HiT summary

Slovenia

Introduction

Government and recent political history

Formerly a constituent part of Yugoslavia, Slovenia declared independence in 1991. Slovenia has a democratic political system with a parliamentary form of state power. The Prime Minister is the head of government and the President represents the Republic and is the supreme commander of its armed forces.

Population

The population is estimated at 1 978 334. Ethnic Slovenes comprise about 88% of the population. About 16% are under the age of 15 years. Unemployment amounted to 7.2% in 2000.

Average life expectancy

Average life expectancy is 71.3 years for males and 78.8 years for females – below the European Union (EU) average but above the countries of central and eastern Europe (CCEE) average in 1998. Similarly, infant mortality in 1998, at 5.2 per 1000, is slightly above the EU and substantially below the CCEE average.

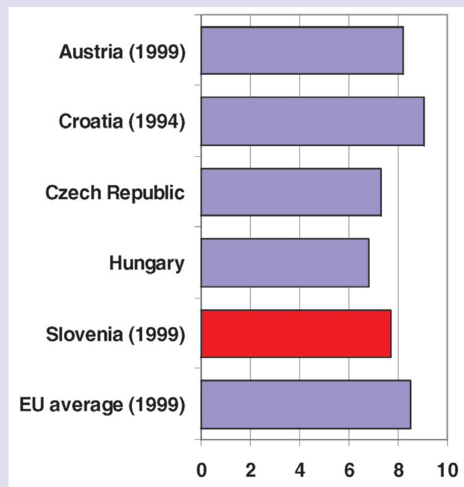
Leading causes of death

Diseases of the cardiovascular system are the most common cause of death in Slovenia, representing almost half of all deaths. These are followed by cancer, injuries, poisoning, respiratory diseases, diseases of the digestive system and others. This pattern is similar to most EU countries.

Recent history of the health care system

During four decades of socialism, Slovenia maintained a health insurance system. In the early 1990s, the system experienced serious financial problems in securing the funds for health care services. These problems, together with the drive towards modernization of the overall social structure, led to the adoption of new health care legislation in 1992.

Fig. 1. Total health care expenditure as % of GDP, comparing Slovenia, selected countries and EU average



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

Reform trends

Legislation enacted in 1992 revised the methods of financing. It replaced direct funding by the Ministry of Health from general revenue, with

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mainly employment-based financing operated by a new public health insurance agency. The legislation also defined roles for both the compulsory and voluntary insurance schemes, and for additional optional insurance. Some of the public health network was privatized, and some formal out-of-pocket payments were introduced, along with free choice of physicians and some elementary gatekeeping functions in primary health care. The care provider contracting processes were formalized and restructured.

Current reform measures focus on harmonizing legislation with that of the EU, improving health care resource allocation methods to increase the incentives to deliver cost-effective care, improving health information systems and encouraging evidence-based clinical practice.

Health care expenditure and GDP

Total expenditure on health was estimated to be 8.2% of GDP in 2001.

Overview

The health care system in Slovenia had few major reforms until 1991. Shortly after the country's independence, liquidity problems led to the introduction of legislation in 1992.

The reforms succeeded in securing an increasing proportion of the GDP for the health care sector, partly because of the introduction of compulsory insurance and partly because most of the population purchased voluntary insurance. During recent years, however, there have been new concerns about a potential deficit in the health insurance system. Problems remain in the form of waiting lists for diagnostic and surgical procedures in hospitals; dissatisfaction of physicians and nurses with working conditions; and dissatisfaction of patients with waiting lists and the quality of services. In addition, prices for pharmaceuticals are relatively high compared with neighbouring countries. The EU accession process may increase costs further through the new dynamics in trade of medical goods and human capital.

Organizational structure

There is a number of key players:

- 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. Its role is currently under review.
- The Ministry of Health develops national health policy and provides regulatory and supervisory support to the health care system and health monitoring.
- The Health Council is the highest coordinating expert body for health care, advising the Ministry of Health on health policy matters.
- The Parliamentary Committee on Social Affairs, Work, Family Matters and Health prepares legislative proposals and other materials for parliamentary discussion.
- The Health Insurance Institute of Slovenia (HIIS) was created in 1992 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. It operates through 56 branch offices.
- The Institute of Public Health of the Republic of Slovenia (IPH) has nine regional public health institutes and was founded in December 1992 to cover the fields of social medicine, hygiene, environmental health, epidemiology, informatics and research activities.
- Local governments of self-governing communities have been delegated some autonomy in planning primary care but have not yet begun to play an active role in decision-making in the health care system as envisioned by the health care reform legislation of 1992.

- The Medical and the Pharmaceutical Chambers were re-established in 1992. The Medical Chamber of Slovenia has become an influential body that has taken over some responsibilities that were traditionally within the scope of the Ministry of Health.

Planning, regulation and management

The Ministry of Health is responsible for much of health care planning. Inter alia, it is responsible for planning secondary and tertiary health care facilities and capital investment for hospitals. There is no explicit planning policy on the introduction of medical technology that requires high capital investment. The annual financial plan for compulsory health insurance prepared and accepted by the HIIS assembly is the framework for the annual partnership negotiating process. Secondary and tertiary services are the responsibility of provider units, and self-governing communities are responsible for primary care. Citizen participation takes place by representation and by active voice.

Decentralization of the health care system

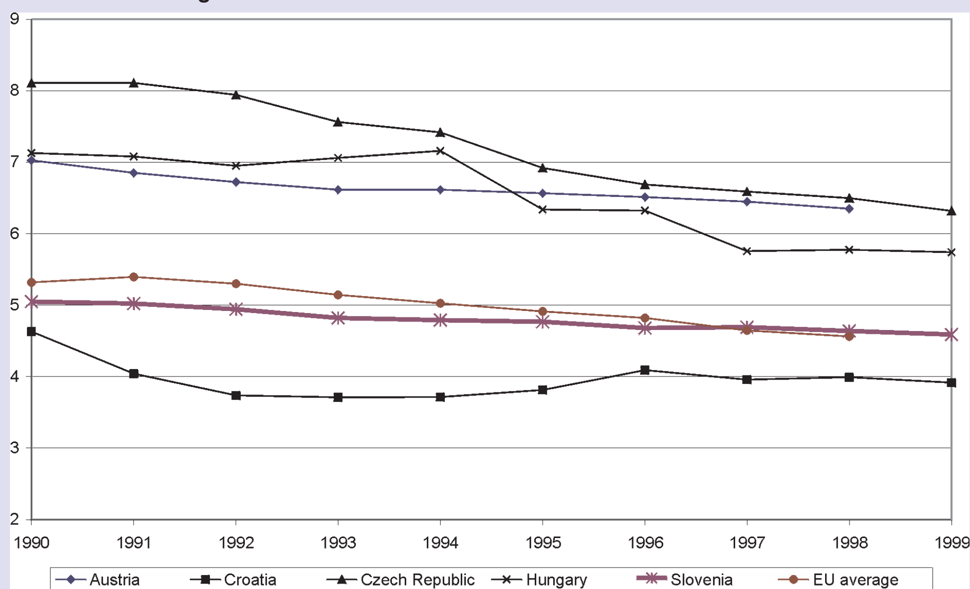
The Slovenian health care system remains relatively centralized. Most administrative and regulatory functions of the system take place at the state level; the lower levels have mostly executive duties. The self-governing communities are said to make limited use of the autonomy they gained in planning health services. Compulsory health insurance is also centrally managed and administered.

Health care finance and expenditure

Health care financing

Statutory insurance is the most substantial source of financing, contributing around 85% of

Fig. 2. Hospital beds in acute hospitals per 1000 population, Slovenia, selected countries and EU average



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

funding. Financing through taxes (including both state budget and locally generated taxes) plays a minor role, amounting to less than 4% in 1998. Voluntary insurance contributed 11.6% of health care funding in 1998. Information is not available on the amount of direct payments not reimbursed through voluntary insurance.

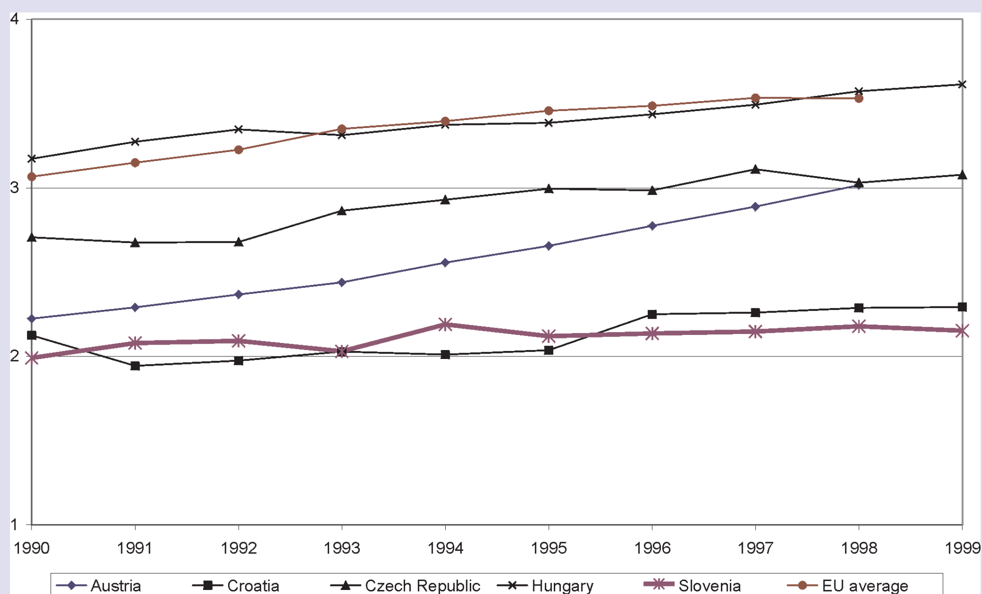
The state budget covers capital investment for all secondary and tertiary health care facilities. Budget financing also covers expenditures for the national public health programme. The self-governing communities collect revenue at the local level to allow capital investment in primary health care facilities.

Main system of coverage

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. 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 without any surcharge non-earning spouses and children. The contributions are proportional to the individual's income. Since January 2002, employers and employees pay 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 consists of people contributing fixed amounts. The National Institute for Employment pays 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. Self-employed, farmers and craft workers 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 and some people argue that self-employed people and other groups are not paying a high enough proportion of their income.

Fig. 3. Physicians per 100 population, Slovenia, selected countries and EU average



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

Health care benefits and rationing

Compulsory health insurance provides all insured people with two types of rights. The first type is entitlement to health care services delivered in Slovenia at the primary, secondary and tertiary levels, including pharmaceuticals and technical aids. The second type comprises specific cash benefits, such as compensation for salary during absence from work. The benefit package of the compulsory insurance scheme covers a full range of benefits, some of which are subject to co-payments.

Overall, health services have not been rationed in Slovenia apart from a few areas such as a reduction in the services available to patients without co-payments and a reduction in spa treatment.

Complementary sources of finance

From year to year private resources within the health care system have increased. The largest source of private financing is voluntary insurance. It rose from 1.5% in 1991 to 8% in 1994 and then to 11.6% in 1998. At present, 95% of all insured people have voluntary health insurance, insuring themselves against the risk of out-of-pocket payments. Formal out-of-pocket payments were introduced in the 1992 legislation. The introduction of voluntary insurance with fixed premiums decreased the proportionality of contributions to income and rendered health insurance more regressive. Co-payments vary from 5% to above 50%. Information is not available on the amount of direct payments not reimbursed through voluntary insurance.

External funding 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. A comprehensive reform project is co-financed by the World Bank through a loan agreement.

Health care expenditure

In recent years, Slovenia has spent between a total of 7.7% in 1993, and 8.23% in 2001 of its GDP on health care. Public health expenditure has been about 7.2% of GDP in 2001 (7.1% in 1993, 6.6% in 1999), the balance mainly comprising voluntary health insurance. The public share of total health care expenditure in 1999 amounted to 86%. Public health expenditure decreased as a proportion of GDP after 1996 mainly because the proportion of private funding increased through co-payments levied on certain services and GDP has risen more rapidly than public health expenditure. Absolute public expenditure estimates for 2001 amount to 313.42 thousand million tolars (6.9% of GDP) spent through compulsory insurance, 8.88 thousand million tolars through budgetary resources (0.2% of GDP) and 3.32 thousand million tolars through local resources (0.07% of GDP).

Over the last two years, expenditure pressures have increased for several reasons, including policy measures such as the high real increase in physicians salaries, and the introduction of a Value Added Tax on pharmaceuticals that led to the increase of health care expenditure. It is furthermore expected that the EU accession process will lead to expenditure increases as Slovenia is likely to adopt prices in pharmaceuticals, technologies, health care services and salaries similar to those in the EU member countries.

Health care delivery system

Primary care

Both public and private providers deliver primary health care. Public providers include health care centres and health stations. In 1999, there were 64 health care centres and 69 health stations. A health station provides as a minimum: emergency health assistance; general practice or family medicine and health care for children and youth; family medicine and basic diagnostic services; and is linked to the nearest health care centre for more complex primary health care services.

A health care centre provides, as a minimum, preventive and curative primary health care for

different target groups of inhabitants. Health care centres are publicly owned by the respective self-governing community. The employees of health care centres are salaried but physicians and dentists have obtained the right to have a special contract for private practice. Because of the absence of policies on future development of the health care centres and a lack of regulation, the introduction of private practice in primary care has encountered some difficulties.

Under compulsory insurance, patients are free to choose their own physician in primary health care, either a physician in a health care centre or a private practitioner with an HIIS contract. The personal physician is usually a general practitioner. Registration is for at least one year. The personal physician acts as a gatekeeper and refers patients to the secondary and tertiary care level.

With 7.4 physician contacts per patient per year, Slovenia is below the average for central and eastern European countries.

Secondary and tertiary care

Access to secondary and tertiary care services is through referral by the personal physician, but cooperation between primary and secondary care leaves much to be desired. Primary health care services and hospitals mainly cooperate on referrals and exchanging test results but do not cooperate over care or disease management.

Specialist secondary outpatient care is performed in hospitals, spas or private health facilities. Hospitals provide about 75% of secondary care, either as inpatient or outpatient care. Clinics and institutes provide more complex tertiary health care services. There are 26 hospitals, including nine regional and three local general hospitals and the main tertiary and teaching hospital, the Clinical Centre in Ljubljana. In addition, there are 12 specialized hospitals. Apart from the Clinical Centre in Ljubljana, there are two other national tertiary institutions, the Institute of Oncology and the Institute for Rehabilitation.

The number of acute hospital beds has decreased from 5.0 per 1000 to 4.6 in 1998, mainly due to the shift from inpatient to outpatient care. The level is low relative to both EU and eastern European averages. The occupancy rate has increased over the past 15 years to 85%. The annual national partnership negotiations (defining the service contracts) have resulted in an agreement that hospital beds and staff must be reduced by 1.0–1.5% annually. However, hospitals attempt to fill the excess bed capacity that thus arises through alternative arrangements such as accommodating patients covered by voluntary insurance and marketing non-standard services. It is still hoped that the HIIS will be able to redirect some of its resources towards primary health care and other types of non-hospital care.

Inpatient admissions have been relatively stable around 16 per 100 population in the past two decades, slightly below CEE and EU averages.

Social care

Social care is mainly provided by the public sector. The community nursing services are based in the health care centre, and work simultaneously with the general practitioners or family physicians in the self-governing communities. Community nurses have picked up all the tasks of district nurses over the past years, including those previously exclusively provided by midwives. Homes for elderly people and disabled people provide long-term health care.

Providing social care for the needs of the growing number of elderly people presents new challenges to Slovenia.

Human resources and training

The level of human resources in health care is officially considered to be well controlled and adequate, and policy has been directed towards maintaining the situation. Thus enrolment at the medical faculty was limited to maintain the same

number of physicians. Nevertheless, prospective analysis of demographic data for physicians and that of the general population indicates potential shortages of physicians in certain regions. The number of physicians per population has remained nearly unchanged in the past ten years with a marginal increase from 1.9 per 100 population in 1990 to 2.1 in 1999 and is lower than in most CEE and EU countries (Fig. 3). There are already some problems in ensuring the coverage of certain areas. In addition, alignment to the EU working time directives may imply that more physicians are needed so that it may be necessary to consider recruiting some physicians from outside Slovenia. Recently it has been decided to increase admissions to the medical faculty by 15%.

The situation with nurses in Slovenia is somewhat different. Their numbers show relatively constant growth.

Pharmaceuticals

Under compulsory insurance, Slovenia has a positive list and a so-called intermediate list. Reimbursement of drugs listed on the positive list is 75%, the remainder of the price being met through co-payments that may be covered through voluntary insurance. Drugs on the intermediate list are reimbursed up to 25% by compulsory insurance. There is also a negative list in place. Physicians are encouraged (but not obliged) to prescribe according to reference prices. Prescriptions are registered and controlled.

The two key problems in the pharmaceutical sector in Slovenia are a high and increasing level of consumption and increasing prices.

Consumption cannot be quantified at the national level because consumption in hospitals and over the table products is not registered nationally. Data on prescriptions are relatively accurate: the average of 5.5 prescriptions per person in 1991 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 and as a consequence, the number declined to 6.3 in 1995.

The electronic health insurance card that is currently being introduced will register prescriptions electronically and is hoped thereby to diminish some over-consumption.

Pharmaceutical prices increased and were relatively uncontrolled until 1995 when the government intervened to determine prices in the wholesale and retail sectors.

The trends of pharmaceutical prices and patterns of prescriptions translate into substantial expenditure increases in Slovenia's pharmaceutical sector over the recent years.

Financial resource allocation

Third-party budget setting and resource allocation

Annual negotiations and contracting in compulsory insurance have three stages and begin at the state level. Each year the Ministry of Health, the HIIS, the Medical Chamber and Pharmacists Chambers and other provider representative institutions negotiate on the services to be included in the insurance benefit package, and determine a budget ceiling for compulsory insurance. For 2000, the agreement maintained the public budget at about 6.5–7.0% of GDP, a measure also intended to contribute to achieving the *acquis communautaire* for accession to the EU. Expenses in excess of 7% of GDP are to be covered by supplemental sources.

In a second stage, the partners negotiate for each type of provider the rights and responsibilities of partners in contract implementation. These are the basis for the third stage which is the contracting process between the HIIS and individual health care providers. The HIIS issues a public tender for contracts with the providers. These 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 contract implementation and the individual rights and responsibilities of the contracting parties.

Payment of hospitals

Hospitals (as well as the health care centres) receive most of their funds through contracts with the HIIS. A prospective budget sets the limits for spending. Until 2001, they were paid according to work to be done, measured in terms of bed-days and high-cost services. In 2001, an elementary per case payment method was introduced that delineates only nine main categories of cases. More detailed payments are calculated from the averages of all cases from the appropriate speciality for each hospital separately. Accordingly, a case might have a different price in different hospitals. A more sophisticated case-mix payment model has been designed, and it will be implemented over a transition period beginning in 2003.

Payment of health care centres and payment of physicians

Primary care centres are paid a combination of capitation and fees for services by a regional health insurance fund. Physicians in primary care may practice under salaried employment either privately with a concession and under contract with the HIIS, or privately independent of a contract. Employed physicians are salaried by the health care centres and health stations. Private physicians without concessions and contracts are paid through out-of-pocket fees or voluntary insurance. They can set their own prices for services that are not reimbursed.

Physicians employed in hospitals or public health care centres are salaried, and there are bonus payments in place. In 2001, physicians' average earnings were 2.5 of the average salary in Slovenia.

Health care reforms

The health care reforms of 1992 introduced compulsory and voluntary social health insurance, private practice, and contractual arrangements between the partners in the system. The changes were mainly directed towards mobilizing supplementary funds. Many key features of the system under the former regime were maintained, such as ensuring a comprehensive range of services to the entire population. Prospective budgets and contractual agreements were introduced to pay hospitals under compulsory insurance. The reform in 1992 is believed to have achieved its prime objective of maintaining the growth of public health expenditure at or below the growth of GDP. The introduction of private practice has encountered some difficulties in the absence of a policy towards a public-private mix in financing and delivering care.

There are new pressures urging for health system reform. These are expenditure pressures, for example, through increasing prices most predominant in the pharmaceutical sector. Another pressure on the public financial income side is that the proportion of self-employed people has increased as they pay lower contributions compared to public sector employees. In addition, the Slovenian population is ageing, and this is contributing to an overall increase in health care demand. There are shortcomings in the delivery of care. For example, coordination of care between hospital and non-hospital service providers needs to be improved, as does coordination between providers of primary care. Recognizing these shortcomings, the government is committed to pursue some structural reforms of the financing and management of the system, albeit at an incremental stage. Pillars of the reform will include improvement of the health information system; the reform of the hospital reimbursement system; the improvement of managerial skills of health professionals and decision-

makers; and improving quality and quality through the introduction of standard quality management and methods of evidence based medicine.

Conclusions

The Slovenian health care system provides universal and comprehensive health care access for all Slovenian citizens regardless of income. The system so far has been successful in diversifying funding sources and thereby maintaining a stable share of GDP spent on health care. The population is relatively satisfied with the health care system and their health status compares well with neighbouring countries. Yet there are a number of problems that need to be addressed in future. In terms of health status and resources there are some regional disparities in health. It is feared that the system may promote further inequalities in access to health care services because affluent people obtain access to more and higher-quality services by paying out-of-pocket or they obtain better coverage through voluntary insurance; the less well-off may not be sufficiently protected. In addition, there are waiting lists for elective procedures, a problem that may worsen as there are potential shortages of physicians in certain regions. With respect to health care costs, an eye needs to be kept on the rising expenditure on pharmaceuticals as consumption of pharmaceuticals and the price levels of drugs are relatively high. This is one of the problems that may become more pronounced when Slovenia joins the single pharmaceutical market of the EU. In addition to problems related to their system, Slovenia faces similar problems to those faced by most other European countries, such as an ageing population, a need to find sustainable solutions for financial protection and a solid nursing care infrastructure.

Table 1. 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 (%)
Austria	6.2	27.2	6.3	75.5
Croatia	4.1	13.9	9.2	86.3
Czech Republic	6.3	18.7	8.8	70.7
Hungary	6.6	22.4	6.7	72.5
Slovenia	4.6[a]	16.1	7.6[a]	*73.2*[a]
EU average	4.2[a]	17.1[e]	8.2[b]	77.0[b]

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.

HiT summary

Slovenia

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The full text of the HiT can be found in *www.observatory.dk.*

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.

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