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BALANCING EQUITY AND EFFICIENCY THROUGH HEALTH CARE POLICIES IN SLOVENIA DURING THE PERIOD 1990-2008

ISKANJE RAVNOTEŽJA MED PRAVIČNOSTJO IN UČINKOVITOSTJO V ZDRAVSTVENI POLITIKI V SLOVENIJI V OBDOBJU 1990 – 2008

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Abstract

Background: *Slovenia's 1992 health reform set the following five goals: introduction of social health insurance system and a system of co-payment for a range of health care services; introduction of private practice in health care; devolution of planning and control functions from the State to professional associations and municipalities, and introduction of licensing and recertification for health professionals.*
Methods: *A descriptive and explorative analysis was done of general demographic, economic and health financing data and the reported data on financing structure. The general population health indicators for the observed period are presented. A broad health policy context was assessed through participatory observation during the whole period and using semi-structured interviews with key national health policy-makers in 2001, which served as a mid-term review.*
Results: *Transformation of health care system in Slovenia led to sustainable health care financing at a level of approx. 8.5% of GDP. This result was achieved at the expense of reduced public funding, which was partially compensated for by the supplementary health insurance and partially by an increase in out-of-pocket expenditures. Private expenditures increased the system's regressivity, which was corrected through risk-equalising schemes and by subsidising supplementary health insurance to the least well off.*
Conclusions: *Slovenia's health care transition took place during a period of economic growth, which afforded stable financing of the system and restricted the capacity of health care providers. This environment had a favourable impact on the general health situation of the population, and thereby reduced pressures on the new system. The previous system was transformed into a mixed social health insurance based system, based on a strong central insurer. The present financing scheme is unlikely to remain sustainable because of demographic trends and other drivers increasing unmet health care needs.*

Key words: health system reform, health care financing, health insurance

Izvirni znanstveni članek
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Izvleček

Ozadje: *Zdravstvena reforma v Sloveniji leta 1992 je imela pet glavnih ciljev – uvedbo sistema socialnega zdravstvenega zavarovanja in sistema doplačil za različne zdravstvene storitve, uvedbo zasebnega dela v zdravstvenem varstvu, prenos funkcij načrtovanja in nadzora z države na zbornice in občine ter uvedbo licenciranja in obnavljanja licenc za zdravstvene delavce.*
Metode: *Zaradi osredotočenja na reforme sistema financiranja smo opravili opisno in eksplorativno analizo splošnih demografskih, ekonomskih, splošno- ter zdravstveno-finančnih podatkov. Predstavili smo tudi splošne*

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populacijske kazalnike zdravja za celotno opazovano obdobje. Širši zdravstveno politični kontekst smo ovrednotili s pomočjo metode opazovanja ob sodelovanju skozi celotno obdobje ter z uporabo polstrukturiranih intervjujev s ključnimi oblikovalci zdravstvene politike v letu 2001 kot vmesno analizo stanja.
Rezultati: *Pretvorba zdravstvenega sistema v Sloveniji je privedla do stabilnega financiranja zdravstvenega varstva na ravni okrog 8,5 % BDP. Tak rezultat smo dosegli na račun zmanjšanja deleža, financiranega iz javnih sredstev, kar smo delno nadomestili z dopolnilnim zdravstvenim zavarovanjem, delno pa z zasebnimi izdatki. Zasebni izdatki so povečali regresivnost sistema, kar smo delno zmanjšali z izravnalnimi shemami, delno pa s subvencioniranjem dopolnilnega zdravstvenega zavarovanja za najbolj finančno ogrožene.*
Zaključki: *Tranzicija zdravstvenega sistema v Sloveniji se je odvijala v obdobju ugodnih ekonomskih razmer, kar je omogočilo stabilno financiranje sistema zdravstvenega varstva in omejilo zmogljivosti izvajalcev zdravstvene dejavnosti. Tako okolje je pomembno vplivalo na izboljšanje splošnih razmer za zdravje prebivalstva in je zmanjšalo pritiske na nov sistem. Prejšnji sistem se je pretvoril v mešani sistem socialnega zdravstvenega zavarovanja, zasnovan na močnem osrednjem zavarovalcu. Sedanja shema financiranja ne bo zdržala dolgo zaradi demografskih trendov in drugih dejavnikov, ki povečujejo nekrite potrebe po zdravstvenem varstvu.*

Ključne besede: zdravstvena reforma, financiranje zdravstvenega varstva, zdravstveno zavarovanje

Background

Transformation of Slovenia's health system over the past 18 years followed the reform guidelines adopted in 1992. A series of health policy reform attempts, strategy and planning designs, and related initiatives taken over the following years failed to change significantly the concept formed in 1992. Steered by the political arena, health policies followed the pattern of reducing the role of the State through delegation of different tasks to other - old and new - stakeholders in the system. The specific goals of the 1992 reform included the following : (see also Table 1.)

1. Introduction of a Bismarckian health insurance system with a single insurer for compulsory health insurance (CHI)
2. Introduction of co-payments for various health care services, subsequently covered by the compulsory insurance to a varying extent
3. Legalisation of private (independent) practice for health professionals
4. Devolution of a set of planning and control functions from the State to the professional associations ("Chambers") and to the municipalities
5. Introduction of licensing and compulsory continuous education of health professionals

Each of these action had its own pace and its own - desired and undesired - effects in the health system. Experience from the previous system defined the political choice to move away from a model characterized by a predominant state control towards a system delegating the most important powers and tasks to different stakeholders in the system. The principles of these processes were:

1. to protect the budget allocated to health care from the direct intervention by the Government,
2. to involve key partners in the system (payers, professional associations, providers associations), and encourage them to participate in the negotiation process and assume more responsibility in the contracting process,
3. to liberalise the entire process of health care delivery.

The main aim was to increase transparency of the system and to ensure that key decisions are taken by consensus by those directly involved in health care delivery. At the same time, lesser direct State involvement and more entrepreneurship were expected. Following the political process, the role of the State was to be reduced to the level of co-ordinating some of the planning and control mechanisms within the health sector. The State would maintain its stewardship role and give away many managerial - and even regulatory - functions. This was done through the supervisory role over the stakeholders to whom the State appointed its previous tasks. These options followed the predominant pattern of reforms across the central and eastern European area.

This papers focuses on and is limited to the developments in the field of health care financing in Slovenia and analyses the areas of compulsory and supplementary health insurance systems and their implementation between 1992 and 2008. We formulated the following research questions:

- What were the key issues related to the introduction of social health insurance in Slovenia?
- What were the issues and problems related to the introduction of co-payment and supplementary health insurance (SHI) in Slovenia?

Table 1. *Organisational changes taking place in the course of the 1990s.*
Tabela 1. *Organizacijske spremembe v devetdesetih letih prejšnjega stoletja.*

Process / proces	**Responsible institution / odgovorna ustanova**	**Regulation / Nadzor**
	Before 1992 / pred letom 1992	*After 1992 / po letu 1992*
Health care budget holder / Nosilec proračunskih sredstev zdravstvenega varstva	Ministry of Health (MoH) – Natl. Adm. for health care / Ministrstvo za zdravje (MZ) – Republiška uprava za zdravstveno varstvo	Health Insurance Institute of Slovenia (HIIS) / Zavod za zdravstveno zavarovanje Slovenije (ZZZS)
Additional payments/insurance / Doplačila/zavarovanje	MoH – “participation fees” / MZ - participacija	HIIS + commercial insurers until 2001 and later only specially regulated commercial insurers / ZZZS + komercialne zavarovalnice do l.2001, kasneje le zavarovalnice, ki izpolnjujejo zakonsko določene pogoje
Registration of providers / Registracija izvajalcev	MoH MZ	Public – MoH / Javno – MZ Private – Professional Chambers / Zasebno – Strokovne zbornice
Private practice / Zasebna praksa	Non existant / Ne obstaja	Physicians and dentists – Medical Chamber of Slovenia (MCS) Pharmacists – Chamber of Pharmacy of Slovenia (CPS) All other professionals – MoH / Zdravniki in zobozdravniki –Zdravniška zbornica Slovenije (ZZS) Farmacevti – Lekarniška zbornica Slovenije (LZS) Vsi drugi zdravstveni delavci - MZ
Postgraduate training / Podiplomsko izobraževanje	MoH / MZ	Physicians and dentists – MCS Pharmacists – CPS / Zdravniki in zobozdravniki – (ZZS) Farmacevti – (LZS)

- What are the present benefits and shortcomings of the goals set by the reform of 1992 in health care financing and how are they related to the equity and efficiency of the system?

Material and methods

1. Background data on general demographic and health indicators (infant mortality, life expectancy; data on the number of providers) for the period 1990-2008
2. General economic data (health accounts and the financing structure data) and indicators for the observed period, focusing on the period 1995-2007.
3. Report on social issues prepared for the entire area of expenditures in the social sector by the Institute for Macroeconomic Analyses and Development in 2009
4. Participatory observation over the whole period and a series of semi-structured interviews with representatives of the main national institutions

involved in policy- and decisionmaking processes in 2001.

Background data were obtained from the databases, reports and national indicator databases of the Institute of Public Health of the Republic of Slovenia and the WHO Health for All database. In 2001 a series of interviews were carried out with the representatives of key stakeholders at the national level and the material obtained was used in the preparation of this analysis as a "mid-term" review of the system changes. Finally, financial data from health accounts for the period 2002-2005, together with some basic financing structural data for the period 1995-2004 were used to assess the changes occurring in the most important streams of health expenditures in Slovenia during the observed period.

We performed an explorative assessment, based on the data available from the routine statistical databases as well as those provided by the special annual reports on CHI (with the Health Insurance Institute of Slovenia) and by the task force on health accounts, set up in 2005 in order to implement the OECD methodology for health accounts (1) in Slovenia. Wherever available we focused on the comparison between the data from the start of the reform and those indicating the situation in 2007/2008. Financial data were unstable before 1995 due to the high inflation rate (over 20% annually), and the health accounts data are available only for the period after 2002. The first author of this paper lives in Slovenia and was in a position to observe the policy debates over the whole period.

Results

I. The context

The main laws of the period were prepared in 1990/1991 (2, 3, 4). On the basis of the accompanying materials and interviews the following aspects were identified as crucial in setting the direction of these laws:

- responsibility of all citizens and inhabitants of Slovenia, employers and the State to actively contribute to health care costs through a CHI scheme, based on the principles of social health insurance,
- health care and health insurance, which is compulsory by law and covers the entire population, is a public and not-for-profit service,
- introduction of supplementary (SHI) and voluntary insurance for increased risks going beyond the legally described rights of the compulsory insurance,
- a negotiation process among the representatives of equal partners determines the extent of programmes of health services at all levels and types of care – "the partnership model",
- CHI to be managed by a public institution and administered by representatives of the insured, certain interest groups (e.g. pensioners, disabled) and employers,
- retaining all the important achievements of the past and gradual introduction of the principle of cost sharing between public finance and private sources.

II. Developments in economic and demographic indicators – the socio-economic background

Between 1990 and 2002 there was only a minor reduction in the total population size. This trend changed after 2004 with a constant increase in the total population due to immigration and, most recently, as a result of a rise in fertility, attributable to the fertility of "babyboomers" grandchildren. The total fertility rate was in decline between 1990 and 2003 (dropping from 1.46 to 1.20) and reincreased to 1.38 in 2007 (5). The most recent increase in birth rates resulted in the first net natural increase after 1993. GDP per capita in PPP$ reached an estimated 26,910 in 2007 (rank 46 according to the World Bank (6)) and already by the time of Slovenia's accession to the European Union surpassed the mark of 70% of the EU average. Health expenditure per capita reached PPP$1800 in 2005, three times the amounts in Bulgaria or Romania, and roughly 50% more than in the Czech Republic or Hungary. These data, together with a steep increase in the share of young people enrolled in the tertiary education, brought Slovenia to the rank 26 measured by the value of the Human Development Index (HDI) - 0.923 (7). The extension of life expectancy at birth was due both to reduced infant mortality and lower adult mortality (Slovenia lagged behind the average of EU-15 in life expectancy at the age of 65 by 1.41 years in 1985 and by 1.09 years in 2005). The gap in life expectancy between Slovenia and the average of the new EU member states widened in favour of Slovenia in less than 20 years (3.6 years in 2005 compared to 1.6 years in 1987). Premature mortality remains an important public health issue in Slovenia with the probability that one male in four and one female in ten will die before the age of 65 (8).

From mid-1990s onwards Slovenia has had a rather consistent growth of GDP per capita, as well as of life expectancy. Figure 1. shows the correlation between the two variables. Figure 2. indicates the relationship

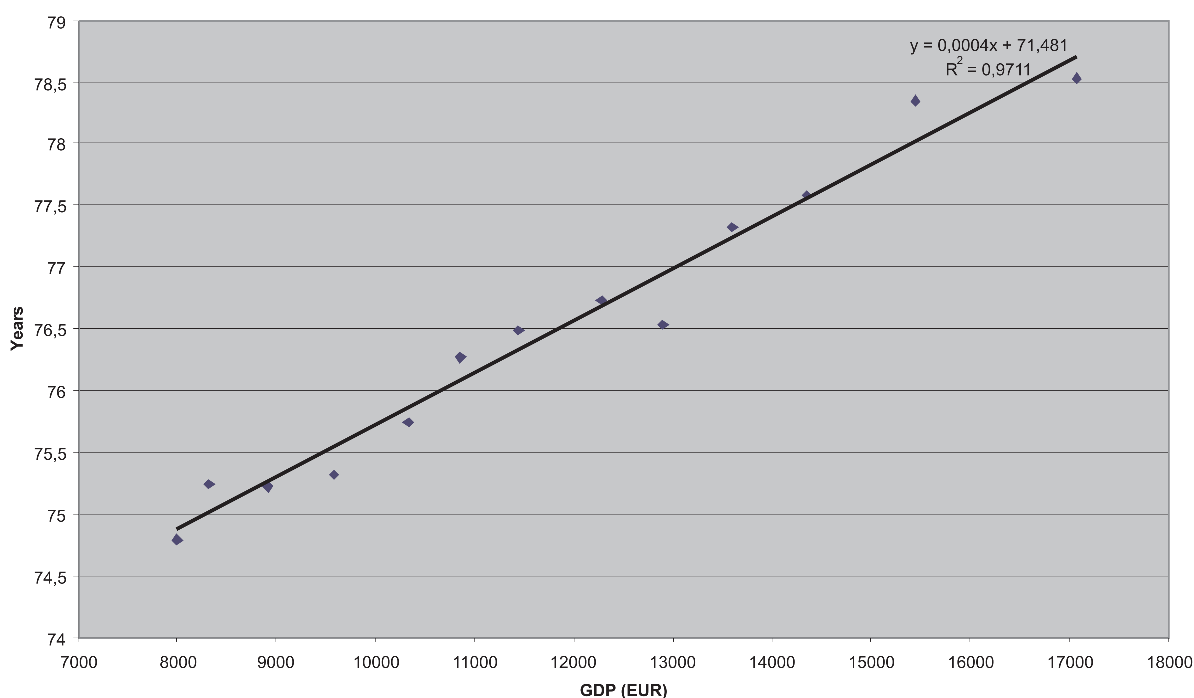
Table 2. *Selected mortality-related indicators for Slovenia 1985-2007.*
Tabela 2. *Izbrani indeksi umrljivosti za Slovenijo 1985-2007.*

	1985	1990	1995	2000	2005	2007
Infant mortality (deaths per 1,000 livebirths)	13.08	8.36	5.53	4.90	4.15	2.78
Umrljivost dojenčkov (št.umrlih na 1000 živorojenih)						
Life expectancy at birth (years)	72.19	73.99	74.79	76.27	77.58	78.53
Pričakovana življenjska doba ob rojstvu (leta)						
Life expectancy at 65 years (years)	14.81	15.66	16.14	16.97	17.60	18.46
Pričakovana življenjska doba pri 65 letih (leta)						

Source: Statistical Annual 2008, Statistical Office of the Republic of Slovenia (9).
Vir: Statistično letno poročilo za 2008, Statistični urad RS.

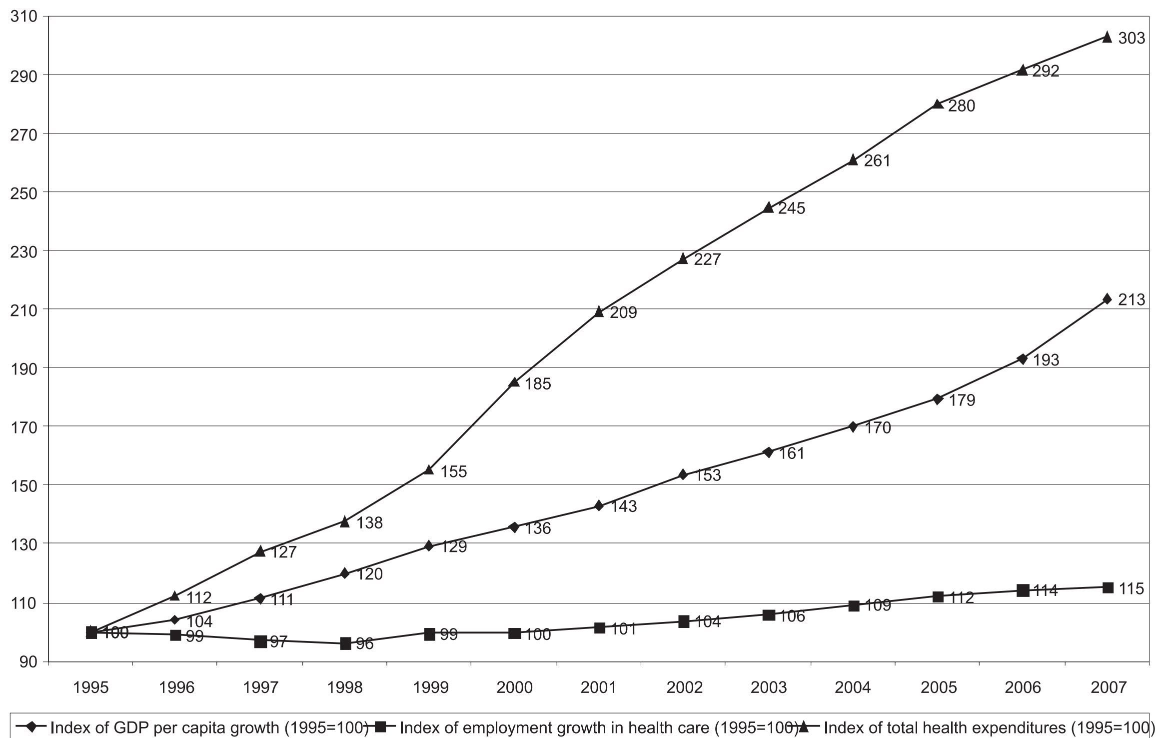
between trends in THE growth and real GDP growth. A gap between the two widened after 1999. Between 2000 and 2007 the growth in THE was 63.8%, and the growth of GDP per capita, 56.6%. In the same period the number of employed in health care grew only by 15%.

Slovenia also shows a low level of social inequality as measured by the Gini coefficient. Slovenia has maintained a relatively low level of inequality with its value of 24 in 2005 - compared with 26 for Austria, 23 for Sweden, 28 for Germany and 30.9 for the Netherlands (10).



Source: Statistical Annual of the Republic of Slovenia, 2008.
Vir: Letno statistično poročilo RS, 2008.

Figure 1. *Correlation between GDP per capita (EUR) and life expectancy at birth (years), 1995-2007.*
Slika 1. *Korelacija med BDP na prebivalca (EUR) in pričakovano življenjsko dobo ob rojstvu (leta), 1995-2007.*



Source: Statistical Annual of the Republic of Slovenia, 2008.
Vir: Letno statistično poročilo RS, 2008.

Figure 2. *Relationship between trends in real growth of GDP per capita, employment growth in health care and the total health expenditure (THE) for the period 1995-2007.*

Slika 2. *Razmerje med realnimi trendi rasti BDP na prebivalca, rastjo zaposlovanja v zdravstvenem varstvu in celokupnimi stroški za zdravstvo za obdobje 1995-2007.*

III. Reform goals, processes and outcomes

The reform process was running through the five goals, but in this paper, we focus only on the two concerning CHI and SHI. These were the specific issues related to the two health insurance developments:

1. Full population coverage by a uniformly prescribed compulsory insurance.
2. Replacing a state-run and state-dominated decision making system by partnership negotiations within the Bismarckian health insurance scheme.
3. Increased transparency of insurance contributions through linkages between employment and/or social status and entitlements.
4. Increased share of own (private) participation in health care costs through the introduction of a supplementary health insurance.

Introduction of a Bismarckian health insurance system with a single insurer for CHI

Reinstituting the Bismarckian social health insurance system was one of the cornerstones of the 1992 reform. It was intended to preserve equity and accessibility, while at the same time ensuring transparency of obligations for payment of contributions. This way Slovenia followed the pattern of other countries of central and eastern Europe (CCEE). Health professional associations were also hoping they would disentangle an important part of the negotiation process on tariffs and budgets from the political level (11).

The Health Insurance Institute of Slovenia (HIIS) is legally defined (3) as the sole provider of CHI since 1992, and they started contracting providers on 1 January 1993. The contribution rates for the active population (i.e. those actively contributing to the CHI from their gross incomes) are split in a typical Bismarckian fashion between employers (paying off the total payroll sum) and employees (paying off their gross salary). The old deficits and debts were consolidated by setting the total contribution rate initially and temporarily (for one year) at 18.25%. Table 3. shows trends in total contribution rates over the period of 16 years (the 2002 rates are still in force), while Figure 3. indicates trends in incomes and expenditures of the HIIS compared against the growth of GDP.

There were serious concerns about the Bismarckian system becoming negatively selective against all those population categories which have difficulty coping with complex administrative systems. In spite of these concerns, the system provided for a large degree of universality as in 2008 only 7570 persons (12) (0.37% of all eligible) were not integrated in the compulsory health insurance system and thus were formally not insured (compared to around 26,000 in 2003 (13)).
In comment to Table 3. we need to stress that the split is not 100% equal between the two sides due to the following reasons: Employees and employers pay a similar percentage for coverage against diseases and injuries out of work (employees 6.36% vs employers 6.56%). However, employers additionally have to pay 0.53% off the payroll for coverage against injuries at work and occupational diseases.
Demographic transition is one of the important long-term pressures on the CHI with pensioners and their family members accounting for 26.6% of all the insured in 2008. Other, less predictable factors included: increases in salaries of health professionals between 1996 and 1999, increases in pharmaceutical expenditures and the introduction of VAT for medicines and medical aids (reflected in the increases of 2001).The Parliament consequently decided to increase the contribution rates from 1 January 2002 by 0.2%. Over the next years the share of CHI in GDP started to decline (see Figures 4. and 5. below). The trade-off was supposed to be in optimistic outlooks for the GDP growth.

Table 3. *Contribution rates from salaries for employers and employees between 1993 and 2007.*
Tabela 3. *Prispevna stopnja iz dohodkov za delodajalce in zaposlene med letoma 1993 in 2007.*

	1/3/1992	5/2/1993	6/3/1993	1/4/1994	1/1/1995	1/2/1996	1/1/2002
Total Skupaj	18.25	13.80	13.25	12.78	12.70	13.25	13.45
Employees Zaposleni	n/a	6.60	6.36	6.14	6.10	6.36	6.36
Employers Delodajalci	n/a	7.20	6.89	6.64	6.60	6.89	7.09

Source: Annual reports of the HIIS 1993-2007.
Vir: Letna poročila ZZZS 1993-2007.

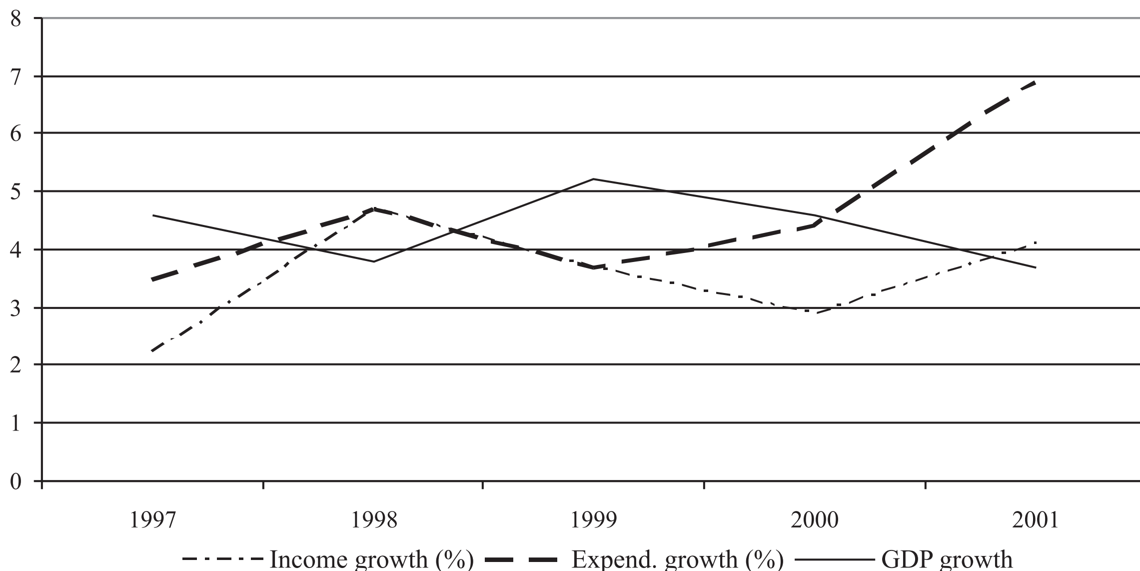
The issues and challenges of CHI set up in 1992 include:

1. Equity concerns – raised by the fact that co-payments were introduced, partly reduced due to the maximising of co-payments at an annual level.
2. Specific protection against personal costs lies in the full coverage for population groups at higher risk - e.g. children and youth, women for all services related to reproduction - and for certain diseases – e.g. diabetes, cancer, communicable diseases.
3. The Health Care and Health Insurance Act (HCHIA) introduced co-payments for all medicines (except for those directly related to point 2.) at the levels between 25% and 75% (depending on the classification in different lists).
4. All emergency services and treatments for life-threatening conditions are excluded from co-payments.

The clear downward trend in public expenditures for health care can be seen from Figure 5. below. Between 2003 and 2006 the average nominal annual growth of health expenditures was 5.7%, while the GDP rose on average by 7.3%.

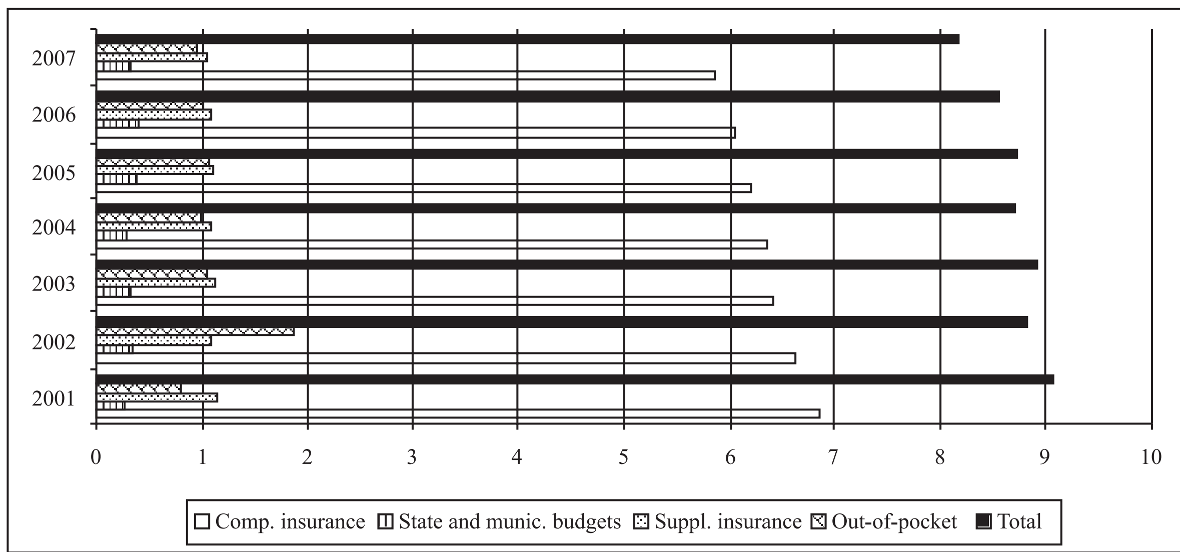
Introduction of co-payments for a range of services, covered to a different extent by the compulsory insurance

An important characteristic of the system of 1992 was the introduction of co-payments for a range of services. This controversial idea was meant to enhance private expenditure and in this way contribute to a different distribution of health expenditure sources. Co-payments existed before 1992, when a system of "participation fees" yielded only around 2% to the THE (14). As indicated by Figure 6. above, co-payments ranged from 0% to 50%. There are no co-payments for certain conditions for which law ensures full coverage, such as communicable diseases, including sexually transmitted diseases, cancer, diabetes and some neuro-muscular disorders. High co-payments would apply only to non-acute services, such as rehabilitation and physiotherapy services, or dental prosthetics, for the rest they account for 5% to 25% of the service fee. The legislator provided for two additional buffers based on population categories, i.e.children, for whom all



Source: Annual report of the HIIS for 2001, p. 42.
Vir: Letno poročilo ZZZS za 2001, str.42.

Figure 3. *Annual growth of incomes and expenditures of the HIIS and the respective growth of GDP between 1997 and 2001.*
Slika 3. *Letna rast dohodkov in odhodkov ZZZS in ustrezna rast BDP med letoma 1997 in 2001.*

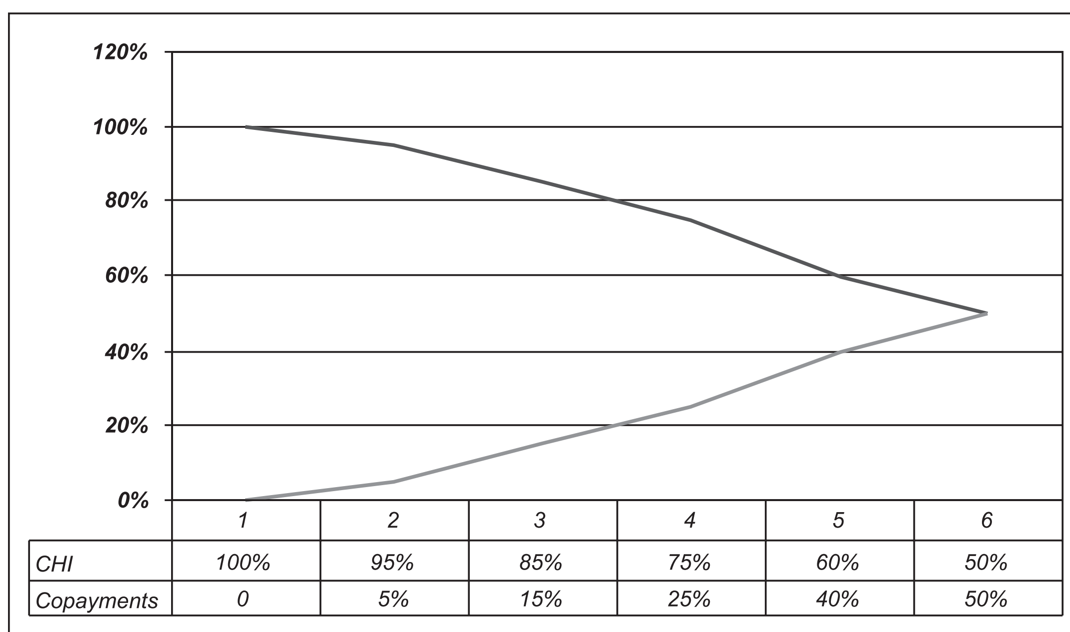


Source: Annual report of the HIIS 2008.
Vir: Letno poročilo ZZZS 2008.

Figure 4. *Share of the health care expenditure by source of finance of the total GDP.*
Slika 4. *Delež stroškov zdravstvenega varstva glede na vir financiranja celotnega BDP.*

Source: HIIS and the Ministry of Finance of the Republic of Slovenia.
Vir: ZZZS in Ministrstvo za finance RS.

Figure 5. *Percentage share of CHI in Gross Domestic Product in Slovenia between 1993 and 2007.*
Slika 5. *Odstotni delež obveznega zdravstvenega zavarovanja in BDP v Sloveniji med letoma 1993 in 2007.*



	1	2	3	4	5	6
CHI	100%	95%	85%	75%	60%	50%
Copayments	0	5%	15%	25%	40%	50%

Source: Health Care and Health Insurance Act, 1992.
Vir: Zakon o zdravstvenem varstvu in zdravstvenem zavarovanju 1992.

Figure 6. *Categories of CHI coverage and the resulting share of co-payments in the price of services.*
Slika 6. *Kategorije obveznega zdravstvenega zavarovanja in ustrezni delež doplačil v ceni zdravstvenih storitev.*

diagnostic and treatment procedurs are free of charge (including medicines), and adults over the age of 75 years. Co-payment was supposed to deflect some of the “unnecessary” use of services and was originally uninsurable. Concerns about its impact on equity in charging the sick led to a small legal niche in the HCHIA providing for the introduction of a supplementary health insurance (SHI) (also called “voluntary”) against co-payments. Successful promotion of this insurance resulted in the inclusion of a vast majority of the eligible population in the supplementary insurance schemes. Between 1992 and 2001 these were run only by two insurance companies; a department of the HIIS dealing exclusively with SHI, and a branch of a commercial insurance company. In the first years, most insured did not feel the burden of the premiums since at first employers were paying individual premiums (even in the public sector!). In 1994, the Court of Accounts (slov. Računsko sodišče) issued an audit report (15), which in the case of the National of Institute of Public Health clearly stated that the employer’s paying of SHI for its employees in the case of a public institution paid out of public funds would be against the principles of sound management of public funds. After this ruling of the Court of Accounts the employed in the public sector had to pay their own premiums.

The introduction of co-payments and the subsequent co-payment insurance schemes had two important consequences – cream-skimming that began in 2002 (which was stopped upfront by the establishment of risk equalising schemes in the HCHIA) and, the redistribution of expenditures in favour of private and out-of-pocket. After the separation of the SHI from the HIIS, three companies dominated the market. As indicated by the graph above, the share of GDP for SHI remained rather stable. The increase in the share of private expenditures in the THE from 22.3% to around 28% was the result of a decline of CHI share in GDP (16). Insurance companies offering SHI are not bound to invest in the provider infrastructure as they do not commission services from them but reimburse their insurees. Furthemore, SHI companies produced surpluses over the last 5 years (17) without rethinking the premium levels, which is partly the result of an obligatory reserve that they had to create by law. Waiting lists are still an important issue and a political priority . The problem is being resolved within the publicly financed providers with public funds. It is true that waiting lists have been shortened in cataract surgery with waiting time reduced to less than a month (2 years in 2002 – data of the MoH) and in acute cardiac surgery. But other problem areas remain, for example, different outpatient consultations with over 6 months waiting time and major orthopaedic surgery, such as hip replacement with over one year, and knee joint replacement with over two years waiting list (latest data of the MoH and Institute of Public Health of the Republic of Slovenia).

Discussion

“Health and wealth”

In Slovenia, unlike in other countries in socio-economic transition, economic changes enhanced positive developments in the population health status, such as positive changes in life expectancy (both at birth and at age 65). Even if Slovenia managed to reduce the gap separating it from the EU-15 to a greater degree than any other new member state, there are other warnings against complacency. As Jagger et al. (18)report, Slovenia stands behind EU-15, Cyprus and Malta and has a smaller relative share of healthy life years in life expectancy at the age of 50 than Poland. This may be related to the fact that Slovenia has one of the lowest effective ages at retirement for both women and men in the EU (55.2 and 59.5 years respectively) (19). Maintaining good health through the middle period of life becomes important for the future. Improved wealth may have also had a positive impact on the recently increased birth rates.

The cost of health workforce (60% of the THE) financed from the public sources grew much faster than the overall GDP. This gap has widened very rapidly since 1999 as a result of incentivising salaries in health care in response to the physicians’ strikes in 1996 and 1999. These changes led to the restructuring of health expenditures. From the available data and other explorative research we could not conclude with certainty that patients’ access to services has been limited as a result. The more likely reason seems to be the undersupply of physicians observed during the same period as Slovenia remains one of the EU countries with the lowest physician/population ratio. This may become a limiting factor for the future provision of health care and may cause problems beyond the presently observed stagnation in primary care (20).

Introduction of a social health insurance system and of additional sources of funding

Social health insurance seemed to be the best or, in practice, the only realistic option for all the key actors. It was introduced through a single central insurer and thanks to its universality, provided for good population coverage. Initially, the creation of a “monopoly” with only one provider granted this status by law was

criticised a lot. Still, the introduction of the CHI in Slovenia and its combination with SHI is regarded as an important achievement (21). Slovenia certainly avoided some of the problems of fragmentation of the health insurance markets experienced in some other countries , such as Poland (22) and Czech Republic (23)). Stability of health care funding offered room for reimbursement of new services and new drugs reasonably quickly. However, on the downside several controversies remain – strong state control over the HIIS, the power that the HIIS has in all negotiation processes and the tiresome process of achieving a compromise over tariffs in the annual contracting process. Other partners consider that annual negotiations for contracting purposes in minute details year in, year out, constitute an unnecessary process. Especially so, because nearly all negotiations to date ended in the Government closing all the open issues (as prescribed in such cases). The State decides on the budget cap for the overall yearly budget of the HIIS as the Ministry of Finance defines for them the same terms as for the national budget.

It was very important that the principle of fairness in income distribution and the related social contributions was applied to CHI. Given there is no upper limit to the contributions that the insured have to pay, CHI remains progressive. The sustainability of CHI was challenged by the introduction of a new salary system in September 2008 (including all salaried personnel in health care) and by the deepening of the financial crisis, which is causing a rapid decline in employment. The situation worsened by the declining trend of public finance over the past five years in the THE. Financial crisis will in turn decrease the incomes of the health insurance and increase the expenditures both in the health and social sectors. As the current age at retirement is still low, the Government is planning measures to extend it to a minimum of 63 years of age. This measure is inevitable in view of the forthcoming quickly advancing ageing projections. Future management of these issues at the national level will define what their impact on the financial stability of health care may be. To preserve the current rights, total contributions to the CHI will have to be increased - either through a higher contribution rate or, through additional sources, such as raising them on all types of personal income under the same conditions as salaries. Otherwise, the only way of coping with the increased needs may be through higher private and co-insurance solutions. Another option would be to redistribute spending through mixed financing schemes for long-term insurance, similarly as it had already been done for voluntary pension insurance, consisting of a compulsory and a voluntary part.

Introduction of co-payments for health care services from the CHI turned into a very important issue and added a significant regressive component to the system. This regressivity was partly reduced by an almost full adherence of eligible adults to the SHI - the last official data from 2008 show that around 90% of the eligible adults hold a valid supplementary insurance. Nevertheless, this insurance remains a source of inequality and regressivity. Supplementary insurance against co-payments, which exists also in some other countries (e.g. France (24) or Denmark (25)) provided for a solution to prevent excessive direct expenses. In the Health Reform of 2003 this situation was to be resolved by gradual inclusion of supplementary insurance into the CHI. The State managed to keep inequalities, at least to some extent, under control as it introduced risk-equalising schemes to curb the overt cream-skimming (26). In 2008, about 15% of the THE (or 1.3% of the GDP) was linked to the supplementary (“voluntary”) insurance.

Contrary to the highly regulated area of co-payments and supplementary insurance schemes, the area of out-of-pocket payments remains unregulated. In the beginning of the 1990s these payments were estimated as “minimal”, which was due entirely to the lack of a monitoring system to structurally capture these data. As a percentage of GDP, these expenditures have not changed over the last five years. The last report on the social situation in Slovenia from 2009 (27) shows that personal and household expenditures for health and health care are in decline when expressed in relative terms and there is no significant gradient across the three of the four income classes. There are several reasons for the nominal growth of these expenditures. One is the unregulated area of long-term care, where shared responsibility exists between the health and the social care sector. As long-term care insurance has not yet been enacted, patients and their relatives depend partly on cash benefits and partly on own out-of-pocket expenditure. Another reason for private expenditure is the rising offer of services for direct payment (e.g. queue jumping for outpatient specialist visits). This is a result of active cost shifting to private expenditures, but also a result of inefficient resolving of waiting list problems, where private providers fill in the gaps.

Conclusions

Slovenia’s story of the health care financing reforms following the socio-political and economic changes occurring the end of the 1980s and at the beginning of the 1990s, resembles and differs from the situation in

other countries in the region. We studied the changes in the financing of health care over the period of almost twenty years. In spite of the fact that this research was limited by the difficulty to obtain good integrated and high quality data, our main conclusion can be that Slovenia has successfully introduced a sustainable and equitable social health insurance system. This has ensured stability to the functioning of the health care system and functioned in a favourable socio-economic context. In parallel with the CHI with its progressivity and strong state control over expenditure, the system owes a certain level of stability to the development of the SHI, which is a regressive component in the Slovenian health insurance setting.

The main challenge for the future remain the doubtful prospective sustainability of the present combination of funding sources. A trend of decreasing public share in financing of health care is unlikely to continue. This may be the result of the ongoing financial crisis and additional sources of equitable funding will be necessary. The alternative may be in shifting certain costs to the supplementary insurance that may result in the classical vicious circle of increased premiums and consequent opting out of the insurance due to high premium costs. Additional increases in out-of-pocket payments are not likely to be socially and politically acceptable, especially as they may become a particular burden to the quickly growing population of the elderly.

A new reform process was launched in 2009, at the right moment to reflect on the best solutions for the future. A mixed public and private system of health care delivery which ensures transparencies of its efficiency, effectiveness and equity seems the most likely preferred option. Higher throughput of the system, which is expected by the citizens and patients, will depend on the efficient management of all resources.

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