Slovenian health care in transition: Studies on the changes in the Slovenian health care system from 1985 until 2010
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2. Health Manpower Planning in Slovenia: A Policy Analysis of the Changes in Roles of Stakeholders and Methodologies

Abstract

A heightened awareness about medical manpower issues can be observed in countries that are in a state of political, economic, and social transition. Slovenia entered the transition process in 1989 and became an independent country in 1991.

Transition and independence influenced its health care in several ways. It changed the health care system and its financing (by introducing a Bismarckian style of social insurance). It then redistributed power from the Ministry of Health to several stakeholders. A major change occurred in the labor market in health care when the flow of health professionals from the newly independent countries greatly decreased. The decrease was partly due to the consequences of the war in the Balkans and partly due to independent labor legislation in Slovenia. Transitional changes brought new stakeholders to the scene, with a resulting redistribution of responsibilities for health manpower policies and the use of various methodologies.

This policy analysis offers a detailed description of the contextual framework, quantitative data on medical manpower development, and, most important, interviews with representatives of the key stakeholders and study of relevant policy doc-

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We conclude that all stakeholders underpin the need for a structured approach toward health manpower planning in the form of a more coherent system of planning, decision making, and control. A compromise on mutual responsibilities between the less dominant Ministry of Health and the two new powerful stakeholders, the Health Insurance Institute of Slovenia and the Medical Chamber of Slovenia, seems necessary.

2.1. Introduction

This article deals with medical manpower planning in Slovenia. While such planning has been a salient topic in health policy and health services research for several decades in the Western countries (and especially in the United States and Canada), it is now gaining importance in the so-called transition countries. Although there was a general idea in the former communist and socialist countries of Central and Eastern Europe (CCEE) that there had been a relative overproduction of physicians, this situation was not uniform among these countries. As the philosophy of the political and social system changed, health manpower planning was one of the policy areas that were altered. Slovenia represents a special challenge in that respect. Although it entered the social, economic, and political transition process along with the rest of the CCEE, the process was coupled with the equally important gaining of national independence from the former Yugoslavia. The combination makes Slovenia an almost exclusive case in the area, comparable only to the experience of the Baltic States. A process of structural, political, social, and economic transition followed by fully recognized national independence marked the last decade of the previous century. In addition, the nearby war in the Balkans interrupted physical and social communication with the former common state. These changes had an important impact on the structure and organization of the health care system. Although the central government in Yugoslavia had only a marginal influence on the organization of health care in the individual republics, there was still a rather dynamic labor market in place. What was once managed, directed, and run by a single stakeholder—the state—has now been transferred to several other stakeholders, thus also giving them more power and more professional as well as political independence.

This study explores the main features of the transition process in health care. A transition from Semashko-Beveridge system to a Bismarckian-style of social health insurance is the hallmark of the change, while deregulation, redistribution of power to the emerging stakeholders, and privatization of health care provision are the other important features of that process. We approached the problem by combining various methods of research:

- Quantitative data from a standard national statistical database,
- A literature and legislature review, and
- Interviews with key representatives of all the stakeholders involved in the process.

We start by elaborating on the contextual framework for the health care system and the medical manpower planning in Slovenia. We describe the country’s more re-
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cent history, which still bears an important impact on the developments in health care, giving special attention to developments over the past three decades. A detailed description of the new health care system and its main characteristics supplements this historical outline. We make both a connection and a distinction between the old practices of manpower planning and the newer attempts still on the way of development. In the second section we describe the developments using quantitative data on medical manpower in Slovenia. In the third section, we present an analysis that has its background in both the socio-political developments in Slovenia and the anticipated changes on the eve of the accession to the European Union. Milestones connected to the changes that affected the present territory of Slovenia over the past hundred years were used to set an environment for comparisons. Finally, we offer a policy and methodology analysis of the stakeholders involved in the process based on interviews with key figures and an estimate of the present situation in Slovenia. We see a need for a more structured approach toward medical manpower planning in Slovenia. A more coherent system of planning, decision making, and supervision should be developed to bring together today’s three main stakeholders: the Ministry of Health (MOH), the Medical Chamber of Slovenia (MCS), and the Health Insurance Institute of Slovenia (HIIS).

2.2. Methods of Research

We reviewed the literature on the developments of health care systems in Slovenia over the past century, giving special attention to the last three decades. Then, we explored the links of these developments with the current and planned positions of the stakeholders. We obtained quantitative background information from the routine statistical sources: the national Health Statistical Annual of Slovenia (1999, 2000, 2001), the WHO statistical database Health for All (2002), the Network of Public Provision of Health Care (2000), and data from the Statistical Office of the Republic of Slovenia (2001). We drew also from Albreht 1999, a quantitative study on the medical manpower situation. Interviews with representatives of the most important stakeholders constituted the core of the research. These representatives were chosen according to their roles in the medical manpower planning process and were interviewed with a semi-structured questionnaire. There were in total eight interviews with seven different stakeholders.

Analysis was performed in three ways: descriptive in the analysis of the historical socio-political development, quantitative information obtained through indicators of manpower supplies over the years and explorative in the case of some statistical data and interview analysis. We then combined quantitative data and legal sources with answers and additional information obtained from the interviews.
2.3. The Health Care System in Slovenia

2.3.1. Historical and Political Background

Slovenia is located in the heart of the southern end of Central Europe, bordering Italy in the west, Austria in the north, Hungary in the northeast, and Croatia in the east and south. It has a surface area of about 20,270 square kilometers (about 7,800 square miles) and a population of 1,990,094 (Health Statistical Annual 2001). It is a parliamentary democracy with a president with limited powers directly elected in a general election. The parliament has ninety members, elected through a proportional system. Two of the members are elected representatives of the two constitutionally recognized minorities—Hungarian and Italian. Slovenia is one of the candidate countries for accession to the European Union.

Until the twentieth century, Slovenia was part of the Austrian (later Austro-Hungarian) Empire for almost five centuries. From 1918 until 1991, Slovenia was part of Yugoslavia (at first called the Kingdom of Slovenes, Croats, and Serbs). In 1991, it became an independent state and obtained international recognition in 1992. Yugoslavia underwent a transformation from a parliamentary form of government to a unitary monarchy following a coup and, after World War II, to a federal state under a socialist system modeled on the Soviet system, later slowly acquiring its own specifics. During the 1970s and 1980s the government became less rigidly authoritarian. But despite changes in the political and economic systems, major controversies remained unresolved between centralized and more decentralized (federal or confederal) concepts, between the interests of the Serb nation and all others, and over the level of democracy, the implementation of a market economy, and rights to public and private ownership.

Political changes stemming from the abolishment of the previous centrally planned socialist economy and the introduction of a Western-style parliamentary democracy, along with self-determination and independence paved the way for the reestablishment of a market economy, while social changes made a certain level of deregulation possible. Free initiative and private entrepreneurship were introduced in various sectors, including health care. The medical profession played a prominent role in initiating some of the reforms, as evidenced by the self-regulating provisions for physicians in the early 1992 laws and confirmed more strongly by the passage of the Medical Services Act (1999).

2.3.2. Demography and Some Basic Epidemiological Facts

Life expectancy for both sexes was 75.8 years in 1999, 79.5 years for females and 71.8 years for males (Statistical Office 2001). A more than 30 percent reduction in the number of childbirths over the past twenty years has caused important changes in the demographic structure. Children from infancy to 14 years constitute only 15.7 percent of the total population, while the elderly of the ages of 65 years and above constitute 14.1 percent. Infant mortality in 2000 was 4.9 per 1,000 live births, one of the lowest in Europe (Health Statistical Annual 2001). Tuberculo-
sis was the leading cause of death until 1929, when cardiovascular diseases began to prevail (Pirc and Pirc 1937). Today, cardiovascular diseases and cancer are at the top of both morbidity and mortality statistics, followed by accidents and injuries. Premature mortality is an important epidemiological feature in Slovenia, especially among men, who have higher incidences of lung cancer, suicide, and fatal traffic accidents. The lag behind the European Union life expectancy is about 3 years for men and about 1.5 years for women.

2.3.3. New Developments
Švab, Markota, and Albreht 2000 describe the development of the Bismarckian style of social insurance from the 1880s until the end of World War I. The system between the two world wars was a mixture of socialist and free enterprise insurance plans. In the first decade after World War II, the state was fully centralized, and Slovenia had little control over the organization of health care within its borders. By the late 1950s, two processes had brought about the first changes: decentralization that reduced the power of Belgrade and rapid development of the providers’ infrastructure. During the 1960s, as the economy began to bloom, a significant need for physicians emerged, especially because of major investments in the hospital sector. Since the 1970s most of the primary care planning has been done at the municipality level, resulting in the expansion of affordable and convenient primary health care facilities. A deepening economic crisis during the 1980s affected health care even more than some other sectors. Physicians’ incomes were at the same level with the better-paid workers in the flourishing industries of those times, especially those in heavy industry. Private practice was outlawed, along with any variation in health care delivery, such as provision of services, insurance, or reimbursement schemes. The share of the GDP dedicated to health care in 1991 was only 5 percent (Saražin Klemenčič 1997) with accumulating financial losses in that sector.

2.4. Medical Manpower in Slovenia: Historical Development
The first medical faculty was established in 1919, but only the preclinical part of the curriculum was available until after World War II. In 1945, a complete medical faculty was established in Ljubljana and facilitated a very quick development of expanding health care provision. However, in 1946, private provision of medical services was abolished and later banned. All health care provision was organized, run, and financed by the state, which also had all administrative responsibilities over medical postgraduate training. The biggest increases in the numbers of physicians occurred in the 1960s and the 1970s with a total increase in physician numbers of 113 percent between 1965 and 1984 (the respective physician/population ratios being 1.02 per 1,000 and 1.86 per 1,000).

2.4.1. Physician/Population Ratios and Trends
In 2000, Slovenia had 4,251 actively practicing physicians (2.15 per 1,000 population) (Health Statistical Annual 2000) with about a third of them working at the
primary level. Figure 1 shows the developments in the number of physicians in Slovenia between 1975 and 1999. Slovenia's annual growth in absolute numbers of medical manpower was about 2 percent in the 1970s and 1980s, dropping to less than 0.5 percent a year in the 1990s. Physician density grew by 10.7 percent in the 1980s and by 8.1 percent in the 1990s (see Table 1).

2.4.2. Physician Distribution by Level of Care

Distribution of physicians by level of care in absolute numbers is shown in Table 2. The number of primary care physicians grew by 8.4 percent between 1981 and 1999, while the number of hospital and specialist care physicians grew by 28.0 percent. However, a 6.2 percent drop in the number of primary care physicians was observed between 1990 and 1999.

Figure 1. Actively Practicing Physicians in the Republic of Slovenia between 1975 and 1999.

Source: Health Statistical Annual of the Institute of Public Health of the Republic of Slovenia (in Slovene), for respective years.

2.4.3. Trends in the Numbers of Medical Specialists

The number of medical specialists grew by 92 percent in the 1970s, by 31 percent in the 1980s and, finally, by only 25 percent in the 1990s (see Table 3).

2.4.4. Regional Distribution

Slovenia is divided into nine administrative regions with populations ranging from just over one hundred thousand in the smallest region to almost six hundred
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thousand in the largest (Health Statistical Annual 2000). The influence of the largest region is of great importance because with 30 percent of the total population, it has 40 percent of the total number of physicians. The ratio between physician densities between the highest- and the lowest-ranked region in 1981 was 1.64, 1.44 in 1990, and only 1.38 in 1999.

2.5. Policies and Methodologies of the Key Stakeholders

2.5.1. The Old Manpower Planning System

Slovenia has experienced various systems of medical manpower planning. In the period right after World War II physicians were appointed by ministerial decree. By the late 1950s there were no limits on the acceptance of students to the only medical faculty in the country, but in 1963, a *numerus clausus* (closed number) was adopted, limiting the number of students admitted. In the former Yugoslavia, beginning in 1963, the constituting republics administered the whole area of social services (including health care and education). Consequently, the universities determined admittance based on political decisions adopted at the republic level. Those decisions were mainly service- and facility-driven since the main growth impulses came in the periods of the intense growth of health care provision (the 1960s and the 1970s). This is the point where there was a strong link between politics, health policy, and manpower planning in health care. An important assumption and solution for longer-term or transient deficits before 1991 was the free movement and the open market of health professionals within the former Yugoslavia. The rest of the common state experienced physician surpluses. Slovenia’s fast-growing health care system was able to employ physicians from other parts of the federal state in the 1970s and the 1980s. An analysis by Albreht (1999) shows that Slovenia in that period had an “imported” inflow of physician workforce that amounted to 1.2 percent to 1.5 percent of its domestic workforce a year. On one hand, the growth observed at the end of the 1980s (see Figure 1) is more evidence that the growth in that period was larger than the output from the Medical Faculty in Ljubljana (Medical Faculty in Ljubljana 1980–1999). On the other hand, the disruption of free movement due to the Balkan wars influenced the uptake of physicians from the area of the former Yugoslavia.

Table 1. Physician Density in Slovenia, selected years

<table>
<thead>
<tr>
<th>Year</th>
<th>1981</th>
<th>1985</th>
<th>1990</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians’ density (per 1,000 population)</td>
<td>1.80</td>
<td>1.88</td>
<td>1.99</td>
<td>2.15</td>
</tr>
<tr>
<td>Dentists’ density (per 1,000 population)</td>
<td>.47</td>
<td>.51</td>
<td>.56</td>
<td>.60</td>
</tr>
</tbody>
</table>

*Source: Health Statistical Annual of Slovenia [Zdravstveno Varstvo], for the respective years.*
SLOVENIAN HEALTH CARE IN TRANSITION

Table 2. Absolute Numbers of Physicians at Various Levels of Care, selected years

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>primary care physicians</td>
<td>1384</td>
<td>1499</td>
<td>1616</td>
<td>1500</td>
</tr>
<tr>
<td>primary care dentists</td>
<td>805</td>
<td>806</td>
<td>1012</td>
<td>1089</td>
</tr>
<tr>
<td>hospital and specialist care physicians</td>
<td>1471</td>
<td>1638</td>
<td>1906</td>
<td>1883</td>
</tr>
<tr>
<td>public health physicians</td>
<td>71</td>
<td>69</td>
<td>108</td>
<td>102</td>
</tr>
</tbody>
</table>

Source: Health Statistical Annual of Slovenia [Zdravstveno Varstvo], for the respective years.

The leading method of manpower planning was based on calculations involving the demographic data of various population groups. Norms for the required numbers of physicians were determined by expressing them in simple physician/population ratios, by each field at the primary level of care and by each specialty for the outpatient visits at the secondary level. The required number of hospital inpatient physicians was determined by combining the physician/bed ratios with the population of the hospital catchment area. The payer, then the state, through various administrative bodies, had a decisive role in determining needs for various types of health professionals. The Medical Faculty, based on its educational capacity, annually filed a proposal that matched that capacity with the needs assessment made by the MOH. Since the 1970s, the National Parliament was required to confirm such restrictions. Although the system had been rather inert and passive, the end of the 1980s saw Slovenia with a well-controlled number of physicians and with negligible unemployment.

Table 3. Main Medical Specialties and Medical Specialists, selected years

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>71</td>
<td>145</td>
<td>177</td>
<td>219</td>
<td>300</td>
<td>356</td>
<td>389</td>
<td>447</td>
<td>487</td>
</tr>
<tr>
<td>Surgery + Orthop.</td>
<td>50</td>
<td>107</td>
<td>136</td>
<td>186</td>
<td>247</td>
<td>305</td>
<td>327</td>
<td>352</td>
<td>359</td>
</tr>
<tr>
<td>Pediat. + School Med.</td>
<td>30</td>
<td>80</td>
<td>109</td>
<td>165</td>
<td>257</td>
<td>287</td>
<td>323</td>
<td>367</td>
<td>383</td>
</tr>
<tr>
<td>Gynecology &amp; Obst.</td>
<td>39</td>
<td>86</td>
<td>115</td>
<td>143</td>
<td>177</td>
<td>189</td>
<td>218</td>
<td>212</td>
<td>233</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>2</td>
<td>25</td>
<td>39</td>
<td>74</td>
<td>98</td>
<td>121</td>
<td>137</td>
<td>141</td>
<td>184</td>
</tr>
<tr>
<td>General Practice</td>
<td>0</td>
<td>0</td>
<td>19</td>
<td>102</td>
<td>164</td>
<td>206</td>
<td>256</td>
<td>282</td>
<td>394</td>
</tr>
<tr>
<td>Occupational Medicine</td>
<td>0</td>
<td>16</td>
<td>48</td>
<td>64</td>
<td>…</td>
<td>142</td>
<td>161</td>
<td>138</td>
<td>150</td>
</tr>
<tr>
<td><strong>Total no. of specialists</strong></td>
<td><strong>297</strong></td>
<td><strong>702</strong></td>
<td><strong>981</strong></td>
<td><strong>1357</strong></td>
<td><strong>1882</strong></td>
<td><strong>2207</strong></td>
<td><strong>2464</strong></td>
<td><strong>2818</strong></td>
<td><strong>3081</strong></td>
</tr>
</tbody>
</table>

Source: Health Statistical Annual of Slovenia of the respective years

The National Institute of Public Health is the only stakeholder or institution that has carried out research into manpower issues before 1992. Kastelic and Schlamberger (1973) and Kastelic and colleagues (1976) used demographic models of the physician and dentist populations to make planning estimates for five-year periods.
Ravnikar and colleagues (1986) for the first time compared the numeric growth of health professionals with the educational system at all levels. Their study shows comparisons with several other countries and makes projections for 2000. Experience and suggestions from these studies were used in medical manpower planning until 1990s.

2.5.2. The New Health System and Its Implications for Manpower Planning

The general setting of the Slovenian health care system is defined by the Constitution of 1991 and by the health care legislation that was adopted in 1992 (Health Care and Health Insurance Act 1992; Health Services Act 1992; Pharmacists’ Services Act 1992). Slovenia is defined as a social state, and health is one of its citizens’ most important rights. By 2000, a new health care system in Slovenia was in place, built on the idea of empowering health professionals through a transfer of administrative tasks from the state to the civil society. Separating the founder, financier, and provider roles was the main feature. Another was the equality of rights of providers, irrespective of the type of provision (public or private). The Medical Services Act (1999) and the National Health Plan (2000) are the two most important documents since the 1992 legislation to outline systems for medical manpower planning. The first important feature of the new health care system in Slovenia was the introduction of a Bismarckian style of social health insurance, based on traditions originating from the Austrian social insurance in the 1890s (Markota and Albreht 2001). Implementation of the system included the establishment of the National Health Insurance Institute as an independent public institution responsible for collection and administration of the compulsory health insurance, and the separation of health care funding from the national budget. Fees are income related and are paid in the same percentage of the gross salary by the employer and the employee. The role of the state is to determine the cap on the total budget of compulsory health insurance by annually setting the percentage of GDP dedicated to health care.

The second feature of the new health care system is the gradual empowerment of chambers of health professionals. The MCS was established in 1992. It is a professional executive body of physicians and dentists. Membership is mandatory by law for all physicians and dentists who work in health care and are providing patient care. Local chambers are also responsible for postgraduate training, for continuous medical education, and for licensing. By determining the numbers of both medical posts and medical specialty training posts, the MCS gets directly involved in the manpower planning process.

The third important feature of the reformed health system is the (re-)introduction of private provision of health services. Introducing private provision of care for health professionals and practically equalizing it with public provision brought elements of competition into the previously rather inflexible health care system.
2.5.3. System Implications for Manpower Planning

The three pieces of legislation from 1992 mentioned above set up the legal side of the health care system. The Health Care and Health Insurance Act (HCHIA 1992) defines the network of public providers of health care—its elements, types of providers by care, ownership, and criteria for the determination of posts. The act describes and defines the types of services and regulates their provision, specifying that the National Health Plan should describe the criteria on which to determine health professionals’ numbers more precisely. The National Health Plan, adopted in 2000 after a lengthy discussion, defines specific criteria. The Health Care and Health Insurance Act also defines the distinct responsibilities between municipalities (primary care) and the state (secondary and tertiary care). This part of the legal framework sets the stage for the MOH as the main administrator of the system (with a consultancy role of the HIIS). The criteria described above represent the base for planning in broader terms at the national strategic level. But there is need for more sophisticated criteria and methodology as described extensively in Reinhardt 1991. A more specific outline for medical manpower planning lies within the Medical Services Act. It defines the role of the MCS with respect to the medical posts and, specifically, to postgraduate training in various specialties. The final decision on the defined network of medical posts lies with the Minister of Health. Still, it is the authority of the MCS to prepare an overview of those posts, to keep the register of all practicing physicians and dentists, and to advise the insurer on the proposed private practitioners. MCS grants specialty training, keeps a list of posts, and appoints tutors. The MOH appoints (on proposal by the MCS) training posts and the institutions that keep them. Given the redistribution of authority to various stakeholders, and especially the empowerment of professional chambers, meant that a new solution for the contracting of services would have to be established. The so-called partner negotiations are a model under which the stakeholders involved in the contracting of services define the most important contents of annual contracts with the HIIS. This process, however, provides the economic input for the definition of needs for physicians and their training posts. Slovenia’s insurance regulatory body, the HIIS, played a key role in strategic and structural affairs throughout the period before the adoption of a national health plan and continues to play an important role in allocation of financial resources. Between 1992 and 1999, the HIIS insisted on a “zero growth” principle. That meant that reimbursement of providers was based on an unchanged number of practitioners. Providers could contract new employees only in replacement of the retired, deceased, or severely handicapped. That principle was enforced vigorously and has contributed to a much slower growth rate in the number of physicians. Public health data in Slovenia are linked with those used for manpower planning. Thus, MOH decision making is based on health statistics and data from health services research as well as from the national database on all health professionals (including physicians and dentists). A large part of the preparation of the National Health Plan and its follow-up are in the domain of the public health system.
2.6. The New Planning Methodologies and Findings

2.6.1. Current Medical Manpower Issues

The new health system maintained the regulatory role of the MOH and its intention is to insure equity, especially with respect to access for all citizens. But we must also take into account the role of the new stakeholders, which arrived on the scene in the early 1990s. Slovenia is short of physicians in primary care both according to the report on health professionals manpower issues that the MOH prepared in July 2000 (Network of Public Provision of Health Care 2000) and according to an analysis of the MCS (Albreht et al. 2000). The deficit is at 0.65 to 1.20 percent of the total workforce. That deficit is present despite the existing pool of foreign physicians that accounts for about 3 percent of the total physician workforce (Employment Office of the Republic of Slovenia 2001). The total deficit is close to 4 percent of the medical workforce. That is equal to an entire generation of graduates of the medical faculty in Ljubljana. There are now signs that immigration is slowly picking up. Most foreign physicians interested in working in Slovenia originate from the countries of the former Yugoslavia (according to the respective shares of applicants for physician licenses in Slovenia by the MCS).

Medical manpower shows two important demographic features that will influence planning. One is aging—the age group 30 to 34 years is 20 percent and 25 percent smaller, respectively, than the age groups 35 to 39 years and 40 to 44 years. As a consequence, physicians of 50 years and older constitute almost 29 percent of the total workforce and by law they may be exempted from certain services (e.g., on-call, night duty, etc.). The other important issue is the increasing percentage of female physicians. Currently, female physicians make up about 55 percent of the total medical workforce, and the number of female graduates in Slovenia reaches a stable 65 percent.

2.6.2. Toward New Planning Methodologies

What options lie ahead for Slovenia’s health-policy makers? Greenberg and Cultice (1997) introduce three models used in manpower planning for physicians:

1. Population utilization patterns, studied quantitatively through statistics and by means of population surveys.

2. Standard physician-to-population approaches with a defined goal or target that guides planning, expressed in the number of members of a population group compared with the number of physicians or dentists.

3. Increase in physicians’ productivity, which is also a means of manpower control.

Slovenia’s previous experience in this field and evidence from our interviews reveal that the prevailing method has been the physician-to-population approach with negotiations about the concrete numbers for each specialty or field. The desire to upgrade this approach can be identified by using functional data, such as the utilization patterns, precisely followed by the national health statistics.
The need for planning arises from the issues described above and from those raised in the National Health Plan (2000), especially involving medical manpower. The health plan, originally conceived as a strategic document, is very practical as well as prescriptive. In a chapter on resources, for example, it lists very precise numbers of resources needed by service and by region. The allocation of human resources continues to follow two models: physician-to-population ratios (in the case of the various types of service at the primary level and outpatient specialist services)—corrected for productivity criteria (e.g., extent of services), and physician-to-resource ratios (in the case of hospital services—these might become modified by the use of prospective reimbursement systems). A lack of a structured methodology is evident in the planning of physicians and dentists in Slovenia. Almost all the work done so far has been in developing two criteria: one for the demographics of the medical professions themselves, and the other for the general population and some specific population groups (children, women, elderly). Functional parameters, such as time needed per patient, per procedure, per diagnosis, per specialty, and in combinations of those, will need to be included. Reimbursement system changes are expected to further stimulate a development into a more prospective and more production-oriented system, the limits set through capped budgets (Health Sector Management Project 2001). Still, two stakeholders have taken the initiative in developing structural elements for delivery and planning of services that will affect manpower planning. The HIIS has developed a system of defining services in combination with budgets. Out of those, based on production criteria (the number and extent of services plus the time needed to deliver them), indirectly, they can calculate the manpower needed. The MCS, meantime, has begun gathering physicians’ and dentists’ definitions of service tariffs (based on production criteria) in an effort to redefine some of the elements that the HIIS is currently using.

There are important considerations regarding the integration process with the European Union. Free movement of people, especially professionals, will have an impact on Slovenia since it is a potential host country. And, related to that, the full harmonization that has been reached with the undergraduate and postgraduate training requirements of the European Union will contribute to larger flows of the workforce both ways.

2.6.3. Stakeholders’ Positions

An examination of the legal background represents a good starting point for undertaking an organized approach to planning. All stakeholders agree that the work done so far at the system level in medical manpower planning is insufficient. They all perceive their legal role in the process as adequate and take part in considerable cooperative information exchange. The differences lie in the solutions proposed. They find that the introduction of independently practicing physicians and dentists has led to a completely different management practice that should be noted in the legal documents. Stakeholders have agreed to the formation of a national committee that
would permanently supervise and coordinate work in this field, proposing that either the MOH or the Institute of Public Health of Slovenia house such a committee.

Conflicts arise over methodology and defining who should be the crucial stakeholder with the most important responsibilities for planning. The MCS wants to play the primary role, but the MOH and the HIIS still consider planning to be one of their important tasks. The MCS definitely won an important political battle when the Medical Services Act was adopted, since it received full control over the field of postgraduate training of physicians and dentists and a key role in the planning of medical posts. Two of the stakeholders see shortcomings in their roles in the process. The MOH wants more involvement in planning of the number of hospital medical specialists and greater empowerment to intervene in less well provided for areas of the country. The Health Council, an advisory body to the MOH, sees its role insufficiently accepted by the MOH. The MOH would like to see a more balanced approach to the number and distribution of medical posts, in view of a compromise of interests of different stakeholders, but also in ensuring a balance between public and purely private practices. The Health Council and the MCS (but also partly the HIIS) find insufficient activity on the side of the MOH. The HIIS stresses that out of need there is an introduction of intermediate solutions, which do not help in solving the problem. The MOH feels that the HIIS’s action receives too much room, while admitting that the HIIS sometimes needs to act on its behalf. But also it expresses reservations about the Medical Services Act. Both situations limit the operative functions of the MOH, which at the same time must remain the guarantor for the stability of the system. The MCS gave more weight to the Medical Services Act, while the HIIS sees much more relevance in the National Health Plan (also in view of its contribution). It introduces, among other things, very detailed tables with manpower requirements by service, type of provision, and region (National Health Plan 2000). According to the interviews with key representatives of the major stakeholders, there is extensive cooperation among these groups, as well as with the Association of Public Providers of Health Care (APPHC), the Slovenian Medical Society, and other ministries and municipalities. Currently, there are three important stakeholders whose interaction will influence decisively the future manpower situation. The first is, clearly, the HIIS with its unchallenged financial power. The others are the MCS, which is getting more influence both legally and practically, and the MOH, whose role, however, is weakening. By 1990 a lot of work had already been done in the field of health services planning, but the economic background has since changed enormously. The MOH made a decisive step to identify the main problems of medical manpower supply by issuing a questionnaire to all providers (Ministry of Health 2000). The results give a clear picture of the lack of physicians in some regions of Slovenia in primary care. Another analysis showed that physicians’ and dentists’ salaries increased in real value three- to fourfold following a strike in 1996 (Ministry of Health 2002). The cost of labor in health care has since gone up consid-
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Substantially and is approaching almost 60 percent of the total expenditure in health care (APPHC 2002). An obvious problem is the severe gap between planning and decision making. Two facts may account for this gap: the stakeholders in Slovenia simply are not accustomed to compromise through negotiation and coordination, and there is no supreme force that can permanently make such decisions on their behalf. The ad hoc solutions used of late reveal a lack of adequate competence on the part of the MOH. It is obvious that the Medical Chamber and the Health Insurance Institute, which hold significant legal authority, are trying to “fill the gaps” on their behalf. The experience of the 1990s, the stakeholders’ positions, and the forthcoming changes suggest the following reasons why a change is needed:

1. The involvement of new stakeholders, mainly the MCS with significant empowerment both directly and indirectly related to manpower planning;

2. Private provision of care with a different approach to manpower needs, on the one hand, and, on the other hand, the reality that public providers still must provide for the educational and training functions (as well as for the physicians working in private practice);

3. Migration (mostly from the area of the former Yugoslavia) stimulated by the lack of physicians in Slovenia, as well as that arising from the accession process to the European Union (the first of the two is inevitable and Slovenia simply has to “import” physicians to cover its needs, while the free movement directive will stimulate movement from European Union member states, and those citizens will have to be given priority after Slovenia becomes a full member state of the European Union); and

4. The end of the period of relatively rapid growth of the GDP that allowed generous policies toward health care (though one needs to note that the medical workforce costs considerably more now than it did about a decade ago, with an increase in share for salaries from about 20 percent in 1989–1990 to the present 60 percent [APPHC 1989–2002]).

Financial issues and constraints on the traditional methods of health care financing may well become an important, if not the primary, controlling mechanism. That should follow the larger share for salaries in total expenditures as well as the important role of the HIIS in the health system. The programs of specialty training were completely revised and reformed in 2001 (along with the guidelines of the European Union of Medical Specialists). The MCS has revised and harmonized all programs with the relevant European Union programs to enable free movement of physicians. A lengthening of the training process will cause a dropout of at least one generation of fully qualified specialists, which may have some impact on insuring the required numbers of physicians. It means that all programs will be extended, posing some threat to the present sources of finance. This is also one of the conflict areas between the MCS and the HIIS, with the MOH functioning as the mediator.
2.6.4. Potential Cooperation and Coalitions

After analyzing the interviews, published documents, and relevant legislation, summing up all the findings in the qualitative analysis, and taking into account the expressed wish of all stakeholders for a working body that would supervise and coordinate efforts in the field of health manpower planning, we identified the following potential coalitions.

Coalition 1—Between the MOH and the HIIS. This coalition would combine the manpower and funding of the HIIS and its financial power with the political authority of the MOH, which is still very much a fact. And though its confirmatory role in various legal acts might seem like little more than a formal step, the MOH can importantly influence decisions. Such a coalition could be seen as a regulatory compromise offsetting the rising political influence and potential monopoly of the MCS in important health care matters. Also, the HIIS has developed a very clear-cut strategy for the development of compulsory health insurance and has managed to have its manpower calculations (based on productivity criteria) included in the National Health Plan. In fact, the MOH and the HIIS have already worked as a coalition in preparing the National Health Plan.

Coalition 2—Between the HIIS and the MCS. This coalition has grown in importance because, eventually, the HIIS will have to be involved in financing the period of postgraduate training to insure its stability. Also, the HIIS had an important role in determining the need for health professionals in the National Health Plan, and a redefinition of that need would require their cooperation with the MCS. The project of medical tariffs initiated recently by the MCS is going to develop into a reimbursement issue that could be of interest to the HIIS. Furthermore, though physicians are very relevant in health care, they are by far not the only segment. HIIS has to deal with all segments and has to take into account various groups of health professionals, and, especially, in the case of negotiations over the annual contracts, the MCS is a partner representing the growing number of physicians practicing independently. Realistically, no final decisions are possible without the explicit consent of the medical profession when dealing with the manpower issues. Bringing the MCS closer would be another big advantage for HIIS.

Coalition 3—Between the MOH and the MCS. This coalition seems less likely than the other two but it could be possible because of the rising importance of the MCS not only in medical circles but also in the health care system as a whole. The feasibility of this coalition depends to a great extent on whether the MOH will begin to approach health issues from a more comprehensive, public health perspective or remain with the more traditional, medically based attitude.

2.8. Conclusions

Slovenia inherited a medical workforce that is of moderate size by international workforce averages and that was controlled by the state, both in numbers and in structure, from 1945 to 1991. Political and social transition helped to bring new...
stakeholders on board. The influence of the state (and of the MOH as its main representative) was purposely weakened. The vacuum left by the reduced role of the MOH was filled partly by the HIIS and partly by the MCS. The HIIS became powerful because it is the only insurer for compulsory health insurance and because it has an important role in resource allocation. From the interviews we learned that all stakeholders find the current results of medical manpower planning far from sufficient and strongly agree about the need for a national body to coordinate health manpower planning that is linked either to the MOH or to the Institute of Public Health of Slovenia. Also, the MOH and the MCS disagree about their mutual responsibilities in the coordination of medical manpower planning. We learned that following the period of extensive growth assisted by high increases in GDP in Slovenia, a more production-oriented system will be put in place along with a better public-private mix in the provision of and financing of health care. Finally, the stakeholders see a tremendous need for a clearer definition of postgraduate training and of their responsibilities for its organization and its financing, and they are well aware of the advantages and challenges of the accession to the European Union for health care.

Overall, the MOH seems to be the weakest stakeholder in medical manpower planning as a result of the purposeful reduction of its power and because of the adoption of the National Health Plan, which shifted some power over to the HIIS, and the Medical Services Act, which shifted some over to the MCS. The reduction of power in the MOH was the result of politically motivated processes both within and outside of health care. Introduction of the mechanism for negotiations for the annual contract with the HIIS put the MOH in the position of a moderator but without a direct involvement as a partner. Production-oriented criteria for manpower definition are the key features of the National Health Plan’s section on human resources. The Medical Services Act gave the MCS full control over postgraduate training and consultation rights in the definition of the network of medical posts. The result of such developments (combined with possible shared interests of the HIIS and the MCS) might lead to a situation where financing and reimbursement principles would be coupled with a medico-centered approach to health care. Classical interests of equity and broader social interests might become of secondary importance in that respect. The preservation of equity (as the original competence of the MOH) has become limited. The MOH can advise on manpower planning issues but cannot intervene directly. Such a situation, combined with full decentralization of primary care organization, makes it very difficult for the MOH to buffer the remaining interregional differences. The combining of public and private provision of health care is one of the main changes that occurred in 1992. Private practitioners already announced demands for a reduced workload (especially when paid by capitation) and that might increase demand for physicians. The MCS as a flexible, motivated organization took over many of the tasks originally performed only by the MOH. The latter has thus lost most of its direct involvement in and influ-
ence on medical manpower. Still, most physicians are salaried, and their salaries are defined in accordance with the general contract for physicians and the general contract for health care—both of which are prepared and co-signed by the MOH. As noted above, physicians’ and dentists’ salaries have grown considerably over the past five years, requiring important shifts in health expenditures in Slovenia. If salaries amounted to relatively small shares in the past (before the transition), they now represent on average about 60 percent of the total expenditures. That is still less than the average of the European Union. Since there are signs of a threatened deficit in the compulsory health insurance, the focus will be shifting from extensive to intensive production parameters. Health care reform makes cost-effectiveness a necessary aim and in that sense the current physician and dentist numbers, their development, and the consequences for both the educational and postgraduate training processes will need to be revised. Postgraduate training has seen considerable changes over the past three years. It is one of the most important areas. Previously, the MOH had all the steps under control. Now, the entire process lies with the MCS. All programs of specialty training were revised according to the recommendations of the professional bodies of the European Union. That means, however, that all training will be prolonged and consequently will be more costly. The solution to its financing at the national level has not yet been found. Currently, it is financed entirely by providers themselves, reducing each resident’s flexibility and tying him or her to a certain provider (even by contract). A looser state control over the educational and health care system, together with the independent position of the professional groups, might lead to imbalances over a longer period. At present, Slovenia is not facing such an extreme. It will, however, need to approach these issues in a more systematic way because of the changes that have already occurred and because of the anticipated freedom of movement of the workforce (some of which will even be warmly welcome in view of the existing and anticipated deficits). The field of medical manpower planning will definitely remain an important topic for several years to come. A broader spectrum of stakeholders in this process will lead to negotiations that are more demanding and more in need of compromise, while new approaches to manpower planning will have to be implemented in order to offer a clearer insight into specific workloads, such as time required and assessment of the general population’s needs and those of specific population groups. All of this is hard to imagine in practice without a move toward a more operative implementation of planning practices in the decision-making process.

2.9. References
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