition, most private providers are contracted by the HIIS and represent part of the public health care network. The employees in public health care institutions have the status of public employees. They are paid in accordance with a collective agreement. The state provides funds for investment in hospitals and clinics and the self-governing communities for investment in public health centres.

Planning

According to the 1992 legislation, the Ministry of Health is responsible for strategic planning and health policy development and implementation, issuing regulations and policy following legislation and earmarking financial resources for these tasks. The Ministry is also responsible for planning secondary and tertiary health care facilities and capital investment for hospitals. Capital investment planning for primary health care facilities was delegated to the self-governing communities. However, the pace and extent to which the communities have taken up this task differs.

For the planning of hospital beds and human resources used in health care, health care plans developed until the late 1980s spelled out targets for the number of hospital beds, the number of physicians, the number of dentists, the number of qualified nurses and the overall number of health personnel employed in the public health system in Slovenia. After the health care reform in 1992, a new planning framework, the National Health Care Programme of the Republic of Slovenia – Health for All by 2004 (9), has been discussed that should also include a plan for the health care network. However, no agreement could be reached for this part of the programme. The parliament adopted the programme in May 2000 without the national plan for the public health care network.

The National Health Care Programme of the Republic of Slovenia – Health for All by 2004 is based on the WHO health for all policy. The strategic objectives of the Programme set out strategic directions, priorities and targets for health system development: building healthy public policy, tackling inequality in health, modifying lifestyles harmful to health, improving the quality of the physical environment, improving the quality of health care services and promoting research in public health. The Programme also represents the framework for action to tackle mental health, alcohol, tobacco, nutrition, the quality of health care and environmental health protection.

National population-based planning standards for public health care facilities are expected to be included within the plan of the public health care network (under development). Self-governing communities are involved in designing the primary care network and in projecting the necessary capacity. These standards would then serve as a framework for implementing the public health care network. So far, the growth of capacity in the primary health care network has been restricted by the number of physicians providing care in the public as well as the private sector contracted by the HIIS. The national planning policy for the introduction of medical technology that requires high capital investment is under development. The Health Council is usually consulted for decisions related to the acquisition of capital investment-intensive medical technology.

Additional planning functions are carried out through annual negotiations and contracting in compulsory health care insurance.

Regulation

The health sector is regulated at various levels and by several organizations. The government and the parliament set the limits of the compulsory health insurance budget and contribution rates, coordinated and respected by the annual planning process of the HIIS. The annual financial plan for compulsory health insurance prepared and accepted by the HIIS assembly is the framework for the partnership negotiating process for each year. The Medical Chamber of Slovenia, the Slovenian Chamber of Pharmacy and the Nursing Chamber of Slovenia have a different regulatory role: they are responsible for controlling professional advancement, including professional auditing of physicians, dentists, pharmacists and nurses. Health care providers are further governed by internal regulations of institutions according to the public health network and contracts between third-party payers and health care providers. The local governments of the self-governing communities are responsible for regulating primary health care services. The director and managers of the national Institute of Public Health (IPH), in cooperation with the Ministry of Health, are responsible for managing the activities of the national IPH and coordinating the regional institutes of public health as defined by law.

Citizen participation

Citizen participation in planning and managing health care services was guaranteed in the former political system through the system of self-management of all public institutions. After 1991, popular participation had to be developed on the new basis of democracy. Citizens may nowadays participate directly in public debates held in the parliament on the health care plan and on regional-level committees of insured people, which have been established to

provide an opportunity for the population to actively participate in planning and managing the health insurance system. Citizens may also participate indirectly through their representatives in the parliament, in the Economic and Social Council of the Parliament, in the HIIS assembly and council, in the Councils of Health Care Institutions and in health-related associations and nongovernmental organizations. A health forum is considered to be lacking as a neutral place for wider discussions on how to resolve health-related issues that require at least relative social understanding and consensus prior to enactment.

Consumer protection

Consumer protection has a relatively long tradition in Slovenia. Two decades ago so-called “complaints books” were introduced by law at all places at which services were performed for citizens. Health care institutions were no exception. The awareness towards the need for consumer rights protection became strong, and when new health legislation was prepared in 1992, a special concern was dedicated to citizens and patient rights. The rights are divided to those connected only to the insured persons (Law on Health Care and Health Insurance) and to the rights that cover all citizens under the same conditions (Law on Health Care Activity). Regulations of the rights are harmonized with international rules and EU legislation. Special attention is given to the procedures of supervision and control inside health care institutions, such as supervision of the health ministry and competent chambers and supervision of the HIIS. Every citizen can request any of the aforementioned supervision if he can prove his personal interest. Also, in the early 1990s the institution of the ombudsman was established. In its annual report, the office of the ombudsman dedicates special attention to the status of patient rights and other rights connected to the health care system. At the Ministry of Health, a special service of advising the citizens regarding different procedures concerning their rights and patient protection was established five years ago.

With the enforcement of consumer protection in health care, the awareness of consumers and patient rights has been growing. A need to better arrange complaint procedures in health care has resulted in a special law on complaint procedures in health care pending approval by the Government. Accordingly, inspection procedures will be reconsidered.

Decentralization of the health care system

The Slovenian health care system remains relatively centralized, and the self-governing communities still have limited responsibility. Most administrative

and regulatory functions of the system take place at the state level; the lower levels have mostly executive duties.

Compulsory health insurance is centrally managed and administered; only executing the tasks and activities adopted at higher levels is delegated to the local levels. The professional chambers and organizations also operate at the state level or through their regional branches.

Local governments are said to make limited use of the autonomy they gained in planning health services. However, local officials often question the efficiency of autonomous health care planning in the self-governing communities with only several thousands inhabitants. Thus, the de facto degree of devolution in planning primary health services from the national government to the self-governing communities cannot be determined yet.

Privatization of health care delivery, which developed towards terminating the public employment of physicians and other health care workers and opening their own practices, is taking place gradually and to a constantly increasing extent. Most practitioners secured the possibility of performing their services by obtaining concessions and hence financing from the compulsory insurance funds. By this they remained in the public network of health care service. Those who have no concession can offer services to clients who pay out of pocket. Of the 1458 professionals licensed for private practice between 1992 and 1999, 959 are contracted by one of the 10 regional social insurance funds. Most private practitioners work in one of the 134 private health care centres (1999), and some rent public premises for their practices. Private practitioners also practice independently in homes for the elderly, other social institutions and pharmacies. About 550 physicians, mainly dentists, operate outside the public system, and their services are mostly covered by direct payments from the patients. In 1999, there were also 26 privately practising field nurses and 80 physical therapists (about one third of the total).

Very few private for-profit hospitals exist in Slovenia outside the public network with no more than 50 beds altogether: for example, a plastic surgery clinic. There is also the opportunity for private investment in new hospitals, although this has not yet taken place.

Health care financing and expenditure

Main system of financing and coverage

Slovenia maintains a Bismarck-type health care system, which was introduced for workers as an extension of a compulsory accident insurance system in 1888. The insurance system experienced many changes. The 1992 Law on Health Care and Health Insurance forms the legal basis for the current system. The law laid the basis for a centralized compulsory health insurance system to be administered by the HIIS. By statute, the HIIS is the sole provider of compulsory insurance. The HIIS operates autonomously and is governed by elected representatives of employers and the insured. In its capacity as the founder of the HIIS, the state has retained some main levers to manage and control operations, such as involvement in determining the contribution rate and the scope of rights (benefit catalogue) and resolving other important issues arising in the provision of public health insurance.

Contributions towards statutory health insurance constitutes the major system of financing health care in Slovenia, providing more than 85% of funding. Virtually the entire population with permanent residence in Slovenia is covered under the sole compulsory insurance scheme either as a mandatory member or as a dependant. Opting out of the compulsory system is not permitted. Coverage is also provided to citizens of almost all EU countries through arrangements governed by bilateral conventions.

Slovenia has 21 categories of insured people, with two main groups. The first comprises white- and blue-collar workers whose contributions depend on income and not risk and include non-earning spouses and children without any surcharge. The contributions are proportional to the individual's income and shared between the employer and the employee. The parliament determines

the contribution rates based on an annual proposal by the HIIS. Since January 2002, all employers and employees are paying a total of 13.45% of gross income: 6.56% by employers and 6.36% by employees, plus an additional 0.53% by employers to cover occupational injuries and diseases.

The second group comprises people contributing fixed amounts. The HIIS determines these fixed contributions independently. The National Institute for Employment pays such a fixed contribution for each registered unemployed person. Other people with no income are registered in self-governing communities, which are obliged to pay a fixed contribution into the national fund. Pensioners pay a contribution of 5.65% of their gross pension. Farmers and craft workers contribute substantially less. Self-employed people, the fifth largest category of insured people in Slovenia, pay contributions according to a fixed proportion of their after-tax income. Those who pay most regularly tend to be employed in the public sector. Some people argue that some categories (such as pensioners, self-employed people, farmers and craft workers) are not paying a high enough proportion of their income.

The HIIS is responsible for invoicing contributions, determining the terms of payment, collecting interest on overdue payments, writing off bad claims and imposing penalties subject to special regulations governing the settlement of taxes and contributions. In practice, the HIIS has delegated these tasks to certain government agencies (the agency of public accounting and the tax administration). The HIIS also determines the criteria and conditions for the potential reduction or write-off of contributions by specific groups of insured people (such as farmers following a drought).

The HIIS may also require additional contributions from employers to adjust for health care claims that are excessive compared with the average for the sector because of occupational diseases and injuries.

The state budget covers capital investment for all secondary and tertiary health care facilities. Budget financing also covers expenditures for the national public health programme, which includes the traditional national prevention programmes as well as some new health promotion programmes, medical education and training, research, the national health information system, cooperation between sectors, the national health sector management project and health care coverage for specific groups such as soldiers, prisoners and refugees. Recently, the parliament endorsed the introduction of excise “sin” taxes on tobacco and alcohol, part of which has been allocated to preventing non-communicable diseases and health promotion. Some of the self-governing communities collect revenue at the local level to allow capital investment in primary health care facilities. They provide for all public services and decide locally how much to invest in health. For reasons explained previously, the

proportion of funding generated by self-governing communities cannot be specified because the self-governing communities differ in the extent they use their autonomy in practice to collect taxes and to invest this in health care. Some of the differences are explained by very different populations covered between the self-governing communities.

Special funds are available from the state budget for developing self-governing communities, and some funding is available from the Ministry of Health for developing emergency units.

Health care benefits and rationing

In Slovenia, there are three dimensions to the population's rights to receive health care. The first right is expressed in the constitutional responsibility of the state to develop economic, environmental and educational policies and appropriate social, fiscal and infrastructural measures, thereby establishing the necessary conditions and incentives for an individual to exercise responsibility for his or her own health.

The second involves mainly employers, who are responsible for safeguarding the working environment. According to 1992 legislation, employers' responsibilities include maintaining health in the workplace, preventing occupational diseases and injuries, providing first aid, ensuring preventive, periodic and special preventive health check-ups of employees, paying benefits to employees on sick leave for up to 30 days and analysing the health impact of technological processes.

The third dimension refers to compulsory health insurance. These rights are defined by the Law on Health Care and Health Insurance and more specifically described in the special regulations on compulsory health insurance accepted and revised by the HIIS. The law and the regulations specify the entitlements of insured people to benefits that are acquired through contributions to compulsory health insurance. The compulsory health insurance provides all insured people with two types of rights: benefits in kind and cash benefits. The first type is entitlement to health care services delivered in Slovenia at the primary, secondary and tertiary levels, including drugs and technical aids. The second type comprises specific cash benefits, such as compensation for salary for absence from work exceeding 30 days and the costs of travel related to referral to health care facilities. The benefit package of the compulsory insurance scheme covers a full range of benefits, some of which are subject to co-payments.

The following services are covered in full:

- all health services for children and adolescents: diagnosis, treatment and rehabilitation of diseases and injuries suffered by children, schoolchildren, minors with developmental impairment and adolescents, as long as they attend school;
- counselling in family planning, contraception, pregnancy and childbirth care to women;
- services pertaining to programmes of preventive care, diagnosis and treatment of infectious diseases, including HIV infection;
- treatment and rehabilitation of occupational diseases or injuries, malignant diseases, muscular or muscular nerve diseases, mental diseases, epilepsy, haemophilia, paraplegia, quadriplegia and cerebral palsy, as well as advanced diabetes, multiple sclerosis and psoriasis;
- health care services related to the donation and transplantation of tissues and organs; emergency health care, including emergency transport; nursing care visits; and treatment and care in the home and in social institutions; and
- long-term nursing care as home visits, and treatment and home nursing in social care institutions.

As services for specific groups and patients are fully covered by the system of compulsory insurance, other services are covered by compulsory insurance only as a certain proportion of the total value of the service (Law on Health Care and Health Insurance). These services thus require co-payments varying from 5% to above 50%:

- at least 95% of the cost of services in connection with organ transplantation and the most demanding surgery, treatment abroad, intensive therapy, radiotherapy, dialysis and other very demanding interventions (co-payments of less than 5%);
- at least 85% of the cost of treatment of reduced fertility, artificial insemination, sterilization and abortion; specialist surgery; the non-medical portion of care and spa treatment in continuation of hospital treatment except for non-occupational injuries; the treatment of oral and dental conditions, orthopaedics, orthodontics and hearing and other aids and appliances (co-payments of less than 15%);
- at least 75% of the cost of medications from the positive list and specialist, hospital and spa treatment of injuries that are not work related (co-payments of less than 25%);

- a maximum of 60% of non-emergency ambulance transport and medical and spa treatment that is not a continuation of hospital treatment (co-payments of 40% or more); and
- a maximum of 50% of the cost of ophthalmological devices and orthodontic treatment of adults; and medications from the intermediate list (co-payments of 50% or more).

The balance is either to be paid out of pocket or, alternatively, the insured person can take out a supplementary co-payment insurance policy. It is believed that, despite the introduction of co-payment for several services and the reduction in spa treatment, health services are too extensive for the available financial resources and have not been sufficiently rationalised and perhaps even rationed. The benefit package has not been limited to a core of essential services, nor are priorities determined based on age or income.

Complementary sources of financing

Statutory insurance is clearly the most substantial source of financing. Financing through the state budget plays a minor role. From year to year the private resources have increased. The largest source of private financing is voluntary insurance (Table 2). However, information on the amount of direct (formal and informal) payments not reimbursed through voluntary insurance is not available.

Table 2. Sources of health care financing (%)

Source	1991	1994	1995	1996	1997	1998
Public						
Taxes	98.5	2.6	2.8	3.4	3.4	3.3
Statutory insurance	–	88.5	86.9	85.7	85.2	85.1
Voluntary health insurance	1.5	8.9	10.3	10.9	11.4	11.6
Direct payments	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown

Source: Health Insurance Institute of Slovenia.

Out-of-pocket payments

Formal out-of-pocket payments in the form of co-payments for services under the compulsory insurance system are in the majority of cases reimbursed through voluntary insurance arrangements.

However, people increasingly make out-of-pocket payments for visits to physicians in private practices who do not obtain a concession and for purchasing services not included in the benefit package of the compulsory insurance system. No information is available on the magnitude of these payments. It is speculated that informal payments were previously made in certain instances, such as to shorten the waiting time for specialist and dental care. Later, there were efforts to formalize these payments, with the main objective of reducing the waiting lists generated under the social insurance contract. Previously informal services were practically legalized by allowing the practitioners to provide certain services in public premises outside office hours.

Voluntary health insurance

Voluntary health insurance was introduced in 1993. It was designed to diversify funding sources and was therefore heavily promoted by the government.

There are no substitute or voluntary full-coverage schemes since opting out of the compulsory system is not permitted. Voluntary insurance in Slovenia can provide supplementary insurance and covers co-payments within the compulsory system levied on certain services and/or additional (non-standard) health care benefits, depending on individual insurance policies.

Insurance premiums are set by the insurers and can vary, but are fixed for a certain set of benefits. The law from 1992 prohibited insurers from selecting those with low risks (known as cream-skimming) in voluntary health insurance for co-payments.

When voluntary health insurance was introduced, two providers were competing: the HIIS, which was legally obligated to introduce voluntary insurance for co-payments, operating as a not-for-profit public insurance company, and a private for-profit insurance company. According to amendments to the Law on Health Care and Health Insurance in 1998, the HIIS founded a new voluntary insurer, Vzajemna (which means “mutuality”), which is independent from HIIS and was established as a mutual not-for-profit health insurance company. It became the largest provider of voluntary insurance. Vzajemna offers voluntary insurance in four areas: coverage of co-payments; coverage of non-standard services (higher quality materials, more convenient procedures, more services in hospitals or health spas); coverage of services not included in the benefit package offered by compulsory health insurance; and coverage of people not eligible to be insured by the compulsory health insurance system. The second largest insurer is the Adriatic Insurance Company, a commercial provider. Several other providers of voluntary health insurance provide niche products, such as travel health insurance.

Upon introduction, there were initial fears that a two-tier system would be promoted. Nevertheless, arguments that this system would end the limitless claims of the compulsory health insurance system for additional resources were stronger.

The preparation of legislation dealing with the introduction and regulation of voluntary insurance projected that 40 000 people would take out policies in 1993, the first year of operation. However, an intensive campaign before the new system was introduced led many large employers (for their employees) and individuals to purchase voluntary insurance. In 1993, 1 200 000 people took up voluntary insurance with the HIIS, and an additional 150 000 opted for supplementary insurance with the Adriatic Insurance Company. Today about 1.4 million inhabitants have voluntary insurance for co-payments: almost 95% of those who otherwise would have to pay cash co-payments have decided to enter into one of two alternative voluntary insurance schemes.

External sources of funding

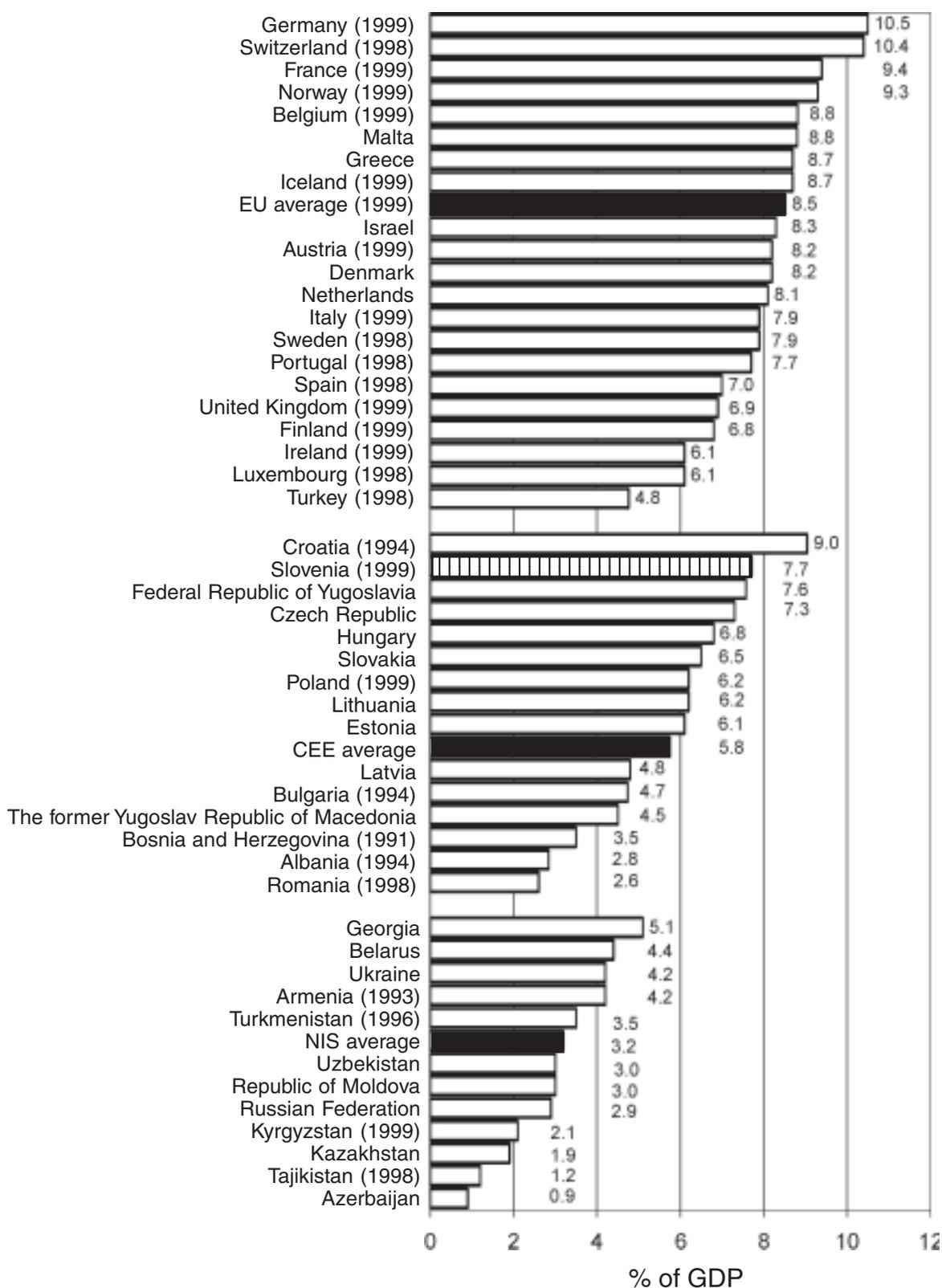
Slovenia has participated in many international technical programmes, including the EUROHEALTH programme of WHO and the PHARE Programme of the EU. As Slovenia has a relatively high per capita GDP compared with other central European countries, external sources have had a very marginal role. Since 1993, some external financing has co-financed legislative activities and institution-building within the process of Slovenia's accession to membership of the EU.

In this regard, the EU has generated the most significant resources, whereas financial contributions of WHO, the United Nations Development Programme and other United Nations organizations have been devoted to specific tasks (such as regulating illicit drug control) and do not play a major role in financial terms. Since 2000, the Health Sector Management Project has been launched in Slovenia, co-financed by the World Bank through a loan agreement.

Effects of the 1992 reform on funding

The introduction of compulsory and voluntary health insurance in Slovenia has had several beneficial effects. An important achievement is the financial sustainability of the health care system compared with the situation before 1992. Introducing voluntary insurance led to the diversification of sources, but the funds generated through compulsory health insurance contributions still represent most of the total public budget. Most private funds derive from voluntary insurance premiums, which have thus gradually replaced direct payments and other forms of private funding.

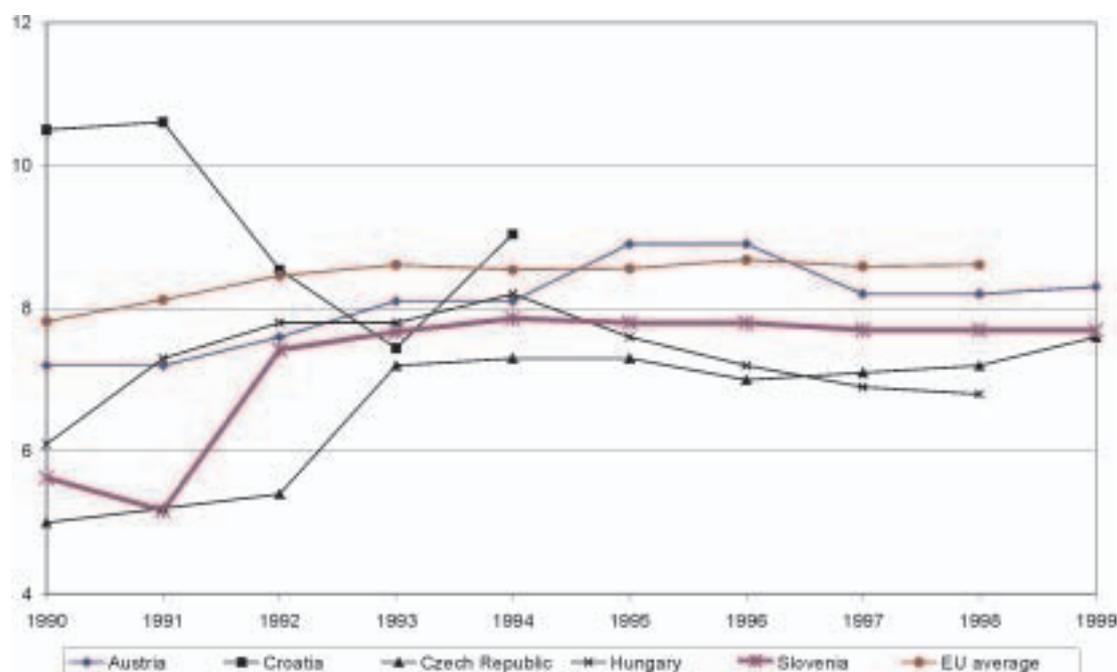
Fig. 3. Total expenditure on health as a % of GDP in the WHO European Region, 2000 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.

CEE: central and eastern Europe; EU: European Union; NIS: Newly independent states.

Fig. 4. Trends in health care expenditure as a share of GDP (%) in Slovenia and selected European countries, 1990-1999



Source: WHO Regional Office for Europe health for all database.

Table 3. Public expenditure on health care, 1992-1997

Public expenditure on health care (compulsory insurance and national and local taxation)	1992	1993	1994	1995	1996	1997
Consumer price index (1992 = 100)	100	133	161	182	200	217
Total public health care expenditure in current prices (millions of tolar)	73 500	104 900	132 200	152 500	175 400	198 800
Public health care expenditure in constant prices (millions of 1992 tolar)	73 500	78 900	82 100	83 800	87 700	91 600
Public expenditure on health as a percentage of GDP	7.2	7.3	7.2	6.9	6.9	6.8

Sources: Health Insurance Institute of Slovenia and Office for Macroeconomic Analysis and Development.

Co-payments and enhancement of the range of voluntary health insurance services have allowed restructuring of the ratio between public and private funds to finance health care programmes. From the initial share of 1.5% in 1992, the share of private funds flowing into the health care system through voluntary health insurance increased to about 13.5% in 2000.

The introduction of voluntary insurance with fixed premiums decreased the proportionality of contributions to income and rendered health insurance more regressive. Premiums for co-payment have reached the level above which they will be hardly available to those with a low income.

Health care expenditure

The share of total health care expenditure in Slovenia amounted to about 7.7% in 1999 (Fig. 3) and has risen to 8.23% in 2001.

Except for the decline in 1991, Slovenia maintained a funding level comparable to those of neighboring countries throughout the 1990s (Fig. 4).

Total public expenditure on health care in Slovenia has been increasing in current prices since 1992 because the general price level has increased rapidly. Measured in constant prices (1992), public health care expenditure increased gradually until 1997 (Table 3). In 2001 the total public expenditure as a percentage of GDP was 7.2%.

Table 4. Health care expenditure by categories, as a percentage of total health care expenditure, 1993-1998

Total expenditure on health care	1993	1994	1995	1996	1997	1998
1. Expenditure on compulsory health insurance	91.0	88.4	86.9	85.7	85.2	85.1
2. Expenditure on voluntary health insurance ^a	6.7	8.9	10.2	11.0	11.5	11.6
Total current expenditure (1 + 2)	97.7	97.3	97.2	96.7	96.7	96.8
Of this:						
Hospital care ^b	31.3	27.8	30.3	31.2	31.3	30.8
Pharmaceuticals ^c	14.8	16.4	15.4	14.4	15.0	15.8
3. Investment (by the state and municipalities)	2.3	2.7	2.8	3.3	3.3	3.2
Total expenditure (1 + 2 + 3)	100.0	100.0	100.0	100.0	100.0	100.0

Source: Health Insurance Institute of Slovenia and Office for Macroeconomic Analysis and Development.

^a Excluding voluntary health insurance through the Adriatic Insurance Company.

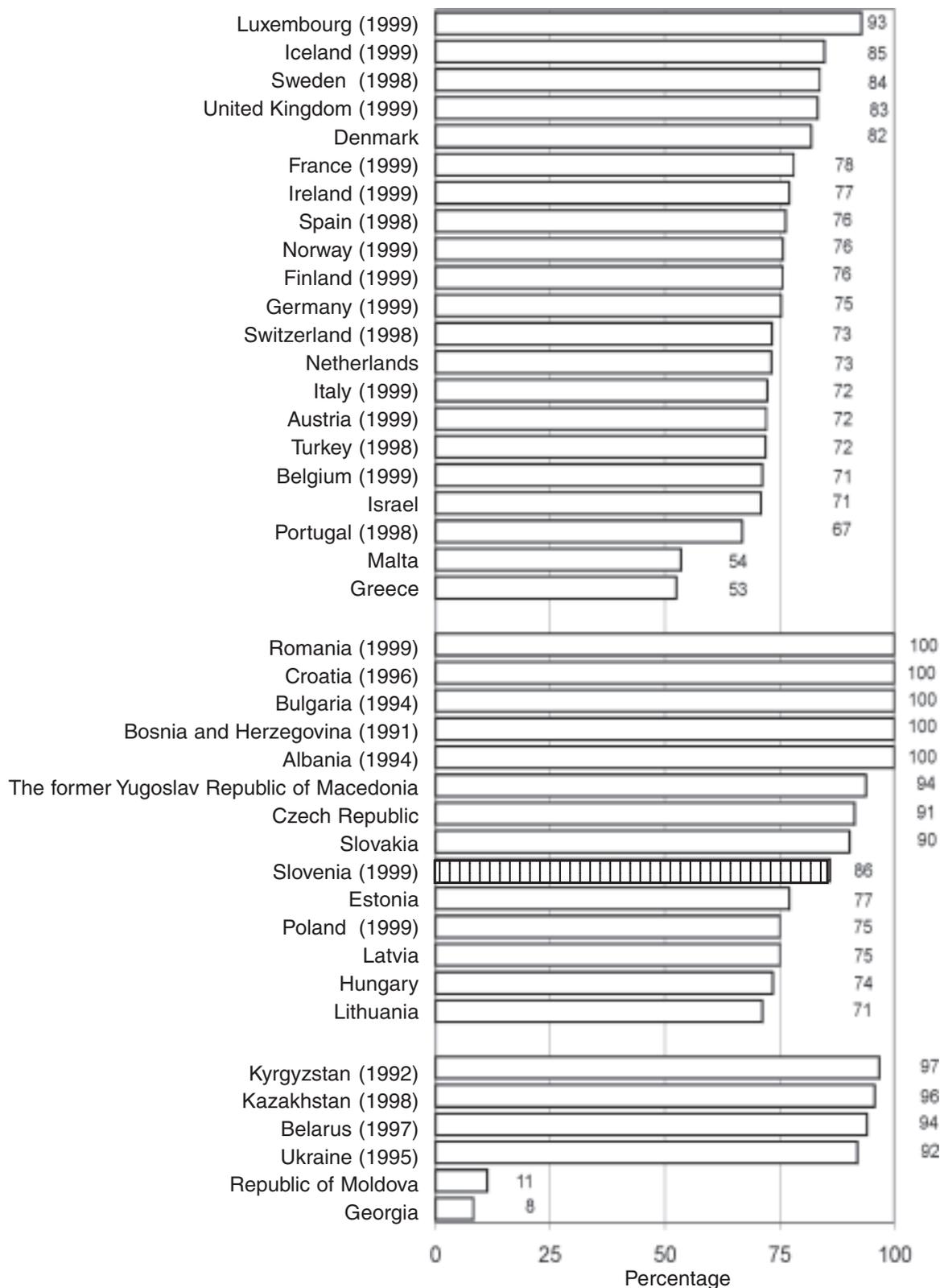
^b Expenditure on compulsory and voluntary health insurance excluding insurance through the Adriatic Insurance Company.

^c Prescriptions only.

Public health expenditure decreased as a proportion of GDP after 1994 mainly because the proportion of private funding increased through co-payments levied on certain services. In addition, GDP has risen more rapidly than has public health expenditure.

The share of income from contributions for compulsory health insurance equalled 6.4% of GDP in 1997.

Fig. 5. Health care expenditure from public sources as a percentage of total health care expenditure in countries in the WHO European Region, 2000 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.

The contribution rate for compulsory health care decreased until 1995, stabilized from 1996 to 2001 at 13.25% and increased to 13.45% in 2002 for the active population. However, due to the policy of keeping wage increases at a lower level than GDP growth, the effect of the stable contribution rate still remains negative, such that the revenue from the health insurance contributions is still decreasing as a percentage of GDP (11).

Structure of health care expenditure

The public share of total health care expenditure was 88% in 2001; this level is between those of some countries of central and eastern Europe and those of the EU countries (Fig. 5).

According to the HIIS, expenditure estimates for 2001 include 313.42 thousand million tolar (6.9% of GDP) spent through compulsory insurance, 8.88 thousand million tolar through budgetary resources (0.2% of GDP) and 3.32 thousand million tolar through local resources (0.07% of GDP).

Table 4 presents certain categories of health care expenditure as a percentage of the total. The expenditure for pharmaceuticals was highest in 1994 (16.4%) and remained constant at about 15% during the 1990s. In 2001 it reached 17.8% of all health care expenditure. Table 4 also reveals a low proportion of total spending allocated to investment during the 1990s.

Increasing expenditure on pharmaceuticals was partly attributed to increasing consumption of medicines in hospital and outpatient care in parallel with relatively uncontrolled price increases for medicines. In 1995, the government intervened to control the drug prices in the wholesale and retail sectors by establishing a new agency (the Office for Medicinal Products) and taking control over price-setting. Increases over the last years are due to the increase in bulk consumption of several drugs as well as the high prices of innovative drugs.

Prospect

Despite the strong features of the health sector and the balance of income generation and expenditure in the past years, Slovenia is neither in a position to maintain the status quo nor even to continue its measured pace of health financing reforms. Indeed, a number of potent, and largely inexorable forces threaten to disturb the financial sustainability of the current system.

First, a series of government and policy decisions in the last 2 years has increased expenditure pressures to the point where deficits have emerged among a number of health care providers and may occur in the HIIS in future. These

decisions include high real increases in physicians' salaries to move towards parity with other professions; the introduction of a value-added tax on pharmaceuticals and other costs of supplies, and the transfer of responsibility to the HIIS for cash benefits payable to unemployed people during periods of sickness.

Second, increased openness and globalization of the economy exposes Slovenia more than before its independence to expenditure pressures owing to technological innovation in health care technology. This factor accounts for a large share of expenditure pressure as in most if not all EU and OECD countries. Like them, Slovenia faces pressure to adapt to an increasing and more expensive market of pharmaceuticals, devices and procedures. The impact of technology interacts with the rapid ageing of the population (see below).

Third, chronic diseases accumulate in ageing populations. Epidemiological characteristics of disease are shifted away from a preponderance of communicable diseases to chronic diseases related to lifestyles (such as cancer, cardiovascular diseases and injuries). This trend too raises the demand for resource-intensive and long-term treatment, which necessitates an expensive transformation in the mix of supply-side capabilities.

Fourth, the dramatic shift in consumer orientations and expectations accompanying the political transformation from the former socialist system has established new benchmarks and norms for the public, as well as for health care professionals. EU accession, of which rising expectations are part and parcel, also creates external pressures to conform to EU standards. With Germany or the Netherlands as Slovenia's new benchmarks, the demand for health services and the supporting infrastructure is increasing. Even if Slovenia could successfully accommodate these "one-time" shifts in demand, it still faces a continuous outward shift, as a result of rising income levels. With Slovene incomes likely to converge on western European levels in the coming years, the high income elasticity of health expenditure may result in continued fiscal pressures.

Fifth, Slovenia is increasingly an international "price-taker" in health. EU accession can be expected to bring pressure to price pharmaceuticals and other imported inputs at levels that avoid incentives for parallel trade within the internal market in Europe, though some EU countries have been able to sustain much lower prices than others through price regulation until now. Not only does Slovenia face relative inflation in health tradeables, it also faces further likely inflation in health care labour costs. In comparison to relative wages in EU countries, relative wages for Slovene health care professionals are lower (labour costs increased from 50% to 60% of sector expenditure over the last

5 years, in contrast with 70% in high-income market economies). In the coming years, the EU will continuously “export” its labour market conditions to Slovenia. This will likely compound the above fiscal pressures.

Sixth, in addition to the price and expectation impacts, EU accession also entails international obligations to participate in cross-border health service and financing arrangements. With an increasingly mobile EU citizenry (forecast to be approximately 10% percent of the population), the obligations represent additional costs for Slovenia (11).

Health care delivery system

Primary health care

Both public and private providers of care deliver primary health care. Public providers include health care centres and health stations. The locations of health care centres correspond to the seats of former self-governing communities (from before 1995), and the locations of health stations correspond to important local centres, which are small towns, hamlets or villages.

Health care centres bear traditions from the ideas of Andrija Stampar, a Croat public health professional who lived from 1888 to 1958. The first centre in Slovenia was established in 1926. The original idea that has survived was that delivery of primary health care should be brought to the local communities and various types of care provided in an integrated approach and targeted to specific population groups. Today, by law and in practice, a health care centre is an institution that provides, as a minimum, preventive and curative primary health care for different target groups of inhabitants, notably many of those who are at higher risk from a public health viewpoint. The types of care include: emergency medical aid; general practice or family medicine; health care for women, children and youth; home nursing; laboratory and other diagnostic facilities; preventive and curative dental care for children and adults; health aids and appliances; pharmacy services; physical therapy; and ambulance services.

In the past, the outreach of different types of care was facilitated by the organization of dispensaries for all these types of care. Some of this is still carried out, especially for children and youth. In addition to the services listed above, there were also antituberculosis and venereal disease dispensaries that later slowly declined in step with the declining prevalence of these diseases

did. Some of these services are still organized but as purely supplementary outpatient specialist services. A health station provides as a minimum: emergency health assistance, basic diagnostic services, general practice or family medicine and health care for children and youth and is linked to the nearest health care centre for other activities described by law.

The personnel delivering primary health care include: general practitioners or family physicians, dentists, nurses, pharmacists, physical therapists, speech therapists, occupational therapists, psychologists or psychiatrists, midwives and other health professionals necessary to carry out the work of the health centre. Social workers are not based in the health care centre. Community nurses are independent but based in the health care centre. Specialists generally work in health care centres part time based on a contract with the health care centre. They may be employed full time according to need.

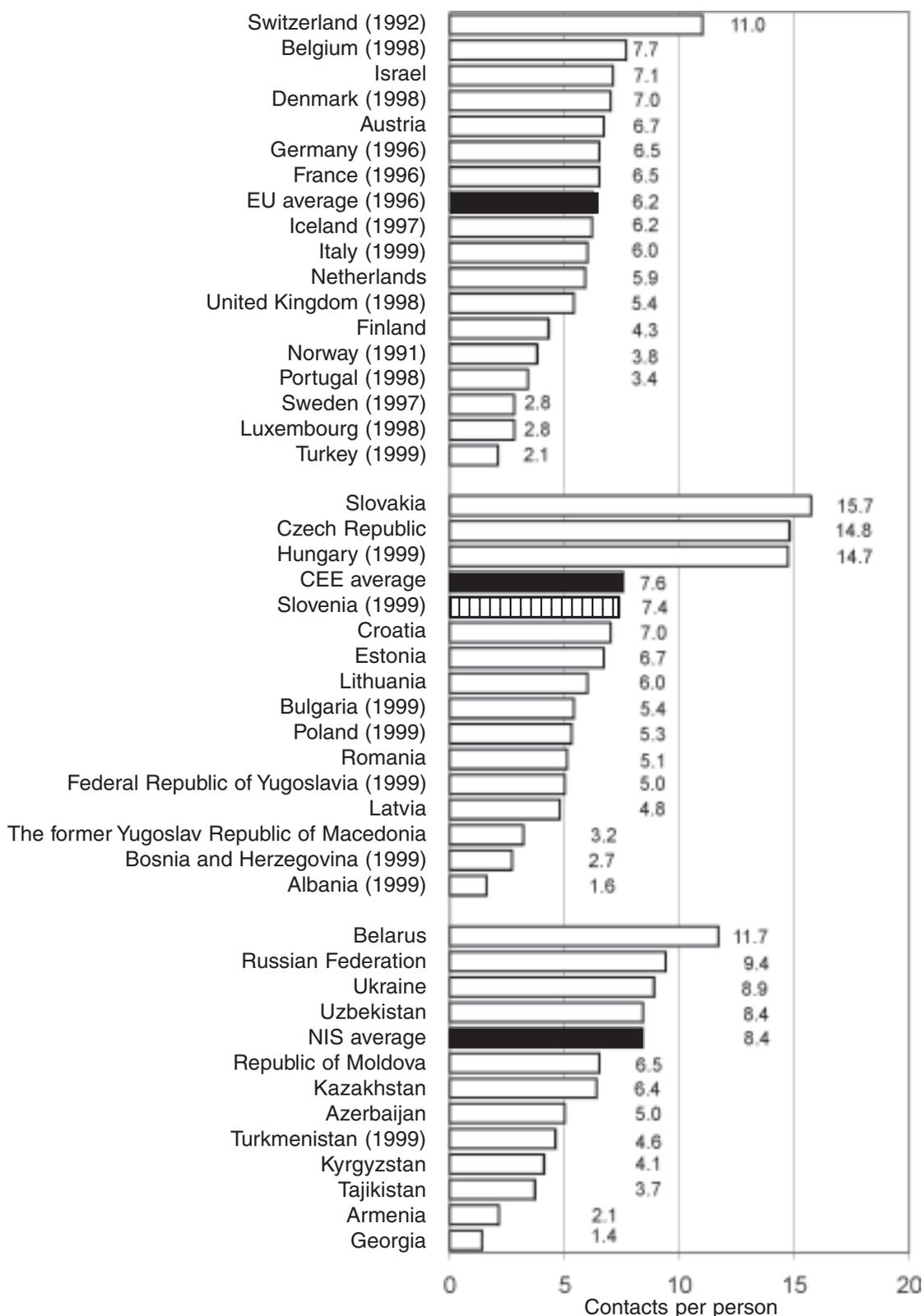
In 1999, Slovenia had 64 health care centres and 69 health stations. A primary health care facility (health care centre or health care station) is available within 20 kilometres from almost all locations in Slovenia. In rural areas, a physician's practice is more that of a family physician and a physician may have as many as 3000 patients, whereas in Ljubljana, the capital, a physician may have as few as 750 patients. The average number of patients per general practitioner is about 1800 (which normally includes only up to 10% of all children since their care is usually organized through primary care paediatricians).

Fig. 6 shows the number of annual outpatient contacts per person for European countries. With 7.4 contacts, Slovenia is still below the average of 7.9 for central and eastern European countries, but is higher than all EU countries, including those with a general practitioner gatekeeping system.

Today, health care centres are operated by one or more self-governing communities, which also provide funds to maintain the premises. Thus, health care centres are publicly owned. All the employed are salaried according to the terms of the general contract for employees in the public sector and a special contract for health care. Physicians and dentists have, however, obtained the right to have a special contract, which means a separate negotiating position with the HIIS that introduces special supplements to their salaries.

Apart from public health care providers, private care is also provided by either individual health professionals acting as providers or by group practices with various combinations of services and specialties. The self-governing community grants concessions for private primary health care providers (based on the consent of the Ministry of Health). Such a concession is a public contract, which ensures inclusion into the network of publicly financed health care providers. It is agreed for an indefinite period, and each party has the right to withdraw from it (with certain limitations and restrictions).

Fig. 6. Outpatient contacts per person in the WHO European Region, 2000 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.

CEE: central and eastern Europe; EU: European Union; NIS: Newly independent states.

A concession is the prerequisite for reimbursement of practitioner services by compulsory and/or voluntary health insurance. Once a concession has been granted and the contract signed, the HIIS is approached to define the terms of the contract for the provision and extent of services and reimbursement. The contract with the HIIS gives the private provider of health care the same rights as any public provider. The only difference is that a private provider cannot apply for public funds for capital investment.

At the time private practice was introduced, the future of primary health care was rather unclear for the following reasons:

- there was an unclear policy on the further development and even existence of health care centres in general;
- due to geographical factors and factors of population size, many self-governing communities became increasingly fragmented and some of them were not able to keep up their responsibilities of operating and investing in primary health care centres; and
- there was a lack of a clear national strategy on the approach to private health care provision and the objectives that should be reached in achieving the adequate or acceptable mix of the two.

Many health care centres actually collapsed and functionally ceased to exist in several parts of Slovenia while still developing and being well integrated into the new concepts in other parts of the country. This resulted in differences in physical access for people in different parts of Slovenia. Part of this problem was also the long unsolved issue of publicly owned premises and their availability for (potential) private providers of health care. As no national guidelines were prepared for this problem until late in the process, many private providers left the publicly owned premises and started developing their own. In some health care centres, some custom-built infrastructure started to lose its main purpose, and the effective costs of maintaining such structures as health care centres became very steep when many profitable services left the publicly owned premises. The problem was finally addressed when the government adopted regulations for renting public premises to private providers.

Private provision introduced competition as a largely unknown (until then) phenomenon in health care. Although private practitioners with contracts with the HIIS work alongside the publicly employed physicians, competition arises by virtue of the competitive process associated with winning a contract.

The rules of compulsory health care insurance entitle patients to select their own physician in primary health care: in the health care centre or in private practice having a contract with the HIIS. The personal physician is in principle a general practitioner, but in urban areas and in some small towns children

would have a paediatrician or a school doctor as their personal physician. This selection is made for a period of at least 1 year. In 2000, about 95% of insured people had selected a personal physician. A similar situation applies to dentists. The 1992 legislation also allows women to choose a personal gynaecologist.

Personal physicians represent the entrance point to the health system (gatekeeper). With a referral from the personal physician, the patient may choose from a range of existing public or private providers of secondary and tertiary care.

The Slovene Public Opinion Poll was most recently carried out in 1999 and included a section on health and health care. A significant majority of the population was satisfied with their general practitioners and their pharmacists, but they were slightly less satisfied with the specialist outpatient and dental services. The causes for dissatisfaction involved primarily waiting times and complicated administrative procedures, and the people who have not visited one of the health professionals doubted that their personal physician would actually do everything possible to improve their health. The consensus of the respondents was that introducing private practice will improve the quality of health care, and those treated by private practitioners demonstrated a higher level of satisfaction than those treated by publicly employed physicians. Over the past 5 years, the percentage of people who consider care provided by private practitioners to be superior in quality to the care provided by public providers has declined.

Public health services

The national Institute of Public Health (IPH) with its nine regional public health institutes represents a network of institutions responsible for the planning and implementing of health protection and promotion programmes in Slovenia. The 1992 legislation clearly defined the role of the IPH. It integrates the daily practice, research, education and postgraduate training functions covering all areas of public health. Traditionally, public health in Slovenia has had three main branches: social medicine, hygiene and epidemiology. Over the last two decades, rapid development and the integration of several fields led to the development of another discipline, environmental health. An important component of all these fields (except for social medicine) is well equipped public health laboratories, some of them serving as reference laboratories.

The IPH maintains several national health statistics databases, including the national death register, the hospital statistics database, the outpatient statistics

database and the database on national health care providers and health professionals. In 2000, a new legal framework was adopted that assigns the IPH and some other institutions to host health registers for their work. It is also the first time that a legal basis was established to allow different health data to be linked through some common personal identifiers. The national IPH is furthermore responsible for environmental and communicable disease control. To some extent, IPH also covers health care organization, health economics and health informatics. The latter two are also developed in several other institutions, especially the HIIS.

The Health Council of the Ministry of Health, in cooperation with national specialty expert groups, proposes and monitors the implementation of the programme of preventive health care and health education for the population. Part of these efforts is also the national programme of social medicine, hygiene, epidemiology and environmental health services.

Several initiatives are currently being undertaken to strengthen health promotion, especially by the Ministry of Health. In 2000, the Minister of Health appointed a new state secretary to coordinate multisectoral activities that can promote and sustain health. A special centre for health promotion was established recently within the national IPH.

Four areas of specific attention have been underlined: food safety and healthy nutrition, physical activity, smoking and alcohol abuse. Comprehensive intersectoral strategies, legislative measures and action plans are in the process of adoption and implementation. Accordingly, the Council for Food and Nutrition has recently been established, as well as the Office for Food and Nutrition within the Ministry of Health. The National Institute of Public Health and the regional public health institutes are expected to run or give expert advice on special programmes focusing on food safety and nutrition, physical activity, alcohol, tobacco and unintentional injuries at the national and regional levels. Existing traditional public health institutes will have to be adapted according to these new demands.

It has been noted recently that differences in health status between different social groups and geographical regions are growing. A pilot project, aiming to reduce inequalities in health, is being implemented in the most disadvantaged region in Slovenia.

More preventive and population health oriented health care has been integrated within primary health care. HIIS is paying for preventive health check-ups and health education and health promotion programmes which are covering groups of the population at risk through their entire life span. A programme to improve maternal health is provided by gynaecologists and includes preventive check-ups during pregnancy.

Fig. 7. Levels of immunization for measles in the WHO European Region, 2000 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.

The screening programmes for cervical cancer and breast cancer are being revised. Preventive check-ups for children and adolescents including immunization are offered by paediatricians and school doctors. In addition, preventive check-ups for adults were introduced in 2001 to screen for specified risk factors for chronic noncommunicable diseases, especially targeting cardiovascular diseases. A national programme and action plan to prevent HIV/AIDS infection was set up in 1995.

Slovenia has high coverage of immunization of children, close to the average of the countries of central and eastern Europe and the newly independent states. Fig. 7 shows the percentage of children immunized against measles in Slovenia and other countries in the WHO European Region. Measles immunization was at 96% in 1999 and Slovenia is on the average.

Secondary and tertiary care

Specialist secondary care is performed in hospitals, polyclinics and spas. University hospitals and university institutes provide more complex tertiary health care services. As already pointed out, the personal physician directly (or sometimes in cooperation with the specialist) refers patients to secondary and tertiary care institutions.

Over the past decades, cooperation between primary and secondary care left much to be desired – cooperation was limited to referrals and exchanging test results. The situation has somewhat improved with a stricter gatekeeping system in primary care and hospitals providing postgraduate training courses for physicians working in primary health care.

Secondary outpatient medical services are provided at the polyclinics affiliated with hospitals or in community health centres contracted through a hospital specialist or consultant. As of 2000, most hospital polyclinics worked within the public network of health care services. These polyclinics also organize outpatient consultation for self-paying patients under regulations certified by the Ministry of Health.

There are also a few purely private health care providers of secondary specialist care and diagnostic services, but most work on contract with the HIIS. Slovenia has no combined public-private polyclinics yet, but the medical and dental professions aspire to move in that direction.

Treatment in spas can be suggested by the personal physician or by a physician in the hospital who is treating the patient. The medical committee of the HIIS can either approve or reject the suggested treatment. The insured

person may also be present at the deliberations of the committee. If the treatment is approved, the committee refers the insured party to the appropriate spa for treatment. If the professionally based evidence favouring treatment in a spa is considered inadequate, the proposal is rejected, but the insured party can appeal to a higher-level committee.

Hospitals provide about 75% of secondary care, either as inpatient or outpatient care. There are 26 hospitals, including nine regional and three local general hospitals and the main tertiary and teaching hospital, the University Medical Centre in Ljubljana. In addition, there are 12 specialized hospitals, which provide orthopaedic, pulmonary, gynaecological and psychiatric care as well as care for children and youth with severe chronic diseases and disorders.

Apart from the Clinical Centre in Ljubljana, there are two other national tertiary institutions, the Institute of Oncology and the Institute for Rehabilitation. All hospitals are state owned, but there have already been some initiatives for private hospital care. Private hospitals may be established out of the network of publicly financed providers. There is also an opportunity for private investment in new hospitals, although this has not yet taken place.

The number of hospital beds declined from 5.0 per 1000 in 1990 to 4.6 in 1998 (Fig. 8 and Fig. 9). This is the result of a policy of moving from inpatient to outpatient care implemented mostly by reducing resources. It is expected to change further with the forecast changes in the hospital reimbursement system. There will also be a further shift to day hospital facilities and a more integrated approach to home care for various patient categories. Fig. 8 shows the relatively lower bed numbers per 1000 population compared with other countries. In early 2001, the Ministry of Health targeted approximately a 1% annual decrease in hospital beds in the following 5 years as well as a decrease in the number of hospitals or hospital departments. To date, no hospital or department has been closed down.

The average length of stay has been declining very gradually in recent years: from 12 days in 1987 to 8.6 in 2001 (1). This figure compares favourably with western European countries, many of which have longer lengths of stay. Slovenia had 16.2 inpatient admissions per 100 population in 1997 (16.6 in 2001); this had consistently increased since 1987. Compared again with western European countries, this figure is relatively low (Table 5).

Hospitals attempt to fill the excess bed capacity that arises through shortening lengths of stay and new alternative arrangements such as accommodating patients covered by voluntary insurance and marketing non-standard services. The HIIS also provides certain incentives to reduce the duration of hospital treatment: until recently through payment for a bed that is not occupied, and since 2001 through payment per case. (See the section on *Resource allocation*).

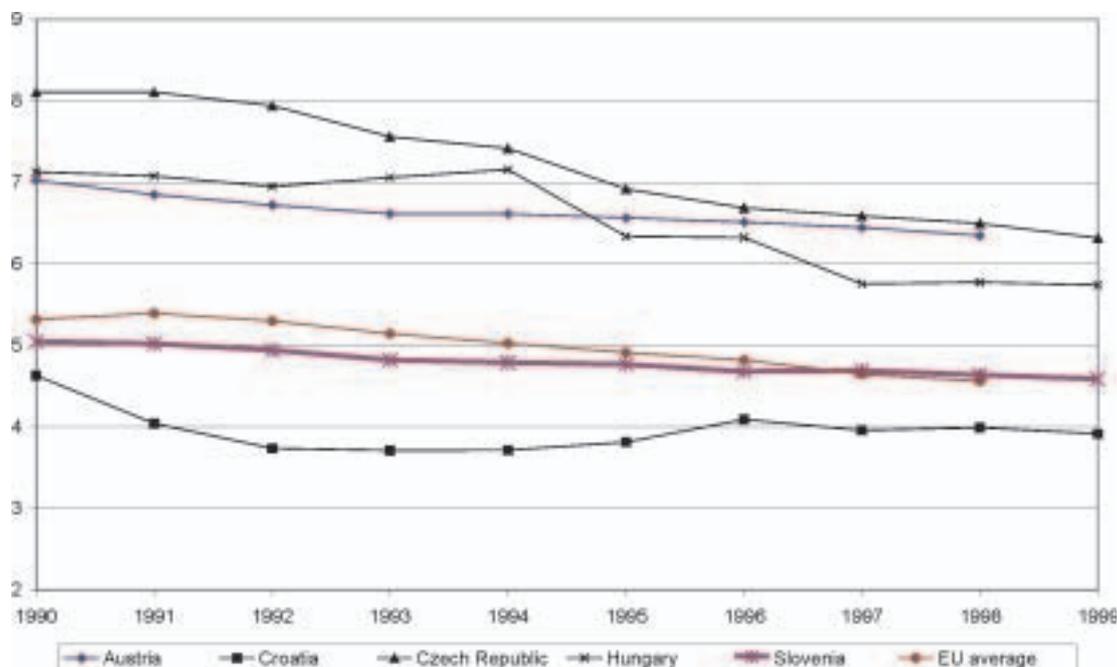
Table 5. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2000 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Western Europe				
Austria	6.2	27.2	6.3	75.5
Belgium	5.5 ^b	18.8 ^b	8.7 ^b	79.9 ^b
Denmark	3.3 ^a	19.1	5.5	79.9 ^a
EU average	4.2 ^a	19.0 ^b	8.2 ^b	77.0 ^b
Finland	2.4	20.2	4.3	74.0 ^e
France	4.1 ^a	20.0 ^a	5.5 ^a	77.4 ^a
Germany	6.4 ^a	20.3 ^a	10.7 ^b	81.6 ^b
Greece	3.9 ^a	14.5 ^c	—	—
Iceland	3.7 ^d	18.1 ^e	6.8 ^e	—
Ireland	3.0 ^a	14.1 ^a	6.5 ^a	83.0 ^a
Israel	2.3	17.5	4.3	94.0
Italy	4.5 ^b	17.1 ^b	7.1 ^b	74.1 ^b
Luxembourg	5.5 ^b	18.4 ^f	7.7 ^b	74.3 ^f
Malta	3.7	11.2	4.6	75.5
Netherlands	3.3	9.1	7.7	58.4
Norway	3.1	15.5	6.0	85.2
Portugal	3.1 ^b	11.9 ^b	7.3 ^b	75.5 ^b
Spain	3.0 ^d	11.2 ^d	8.0 ^d	77.3 ^d
Sweden	2.5	15.6 ^b	5.5 ^a	77.5 ^d
Switzerland	4.0 ^b	16.4 ^b	10.0 ^b	84.0 ^b
Turkey	2.2	7.6	5.4	58.7
United Kingdom	2.4 ^b	21.4 ^d	5.0 ^d	80.8 ^b
CEE				
Albania	2.8 ^b	—	—	—
Bosnia and Herzegovina	3.3 ^b	7.2 ^b	9.8 ^b	62.6 ^a
Bulgaria	—	14.8 ^d	10.7 ^d	64.1 ^d
CEE average	5.9	19.1	8.3	72.8
Croatia	4.1	13.9	9.2	86.3
Czech Republic	6.3	18.7	8.8	70.7
Estonia	5.6	18.7	7.3	66.1
Hungary	6.6	22.4	6.7	72.5
Latvia	6.1	20.0	—	—
Lithuania	6.3	20.9	8.3	76.0
Slovakia	6.9	18.9	9.4	71.0
Slovenia	4.6 ^a	16.1	7.6 ^a	73.2 ^a
The former Yugoslav Republic of Macedonia	3.4	8.9	8.4	60.1
NIS				
Armenia	4.9	4.9	10.3	28.2
Azerbaijan	7.3	4.7	15.4	28.5
Belarus	—	—	—	88.7 ^f
Georgia	4.3	4.5	7.8	83.0
Kazakhstan	5.5	14.1	11.5	97.0
Kyrgyzstan	6.1	15.5	12.3	90.2
NIS average	6.4	15.3	12.9	84.6
Republic of Moldova	6.3	13.1	11.9	66.6
Russian Federation	9.2	21.1	13.5	85.8
Tajikistan	5.9	9.0	13.2	59.8
Turkmenistan	6.0 ^c	12.4 ^c	11.1 ^c	72.1 ^c
Ukraine	7.2	18.4	12.7	88.1

Source: WHO Regional Office for Europe health for all database.

Note: ^a 1999, ^b 1998, ^c 1997, ^d 1996, ^e 1995, ^f 1994, ^g 1993, ^h 1992, ⁱ 1991, ^j 1990.

Fig. 8. Hospital beds in acute hospitals per 1000 population in Slovenia and selected European countries, 1990-1999



Source: WHO Regional Office for Europe health for all database.

Social care

Community nursing services are organized in all self-governing communities and are based in health care centres. Community nurses have taken on all the tasks of district nurses, including those previously provided by midwives, and represent the link between health care and social care services. Although their main tasks should primarily be preventive activities and health education, most of their work (80%) is still devoted to curative activities.

Homes for elderly people and disabled people provide long-term health care. Access to long-term care in these homes is through the local community social agency based on the recommendation of the physician. A permanent physician on the staff provides health care in the homes for elderly people in cooperation with registered nurses. Based on need, secondary specialists are also consulted or called in. The level of care for chronically ill and incapacitated patients is relatively high in these institutions. Nearly all these homes are public. The demand has risen because the Slovene population is ageing, and two options are being considered to increase the availability of services. One follows the attempts to find financing and reimbursement niches to solve the superfluous bed capacity in hospitals.

Fig. 9. Hospital beds in acute hospitals per 1000 population in central and eastern Europe, 1990 and 2000 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.

CEE: central and eastern Europe.

Slovenia

These superfluous beds may be offered as extended-stay departments for publicly owned institutions to reduce the waiting period for acceptance into homes for elderly people. This option is reflected in current plans to enable a bridge between a hospital setting and home care for those who are expected to recover well in the short term. This should especially apply to patients recovering after surgery, who would be discharged sooner from a regular department and quickly receive rehabilitation treatment and nursing care at a nursing department. Such departments would be opened at several general and clinical hospitals to reduce costs and more rapidly rehabilitate certain categories of patients.

The second option is to increase long-term community nursing care facilities and home treatments. On average, every year up to two new public homes for elderly people are opened, but as this trend is not financially sustainable, solutions are needed quickly. Once again, the Slovenian population is ageing and providing for the needs of the growing number of elderly people presents new challenges. Enabling them to maintain self-sufficiency and an optimum quality of life at home as long as possible is a major task requiring attention in the future.

Human resources and training

Prospective analysis of demographic data for physicians and that of the general population indicates potential shortages of physicians in certain regions. Currently, there is no unemployment among physicians, and problems in ensuring the coverage of certain areas are sometimes reported. Thus, recruiting some health care workers from outside Slovenia may be considered. Fig. 10 and Fig. 12 show trends in the number of physicians in Slovenia and selected European countries. The policy of the last few years has been reflected in a markedly slower rate of growth in the number of physicians in Slovenia. Growth has also been slowed in the past few years in other countries with previously high growth rates. Slovenia still has many fewer physicians per capita than most EU and central and eastern European countries (Fig. 10). Within the group of EU countries, only the United Kingdom has fewer physicians than Slovenia, and only Romania and Albania in central and eastern Europe.

In order to meet the EU working time directives for physicians, Slovenia, as is the case with all EU countries, will have to introduce a maximum of 48 working hours per week. Working hours often exceed this maximum and it is thus projected that the number of physicians will have to increase from 4500 to 4800 by 2010.

It is planned to hire an additional 400 physicians in order to improve accessibility to health care services. The situation is somewhat different with nurses. Fig. 11 shows trends in the number of nurses per 1000 population in Slovenia and selected European countries. Their numbers show relatively constant growth and are at a higher level than in Austria or Croatia. Slovenia has more nurses than most central and eastern European countries. A high proportion of nurses work in outpatient settings, both in primary and secondary care, whereas there are relatively fewer nurses in hospitals.

The admission to medical school increased by 15% during the last few years. Basic medical education for physicians takes 6 years. After graduation from the School of Medicine (at the University of Ljubljana) there is an obligatory internship of 6 months, which is then extended into an obligatory postgraduate training programme (“secundariate”) lasting for an additional 18 months. Dentists have an internship period of 12 months, which completes their obligatory postgraduate training period.

Physicians and dentists who work in health care and practice their profession with patients have to become members of the Medical Chamber of Slovenia and need to be licensed. Every physician and dentist must undergo an examination every 7 years to renew his or her licence. Postgraduate courses are organized to accommodate the range of specialties and give special points required for admission to the re-certification examination (which can then be skipped if the number of credits is sufficient).

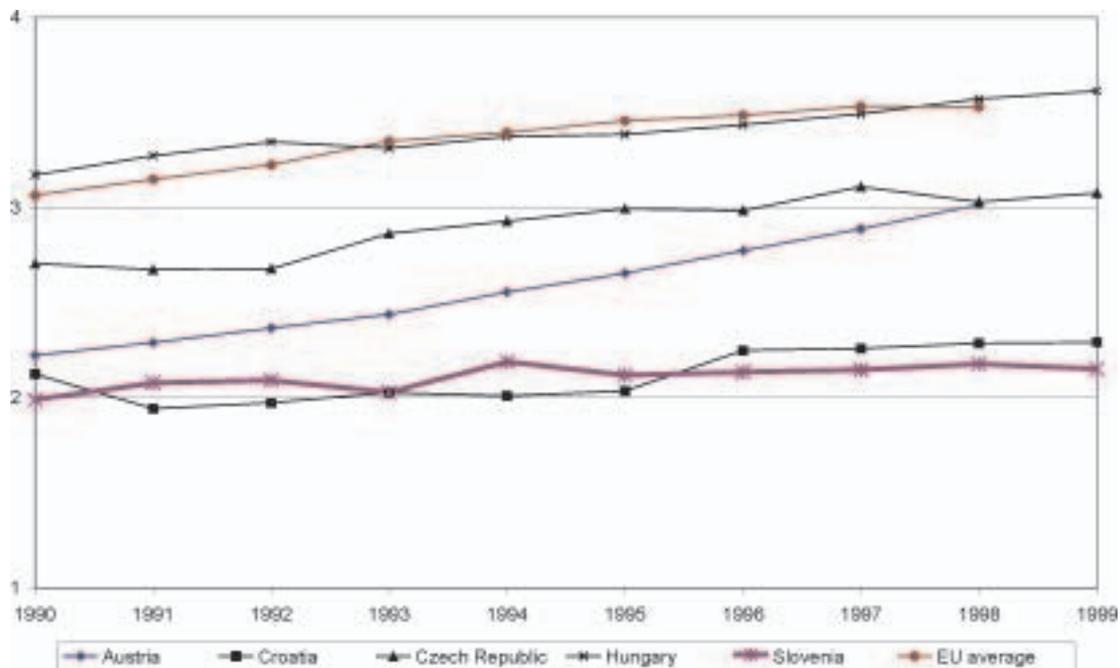
Most courses are intended for general practitioners. General medicine has transformed gradually into family medicine and is taught as a subject in the undergraduate programme in addition to being a specialization in its own right. The Faculty of Medicine of the University of Ljubljana has a Department of Family Medicine with a well defined teaching staff. To be granted a full licence to practise in the field, general practitioners have to specialize in a 4-year programme, which also includes a comprehensive programme of public health (social medicine). In the context of this transition, additional training is envisaged for physicians now exclusively treating children and young people.

Since 1999, all postgraduate specialist training has been reformed. Some new specialties have been introduced, and the older core curricula have been thoroughly revised and harmonized according to the guidelines of the European Union of Medical Specialists for each respective specialty.

Undergraduate training in public health is limited to the modest introduction courses received by medical, pharmaceutical and nursing students. An exception is the programme for public health for health inspectors.

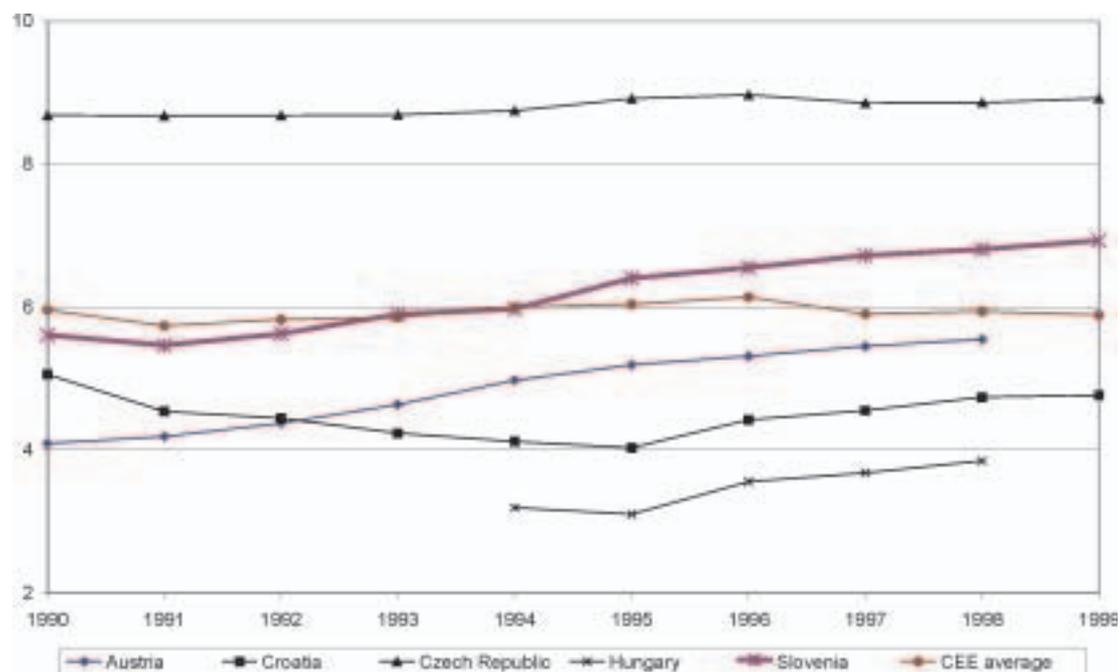
There is a well developed medical specialty in epidemiology, hygiene and social medicine, requiring 3 years of training beyond the medical degree.

Fig. 10. Number of physicians per 1000 population in Slovenia, selected European countries and the EU, 1990-1999



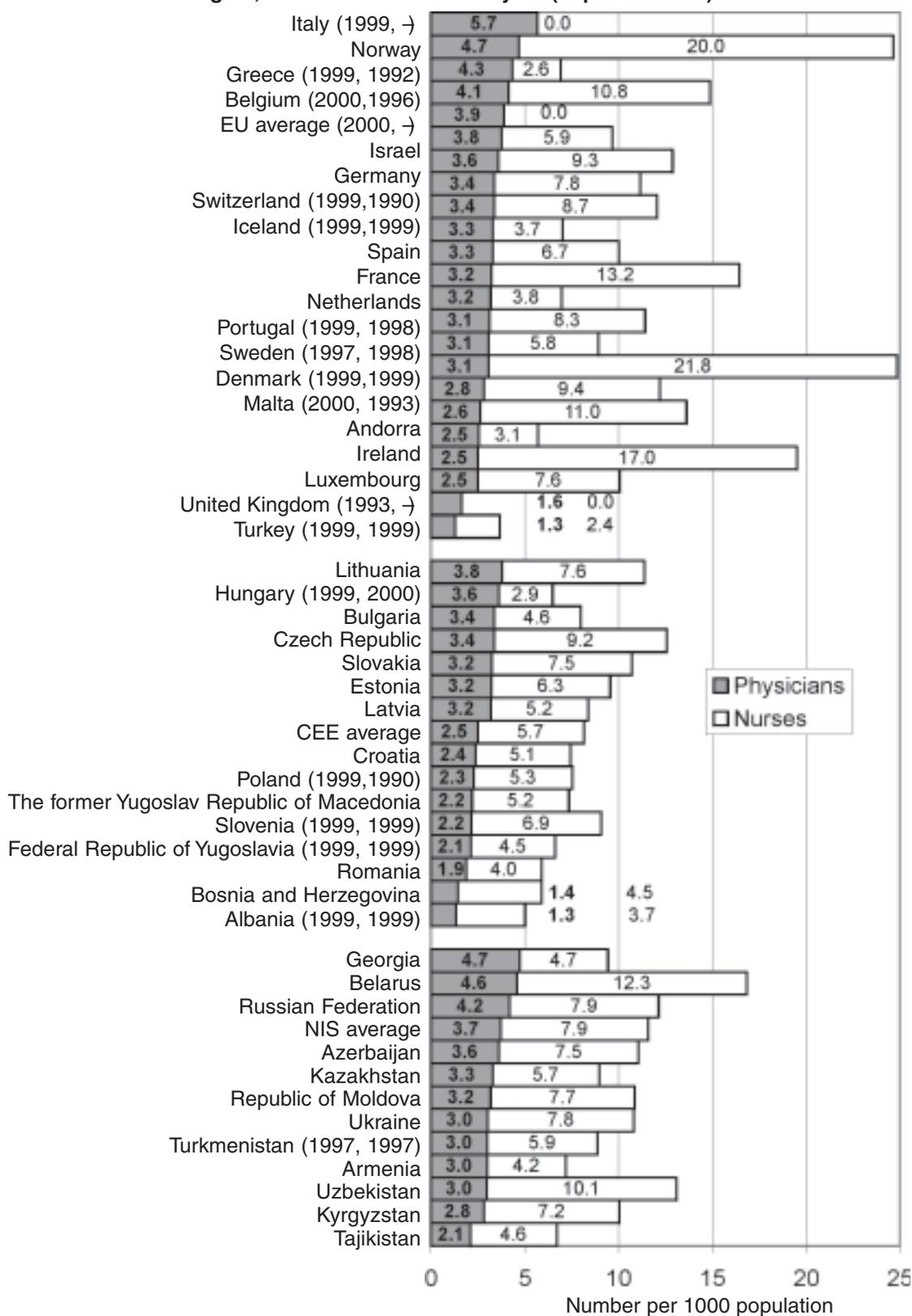
Source: WHO Regional Office for Europe health for all database.

Fig. 11. Number of nurses per 1000 population in Slovenia, selected European countries and the EU, 1990-1999



Source: WHO Regional Office for Europe health for all database.

Fig. 12. Number of physicians and nurses per 1000 population in the WHO European Region, 2000 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.

CEE: central and eastern Europe; EU: European Union; NIS: Newly independent states.

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There are also training programmes (postgraduate courses of two semesters and 400 hours) in social medicine, occupational medicine, health care for children, youth and women and dental public health. The graduates can continue their studies at the Andrija Stampar School of Public Health in Zagreb. The minor part of this programme (credit points) is also acknowledged as a part of the postgraduate studies in biomedicine at the University of Ljubljana. The postgraduate courses are founded by participants themselves or by the institutions where they are employed. Nevertheless, besides specific public health disciplines, there is no school of public health functioning under that name in Slovenia but preparations for founding a school of public health have been initiated.

Training in nursing is provided at the secondary school (medical technicians), high school (registered nurses) and university levels (interdisciplinary study for health educators). Additional training (specialization) is required for community nurses, psychiatric nurses, geriatric nurses, surgical nurses, intensive care nurses and nurses involved in medical informatics. Bachelor degree study is provided by two schools: one is part of the University of Ljubljana and the other one of the University of Maribor. A new university-level curriculum for nurses, which began in 1993 at the University of Ljubljana (Faculty of Education), is based on the principles of primary health care with a strong emphasis on health promotion and prevention, and includes health management and health education as a course of instruction. In addition to general nurses, health educators and midwives there are other professions with different levels of education employed within health care, such as physical therapists, occupational therapists, sanitary engineers and dental technicians, including orthodontic and prosthetic technicians.

The importance of nursing has grown immensely in recent years. It is felt that new developments in medicine, nursing and new high technologies require more nursing staff with higher educational levels, capable of taking over some of the tasks presently performed by physicians. Because no nursing studies were organized at the university level, nursing professionals in Slovenia are currently taking master's and doctoral degrees in nursing at the Faculty of Education, the Faculty of Organizational Science and in other European countries.

To summarize and conclude, the health sector in Slovenia is facing challenges in sustaining an adequate number of physicians to cover services in remote regions. This is somewhat different with the numbers of nurses. In addition, the health sector in Slovenia faces problems with health care personnel, which can be linked to poor utilization of working time and insufficient training.

The system is very oriented towards treatment, and comprehensive and demanding new public health activities are difficult to carry out because of deficiencies in the capacity of public health care professions. These are most marked in management, strategic planning, health care supervision (surveillance) and preventive health care.

In addition, short-term policies and measures are needed to curb existing and rising imbalances in staffing and productivity, which are closely linked to performance and quality of health care institutions, individual clinical practice and patient satisfaction and health outcomes.

Pharmaceuticals and health care technology assessment

Regulations

The framework law for the market authorization of pharmaceuticals is the Law on Medicinal Products and Medical Devices adopted in 1999 and harmonized with the pharmaceutical portion of the *acquis communautaire* of the EU. Drugs are registered by the Office for Medicinal Products, which was founded in 1996 and operates within the Ministry of Health. Its main objective is to implement the national policy on drugs and medical devices. A medicinal product may only be marketed after marketing authorization by the Office. The import of serum, vaccine, blood products and radiopharmaceuticals is subject to specific authorization procedures. A national register of medicinal products is published in cooperation with the national IPH. The register also contains the prices and enables physicians when faced with a selection of equally effective drugs to choose the cheaper ones. A register of medical devices is being developed. The Office issues permits for the manufacture of medicinal products and medical devices according to good manufacturing practices and recently ISO 9001 and approves market authorization for medicinal products. The procedure employs a modified approach for specific groups of medicinal products that have already been approved for marketing in the EU according to a centralized or decentralized procedure (for example, for orphan medicinal products and others). Companies may manufacture medicinal products only after they have been authorized. Prices are controlled by basing pricing criteria on reference prices, negotiations or cost-effectiveness.

The medicinal products committee of the Office evaluates medicinal products and medical devices, for example, by commissioning clinical trials.

About 100 clinical trials are performed annually in Slovenia. Most are multicentre, international clinical trials. The clinical testing of a drug requires ministerial approval of clinical tests based on an examination of documents relating to the test.

The Institute of Pharmacy and Drug Research, a public institute founded in 1955, is responsible for controlling the quality of medicinal products, and the Standards and Metrology Institute is responsible for certifying and standardizing medical devices.

The special interdisciplinary commission of the HIIS (according to legislation on classification and pharmaco-economic criteria) classifies drugs covered by obligatory health insurance on positive and intermediate lists. Medicinal products on the positive list are reimbursed 75% by compulsory insurance, and 25% is paid by voluntary insurance or out of pocket. Medicinal products on the intermediate list are reimbursed 25% by compulsory insurance. A negative drug list contains products not eligible for reimbursement. For children, youth and certain diseases, the law mandates that the compulsory health insurance pay all drug costs. The use of generics in Slovenia is quite extensive although there are no specific incentives for prescribing generics.

Prescribing and distribution

All prescriptions are registered. Each physician has a prescribing number, and the type and volume of the drug the physician prescribes is recorded. In 1996 a bar coding system was introduced to monitor drug prescriptions.

Drugs are distributed through wholesalers or private importers, who obtain drugs from domestic production or through imports and sell them to public or private pharmacies. Two firms represent Slovenia's pharmaceutical industry, Lek in Ljubljana and Krka in Novo Mesto, both of which are private corporations. Most of the domestic pharmaceutical manufacture is export oriented. Slovenia has no restrictions on private ownership. Pharmacies are reimbursed by a fee-for-service system according to a list of pharmaceutical services, including checking the data from prescriptions, instructing patients, preparing magistral preparations (custom-mixed pharmaceuticals), galenicals (preparations with organic ingredients) and others.

All these standard services are assigned pharmacy fee points by the same measures as other health care services. The point values also include material costs and pharmacist's wages. The manufacturer's price, wholesaler's margin and pharmacy fee together determine the price of the drug.

Consumption

Slovenia has relatively high drug consumption. The money spent on pharmaceuticals is not exactly known, because the consumption of medicinal products in hospitals and those dispensed without a prescription in pharmacies are not recorded at the national level.

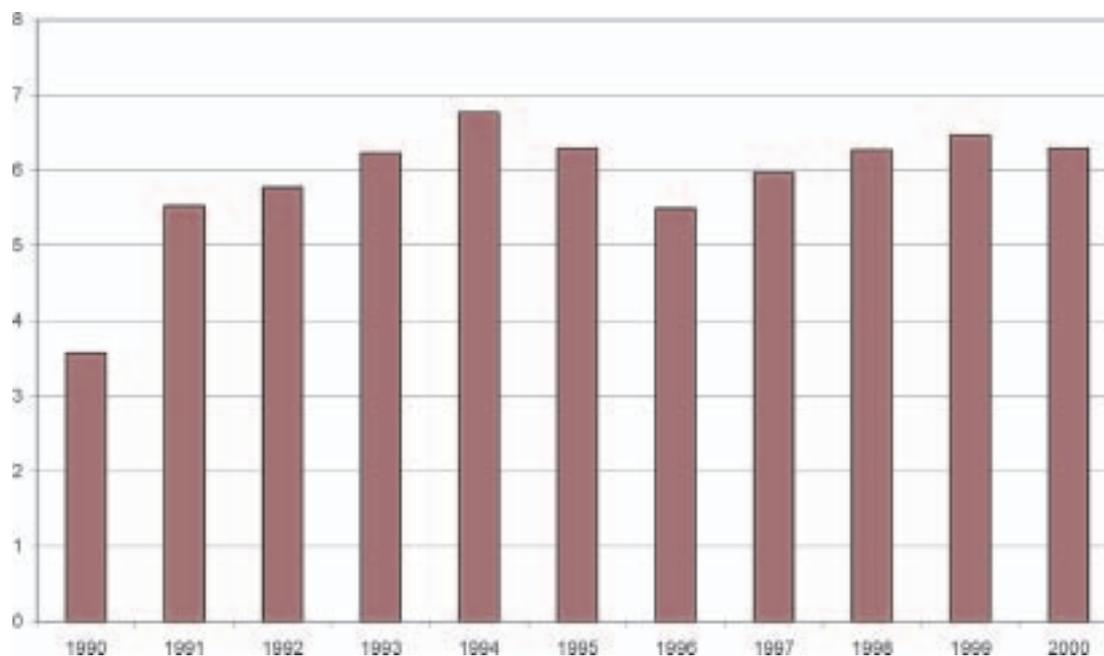
The data gathered from prescriptions are more accurate. Prescription pharmaceuticals started to be monitored in 1974, when the automatic processing of prescriptions was launched. Since then, several improvements have been made. Now physicians are informed periodically of the volume of drugs they prescribe. Consumption of pharmaceuticals according to age groups is generally highest for groups older than 60 years, younger than 1 and 1–3. Over the last decade, the most frequently prescribed drugs were those for circulatory diseases, followed by drugs for parasitic and infectious diseases and drugs for respiratory diseases. These three groups account for one third of all drug prescriptions in Slovenia.

The consumption of prescription drugs has grown in recent years (Fig. 13). In 1991, an average of 5.5 prescriptions per person were issued. The number increased until 1994, peaking at 6.8. This trend continued into early 1995, prompting measures to limit the number of prescriptions physicians were permitted to write. Thus, the number declined to 6.3 in 1995. In 1997 the largest category of prescriptions was for cardiovascular disease medicines, amounting to about 26% of all prescription costs.

The HIIS has faced increasing pharmaceutical costs in recent years mainly because the price of medicines has increased rapidly, in particular of innovative drugs which are also increasingly prescribed from year to year (Fig. 14). In 1995 the government intervened under special legislation to control drug prices in the wholesale and retail sectors by determining the prices. As a result, the rate of increase slowed substantially.

The number of drugs on the positive list was reduced in 1997, but the number on the intermediate list increased. Since the share of co-payment is higher for the intermediate list, this greatly increased the medication expenditure in voluntary health insurance. Thus, the final outcome of the years 1997 and 1998 was a considerable increase in pharmaceutical expenditures beyond the planned level.

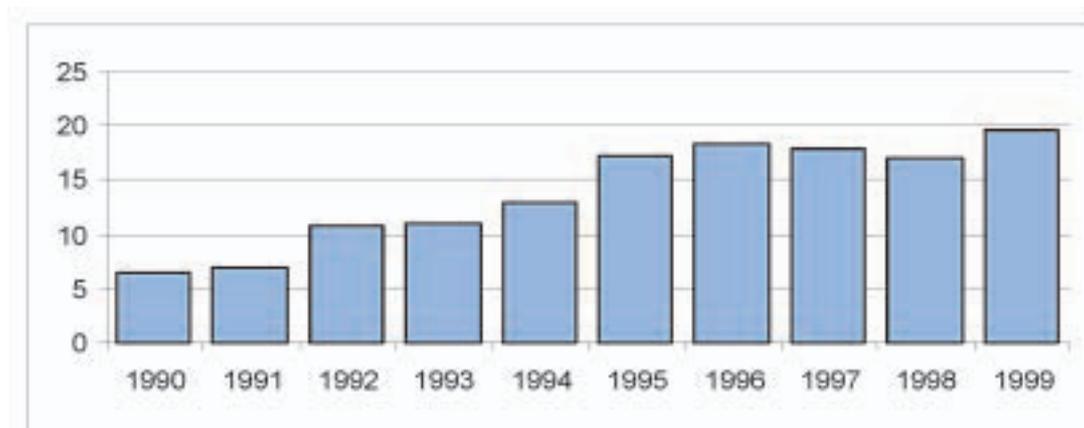
In 1996, the Ministry of Health published prices in the drug register along with a recommendation to physicians that, among a selection of equally effective drugs, the less expensive ones should be chosen. There are plans to implement intensive measures to control imports and the use of all types of drugs. The list of reference drugs which will promote the use of less expensive drugs by the means of insurance limitations is under preparation.

Fig. 13. Number of prescriptions issued per capita per year, 1990-2000

Perspectives

Despite the measures taken to date, the situation remains unsatisfactory. Comparative data show that drug consumption is still relatively high compared with other European countries. The general health status and needs of the Slovenian population do not warrant such a level of drug intake. A set of measures has already been taken to address the pharmaceutical sector.

For example, it is expected that the introduction of electronic prescriptions (a health insurance card issued to almost all insured people) will make the drugs prescribed for each insured person more transparent. Unnecessary drug prescribing will be prevented as well as incompatible drug combinations.

Fig. 14. Cost of an average prescription in US dollars, 1990-1999

In order to improve introduction on drugs for physicians, an electronic database of medicinal products is being established that will be accessible to all physicians, including drug codes, registered names, non-proprietary names, ingredients, indications, side effects, doses and prices.

It is anticipated that the database will contribute to solving this problem. Together with the Ministry of Health, the Slovenian Chamber of Pharmacy and the Medical Chamber of Slovenia, the HIIS is preparing comprehensive and comprehensible information for presentation on radio or television and in print about rational drug use and the harmful consequences of use without professional medical justification.

Further action may need to be taken in light of Slovenia's EU accession process. Within the scope of the national programme for the adoption of the *acquis communautaire*, Slovenia is harmonizing its pharmaceutical and medical devices legislation with EU legislation. Legislation related to the pharmaceutical sector is mainly transposed by amending and modifying the Medicinal Products Act, which has been complemented by at least 30 regulations. These additional provisions regulate how certain parts of national legislation are to be changed when the EU legislation comes into force when Slovenia becomes a member. Another activity is harmonizing procedures for obtaining marketing authorization for drugs already distributed in Slovenia. According to the Department of European Integration of the Ministry of Health, most harmonization measures had been accomplished by the end of 2000. Legislation related to medical devices is being harmonized in cooperation with the Ministry of Science and Technology and the Standards and Metrology Institute.

Financial resource allocation

Third-party budget setting and resource allocation

There are three stages in the annual process whereby resources are allocated from the compulsory health insurance scheme. The first stage involves the Ministry of Health (representing the state), the HIIS (representing the third-party payer), the Society of Health Institutions of Slovenia, the Medical Chamber of Slovenia, the Slovenian Chamber of Pharmacists, the Community of Slovenian Natural Spas, the Community of Slovenian Organizations for Persons with Special Needs, and the Community of Slovenian Social Institutions (representing providers). They negotiate over several months to agree on the services to be included in the insurance benefit package and to determine the total cost of the health care programme to be paid by compulsory insurance.

This general agreement describes the type of services and defines the total capacity, needs and extent of services based on the general framework of the funds for that year. It therefore defines the total level of government funding, which was set at about 7% of the GDP in 2000 and 2001. If the partners cannot agree on the content of the annual agreement, they face arbitration. If arbitration fails, the dispute is settled by the government.

In the second stage, the partners (Ministry of Health, HIIS and relevant representatives of providers) negotiate for each type of provider (health care centres and private practices, hospitals, pharmacies, spas, social care institutions and tertiary institutions) the rights and responsibilities of partners in contract implementation and execution of the programme, norms and standards for defining capacities for carrying out programmes, mode of payments, criteria

for the transfer of funds between interdependent activities and similar factors. The agreements at this level have to be in line with the general agreement and represent the basis for agreements between HIIS and providers.

The third stage of the negotiations involves two parties: the HIIS and each individual provider. The HIIS issues a public tender for contracts with the provider. Individual contracts with health care providers (public health centres, hospitals and private practitioners) are then drawn up, taking into account the general agreement and the agreement for the respective type of provider. The contracts detail the type and volume of services to be provided as well as the prices of programmes or services, the method of calculation and payment, the supervision of the implementation of the contracts and the individual rights and responsibilities of the contracting parties.

Payment of hospitals

It is the responsibility of the HIIS to negotiate annual contracts with each hospital, which specify a target activity level and a budget ceiling. The hospital must meet its target or else it is liable to repay a proportion of its share. However, no additional payments apply if the target is exceeded. In practice, there have been occasions when the targets were revised during the year, or where a hospital experiencing financial difficulties received additional funding.

The approach that has been applied to date involves, in effect, establishing a relative costliness factor for each type of hospital, which is based largely on its expenditure history. The product of each hospital's target activity and the relevant costliness factor establishes each hospital's share of the available budget. While this process has significant merits, the use of each hospital's expenditure history is a basic weakness in the process.

The target quantity of work and its value in budget terms have been determined in several ways over the last decade. Prior to 1993, the main basis was a sum of cost-weighted items of service, most of which were medical procedures. A typical inpatient episode would therefore comprise a mix of several items of service, each with its own cost (or payment) relativity.

One advantage of this model was that the same classification of products could be used for both hospital and medical specialist payments (and hence for inpatient, outpatient and non-hospital medical care). The main weakness was that it gave little useful information about the nature of inpatient services. A single procedure (such as a diagnostic test) could be used as a component of many different episodes of hospital inpatient care.

Fig 15. Financing flow chart

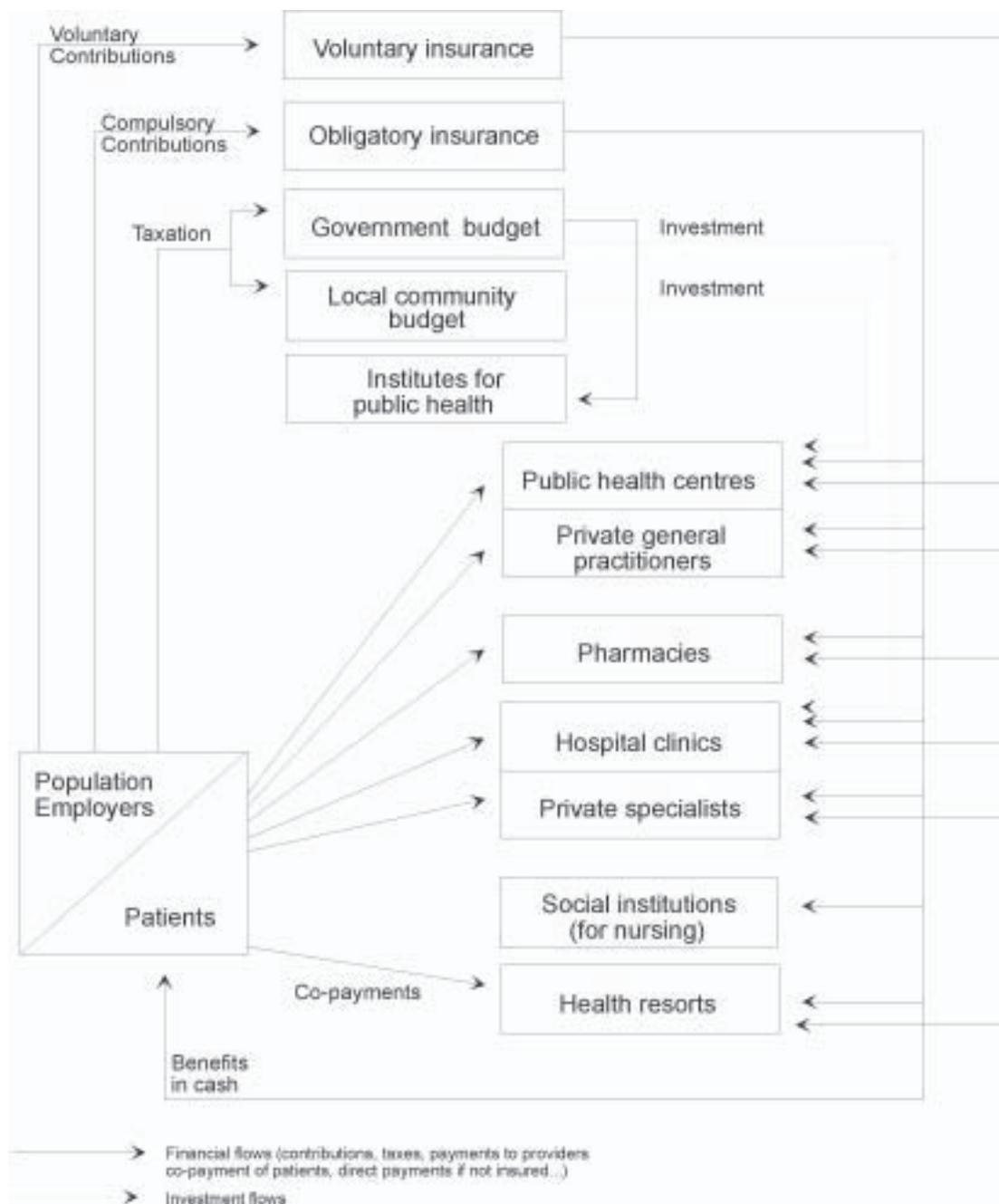
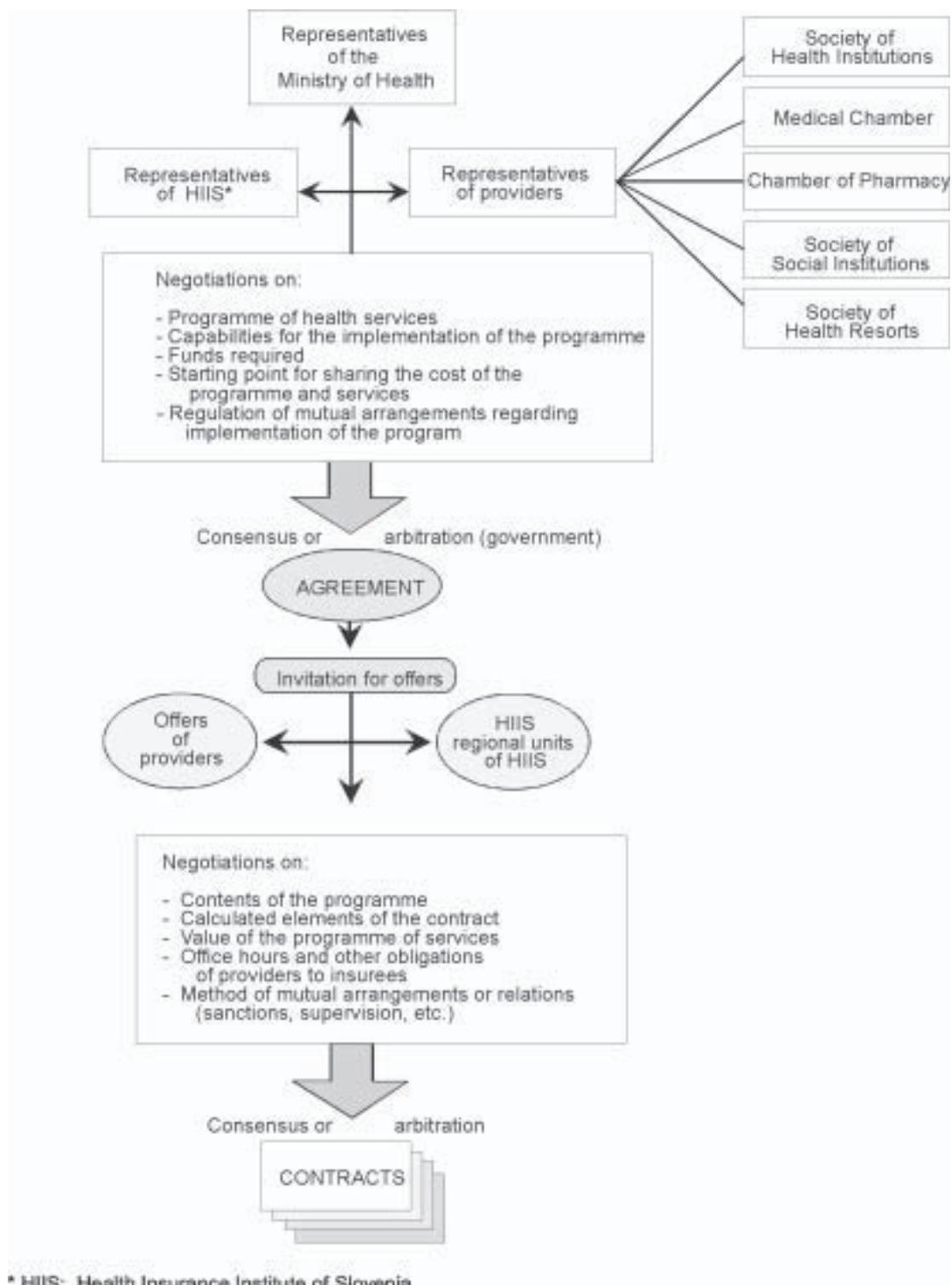


Fig. 16. Process of partnership negotiations



This approach did not provide an adequate basis for judging whether payments to hospitals were fair, or whether care was efficient or of high quality. It encouraged the over-provision of items of service, and of items with high payment relativities. It gave undue emphasis to medical procedures involving technological devices, and did little to recognize or ensure fair payment for nursing and physical care.

In 1993, there was a change from items of service to inpatient days of stay as the units of production for which payment was made. It was again a budget share method, but production was defined prospectively in terms of the number of inpatient days for each of a short list of specialties or clinical departments (such as obstetrics, paediatrics or orthopaedics). The payment relativities for each type of inpatient day were based on an analysis of payments made on the basis of items of service in previous years.

The basis for each hospital's share of the budget was again a prospectively set volume of services, and again hospitals carried the risk of service provision in excess of the funded target. However, the volume targets did not only reflect historical levels, but were also influenced by expected rates of inpatient days in the service area of each hospital. Thus a minor element of needs-based funding was introduced.

Not all kinds of costs could be easily associated with days of inpatient care by a specialty-departmental category. Unusually high cost elements not closely related to days of stay were therefore funded from a separate pool called the "extra-charge materials" budget. It became progressively less common for the targets to be revised during the year, or to provide additional funding to a hospital experiencing financial difficulties.

The main strength of this model was that it provided more useful information about the care being provided to inpatients according to their care needs. It also gave incentives to hospitals to reduce the level of provision of items of service. However, it gave no incentives for hospitals to control lengths of stay. In recognition of this problem, an additional funding pool was established that paid hospitals for "vacant beds". In practice, few hospitals responded to this incentive and only a small amount of compensation was claimed in this way. In total, this model provided a fairer basis for splitting the available budget, at least in some respects. However, the incentives for efficiency and improved quality of care remained weak.

A per case model has applied since 2000. In other words, there was a change from inpatient days of stay to complete inpatient episodes as the units of production for which payment was made. Again, the basis for setting the payment relativities was analysis of actual payments made by inpatient day in previous years.

Otherwise, few changes were made. The model was still budget share, and production continued to be defined using a simple high-level classification of specialties and departments. It consists of internal medicine, surgical, gynaecological, paediatric, psychiatric, ophthalmological, dermatological, otorhinolaryngological, maxillary surgical and others.

The payment method by cases is seen as a step forward in many respects. It increased the utility of information in terms of the care being provided to inpatients according to their needs. It gave incentives to hospitals to reduce the level of provision of items of service and to reduce lengths of stay. It also provided a fairer basis for splitting the available budget.

However, an obvious weakness was that the case types were imprecisely defined. Equally important, the relative costs of each type of case were not able to be estimated with any precision, and were based on expenditure history rather than any notion of the cost of appropriate clinical practice. There was much clinical variation within the “case groups”, and this not only meant that there were disagreements about the equity of budget allocations but it also limited the analytical value of the data for purposes such as service planning and evaluation. Plans for refinement of this model are discussed below.

Payment of primary health care

The negotiating process described above also applies to primary health care. The health care centres and stations are paid a combination of capitation and fees for services.

Recently, the Ministry of Health introduced a new preventive health programme. Primary care physicians are reimbursed in full for their services only if the prevention programme has been fully implemented, if their referrals have not exceeded the national average by more than was agreed in the contract with HIIS, and if there are no long waiting lists. This is one of the measures of the Ministry of Health to stimulate primary practitioners to engage in prevention activities and to provide some degree of gatekeeping by discouraging unnecessary referrals to the secondary level.

Private providers who hold a concession have the right and responsibility to bid for contracts in the public tenders announced annually by the HIIS. Again, the contract with the HIIS clearly specifies the scope of the contractual work, its monetary value and the price of specific services. Private providers without a concession and contract can set their own prices for services, which will then not be reimbursed under HIIS insurance.

Payment of physicians and other health care staff

As explained earlier, physicians may practice in several ways: privately with a concession and under contract with the HIIS or privately without a contract.

Employed physicians are salaried under the conditions of the special contract (collective agreement for physicians). This is a sub-law to a more general contract, a collective agreement for public sector employees.

The salaries of physicians may vary by between 15 and 20% because of performance incentive payments as determined by the management of the hospital or health care centre. They can further vary according to the physician's post and length of career and on out-of-hours work and bonuses, such as for increased responsibility, academic achievements and specific working conditions.

Physicians and other staff in private practices with a concession are salaried by the relevant contract (see above), and funds for the salaries are foreseen in the contract of private provider with HIIS. Private physicians without a contract with HIIS are paid through out-of-pocket fees and are free to determine their own salary and those of their staff.

In 2001, physicians' average earnings were about 2.5 times the average salary in Slovenia. In the last few years, physicians have negotiated significantly higher salaries and there have been two strike episodes by doctors over pay and working conditions. The physicians' trade union (like other trade unions) negotiates salaries directly with the government.

Nurses also have a specific contract (collective agreement for nursing), whereas other health care staff (such as pharmacists and physiotherapists) are salaried by a collective contract for health care and social care activity, another sub-law to the collective agreement for public sector employees. A nurse's average salary was about 20% higher than the average salary for all professions in Slovenia.

Health care reforms

The health sector in Slovenia, like that in most other countries, has been in a state of continual change for several decades. The causes are well known: increased expectations for care, an ageing population, new knowledge, more effective and expensive technologies, etc.

Like other transition economies, the 1990s have provided additional challenges to Slovenia. One important aspect was the need to ensure a reasonable degree of economic and social stability. For this and other reasons, health sector reform has been undertaken with a considerable degree of caution. There are now, however, signs that the pace of reform will increase.

The 1992 reforms

It was necessary to take urgent action when Slovenia became an independent state in 1991 and began the process of transformation to a market economy. The state of the health care system at that time was far from satisfactory for a variety of reasons. One was that the already high expectations of free health care of Slovenians increased during the 1970s and 1980s. This contributed to a progressive increase in health care staff and facilities, while health care professionals' salaries remained at comparatively low levels. This situation exacerbated the low levels of motivation among care providers. Moreover, the health care sector had not been given the opportunities or the incentives to improve managerial skills.

Legislation enacted in 1992 was directed at addressing the most significant problems. In particular, it revised the methods of financing by replacing direct

funding by the Ministry of Health from general revenue with mainly employment-based financing operated by a new government agency, the Health Insurance Institute of Slovenia (HIIS). The Act defined roles for both the compulsory and the voluntary insurance schemes. On the supply side, the most important practical change was the privatization of many parts of the public health network and associated changes such as the introduction of free choice of physicians and some elementary gatekeeping functions in primary health care. It also formalized and significantly re-structured the processes of care provider contracting.

The Act also established a basis for ongoing policy setting and strategic planning, which was finally manifested in the document “The National Health Care Programme of the Republic of Slovenia – health for all by 2004”. This document incorporates many critically important ideas, such as financial sustainability and a change of emphasis from treatment to health prevention and promotion.

The reforms were effective in many respects and Slovenia passed through the critical years of transition with a remarkable degree of success in comparison with many other transition economies. A stable process of financing was established and the health status of the population continued to improve in spite of the country’s socioeconomic upheavals.

Accelerating the pace of reform

As noted above, the 1990s was a period of stabilization in most respects. However, many of the good ideas that emerged through the planning process failed to make a major impact in practice. It is widely recognized that the next decade should see an increase in the rate of change.

One reason for growing concern is the perceived increasing pressure on health expenditure. Factors that have contributed to the concern during the 1990s included the introduction of new programmes such as extended hospital care, home care and elderly home care.

Other factors specific to Slovenia were the introduction of a value-added tax in 1999, increases in the salaries of employees in the health care service, and the equating of the prices of drugs of domestic and foreign manufacturers to 85% of the average of comparable prices in Germany, France and Italy.

A few of the current and planned reforms are summarized below. There are many complexities, but the two dominant strategies are clear. First, there must be systemic solutions in order to prevent gains in one part of the health care system leading to unintended losses of performance elsewhere.

Second, systemic changes will need to be complemented with continual improvements in the ways that clinicians deliver care on a daily basis. Unfortunately, systemic changes are frequently made without any serious attempt to associate them with the process of delivery of care.

The remainder of this section is a brief overview of some of the directions of change. It should, however, be sufficient to illustrate the planned practical application of the two dominant strategies.

Financing: strengthening the dominant government insurance scheme

No major changes are envisaged with regard to financing. There is widespread support for the current approach of a dominant public compulsory insurance scheme in view of its equity, and its cost-effectiveness: only 3% of revenues are consumed by administration (compared to 6% in other OECD countries, for example Germany).

There is no great pressure to change the method of contribution, whereby most people contribute by way of their employment. It is also unlikely that any change will be made to operational responsibilities, which are currently assigned for the most part to a separate public agency, the HIIS.

The range of services covered by the scheme is very wide at present, and there are frequent proposals for a reduction of scope. Like other social democracies, Slovenia is finding that the definition of “basic” and “essential” services is far from easy, and therefore it seems unlikely that the range of covered services will be significantly reduced in the near future.

Optional additional insurance: a question of types of benefits

As in many other countries, there continue to be debates about the role to be played by voluntary insurance. As noted elsewhere, most Slovenians have opted to buy this and there are no major disagreements about the level of participation.

There are, however, some important issues that are likely to be the subject of ongoing debate. The most important may be the issue of the types of services covered by voluntary insurance. For most people, it is useful only in that it covers co-payments for services already included in the compulsory scheme.

This raises several important questions. For example, if most people have optional additional insurance for co-payments, would it not be more efficient simply to increase contributions to the scheme and reduce or eliminate the co-payments? A related question is whether current arrangements reduce the

desired level of progressivity: while contributions to the scheme are largely income-rated, contributions to voluntary insurance are not.

It may be worth considering restricting voluntary insurance to the cover of services that represent low value-for-money, which could then be eliminated from the “basic” package.

Setting the health care budget

There are no plans for the government to reduce its tight control over the level of spending on health care. However, it is intended that methods of consultation with the community at large will become more sophisticated and effective in due course. Some aspects of health care spending have not been fully debated in the public domain.

Controlling service utilization and costs

It is not likely that any significant changes will be made with respect to control of service utilization and consequent costs, at least in terms of broad policies. It has long been the view that supply-side incentives are better than most types of demand-side incentives. The notable exception is that of encouraging people to manage their own health more effectively through health promotion programmes and in other ways. However, the style of the supply-side incentives is likely to change quite significantly over the next decade, as illustrated later in this chapter.

The issue of co-payments and other forms of out-of-pocket payments will continue to be a matter for debate, in the context of cost containment. As noted earlier, most co-payments are covered by insurance and therefore have little impact on demand, but this may change.

Some people remain doubtful of the feasibility of strengthening supply-side incentives in the short run, and continue to argue for increased demand-side controls including expanded co-payments as an interim measure. The intellectual arguments against this view are significant, and there is a growing concern that, once demand-side incentives are established, it will be very hard to remove them. Much depends on whether the supply-side changes that are being made at present are able to deliver acceptable results within two or three years.

Resource allocation: a blend of needs-based and output-based models

In principle, money should follow patients: health care resources should be allocated in accordance with needs. However, it is also necessary to accept the

reality that care providers must respond to the narrower set of needs of patients who present for care. It follows that Slovenia is considering a mix of needs-based and output-based resource allocation models.

Allocating resources according to need

There have been attempts for many years to try to ensure that all of Slovenia has equal access to health care services, by means of adjustment to budget allocations of the care providers. However, there has been only moderate success, and current plans envisage much more concerted efforts in the near future. Important technical developments are expected to include better measures of need, not only by use of age-sex patterns of morbidity and mortality, but also socio-economic indicators.

The major problem may well be that of establishing structures whereby each region's budget share might be effectively distributed among all types of care providers. At present, budget splits between major service categories, such as hospitals and general practice, are made at the national level – thus hindering the process of reallocation of resources to suit each region's particular circumstances.

Output-based payments for care providers

Payments to care providers have been, and will continue to be, predominantly output-based within the framework of a budget share model. This approach is illustrated later in the chapter with reference to acute inpatient services.

There are three important trends within this general strategy. First, there is a determination to change the balance of objectives to be served by the scheme's resource allocation processes. In the past, the dominant concern has been to ensure the survival of existing health care facilities. It was claimed that, by preserving hospitals' budget allocations, this would indirectly also deliver equity of access for patients. However, the reality was that the well-being of care provider institutions rather than users was the dominant concern.

In future, the intention is to ensure that people's needs are directly addressed. Moreover, much more emphasis will be placed on using budget allocations to encourage and reward improvements in methods of care.

Second, there will be further moves towards definition of progressively larger packages (or bundles) of care for which payments are made. This will not only be restricted to improved applications of per case payment (the bundling of services relating to an episode of care in a single setting) and of capitation for services like general practice. It will also include extension of application of the episode management unit, whereby products may comprise more than one episode of care in different care settings.

Third, much more precise methods of categorisation of services will be progressively introduced. In addition to implementation of the Diagnosis Related Groups (DRGs) classification for acute inpatient care, it is anticipated that sophisticated classifications will be introduced for rehabilitation, intensive care, outpatient clinic services and home care.

Moreover, important types of care are being progressively defined according to clinical pathways. Inter alia, this will greatly reduce the ambiguity that is present in, for example, the DRG for hip replacement (in terms of conditions and treatments, but also with regard to quality of care and expected outcomes), which is a significant contributing factor to misunderstandings between purchasers and care providers (and the associated increased level of dispute, loss of trust and inefficiencies in care provision).

The precision of definition of health care products is not only relevant to fair payment. It is also necessary if Slovenia is to establish a pre-requisite for benchmarking with respect to quality of care and outcomes.

Standard and actual average costs as the basis for pricing

The payment rates for health care products have been almost exclusively based on estimated actual average costs in previous years. However, payment that is based on last year's average costs assumes that last year's methods of care were satisfactory, when the evidence suggests that this is often not the case. Increased use will consequently be made of standard cost, defined as the cost of providing quality care in an efficient way.

It is recognized, however, that actual average costs must be routinely estimated in an efficient way. They are useful as a basis for validating the standard costs and for setting prices for low volume health care products. In the first half of 2002, a standardized method of actual average costing was successfully piloted in three hospitals, and it is expected to become a routine process in all hospitals within two years.

Controlled competition between care providers at the margins

Most care provider facilities are likely to remain in government hands for the foreseeable future. There is little likelihood that more for-profit forms of non-government involvement will emerge, such as private capital investment. However, a slow trend towards various forms of non-government involvement in care provision is expected. One factor is that there should be an element of competition for business, if only to provide a stimulus to the government sector.

The main opportunities, however, are seen to lie in competition between government care providers for additional business at the margins. In other words,

the majority of the activity will be determined prospectively as in previous years, but competition over a narrow range of products will be encouraged if this can be shown to deliver benefits to the community as a whole. This will require establishment of a greater degree of freedom for care provider agency managers than is currently the case, and the development of their skills with regard to such matters as measurement of marginal costs and adjustment of the level and mix of clinical staff.

One area under consideration is competition to provide services for patients on waiting lists. Another is competition to provide services that are currently available in low volumes at several facilities that are in close proximity to each other. There are other ways to rationalize services in the interests of economies of scale and improved quality of care, however, and competition is not seen as a substitute for increased collaboration. A related objective is to encourage care providers to re-assess their service capacity: in short, the current utilization of facilities is inefficient.

Use is already made of the market in some circumstances. Patients will continue to have considerable choice over the selection of general practitioner and hospital services. However, it is recognized that patients cannot always make the best choices by themselves, and therefore it is necessary for the insurer to play a stronger and more informed role in future. Consideration is presently being given to various kinds of models that allow choice to be shared by insurers and individual patients, including preferred provider methods.

Managing the health care sector

Slovenia has considerably improved its processes of management over the last decade, but many of the weaknesses that existed at the time of independence have still not been fully overcome. Activities that will address the learning needs of both clinicians and non-clinicians are therefore being initiated or strengthened.

Improving management at all levels

A training programme for non-clinical managers was launched in 2002. Its targets include orientation towards planning and evaluation that focus on outcomes (rather than inputs and processes), encouragement of innovation, problem-solving techniques that recognise the cultural determinants of performance, and improvement of change implementation processes through the use of techniques such as soft systems methodology.

An important component will be that of building bridges between resource management and clinical decision-making. In the past, leadership has tended

to rest mostly in the hands of doctors in the past, and many of them have had insufficient opportunities to learn about the broad scope of management of health care including the governance of resource use and budgets in general.

Clinical governance and improving the process of care

The most valuable assets of any health care system are its clinicians. Slovenia's clinical workforce has many strengths, including a high level of training and a commitment to ethical service. However, there are some weaknesses that need to be addressed including the establishment of a better basis for workforce planning and deployment according to health care needs.

Two ideas will be given particular emphasis over the next few years. First, it is intended that clinical practice guidelines and clinical pathways will form the core of clinical work process control. An ambitious programme to develop guidelines and pathways was initiated in 2002.

Second, a major effort will be made to improve relations between health care professionals, and particularly between doctors and nurses. It is recognised that medical culture, while providing the main platform for continuous improvement in health care services, also has its negative features, including promotion of medical autonomy over teamwork, in some circumstances. A start has already been made, through such activities as training in doctor-nurse communication.

Health promotion and illness prevention

As noted earlier, Slovenia has developed sound strategies for increasing the emphasis on health promotion and illness prevention, but implementation has been slow and uneven. Several programmes have been designed, including those addressing smoking and excessive alcohol consumption, which promote healthy nutrition and increased physical activity

The main constraints appear to be the difficulty of reallocating finances from curative services and a lack of interest or skill on the part of many clinicians – especially those in hospitals. In total, these factors have led to a passive approach.

Nevertheless, some significant advances have taken place. The challenge for the future is to extend and refine the work. This will require more systemic support from the Ministry of Health, within the framework of an updated national programme of health promotion. It will also require hard decisions to be taken regarding financing: new money is useful, but there is ultimately no alternative but to divert funds from curative services. Finally, more needs to be done to involve the community. This should include the establishment of local bodies and programmes in which consumers are given a significant degree of power.

Quality of care

It is often claimed that a satisfactory level of quality of care is guaranteed by the high levels of training and competence of clinicians. There are, however, indicators that give good reason for concern including the ample evidence of clinical practice variations.

However, the fundamental weakness is that information systems at all levels, and both within and outside individual health care provider agencies, are inadequate to allow any firm conclusions to be drawn. A major focus of the next round of reforms will therefore be the establishment of a system of continuous total quality management including the management of patient care, information, training in quality matters, the environment, human resources, organization performance and leadership.

In 2000, HIIS introduced the electronic health insurance card, which resulted in more simple administrative procedures, improved communication between service providers and insurers, and enhanced data security.

A draft document, "The quality of the health care system in the Republic of Slovenia", looking at the present situation, has been prepared. A Department for Quality in Health Care has been established at the Ministry of Health. A system of voluntary reporting of sentinel events is now well established. A tool enabling hospital leaders to systematically approach these events has been distributed and proved to be successful.

A proactive approach regarding the development of clinical practice guidelines is underway and a draft version of a Slovene Manual on the Development of Clinical Practice Guidelines has been distributed to clinical guidelines groups. Guidelines will serve as a basis for clinical pathways development. A pilot project on clinical quality indicators has been accomplished and is now going on as a regular activity initiated at the Ministry of Health and Medical Chamber. Categorization of patients into groups regarding different levels of nursing care has also been completed and implemented.

A retrospective approach with an internal audit in health care organizations is in place. An external audit of individual physician is a continuous ongoing activity. However, a system auditing a health care organization as a whole is still lacking, though generic standards are being prepared.

Consideration is also being given to providing financial incentives to improve the quality of care and outcomes. One possibility is that the use of clinical pathways with built-in quality and outcome measurement processes will attract higher payment rates. Other possibilities include the linking of payment rates to the results of independent checks on patient satisfaction. In general, more

needs to be done to inform patients about quality of care, involve them of its management and help them to appreciate their rights.

Reform in action: payment for acute inpatient care

It was noted earlier that there has been a transition since 1993 from units of service, to bed-days, and finally to per case as the basis of counting and payment for hospital inpatient services. While this has represented a path of continuous improvement, few people are satisfied with the current arrangements. A new model is, therefore, under development at the time of writing, and some of its features are outlined below.

Precise differentiation of major product categories

An elementary challenge is the precise definition of the services to be treated as acute inpatient. For example, one important boundary is that between acute inpatient and intensive care. This will be treated as a separate product, because it is rightly not available at all hospitals. Equally important, the need for intensive care cannot be reliably predicted by use of acute inpatient classifications like DRGs.

Using a DRG variant to define acute inpatient case types

It has been decided that a DRG variant will be used, because it is the de facto international standard. However, there are concerns about the structural weaknesses that remain after two decades of use, such as unnecessary dependence on the idea of a single “principal” diagnosis.

Several DRG variants are currently being appraised. Once the variant is selected, it is intended that the government will contract a single provider of software and related materials.

It is unlikely that any changes will be made to the DRG classification structure before the routine allocation of cases to DRGs begins on 1 January 2003. However, a high priority is that of establishing a process whereby changes can be made in the classification from time to time, mainly to reflect changes in clinical practice. An expert clinical group is being established to provide ongoing advice on refinement.

The handling of special cases: inter-hospital acute transfers and high-cost outliers

In effectively designed health care systems, patients may be transferred between hospitals during the period that they need acute inpatient care. The key to the design of transfer rules and payment rates is to make sure that no hospital will

gain or lose financially from the decision to transfer, and consequently the clinicians can make decisions exclusively on the basis of ensuring the well-being of the patient. Different payment models will apply for upward and downward transfers.

Special payment rates may apply for a small number of patients who require significantly more than the average amount of care for the DRG to which they belong, using a “stop-loss” model. In contrast, no special arrangements apply for low outliers because this would dilute the per case payment incentives.

Improving the incentives for same-day treatment

Until recently, there were different payment rates for same-day and overnight-stay cases for the same case types, and the rates for same-day treatment were usually much lower. A consequence was that many hospitals were failing to move towards same-day treatment simply because overnight-stay episodes were more profitable.

A transitional process began in mid-2002, whereby a single payment rate was introduced for each of a set of case types that should mostly be treated on a same-day basis. The rates were based on the estimated costs of good clinical practice, but with an upward adjustment to take account of one-off investments that might be needed in order to establish same-day treatment methods.

Using both standard and actual average costing to inform resource allocation

As noted above, the main basis for price setting will be standard cost where practical. From 2003 onwards, the prices of progressively larger numbers of acute inpatient products will be defined by costed clinical pathways. However, actual average costs will apply for low-volume case types where it would be too time-consuming to estimate standard costs (at least in the short and medium term).

In 2003, when there will not yet be reliable Slovenian data on cost per DRG. Use will therefore be made of actual average costs from other countries, which will be adjusted to take account of such factors as the different ratios between labour and non-labour input prices.

Managing DRG information: production and validation

Methods of data collection are being redesigned, taking account of experiences in several other countries. With regard to the recording and coding of clinical data, it is intended that the responsibility will continue to rest with clinical teams. Methods used in many other countries, which involve the use of

professional coding staff (medical records administrators, health information managers and so on), have been firmly rejected.

It is unlikely that any major investments will be made in computer support, at least in the short term. For example, there is no intention of investing in expensive commercial coding software. If this kind of software is judged to be cost-effective, in due course it will be developed within Slovenia. The decision to continue to treat coding as a component of good clinical practice means that there will be less potential for such software: clinicians rapidly become familiar with coding methods within their own area of specialisation. The coding of unusual comorbidities presents more difficulties. However, they can be handled by such methods as coding advice documentation and the linking of coding to the use of clinical pathways.

An audit programme is currently being developed to manage such risks as the incorrect selection of principal diagnosis and the overstating of relevant comorbidities. Another area that has recently been given special attention is unnecessary admissions. In the past, there have been financial incentives for hospitals to admit patients although inpatient care was not cost-effective. Inter alia, this has included the phenomenon termed the “empty case”, whereby patients have been admitted unnecessarily simply to meet a hospital’s volume targets. In 2002, national criteria were introduced on an experimental basis. Hospitals are expected to take account of them and institute control methods where necessary. There will be periodic external reviews.

Hospital shares: the same payment for the same product

As noted earlier, it has been the practice in Slovenia to take account of hospitals’ different product mixes (and consequent costs) by using a payment rate multiplier for each type of hospital. While this might have resulted in a fair allocation, it was not possible for everyone to have a common understanding of the reasons why any hospital’s payment rates were set at a particular level.

The new model, however, will make the factors more explicit – and consequently more open to critical evaluation. This will, in turn, lead to research that will improve the product classifications and payment relativities between products, and consequently to fairer allocations between hospitals and their patients over time.

The dominant idea is that each product (such as tonsillectomy or treatment for acute myocardial infarction) will be defined by DRGs, and the same payment will be made to all care providers for cases in the same DRG. Separate payments will then be specified for the non-DRG products. For example, it is expected that intensive care will be paid on a per day basis, but with prospectively agreed volume targets.

The starting point for payment for health care professional education will be reimbursement of the costs of teaching positions, consumables and facilities. A similar approach will be taken for research. In general, there is no easy way to determine the methods of payment for products not included in payments by DRG. The most obvious cause is that data systems were never established to provide needed information. A transitional approach, whereby the hospitals themselves have the opportunity to provide information relevant to pricing, will have to be developed.

A carefully designed transition path to fairer and more transparent payments

It would be unwise to immediately implement the new model in full for two main reasons. First, it will contain significant errors due mainly to data weaknesses.

Second, even if the model were perfect, it would still be unwise to increase or decrease a hospital's revenues by a large amount without adequate notice. Hospitals are complicated enterprises that respond poorly to most types of sudden change. It is therefore essential to introduce changes over a transitional period, and to use the information gained initially in terms of responses to change to inform subsequent steps.

In total, the reform approach may be characterised as the interaction between a long-term strategy and the implementation of short-term changes that are consistent with that strategy. Experiences of the effects of implementation will, in turn, lead to refinement of the long-term strategy.

Health for all as an input to reform

The World Health Organization (WHO) provides support to the Ministry of Health and to the health care sector in developing health policies in accordance with the health for all (HFA) strategy. WHO promotes the exchange of knowledge and collaboration between Slovenia and other Member States within the framework of WHO and other entities such as the EU PHARE Programme.

HFA represents an important aspect of health policy in Slovenia. National coordinators have been appointed to work towards specific targets. Within the medium-term programme agreed with WHO, the coordinators monitor and organize activities with respect to specific targets.

The finalization of Slovenia's HFA plan (The National Health Care Programme of the Republic of Slovenia – Health for All By 2004) took nearly eight years. Its contents were affected by political and sectional influences and therefore do not always present the most sensible compromises. Presently,

strategic documents on the new priority public health areas based on Slovenia's HFA plan are under development in cooperation with WHO. However, the implementation of new strategies will require reforming traditional public health services in Slovenia.

Accession to EU membership

Many elements of the reform activities have been influenced by Slovenia's desire to join the EU. Following independence in 1991, Slovenia accelerated the reforms needed to transform the economy, the constitutional and legal systems and state administration. A parliamentary declaration in 1996 set the objective of being prepared for EU accession by the end of 2002. The accession conference between Slovenia and the EU on 31 March 1998 commenced negotiations for EU entry and sped up the process towards full membership.

The bodies dealing with EU accession in Slovenia have mainly been established for legislative measures: the government Office for European Affairs, which coordinates preparations for Slovenia's integration into the EU and the related management of interdepartmental preparations for negotiations with the EU. The negotiating team for accession was set up in 1998 as a group of ten experts. The team is responsible for negotiating the 31 chapters of the *acquis communautaire*, the entire body of European laws, that the candidate countries have to adopt and implement by the time of accession to the EU. The Department of Negotiations is responsible for coordinating and supporting the negotiation process. The government invited the social partners and nongovernmental organizations in Slovenia to actively participate and initiated a tripartite social dialogue.

To harmonize with the *acquis communautaire*, Slovenia has passed substantial social policy legislation. There has also been substantial legislative activity related to: occupational health and safety, disability insurance, a reform of the pension system, equal opportunity policy for gender and labour law. National programmes were adopted on poverty and social exclusion and on social security. A programme on parenthood and family income was going through parliamentary hearings in 2001. Slovenia has already temporarily closed negotiations for the chapters on social policy and employment, environment and the free movement of goods and fields relevant to public health and health protection.

Future social policy issues will include coordinating social security for migrant workers. Bilateral agreements between several EU countries and Slovenia already guarantee that Slovenian citizens and citizens of the EU countries will be treated comparably in acquiring and maintaining social security

rights.

Social affairs are being dealt with comprehensively in Slovenia with the help of the EU PHARE Programme, but most health-related activities dealing with EU accession are within sectors. Much work is being devoted to preparing legislation in areas such as manufacture, trade and the use of chemical products and pharmaceuticals, food safety and blood supply. Slovenia is participating in four disease prevention and health promotion programmes of the EU: health promotion, combating cancer, preventing drug addiction and preventing AIDS and other communicable diseases.

Slovenia has completed most of the administrative action related to the free movement of goods, services, people and capital. Adequate administrative capacity in health care is a precondition for coordinating and implementing the present and future EU common standards. Slovenia set up a special intersectoral project under the auspices of the EU PHARE/Consensus Programme. One of the main objectives is to strengthen administrative capacity in health care and to facilitate coordination and cooperation at the EU level.

Conclusions

The Slovenian health care system provides universal and comprehensive health care access for all Slovenian citizens regardless of income. The health care reforms of 1992 in Slovenia were prompted mainly by the need to increase transparency in the financial flows of the health care system, diversify existing funds, mobilize supplementary funds and regain control of escalating health care costs. In addition, the changes introduced attempted to maintain the positive features of the system achieved under the former regime, specifically equity in health care and ensuring a comprehensive range of services for the entire population. The main means selected to achieve this involved introducing a system of compulsory social health insurance, introducing complementary voluntary insurance and privatizing physician practices in primary or specialized outpatient health care.

Some evidence of the success of these reforms became apparent in the early course of implementing reform. Perhaps the most successful feature of the reforms was that additional funds were rapidly mobilized for health care through an effective shift towards compulsory insurance. In addition, far larger segments of the population purchased voluntary insurance than originally anticipated, thus further increasing the total resources available for health care in the early 1990s.

Perhaps the most remarkable phenomenon – albeit not only determined by the health care system – is that Slovenia maintained the general trend of improving the health status of its population despite the country's socioeconomic transition.

Since independence, Slovenia has been increasingly moving towards becoming an industrially highly developed system. As such, it also shares some

of the challenges reported by most industrialized health care systems: rising financial debt through expenditure pressures in medical equipment and pharmaceuticals, rising health care demands and diminishing health care income through an ageing population, rising costs through increasing expectations of the population and regional inequalities in health status and resources. There are also some problems specific to Slovenia such as increasing volumes of care delivered by providers to reach competitive incomes that led to liquidity problems in public institutions with other consequences, for example, that medical equipment operated by public institutions became largely outdated and waiting times for elective procedures increased. Some problems have yet to be addressed by the government such as acting upon a partly inequitable collection of contributions in the compulsory system and improving regulation of primary and specialized care provided by private practitioners and financed under the compulsory system.

There is still a conflict between the high inherited expectations of the population and the limited resources of the public system. Achieving social consensus on the definition of priorities will therefore also require the participation of the Slovenian public.

The Slovene Public Opinion Poll was most recently carried out in 1999 and included a section on health and health care. More than half the people surveyed were satisfied with outpatient, specialist and dental care and perceived the system as being equitable. Causes for dissatisfaction involved primarily waiting times and complicated administrative procedures. The consensus of the respondents was that introducing private practice was expected to improve the quality of health care, and those who underwent treatment by private practitioners reported greater satisfaction than those treated by publicly employed physicians. Overall patient satisfaction with private providers remains high, although the share of those favouring the private provision of care has gradually decreased in surveys.

An immediate challenge is to complete the work harmonizing legislation with EU legislation, which tends to consume resources that are not available to invest in further developing the health care system. Such developments, for example, are envisaged in the longer term by increasing regional capacity to implement health policy and the development of insurance for long-term nursing care for the ageing Slovene population. The implications of the reforms in the 1990s on the future direction of the Slovenian health system are uncertain. Some of the measures initiated, such as cost-containment measures including

the introduction of co-payments and private supplementary insurance for people who can afford it, threaten to undermine the equity achieved under the former system. Fears have been expressed that this may be a possible scenario, as relatively affluent people obtain access to more and higher-quality services by paying out of pocket or have better coverage through voluntary insurance.

Perhaps the most promising reforms are those that have just begun, which focus on creating more incentives for care providers to improve their cost-effectiveness. They include more sophisticated applications of output-based funding, standard costing of clinical pathways as the basis for pricing, and the development of better methods of clinical work process control in general.

To conclude, Slovenia faces dilemmas and uncertainty in the development of health care, but these do not differ essentially from those encountered in most European countries and other industrialized countries. These include the questions of how to preserve health and social security in the light of a situation that will be even more marked by the problems of an ageing population and a related increase in chronic degenerative diseases and growing needs and requirements for health care services.

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European
Observatory
on Health Care Systems

The Health Care Systems in Transition (HIT) profiles are published by

The European Observatory on Health Care Systems

WHO Regional Office for Europe
Scherfigsvej 8, DK-2100 Copenhagen Ø
Denmark

Tel.: +45 39 17 13 63

Fax: +45 39 17 18 18

E-mail: observatory@who.dk

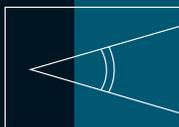
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ISSN 1020-9077



Slovenia

Health Care Systems in Transition

Vol. 4 No. 3 2002