Slovenian health care in transition: Studies on the changes in the Slovenian health care system from 1985 until 2010
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Citation for published version (APA):

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3. Changes in primary health care centres over the transition period in Slovenia

Abstract

Background: Primary health care centres (PHCCs) were a characteristic of the former Yugoslav health care system introduced widely in Slovenia. Transition brought structural changes to health care and the position of the PHCC’s was challenged. This paper investigates (i) PHCCs’ perception of transition changes in health care, (ii) changes in resources and services, and (iii) changes in the relationships between PHCCs and new primary health care providers. Methods: We mailed a self-administered questionnaire with 42 questions divided into 8 chapters and related to the period between 1990 and 2000 to all 65 PHCCs in Slovenia. Questions were of three types, grouped according to the aspects we were trying to explore: perceived changes, actual changes and relations with new providers.

Results: We obtained 57 questionnaires representing PHCC catchment areas covering 93.7% of the Slovenian population. Municipalities’ position versus PHCCs was reinforced but their role remains ambiguous. The number of employees was reduced by one third, capital investments are still ongoing, but the scope and volume of services has shrunk. Relations with the Health Insurance Institute of Slovenia

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(HIIS) were considered controversial while the influence of the public providers’ association is perceived as marginal.

Conclusions: PHCCs have survived the transition both structurally as well as functionally. However, an unstructured approach to system changes in primary care, a poorly managed process of introducing private provision, and a monopoly position of the HIIS affected their situation. The challenges for the future will be in preserving their public health functions, in increasing efficiency and in establishing clearly defined relations with private providers.

Keywords: transition in health care, primary care, private provision

3.1. Introduction
Changes to the health care system in Slovenia have been running parallel with the political, economic and social transformation. This development was coupled with a process of gaining independence and international recognition. Transition in Slovenia’s health care faced several challenges, which derive either from the change in the socio-political system, or in Slovenia’s independence from the former Yugoslavia. Political and social changes were reflected in the basic system laws for health care that were adopted in 1992 [1,2,3]. That process was strongly physician-driven. The main issues were as follows:

i) Self-regulation and autonomy of the main groups of health professionals;
ii) Privatisation of health care delivery;
iii) Introduction of a new health insurance scheme.

Self-regulation and autonomy of health professionals together with privatisation of health care delivery had been longstanding aspirations of physicians, dentists and pharmacists. Health professionals as well as the political arena favoured a shift towards an insurance system. Consequently, a Bismarckian social health insurance model was adopted. Given these basic changes, together with a legal provision for municipalities to be administrators of primary health care centres (PHCCs), we can identify the following potential challenges for the latter:

i) A changed environment for PHCCs in view of the new reimbursement and contracting arrangements and a strong dependence on the municipality;
ii) A spontaneous move of a certain number of health professionals to private practice;
iii) The need to integrate various services previously offered exclusively by PHCCs and now provided both by PHCCs and by private practitioners.

Based on the challenges posed by the reform, we formulated the following research questions:

i) How do PHCCs—as public providers of primary health care—perceive the recent changes in health care?
ii) What changes have PHCCs incurred in terms of human resources, volume and type of services, facilities, etc.?
iii) What is PHCCs’ current arrangement and relationship with their founder(s), private providers of care and the Health Insurance Institute of Slovenia (HIIS)?

This paper describes the results of a research performed by means of a mailed self-administered questionnaire sent to all 65 PHCCs in Slovenia. First, we present some historical and contextual background, followed by presentation of objectives, aims, and material and methods. We then describe the results, followed by the discussion and conclusions.

3.2. Historical background

Organised primary health care has a long tradition in Slovenia. Andrija Štampar’s ideas found fruitful ground in Slovenia in the 1920s and resulted in the establishment of the first PHCC as early as 1926 [4] and the first PHCC for school children even as early as 1924 [5]. Before World War 2, health care provision depended on private providers. Human resources were scarce and bringing health care provision closer to the population, integrating preventive and curative services for vulnerable population groups were the key issues then, with physical access in the forefront. PHCCs slowly developed over time and included the following services: general practice, mother and child care, prevention of communicable diseases. These services were coordinated by the Hygiene Institute of Ljubljana (the present National Institute of Public Health). Later, adult and youth dentistry, community nursing, physiotherapy, and diagnostic services were added to a typical PHCC structure [6].

After World War 2, changes in health care organisation and provision had an important impact on the future development of PHCCs. Health care became a national service, which was closest to the Semashko’s model. The State had the central role but, due to the specifics of the Yugoslav decentralisation, with varied developments around the country. Three important facts affected provision of primary care:

i) Communicable diseases were a major problem still in the 1940s and in the 1950s (classical public health problems);

ii) Poor overall communication infrastructure made worse by complex geography (difficulties in physical access);


For organisational issues and also for public health reasons, the State had to provide for a widespread service in primary care organised in providing outreach with dispensary clinics. The only private providers who remained in practice after World War 2 were those who had been in practice when prohibition came to force. They were allowed to continue practising in their own premises until retirement. Slovenia saw two major periods in PHCCs development, first, expansion and growth in the 1950s and the 1960s, followed by the efforts to improve the quality of the facilities and the infrastructure in the second half of the 1970s and in the early 1980s. The latter was often financed by self-contributions of the local population in various areas of Slovenia, voted for through local referenda.
3.3. The recent developments – the transition

Transition brought about changes, where political and social changes were leading the way to an economic restructuring. With the introduction of new stakeholders it seemed necessary to develop a partnership model. It represents the means of negotiating the general outlines and some particularities of the general contract for health care delivery and its reimbursement at all levels of care. The partnership model should ensure a consensual approach to the fair sharing of resources made available through the compulsory insurance funds. It involves representatives of the HIIS, the Medical and Pharmacists’ Chambers (as representatives of private providers of care), Association of Public Providers of Health Care (APPHC), natural resorts and spas, nursing homes, and other social care institutions. These partners negotiate the volume of services and their pricing. Introduction of private provision of care and of a social health insurance system, coupled with an initial level of state deregulation were the main features of the change. The MoH handed its role as the main financier of health care delivery over to the HIIS who became the main purchaser of health services in Slovenia. However, the MoH preserves the role of granting concessions for hospital and specialist outpatient services while concessions for primary care are granted by municipalities. Changes preserved previous organisational aspects and the mission of PHCCs [7] (i.e. the key role in primary health care). The main stakeholders and their functions are listed in table 1. Granting of concessions was a completely new issue stemming from the privatisation of health care delivery. The future private provider has to provide proof of compliance with the norms and standards for individual practice in the respective professional field and dispose of adequate facilities (owned or hired). Holding a concession is a condition for a contract with the HIIS for potential providers who wish to have their services reimbursed. In practice, almost all practitioners at the primary level opt for a concession since most of those services are included in the basic benefits package. There is a controversial situation occurring in many municipalities. Although, municipalities are founders of the respective PHCCs, they can influence its future through granting of concessions to private providers. Changes in primary health care have been studied previously. Švab et al. [8] addressed them from a historical and developmental perspective. Markota et al. [9] tried to assess the Slovenian health care reform from the top management and financing aspects. Several pieces of research were dealing with patient satisfaction in GP offices. Private provision of care is dealt with from the national level perspective [10] and by obtaining survey feedback exploring the public/private mix [11,12,13]. There were also four population surveys, which had a certain number of questions on health care [14] and confirmed a high level of acclaim for general practice. A study by Švab et al. [15] explored views of private independent practitioners related to the health care reform. All these studies explore the circumstances related to private provision as well as patient/user satisfaction with changes in organisation and delivery. None of the studies quoted above dealt with the PHCCs’ perception of the changed environment. Our study aims at filling that gap.
3.4. Objectives and aims

The main aim of this research was to explore perceptions and views of PHCCs' management of transition changes in primary health care delivery in Slovenia. Considering that, we wanted to explore the experience of PHCCs, given their previous 'monopoly'. Our most important objectives were:

i) To explore perceived changes regarding the relationships with private providers both on formal and practical solutions and on concession granting;

ii) To explore changes in the overall and the current manpower situation and that of the five main groups of health professionals (physicians, dentists, pharmacists, nurses, and health technicians);

iii) To get an overall picture of the sources and purposes of recent capital investments;

iv) To explore changes in the type of services provided and compare the two cross-sectional situations (1990 and 2000) – both reported through this questionnaire;

Table 1. An overview of the main functions and the stakeholders involved in their implementation

<table>
<thead>
<tr>
<th>Function / step</th>
<th>Main stakeholder</th>
<th>Other stakeholders/partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical degree certification</td>
<td>Medical Faculty</td>
<td>Medical Faculty</td>
</tr>
<tr>
<td>Postgraduate training posts</td>
<td>Medical Chamber</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Basic certification</td>
<td>Ministry of Health</td>
<td></td>
</tr>
<tr>
<td>Registration</td>
<td>Medical Chamber</td>
<td>National Institute of Public Health</td>
</tr>
<tr>
<td>Licensing</td>
<td>Medical Chamber</td>
<td></td>
</tr>
<tr>
<td>Concessions</td>
<td>Ministry of Health</td>
<td>Medical Chamber</td>
</tr>
<tr>
<td></td>
<td>Municipalities</td>
<td>Health Insurance Institute</td>
</tr>
<tr>
<td>Medical and dental posts</td>
<td>Ministry of Health</td>
<td>Health Council</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical Chamber</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Institute of Public Health</td>
</tr>
<tr>
<td>Needs evaluation</td>
<td>Health Council</td>
<td>National Institute of Public Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Insurance Institute</td>
</tr>
<tr>
<td>National Health Plan (NHP)</td>
<td>National Assembly</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Institute of Public Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Insurance Institute</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical Chamber</td>
</tr>
</tbody>
</table>
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v) To explore the relationship between the PHCC and private providers in the area;
vi) To explore the relationship with the founder(s) (i.e. municipalities);
vi) To explore the PHCCs’ views on the relationships with stakeholders in health care and, in particular, the contracting/purchasing role of the HIIS;
viii) To obtain any suggestions and additional responses on all of the topics above.

3.5. Material and methods

A questionnaire with 42 questions divided into 8 chapters (according to the aims listed above) was circulated to all 65 PHCCs in Slovenia in spring 2001 (see table 2.). It was addressed to PHCC directors together with a letter explaining the aims and objectives of the study. We included a self-addressed envelope for the return of the questionnaire. Replies arrived in two rounds, the original one and the one that followed a reminder letter.

Table 2. Structure of the questionnaire used to survey primary health care centres in Slovenia.

<table>
<thead>
<tr>
<th>Basic data</th>
<th>Official name, year of establishment, founder, total number of employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital investments and their purpose</td>
<td>Year of the last extensive refurbishment, investor(s), reasons for investments and their implementation</td>
</tr>
<tr>
<td>Changes in types and volume of delivery</td>
<td>Types of services previously and currently delivered, reasons for introduction and abolishment of services</td>
</tr>
<tr>
<td>Changes in the number of employees</td>
<td>Increases or decreases in workforce, categories of health professionals missing, employment of foreign workforce</td>
</tr>
<tr>
<td>Introduction of private provision of care</td>
<td>Estimation of the process, agreements and contracts for specific service provision, concession granting process</td>
</tr>
<tr>
<td>Relationship with the founder (municipality)</td>
<td>Satisfaction with the relationship, representation of the founder in the bodies of the PHCC</td>
</tr>
<tr>
<td>Contracting of services</td>
<td>Contractual relationship with the HIIS, negotiation process, partners’ roles, duration of contract period</td>
</tr>
</tbody>
</table>

3.6. Results

The process of administration and collection of questionnaires resulted in the full completion of 57 questionnaires. The responding PHCCs’ population catchment areas cover 93.7% of the Slovenian population. All the questionnaires received were filled out completely.

3.6.1. Basic data

All PHCCs had to be re-established according to the regulations of the Law on Public Institutions [16] so the respective municipalities passed statutes between 1991 and 1995. In 35 cases there was only one founder (a single municipality in 33
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cases and the State in 2 cases). In others, several municipalities share founder responsibilities (mostly since 1995). The total number of employees was reduced by one third according to the self-reported numbers which we then compared with the routine statistics and found the same trend (see Table 2). Based on the two self-reported numbers of employees from 1990 and 2000, we calculated the ratio of the five typical professional groups against the total number of employees. It ranged from 0.43 to 0.81 in 1990, with a mean value of 0.64, while in 2000 the range was from 0.52 to 0.79, with a mean value of 0.67.

3.6.2. Capital investments and their purpose

Only eight PHCCs had no investments over the past 10 years and in 45 out of the 49 who had had them, they took place over the last 5 years. Providers mostly financed them out of their own resources, partly with the support of the municipalities. In a fourth of all PHCCs (17) the number of provider locations was reduced, while it has increased in four. The available practice surface increased in 14 PHCCs and was reduced in 15. The self-perceived reasons were: change in the volume and scope of services delivered (20 cases), adaptation of facilities to the standards (18 cases), and in three cases adaptation of the number of locations. In 16 PHCCs capital investments are planned in the near future and in 13 the available practice surface will increase in size.

3.6.3. Changes in types and volume of services delivered

Only one PHCC does not deliver GP services any more due to private provision in the area. Types of services vary by size of the catchment area. General dentistry, gynaecological primary care, diabetology, and pulmonology are often not available at the PHCCs any more as they are delivered in private provision. New services introduced over the last period were mostly: specialist services (e.g. ophthalmology, orthopaedics and neurology), emergency services, and outreach services (e.g. health care of illicit drug users, screening of developmental disorders in children). The volume of services delivered has mostly decreased (20 cases) or stayed the same (27), while 10 PHCCs observed an increase.

3.6.4. Changes in the number of employees

Forty-two PHCCs experienced reductions in the total number of employees and only fifteen had no change. The numbers reduced due to movements to private provision of care (39 responses) and in 14 cases partly due to increased efficiency. As many as 37 experienced a deficit with at least one category of health professionals, mostly with physicians (32) and dentists (16), while 4 reported a lack of nursing staff. However, only half of them (19) received some sort of assistance in the search for staff, mostly by the local employment office. The number of foreigners represents <1% of the total workforce. Most of them originate from the area of former Yugoslavia and half of them are physicians, while 25% are dentists.
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Table 3. Numbers of some groups of health professionals employed by PHCCs in 1990 and 2000 [17, 18].

<table>
<thead>
<tr>
<th>Health professional group</th>
<th>1990</th>
<th>2000</th>
<th>Difference (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>955</td>
<td>767</td>
<td>-17.8</td>
</tr>
<tr>
<td>Dentists</td>
<td>558</td>
<td>308</td>
<td>-42.7</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>6</td>
<td>5</td>
<td>-25.0</td>
</tr>
<tr>
<td>Nurses</td>
<td>743</td>
<td>504</td>
<td>-32.3</td>
</tr>
<tr>
<td>Health technicians</td>
<td>1988</td>
<td>1498</td>
<td>-22.2</td>
</tr>
<tr>
<td><strong>Total number</strong></td>
<td><strong>6844</strong></td>
<td><strong>4484</strong></td>
<td><strong>-33.2</strong></td>
</tr>
</tbody>
</table>

3.6.5. Introduction of private provision of care

Only eight respondents believe that the introduction of private provision was performed in an efficient and rational way. The overall perception of this process is that it was chaotically introduced and generally poorly managed at the level of the MoH. Undefined final share of private provision (34), lack of defined goals for private provision (30), and lack of co-ordination between the MoH and the municipalities (29) were the most frequent answers (absolute number of replies in brackets). Arrangements with private providers are most frequently for the on-call/night duty service (34). In half of the cases, co-operation with the private providers is seen as at least partly successful. The two main complaints are:

i) A need for a better definition of the concessionaire’s responsibilities and;

ii) The definition of more coherent conditions for private provision at the national level.

In view of that, as many as 52 respondents believe that granting of concessions should be regulated differently. Twenty-seven believe that a different legal definition should be sought, while twelve thought that it would be better to regulate it at the level of the State (i.e. MoH). Eleven PHCCs saw the whole process as entirely successful and seven as completely unsuccessful.

There were a large number of answers to the open-ended questions in this area and they dealt with:

- Lack of co-ordination between the MoH and municipalities;
- Lack of vision on the process and outcome of introducing private provision;
- Differences in freedom to manage a public vs. a private institution;
- PHCCs acting as a universal but inadequately supported backup for manpower shortages;
- Backup for postgraduate training issues.
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3.6.6. Relationship with the founder (municipality)

Twenty-five PHCCs changed their founder in the observed period; seventeen of them now have more than one founder. Only 18 PHCCs see those relations successfully settled. The most common problem is an inadequate approach to investments at the PHCCs, followed by the lack of interest in managing the PHCC and an insufficient level of co-ordination between the PHCC and the municipality. Excessive interference was stated as a problem only in nine cases. In 24 PHCCs they see the representation of the founder in the managing bodies as a successful solution, while 7 thought it was bringing in too much political influence and 12 wanted to see it revised. In the open-ended questions the most frequent comment was that the smaller municipalities do not have adequate staff to face health care planning.

3.6.7. Contracting of services

Only 11 PHCCs see the present contracting mechanisms as suitable. The others believe that the partnership model of negotiations and the role of the MoH need adjustment in the near future (17 each). All respondents stated that the role of the HIIS is too strong and 13 want to see its role changed, while insufficiency was seen mostly with the APPHC (34) and with the MoH (17). Current annual contracting of services should be extended to longer periods according to 41 PHCCs. The reason for that lies in possibilities for better planning (35) and in reducing year-to-year oscillations (12).

3.7. Discussion

PHCCs have passed a transition period over the past 10 years as several circumstances challenged their existence. The social and political environment posed several demands, such as introduction of competition and other market elements to health care as well as more efficiency. On the other hand, there was uncertainty about the community-based and public health orientation of primary care in Slovenia. Competition and market elements were implemented through introduction of private provision of health care, steered by the process of granting concessions. Moves to private provision caused a reduction of employees in PHCCs by one third, followed by a reduction in the range and volume of services as those services were then provided elsewhere. A net deficit of physicians and dentists was observed, that was only partly relieved by foreign professionals. Foreign professionals constitute <1% of the employed, so that remains a rather marginal problem. At the national aggregate level, there has been almost no change in the share of key health professionals in the total number of employees. On the other hand, PHCCs reacted by developing new outreach services and followed the strategy of providing diversified care, including specialist outpatient care. It seems that efficiency suddenly became a driving force in PHCCs, and they seem to have responded quite well to this challenge. That is also evidenced in the forthcoming investments and development.

The other consequences relate to the relationship between the PHCC and their founder—the municipality. The original problem, exposed firmly by the managers
of PHCCs, was that the MoH did not steer the processes of change at the primary level correctly. There was lack of vision and of a defined end volume or share of private provision. The same concerns were expressed at two 1-day workshops organised in 1995 [19]. The MoH should have co-ordinated the process better by involving municipalities and developing guidelines for its introduction. This process could have been also better managed, organised, and implemented and there was poor coordination between the MoH and the municipalities. With a late response to rising problems related to the fragmentation of municipalities (from 1995 onwards), the MoH tried to coordinate management and concession granting activities but a lot of time had been lost at that point. And last, but not least, there were several negotiators for the same services on the provider side. Despite the public debate about the difficulties in arranging a stable relationship between the PHCCs and local private providers, those relations seem to work rather well in a large number of cases. Still, there is a discrepancy between the tendencies to privatise delivery of primary care while the administration of the system remains firmly a public function and responsibility. Municipalities are in an ambiguous position. On the one hand, they are founders of the PHCCs and, on the other hand, they are responsible for granting concessions to private providers. This discrepancy was brought in at the system level at its design phase. But no PHCC was closed down and public health interest has been preserved through the keeping of the spatial distribution of the main services delivered. Fierce public discussions [20] still run around the granting of concessions to physicians who wish to start their private practice.

The role of the HIIS is a controversial one. On the one hand, it was seen as having too much power in the system. Management favours longer contracting periods that would introduce more stability and offer better planning possibilities. An additional effort made by the HIIS is expected to define inputs for contracting beyond the simple calculations of full-time equivalent proxies, volume performance and fixed budgets. On the other hand, the HIIS is seen, as evidenced through open-ended questions, as the stakeholder, which has ensured the financial stability of the entire publicly financed health care system over the last decade.

3.8. Conclusions

PHCCs in Slovenia are still in the process of transformation that was brought about by a significantly changed environment following structural changes in Slovenia’s health care system. Slovenia’s politics never anticipated an abolition of the pre-existing public structures, like PHCCs. That helped most of the PHCCs to survive the dynamic period rather well and keep most of their structures in place. On the eve of the reform of 1992, health policy decided to keep PHCCs as the focus for primary health care activities. As a successful solution that has survived several political systems, they are now confronted with new requirements and a more complicated setting of several stakeholders.
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There is a clear legal definition of PHCCs (the Health Care Services Act as well as the National Health Plan) as the main providers and co-ordinator of activities at the primary health care level. PHCCs perceive the development of private provision rather critically since it has seen rather partial responses in different areas. The problem lies in the way it had been introduced, not in the mere fact that it represents competition to public providers. On the other hand, there are the municipalities and their double competencies (both public and private) that make them the key players at the local level. That role seems to be insufficiently pursued, mostly due to the specifics of health care and the random, sometimes chaotic, nature of private provision development. PHCCs therefore feel that they are the ‘losing party’ at the crossroads of the Ministry’s interests (which are least defined), the HIIS, and the municipalities.

The same goes for important issues such as responsibilities for the technical and administrative personnel that remain employed at PHCCs after the departure of the key health professionals, backup for certain services (on-call and emergency), and ensuring adequate funding for postgraduate training (especially for physicians). Adaptation to the new situation in terms of efficiency despite the loss of one third of their total manpower and selection of new services reflect a positive overall impact of the change. The idea of having a public institution to keep a coordinating role of certain public health functions is a direct extension of the early Štampar’s ideas from the 1920s. Given the changing environment, it appears necessary to re-evaluate that role and to consider new organisational solutions as well as new ways and means of contracting services at the primary level. Private provision and competition for public funds demand a more proactive managerial action on the side of the PHCCs, especially in negotiations with financiers who want to contract with them. Public health orientation and functions, such as broader preventative services, will continue to be expected from the PHCCs in the future. Clear definition of the mutual responsibilities in assuring continuity of care to the population between PHCCs and private providers will remain a challenge to be managed by the municipalities with assistance from the MoH. Harmony in these relations will assure stability of health care in Slovenia at its most important level, the primary care level.

3.9. Key points

Study question: what are the perceptions of transition changes, changes in resources and services and relationships between the PHCCs and new stakeholders in primary care?

Method: a self-administered questionnaire circulated to all PHCCs in Slovenia with the three aspects explored: perceived changes, actual changes in resources, and services and relations with the new providers in primary care.

Main results: PHCCs role is quickly changing and their relationship with the municipalities was reinforced though ambiguity. The number of employees was reduced by one third with a continued trend of decrease, the volume and the diversity of
services shrunk. Their association’s influence was perceived as insufficient while the position of the HIIS was seen as too strong.

Implications: closer attention will have to be paid to the regrouping of stakeholders at the primary care level, both from the Ministry of Health as well as from the municipalities. The latter are responsible for organising delivery of primary care. Imbalances in the negotiating mechanism between the representatives of the PHCCs and the HIIS bring additional queries to the future of PHCCs which have to be more clearly defined by national health strategies.

3.10. References
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