Slovenian health care in transition: Studies on the changes in the Slovenian health care system from 1985 until 2010
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1.1. Introduction

While all modern societies of the late 20th century started transforming due to different external and internal stimuli, the socio-economic transition in the central and Eastern European countries has been (and, in part, still continues being) one of the largest and most profound 'natural' societal experiments in modern history. Political and social tensions resulted in launching processes that have had an impact on almost every aspect of life. Economic crisis, which in part had a different background in these countries than in the Western democracies, brought about a further driver for the implementation of more profound changes. These processes resulted in structural reforms and changes, transformation attempts and repositioning of key stakeholders in health care as well. They followed a clear - sometimes explicit and sometimes implicit - political agenda, which proclaimed replacement of some of the old values with new ones or, suggested to return to some of the old principles, such as private ownership and private practice. The old values that were deemed outdated were predominantly those of the previously implemented egalitarianism, role of the State and, in general, the predominance of broader societal values over those of individuals. The Leitmotiv of most of these changes was parliamentary democracy, private property and devolution of state functions to empowered stakeholders. Some of these processes followed the longstanding desire for change, often taken by the nostalgia of the period before World War 2. As much as
these views sound unusual at this point, at the time when transition was about to start, they were seen as the guiding light for changes. The president of the Slovene Medical Society in one of his speeches in 1992 said: ‘We first need to return back to the situation in 1939 and continue from then on in order to be able to continue our democratic history!’ The changing role of the state in healthcare systems is an important issue, not only for the countries of central and Eastern Europe, but also for the old democracies. By choosing a particular healthcare system the policymakers also define the State’s role in such a system.

At the time when the transition changes started, the countries of central and Eastern Europe (CCEE) had three basic options in choosing the most suitable healthcare system:

1. a Beveridge system
2. a Bismarckian system
3. a Semashko’s system

The Beveridge system is named after the British economist and social insurance founder in the 1940s, Sir William Beveridge. It was based on the Beveridge Report from 1942 entitled ‘The Way to Freedom from Want’. This report recommended provision of health care for all people through central taxation and other compulsory financial contributions and that a system of universal benefits should give support during unemployment or sickness and after disability and retirement. The National Health Service Act of 1946 established the provision of services, free-of-charge established in 1948. The Beveridge system assumes a strong interest of the State expressed in the budgetary supervision of health care, its ownership of key resources and in the salaried nature for the majority of the health care professionals. A Beveridge system is further promoted by the progressivity of fund collections and through services, which are free of charge at the point of entry into the health system. In these systems the government and the parliament retain important specific measures regarding the control over the global health budgets and thus over the equity of a country’s health care.

‘The object of government in peace and in war is not the glory of rulers or of races, but the happiness of common man.’ Sir William Beveridge

A Bismarckian health system or a social health insurance system stems from the original social health insurance established in Germany in 1883 with the adoption of the first law on health insurance during the term of Chancellor Bismarck. A part of a social legislation package adopted in the 1880s and intended to buffer the rising social tensions; it meant an important step towards the State’s role in regulating the relationship between patients on the one side and health care providers on the other. The principle of sharing costs of insurance between employers
and employees and consequently providing free treatment and sickness benefits has survived for more than 125 years and has spread over a large part of Europe in the meantime.

‘The State must take things in its own hands!’ Count Otto von Bismarck

The third principal type of a health care system, which is important in Europe, though mostly historically today, is the Semashko health care system. Its founder, Nikolai Alexandrovich Semashko, who was the People’s Commissar of Public Health in the Soviet Union between 1923 and 1930 [5] designed it as a state-run system in order to cope with the huge public health problems Russia and other Soviet countries were facing in the 1920s. Financing of health services is entirely through the state budget, with publicly owned health care facilities and publicly provided services. Different levels of state administration – central, regional, and local – were responsible for planning, allocation of resources and managing capital expenditures. Its special characteristic was the setting up of polyclinics as special multi-specialty points of entry into the system and a system of SanEpid stations for the public health activities. The system was transplanted into all countries of central and Eastern Europe (with the exception of Yugoslavia) after World War 2. It was then gradually abolished in all of these countries in the early 1990s.

Obviously, there was no wish to continue with the Semashko’s system, which was not only laden with emotional opposition, but also outdated and incapable of getting steered for the needs of the public health challenges the societies of the countries of central and Eastern Europe (CCEE) were facing. Therefore, only the choice between ‘Beveridge’ and ‘Bismarck’ remained, where the battle even from the start seemed uneven. Nostalgia about the ‘old days’ was reflected in the return to the Bismarckian social insurance systems [6], which seemed to prove very attractive to the majority of CCEE [7]. Moreover, it seemed a political imperative at the time, to withdraw from the opinion that the state should be the main regulator and also the main deciding factor [8]. Instead, it should be replaced by the interested communities, which eventually led to a specific corporativist philosophy. It is reflected in the empowerment of key actors and partners in the system, where they take over different tasks previously exclusively organised and delivered by the state [9]. This is clearly represented in Table 1 below.

The geographically extensive area of CCEE, today showing a multitude of independent countries, ranging from the Baltic Sea down to the Black Sea and the Adriatic, is by no means homogenous. Historical and social developments prior to 1945 had an important impact on the transitional changes. In spite of the seemingly common stem, these processes ran differently in different countries, even in those which shared a much more common political setting. Some countries saw two processes running in parallel – one, which was the socio-economic transition and the other, which was in establishing an independent state
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Table 1. Types of healthcare systems with respect to the State’s role. (Rothgang et al. [1]).

<table>
<thead>
<tr>
<th>Type of healthcare</th>
<th>Underlying values and principles</th>
<th>Financing</th>
<th>Service provision</th>
<th>Regulation (dominant regulatory mechanism)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National health service</td>
<td><strong>Equity:</strong> equal access to services for everyone</td>
<td><strong>Public:</strong> taxes according to income (direct taxes) and consumption (indirect taxes)</td>
<td>Public providers</td>
<td>Hierarchy; comprehensive planning and tight control of the state</td>
</tr>
<tr>
<td>Social insurance system</td>
<td><strong>Solidarity:</strong> Equal access to services for all members of insurance funds</td>
<td><strong>Public:</strong> contribution according to income</td>
<td>Private and public providers</td>
<td>Collective bargaining; legal framework and some control by the state</td>
</tr>
<tr>
<td>Private (insurance) system</td>
<td><strong>Principle of equivalence:</strong> service according to ability to pay</td>
<td><strong>Private:</strong> premium according to individual risk</td>
<td>Private providers</td>
<td>Markets; limited control of insurance and service provision by the state</td>
</tr>
</tbody>
</table>

The latter is a common feature of the Baltic States and the former members of the Yugoslav federation [10]. Furthermore, individual societies, professional communities and political groupings in these countries had different expectations from the transition processes. They ranged from the more independent positioning of the medical profession and re-introduction of private practice to attracting foreign capital to invest in the previously neglected health care infrastructure. The magnitude of these individual steps was different and prioritisation also differed largely.

Apart from the fact that there was a preference for the Bismarckian model, we can see some elements of the more liberal approaches and also of a state-regulated system. There is a constant interplay of these elements, while the basis for the overall framework is set by the principles of the social health insurance [11].

There are several key issues that are important in evaluating the extent and the impact of reform changes in the CCEE. These will be outlined in the introduction and the specific situation in Slovenia will be elaborated

1.1.1. Health workforce planning

Health workforce planning is one of the key problem areas for the CCEE. Most of them used to have a very numerous health workforce, which was pauperised by the small incomes and by the social perception that these professionals are just doing their jobs to the service of the community and society. This has sometimes led to deviations, such as the under-the-table payments [12, 13]. Facilities were more ex-
tensive than those in the Western part of Europe and the demand for health professionals was consequently very big. As the transition processes set in, there were many challenges regarding the sustainability of such a quantitatively generous infrastructure. The next important reason for many CCEE was in the fact that incomes of their health professionals remained low or comparably low, not only with respect to the most developed countries in Europe but also compared with some other professional groups in their own countries. This affected decisions of young people when opting for their preferred studies but helped in reducing the surplus. Loss to emigration was important in some of the CCEE, but research that will shed more light on this issue is due in the next two years.

1.1.2. Primary health care

Primary health care is often politically declared as a priority and as a cornerstone of a rational health care system. Apart from the traditional role played by general practitioners (GPs) and other categories of health professionals in primary care settings, there are newer concepts and approaches, especially those directed at improving lifestyles, modifying them and providing for healthier choices through health promoting activities. The area of central and Eastern Europe inherited a very heterogeneous infrastructure at the primary health care level. In all countries dominated by the Semashko’s system, we can see big numbers of health professionals in polyclinics providing rather limited care and almost no additional value in complementary activities, such as health promotion. In contrast, Yugoslavia did not follow the same path and primary care was delivered by the primary health care centres (PHCCs), which were designed as an original setting integrating preventative and curative activities with a considerable role for all key professional groups in the health sector. The general opinion about these services in the population using them was quite positive with good to excellent opinions in total ranging up to 85% [15].

1.1.3. Public health infrastructure

Public health infrastructure is supposed to be supporting health policy decisions, steering them and providing assessment of their impact on the population’s health. Furthermore, it should be in the forefront of proposing new approaches, new priorities and new interventions to improve health, prevent disease or reduce the disease burden. Transformation of the infrastructure, which in the past served different health policy goals, represented a special challenge for all CCEE. While staff in many clinical institutions was growing at high rates, it was shrinking in public health, thus further weakening one of the cornerstones of a health system oriented towards population health. Certainly, taking into account the burden of diseases and its specifics in all CCEE [14], these countries’ societies would benefit greatly of a more health promoting and more public health intervention based approaches, involving public health professionals with specific knowledge and skills.

2 Project Health Prometheus, co-financed by the European Commission, under the 7th Framework Programme for Research in the European Union.
1.1.4. Privatisation

Privatisation was one of the unique universally outlined principles that penetrated into all societal structures involved with service delivery. In health care, privatisation can range from being very comprehensive to having only a few modalities present. Privatisation of the different types - privatisation of delivery, privatisation of insurance, privatisation of infrastructure and privatisation of management - can be implemented partially, fully or in different combinations of the above. In most countries, these decisions depended on the specific political setting, which had its own priorities in this process. In all CCEE, a certain degree of privatisation was introduced at the very start of the reform process and later, policies were either evaluated (rarely) or continued at a faster or slower pace.

1.1.5. Hospital care

In many CCEE hospital infrastructure was very extensive and was intended for medium- to long-term stays of patients requiring hospital or intense specialist care. Consequently and as previously mentioned the requirements for the number of staff followed the extent of this sub-sector. When hospitals were faced with increasing pressures to optimise their delivery of care, they had to approach it from different angles. This process partly depended on the owners, which were very often still the states. In some countries, such as Estonia, the transition towards a new system was quick, with reductions in hospital capacity and mergers, a process that was launched as a managerial action, not as a result of financial constraints. In other countries different reimbursement mechanisms were introduced with the aim of stimulating a softer transformation of the capacities as well as of the types of services hospitals were delivering. Reimbursement systems and strategies have always played an important role, alongside with the political will to actively change or transform this sub-sector.

1.1.6. Health care and health system reform

Health policies developed with different speed across the region. In some countries, health care was a priority area and in such cases the subsequent developments were unfolding rapidly. Some countries were more cautious and were implementing most of these reforms slowly and through constant measuring of the public opinion pulse. The climate for reforms was explicitly positive especially at the very start of the processes at the beginning of the 1990s.

Apart from the internal circumstances and socio-political demands for changes in the health sector, most of the CCEE were faced with external interest in getting involved in the steering of changes, transformations and reforms. This process often enriched the domestic debates and provided first hand objective experience about foreign solutions, whether successes or failures. International organisations, such as the World Bank and the World Health Organisation, got involved in assisting in the reform processes of this group of countries. But, it often proved true that there was much more benefit from these consultancies in countries where the domestic
workforce, administrative infrastructure and organisational climate were favourable and would assist in promoting the reforms. In some cases, these interventions resulted in failures, also due to the inappropriate methodologies used or due to insufficient involvement of the domestic expertise [16].

1.2. Some facts about Slovenia

Slovenia is a country in the southern part of central Europe, geographically squeezed between the south-Eastern chains of the Alps, which through their hilly extensions cover around a third of the country, the northern Adriatic coast, the river valleys of Soča, Sava, Krka, Savinja and Drava, the Pannonian plain extending into the plains of Prekmurje and Dravsko polje and the beginning of the Balkans. This geographical mix is closely related to the historical developments, which had been turbulent at times, but defines an important positioning of the country with respect to its neighbours - Italy in the west, Austria in the north, Hungary in the north-east and Croatia bordering in the east and south and also having the longest border. Slovenia’s surface is 20,250 square kilometres and was populated by 2,032,362 inhabitants on 31 December 2008 [17]. Just slightly over a half of them live in urban areas, the rest still live in hamlets and villages of sizes between 3,000 and 5,000 inhabitants. The population is ageing in two directions, due both to the process of extension in life expectancy as well as due to declining birth rates. The latter were in decline intensely after 1980, but then its intensity was becoming much more alarming in the 1990s, when the number of births dropped from 22,000 in 1991 to a record low in 2003 with slightly over 17,000 [18]. Since 2004 birth rates are rising again, but fertility remains with 1.58 in 2008 at one of the lowest levels in the European Union. Consequently, the demographic transition is advancing, taking into account the declining number of childbirths and the extending life expectancy. The latter was in 2008 with 78 years for both sexes and with 75.5 years and 82.5 years for males and for females respectively the longest among the new member states of the European Union (excluding Cyprus and Malta). At first these improvements were, to a large extent, due to the rapidly declining infant mortality (while it was 13.9 per 1000 childbirths in 1984, it dropped to 6.77 in 1993 and then to 2.62 in 2008), but later reduced mortality due to cardiovascular diseases in the middle-age period before 65 years of age was an important contributor (88.5 per 100,000 in 1989 dropping to 40.32 per 100,000 in 2008). Premature mortality is marked by the considerable burden of deaths caused by external causes (mostly suicides and traffic accidents) – in 2008, the SDR for all deaths caused by external causes before 65 years of age was 41.42 per 100,000 (Netherlands 16.44 [19]), that of suicides was 15.12 per 100,000 (NL 7.73) and victims of traffic accidents 13.67 per 100,000 (NL 3.63).

Undoubtedly, many of these improvements came as results of a favourable economic development that, for example, increased the GDP per capita by 50% between 1999 and 2006 alone – see Table 1 below.
1.3. The case of Slovenia in health care transition

As a constituting member of the Yugoslav federation, the Socialist Federative Republic of Yugoslavia (SFRY), Slovenia was sharing the health care system with other federal members – the republics. Between 1945 and 1952 the political system (and with it also health care system) was a typical centrally-planned system, where private initiative – including private practice of health professionals – was abolished and banned. Even though formally a federation, the central administration was the dominating factor. In 1953, the first changes to the previous inflexible system arrived with the loosening of certain federal regulations through a special constitutional law, which also introduced the core principles of self-management [20]. This materialised further at the political level with the constitution of 1963 [21], where an outline of a true federal state was designed. The major move towards a loose federation came with the constitution of 1974 [22], which was a political response to the ‘autonomist’ movements of the early 1970s. The constituting republics of the Yugoslav federation got full control over health, social and educational systems as well as over police, so these services were no longer defined at the federal level. Today, with the devolution processes in Italy, Spain and the UK, such solutions are no longer exceptional, but more and more common (and also appear much less ‘threatening’). At the same time, health care was organised in a decentralised fashion within the republics with strong elements of a Beveridge-like system, based on budgets, which were then allocated to the locally responsible administrative bodies – self-managing interest communities (Slovene: samoupravne interesne skupnosti – SIS) – comparable with local health authorities. This system was not economically and managerially sustainable so its economic base collapsed in the late 1980s. This col-
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lapse was further quickened by the severe economic crisis in Yugoslavia in the second half of the 1980s.

Figure 1. Map of Slovenia.

Similarly to the countries of central, Eastern and south-Eastern Europe, Slovenia has gone through a process of profound socio-economic and political changes that affected all aspects of life and, in particular, the setting, functioning and the modalities of delivery of services in the social sector [23]. Health care was one of the foci of the largest expectations in all the most important stakeholder groups – politics, professionals and patients. Slovenia (along with the former Yugoslavia) never adopted the Semashko system and its principles, which were otherwise introduced throughout Central and Eastern Europe. The reasons for such an approach were not only political. On the contrary, Slovenia benefited from the public health reforms and approaches introduced by Andrija Štampar already in the 1920s. Looking across the different sub-sectors in health care, we can see important differences in the impact these processes had. The process of gaining independence from the former common federal state in turn affected the economy much more importantly than health care. The reason is very simple as health care had previously been decentralised. But as there is a strong link between the processes and reforms in the economic area and the country’s potential to sustainably finance the development of health care, it is a problem that had (and continues having) its impact on health care. Many of the po-
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tential policy, structural and organisational options that were put on the table were reminiscent of the main ‘known experience’ that Slovenian regions had in the past. That was the Austrian and German type of Bismarckian health insurance and the correspondingly strong role of the medical professionals in these countries.

Socio-economic and political transition has made a multi-faceted impact on the health sector. One of the important triggers for changes was in the deepening financial crisis preceding the actual political changes. The actual collapse of the financing system in 1989/90 required an intervention at the state level, even independently from the more profound structural and organisational reforms and changes [24]. The new system was then set up through the adoption and implementation of the basic ‘system’ legal acts in 1992. This set the scene for the reform changes in health care which were rather complex. There are similarities between Slovenia’s transition and that of the Baltic countries. There were three simultaneous social, political and economic processes – political changes and broad reforms, economic changes and the setting up of an independent state. The latter was not that important for health care as this had previously been devoluted to the republics of the former federation.

My interest in wishing to explore these processes, changes, developments and impacts was motivated by two principal reasons. The first was in my position as a researcher at the National Institute of Public Health in the Department of Health Care Organisation, which brought me into a unique/optimal/privileged position of being able to observe the development of the health reform processes. At the start of my professional career in health services research I could act as an observer, while later I became also personally involved in some of the processes in preparing the evidence for health policy decisions. The second was in my professional curiosity, which led me to explore and analyse the implementation of the different health reform processes and their impact on the everyday functioning of the health care system. I was particularly intrigued by the unfolding changes, which differed from the developments in many other countries, but also in finding similarities. It is curious to explore what the specifics of these processes could be in the case of Slovenia and why the course of reforms taken in Slovenia would be different with respect to some other countries in a similar situation at the beginning of the 1990s. It was also important that transitional changes in the Slovenian health care had not been previously structurally and comprehensively studied at the health system’s level. Contrary to other countries in socio-economic and political transition Slovenia did not trigger much external interest in studying its health reforms and health policy transformations.

1.4. Outline of the thesis, research questions and the outline of chapters

The thesis will raise six themes that are relevant for all CCEE, but this study is about the developments in Slovenia. Six analyses will be presented covering three health care sub-sectors and three important health policy and health reform topics of the health care transition in Slovenia. The following research questions are posed:
### Table 1. Outline of the thesis

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Research aim</th>
<th>Design</th>
</tr>
</thead>
</table>
| **Chapter 2**  
Health workforce | To study the key actors and the factors influencing the developments in the planning of the number of physicians in Slovenia. | Descriptive using the policy documents and decisions, and explorative in analysing statistical data and the interviews with key actors/stakeholders. |
| **Chapter 3**  
Public health infrastructure | To study the organisational changes in functions of Slovenia's public health infrastructure between 1990 and 2008, To study the positions and actions of the main stakeholders in public health in the context of legislation and socio-political background. | Descriptive using the key legal acts and other top level documents to define the framework of activity of the public health institutes and explorative in analysing the relationships between key stakeholders and their interactions |
| **Chapter 4**  
Primary health care centres | To study the perceptions of the recent changes in health care by the primary health care centres' management; To study the changes primary health care centres (PHCCs) incurred in terms of human resources, volume and types of services, facilities, etc. To study the arrangements and relationships between PHCCs and their founders, private providers of care and the Health Insurance Institute of Slovenia (HIIS). | A survey of key managers of primary health care centres to explore their positions and views on the transition processes; a descriptive part was added with the statistical data on the workforce in the centres and the degree of privatisation. |
| **Chapter 5**  
Privatisation of the Slovenian health care | To study the reasons and the background of privatisation in Slovenia, its nature and extent in quantitative terms and the facilitating and hindering factors in the course of privatisation process. | Descriptive in using statistical data on the number of private health care providers, explorative in conceptualising privatisation in Slovenian health care and placing it within an internationally relevant taxonomy and typology, while it was evaluative in the definition and rating of factors that have had an impact on the course of privatisation. |
| **Chapter 6**  
Hospital infrastructure and its performance | To study the developments in the Slovenian hospital infrastructure and to analyse their performance in the framework of the introduction of different reimbursement models. | Descriptive in presenting the characteristics of the hospital infrastructure through time, explorative in analysing the developments in the key legal documents regulating the health care system through a time span of 18 years, evaluative in analysing the relationship between health policy interventions and key indicators of hospital performance. |
| **Chapter 7**  
Health reform and health policy developments | To study and analyse the outcome of the implementation of the five goals of the reform – what are the present benefits and shortcomings of the goals set by the reform of 1992 and how are they related to the effectiveness and efficiency of the system. | Descriptive in detailing the key policy documents, describing them and the respective statistical data, explorative in assessing the changes in policy and reform approaches and in using semi-structured interviews with stakeholders, qualitative in using participatory observation. |
1. What were the developments in the Slovenian health care over the period of the last two decades? (the descriptive analyses)
2. What were the relationships between key actors in the system, their interactions and co-operations and their key decisions influencing the health system transformation? (the explorative analysis)
3. What were the consequences of the main developments in health reform and health policy in Slovenia? (the impact evaluation and analyses)

For the identified six distinct themes a set of specific research questions were formulated, which are summarised here below, but they are elaborated in detail in each of the chapters of this book. In Table 1. (above) an outline of the thesis is presented.

Chapter 2. Health workforce:
   a) Who were the actors and what were the factors that influenced the developments in the planning of physicians in Slovenia?

This chapter discusses policies related to the health workforce planning issues. It focuses on medical workforce, whose numbers were controlled by the decisions taken at the national level in a conservative and restrictive way. The level to which this issue had been previously neglected became clear with the independence of Slovenia and the following enhanced development of health care. It was then when the problem of shortages of physicians (but also dentists and nurses) surfaced and has continued to this date. Previously the process was steered only by the MoH and the universities as key stakeholders, but with the changes introduced between 1992 and 1999, it got much more complex. It now involves additional actors, so the role of the State in managing the admissions to the medical studies and its role in steering and governing formerly completely public health care system and the changes in the relationships between the old and the new stakeholders were explored.

Chapter 3. Primary health care:
   a) How do managers of PHCCs – as public providers of primary health care – perceive the recent changes in health care?
   b) What changes have PHCCs incurred in terms of human resources, volume and type of services, facilities, etc.?
   c) What is PHCCs’ current arrangement and relationship with their founder(s), private providers of care and the Health Insurance Institute of Slovenia (HIIS)?

In the chapter on primary health care (Chapter 3), we elaborate on the changes affecting the position and the role of the primary health care centres, which needs to be elaborated soon, elaborates on the changes in the organisational setting of the primary care delivery focusing on the developments regarding primary health care centres. A survey among health managers has been carried out. Primary care institutional arrangements in Slovenia are the legacy of an 80-year long process, starting in the 1920s with the setting up of the primary health care centres. Transition chal-
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lenged this special feature of the Slovenian and Yugoslav health care system raising different controversies and the developments in these relationships were studied.

Chapter 4. Public health infrastructure

a) What were the organisational changes and changes in functions of Slovenia’s public health infrastructure over the period 1990-2008?
b) What were the positions and actions of the main stakeholders in public health in the context of legislation and socio-political background?

In this chapter, changes in the public health infrastructure are studied. An important element in implementation of health policies, public health institutes were exposed to ‘mood swings’ of health policy makers, which made the contemporary development of these institutes rather uncertain. Formally and compared to other subsectors of health care, public health infrastructure has gone through the least formal changes, but there have been many minor changes that had an impact on some of the services delivered by these institutes. And this is what caused a slow and gradual transformation in this important sub-sector of the public health infrastructure.

Chapter 5. Privatisation

a) What were the reasons and the background of privatisation in Slovenia?
b) What was the nature of privatisation?
c) What was the extent of the privatisation process in numbers?
d) What were the influencing (facilitating and hindering) factors for privatisation?

Chapter 5 touches upon one of the most important aspects of changes in the organisational setting in countries undergoing a system transition, which is privatisation. It was one of the most important features of the reforms in health care, but it also brought about different controversies around the future role of public and private provider and their inter-relationships. Privatisation provided for a more dynamic environment in health care, but also brought about new problems and more complex inter-institutional arrangements necessary for better steering and management of the reformed system.

Chapter 6. Developments in hospital infrastructure and its performance

a) What were the changes in the organisation and management of the hospital sector in Slovenia in the course of the last 18 years?
b) What were the developments in terms of volume and types of hospital care?
c) What policy choices were developed in Slovenia regarding hospital care in terms of their structure and market orientation?
d) What impact did the two major policy interventions – introduction of case-based payments in 2001 and of the DRGs in 2003/4 – have on the average length of stay (ALOS)?

This chapter explores the interactions between the policy initiatives and the developments in the hospital sector, together with the driving forces that interacted with
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them. Health policy consistently focused its activities on the hospital care changes, whether they were infrastructural or involving reimbursement models. Changes in the overall capacity of hospitals are explored and historical alternatives for changes in their management. The hospital sector has undergone important changes in terms of capacity and reimbursement policies. It was therefore interesting to explore what impact these top-down decisions had on hospital performance. One of the assumptions explored was that hospital care would start changing along the lines of a more efficient service, better adapted to the needs of acute patients.

Chapter 7. Health policy developments

a) What was the outcome of the implementation of the five goals of the reform — what are the present benefits and shortcomings of the goals set by the reform of 1992 and how are they related to the effectiveness and efficiency of the system?

Chapter 7 analyses the specific health policy developments in Slovenia over the entire period of transition. Developments in health policy partly followed the same principles as in other countries undergoing transition processes. Reforms were most often launched and directed top-down. The reform goals are studied and explored in detail and then elaborated taking into account processes that have been running over the past two decades. These interventions aimed at reallocating responsibilities and increasing performance of the health care system. These expected outcomes have not been a rule once the changes were implemented.

1.5. References

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