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

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Publication date
2011

Citation for published version (APA):

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Abstract

Objectives: To discuss the background, nature and facilitating and hindering factors of the privatisation process in health care in Slovenia.

Methods: Descriptive analyses of legal and policy documents mapping the situation in Slovenia against an internationally established taxonomy and typology. Description of the scope and volume of the different types of privatisation.

Results: Determined by the political will, privatisation in health care in Slovenia has been a gradual process. In 2008, it applies to 30% of the primary care providers (GPs, paediatricians and school medicine doctors), almost 60% of providers in dentistry and about 20% of providers of outpatient specialist care. In the hospital setting, privatisation remained limited and there have not been significant private investments in health infrastructure. Privatisation of health insurance (including insurance to cover co-payments) has steeply risen to 15% of the total health expenditure (THE), while out-of-pocket payments reached 12% of the THE.

Conclusions: Slovenia’s privatisation in health care is focused on primary health care and on health expenditures. Controversies over its extent kept privatisation contained and controlled. Today’s share of private provision of health services remains

at the conservative end of the European Union. Private expenditures for health services increased considerably, while privatisation of health infrastructure and management has so far been limited. Concerns about the future course of privatisation relate to the issues of equity, fairness and solidarity.

5.1. Background

Historically, private practice existed in Slovenia since the beginning of the organised medical profession in the 19th century. Until World War I most of the health care facilities were either private for direct payment or belonged to charities, with the exception of the state owned military facilities. In the period between the two world wars, developments went in two directions. At the primary care level, primary health care centres were established, which were mostly owned by municipalities. Certain key institutions, such as the school children primary health centre, the dispensaries for the protection of mothers and children, etc., were also owned by municipalities and physicians would be salaried. At the level of specialists, outpatient care private provision and ownership were most frequent, while hospitals were state-owned. After World War II, private practice in Slovenia continued until 1947 when licenses were suspended and then banned completely in 1957. Between 1957 and 1992 private practice continued to a limited extent as a ‘grey market’ activity, predominantly among dentists. Physicians and dentists were keeping hopes that transition would lead to the legalisation of private practice. This resulted in a civil movement leading to the formation of the Medical Chamber of Slovenia (MCS) in 1991. Such a process did not run in isolation, but was rather symbolic of the transition processes in other former socialist countries of central and Eastern Europe. Privatisation became an important issue of the overall reforms. In 1989/1990 some republics of the former Yugoslavia (especially Slovenia and Croatia) saw privatisation as a political priority with the return of parliamentary democracy. In other central European countries, privatisation had also been in the forefront of political demands of health professionals. The main reasons for this were twofold: firstly, privatisation was seen as necessary for the implementation of the concept of physicians as free professionals and, secondly, it was expected that it would bring more efficiency and patient-friendly atmosphere into health care as a whole. There was another ‘informal’ reason for promoting privatisation—informal payments, which were very common in many of the central and Eastern European countries. Privatisation was seen as means in overcoming informal payments’ practices. Health care was suffering from managerial inefficiency, loss of motivation and financial losses, under-investment, low salaries for health professionals and general under-funding. All of this contributed to health care becoming an important field for the implementation of privatisation policies. There had been a growing perception of health care as a commodity instead of a social benefit, which gave more influence to ideologies based on market forces. Political expectations went in the direction of explicit privatisation. Former state employees saw an opportunity of gaining independence through a self-managed single-handed practice. Once more professional and work independence
were to be gained, there was, realistically, the wish to also increase their incomes. Overall, privatisation was seen as ‘the magic cure’ for the problems of the public sector, even as far as potentially providing solutions for understaffed posts in remote areas. Privatisation of health care investments was supposed to provide attractive options to stay in the country and work under independent management.

This paper poses four research questions in the exploration of the privatisation process in the Slovenian health care:

1. What were the reasons and the background of privatization in Slovenia?
2. What was the nature of privatisation?
3. What was the extent of the privatisation process in numbers?
4. What were the influencing (facilitating and hindering) factors for privatisation?

At the beginning one of the proposed existing definitions of privatisation and its modalities in health care is introduced. We supplement it with an outline of the taxonomy and typology of privatisation in the health care sector. In continuation the developments in Slovenia are presented comparing them with the proposed definition. The nature and the types of privatisation as it unfolded in Slovenia are presented and put in the context of facilitating and hindering factors for privatisation. As an illustration of the extent of privatisation some statistical data are included. In conclusion, we present the controversies, which remain in view of the positions of stakeholders and their opposing views on the past and the future process of privatisation in health care in Slovenia.

5.2. Materials and methods

5.2.1. Defining privatisation

According to the European Observatory on Health Care Systems and Policies [1] privatisation is ‘the transfer of ownership and government functions from public to private bodies, which may consist of voluntary organisations and for-profit and not-for-profit private organisations’.

In principle, privatisation defines the turning of public assets over to private ownership. An additional important issue of privatisation is the development of not-for-profit versus for-profit private delivery. For that purpose we have chosen for our study the taxonomical categories proposed by Saltman [2] (see Table 1).

We also compared the course of privatisation in Slovenia with the typology proposed by Maarse [3], where levels of privatisation can be structured as the different privatisations:

1. Privatisation of health care financing,
2. Privatisation of health care provision,
3. Privatisation of health care management,
Table 1. Public/private taxonomy in the health sector.

<table>
<thead>
<tr>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>Public, but not-state</td>
</tr>
<tr>
<td>Ministry of Health (MoH)</td>
<td>Regional and local government</td>
</tr>
<tr>
<td>National Boards</td>
<td>Public corporations</td>
</tr>
</tbody>
</table>

The definition of privatisation, the taxonomy and the typology of privatisation were taken as a matrix against which the Slovenian situation is described, characterised and evaluated.

In order to analyse the information previously published on the background and on the reasons for privatisation, we carried out a search of nationally relevant documents through the Slovenian national bibliographical database (COBISS—http://www.cobiss.si), using the keywords ‘privatisation of health care’ and ‘private work, health care’. We also carried out a search for ‘privatisation, health care, Slovenia’ in PubMed. The search for documents in the COBISS database yielded 25 hits with the keywords ‘privatisation of health care’ and 15 hits with ‘private work, health care’. Out of the 25 hits under privatisation of health care nine were professional and scientific papers; seven were graduation theses from the faculties of public administration, law and economics, seven newspaper articles and two monographs. A thematic issue of Bilten, a Slovenian journal for health care management, economics and informatics, was entirely dedicated to the issue of privatisation in health care in 2006 and three articles were referenced in this analysis. Out of the 15 papers on private work in health care ten were graduate theses, three were MSc theses, one was a newspaper article and one was a survey report. The search in the PubMed base provided only four papers and the main findings from all are included in this paper. Out of the documents obtained through all of these searches, we selected those fulfilling the following criteria: quantitative information about the number of private providers, survey data on patient and health care user satisfaction with private health care, policy documents regulating the area of privatisation in health care, published studies on privatisation and position papers. We carried out a policy analysis of the legal and policy strategy documents, putting the processes in line with the taxonomy and the four areas of privatisation, together with an analysis of the facilitating and hindering factors, influencing their development. We also present the statistical information on the number of providers as well as the number of health professionals employed in the private sector. The analysis was linked to previous work related to the transformation of primary health care centres in Slovenia [4], where also interactions between public and private providers were explored. Key background documents are listed below:
Privatisation of health care in Slovenia in the period 1992-2008

I. Strategic documents
Health reform 2003 [5].
Strategic points for the preparation of the national health plan 2007 [7].
Strategy of the Medical Chamber of Slovenia [8].

II. Health Plans
National Health Plan [9].
Resolution on the National Health Care Plan 2008–2013 [10].

III. System legal acts
Health Care and Health Insurance Act [12].
Pharmacy Services’ Act [13].
Medical Services’ Act [14].

Reports from general population surveys [15, 16] and on views about dental health care [17] were used as well as the statistical data on the number and share of private providers in primary health care.

This paper presents a policy analysis of the implementation of these general political aims, positions of stakeholders, typology of privatisation, facilitating and hindering factors and the present situation, 16 years after the adoption of the Health Services Act and Health Care and Health Insurance Act.

Table 2. Reasons for privatisation.

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Internal</th>
<th>External</th>
</tr>
</thead>
<tbody>
<tr>
<td>On the side of patients</td>
<td>Dissatisfaction with poorly managed public services</td>
<td>Patient rights – to choice, to diversity, to higher quality</td>
</tr>
<tr>
<td>On the health policy side</td>
<td>Privatisation as part of the general social processes</td>
<td>Privatisation as the option for ‘competition’, ‘market-oriented’ health care</td>
</tr>
<tr>
<td>On the side of providers</td>
<td>Re-introduction of private practice</td>
<td>Quality, competition, ‘better overall performance’</td>
</tr>
</tbody>
</table>

5.3. Results

5.3.1. Reasons, goals and legal background for privatisation

Table 2. states the reasons for privatisation as brought forward in the health care policy literature (see below). The most frequent features of market-oriented health care reforms are the privatisation of provision and financing of services, which had previously been publicly organised and/or financed (that is by the state or local community).

Judging from the general population opinion surveys, which screen attitudes to private practice since 1994, some of these goals were achieved. In all of these surveys, private practice scored high on satisfaction (at least 85%) and performed better
on some of the basic indicators, such as organising appointments, specified waiting
times, better access to certain diagnostic facilities.

Exploration and analysis of the key strategic documents that formed the policy
base of the health care reform showed that they did not explicitly state the goals for
privatisation in health care. The background materials and comments stated such as:
‘increasing the variety of services’, ‘improving access’, and ‘providing more choice’,
‘increasing efficiency’, and competition in health care. These were implement-
ed in the legislation of 1992 primarily through the introduction of private practice
for health professionals and in introducing co-payments and voluntary health ins-
urance schemes (both to increase personal expenditure). The latter neutralised the
expected decreases in the number of visits in specialist outpatient care that the co-
payments were supposed to have. The State empowered municipalities with the re-
sponsibility of managing the primary health care network. The absent health strate-
gy, undefined privatisation of state property and a lack of a consensus of social part-
ers and no decision on public–private partnerships in health care provided a poor
basis for privatisation of health care facilities or of health insurance. At the begin-
nning of 1990s there was little room for a managerial change in the management of
health care facilities. The key issue in privatisation was in offering the possibility of
private practice to health professionals as a legal entitlement. Managerial goals, such
as reductions in public spending or increasing efficiency, were of lesser importance.

Private practice in the public sector is legally regulated through a process of three
phases:

1. The condition of qualifications—the phase where professional qualifications
   are checked by the respective professional body (e.g. Medical Chamber).
2. The condition of premises—the phase where the proposed premises are checked
   against the standards adopted by the MoH.
3. The condition of the tender (only recently fully implemented)—the phase
   where a tender is open for concessions by the municipality (in the case of prima-
   ry care) and by the MoH (in the case of secondary and tertiary care).

5.3.2. The nature of the privatisation process

Applying Saltman’s taxonomy to the developments in Slovenia we can identify the
following (see Fig. 1 below):

1. On the public side, we have the State, owner of almost all hospitals, public
   health institutes and other national health care institutions.
2. Municipalities remain owners of the primary health care centres (PHCCs) and
   administrators of primary health care, including the control over the extent and
   pace of private provision).
Figure 1. Regulation of the private practice setup.

- **Application to become a private provider**: (the respective chamber or the MoH)
- **Verification of requirements for private practice by the MoH**
- **Fulfilled**
- **Listing of a private provider with the respective chamber of the MoH**
- **Applying for a concession**: (MoH for specialist care or municipality for primary care)
- **Bidding for a contract with the HIIS**: (Private providers as a part of the public system)
- **Working for out-of-pocket payment**: (Purely private providers)

3. Provision of health care was split between public providers and private providers. Private providers are mainly of three types:

   a. **Independent private providers**: (de facto for-profit providers, who form the majority of private providers) who are part of the publicly controlled network of providers contracted through the Health Insurance Institute of Slovenia (HIIS) on an annual contract and generally financed from public sources. This type is preferred for private practitioners at the primary care level and for those delivering expensive and/or complex services.

   b. **Purely private providers** working for direct payment of their services or, in rare cases, for private insurance. These are not in a contractual relationship with the HIIS and their sources of finance are private. This is typical of around 12% of all dentists and of a small number of single-handed specialist surgeries.

   c. **Mixed-financed private providers** are increasing in numbers, especially among specialists. In these cases, a provider opts for a part-time contract with the HIIS, selling out the remainder of his time to private patients for out-of-pocket paid services.

4. **Not-for-profit private providers** are not common in health care and represent less than 1% of the total private provision. Involvement of the Catholic Church in provision of health care had been discontinued in 1945 and today it is mostly limited to charitable work. Today’s exceptions are NGOs in the field of mental health and not-for-profit groups dealing with social rehabilitation for different addictions (Table 3).
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Table 3. Number of private practitioners in primary care (GPs, paediatricians, dentists) between 1999 and 2006. Source: Register of physicians and dentists of the Medical Chamber of Slovenia.

<table>
<thead>
<tr>
<th>Profession</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>Ind.2006/1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>147</td>
<td>8</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>150</td>
</tr>
<tr>
<td>Paediatr.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>31</td>
<td>34</td>
<td>43</td>
<td>427</td>
<td>427</td>
<td>427</td>
<td>427</td>
<td>427</td>
<td>155</td>
</tr>
<tr>
<td>Dentists</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>370</td>
<td>413</td>
<td>457</td>
<td>457</td>
<td>457</td>
<td>457</td>
<td>457</td>
<td>457</td>
<td>133</td>
</tr>
</tbody>
</table>

In Slovenia there is a dominant social health insurance scheme with generous coverage under the compulsory health insurance. An important addition to this is the supplementary insurance for the coverage of co-payments. This added a regressive component to the Slovenian health insurance structure [5] and that had been partly modified by the introduction of risk equalising schemes. Privatisation was important at the level of health care delivery and so far developed as an important process only in primary health care. There was no privatisation of health care facilities. Three papers deal with the privatisation process from different points of view. Švab and Progar [18] discuss the extent of the privatisation process in primary care, Markota et al. [19] deal with the main topics of the Slovenian health care reform and Černič Istenič M [20] focuses on the privatisation process at its early stages.

5.3.3. Typology of privatisation in health care in Slovenia

In view of the typology proposed by Maarse, we can identify the following ‘privatisations’ in Slovenia:

1. Health care financing transformed from public expenditures having a share of 98% in total health expenditure (THE) in 1991 to only to 72.4% [21] in 2005. Statutory health insurance remained in the hands of a single national insurer and the principal public source of financing health care. The remainder can be considered as private funding, which we can divide into:

   a. supplementary insurance schemes for coverage of co-payments instituted by the Health Care and Health Insurance Act from 1992, and
   b. out-of-pocket payments paid for:
      i. Services not included in the compulsory health insurance,
      ii. Services with providers who do not have a contract with the HIIS,
      iii. Co-payments (in absence of a supplementary insurance).

Supplementary health insurance is an insurance against co-payments incurred in using certain services, which attract them. Some disease categories, such as communicable diseases, cancer and diabetes, and some services (e.g. reproductive health), are excluded from co-payments. The level of supplementary health insurance is of approximately 15% of the THE, while that of out-of-pocket is of 12% of the THE [22]. Two of the three providers of this insurance are general insurance companies, while the third specialises in this type of insurance. Through the amendments of
the Health Care and Health Insurance Act, risk equalising schemes were enacted in 2005 [23].

2. Health care provision is the main area and the focus of privatisation in health care. As we can see from the statistical data, the share of private provision has reached 22.6% of all GPs in 2006 [24], which is a level comparable to those in Finland [25] or Sweden [26].

3. Health care management is an area, which the State sought to regulate through the development of a state-recognised training. In the 1990s privatisation of health care management was made impossible as the Health Care Act defined the exclusive right of physicians to occupy key managerial posts in health care. In the meantime management has become open to other professionals on equal terms.

4. Privatisation of health care investment is still very limited. A part of the single-handed practices depend on the private investment in the premises, all of them on private investment in equipment. There are several private sanatoria, some of them delivering diagnostic services and others general surgical procedures.

5.3.4. Quantitative data on private practice

Dentists, GPs and paediatricians in primary care have been the largest groups moving into private practice. The total number of private practitioners remained low (less than 10% of all) until 1999. After this year a more intense process of private practice started (see Table 4.). In 2006, 22% of all GPs and 25% of all paediatricians in primary care worked as private practitioners. The overall approach (including reimbursement, such as capitation) favoured independent contracting through the HIIS by using compulsory and supplementary insurance funding over pure privatisation. This is reflected in the fact that only four GPs and none of the paediatricians worked without a concession, which shows an almost complete inclusion of private providers into the independent contracting system of the compulsory health insurance. In some segments, such as dentistry, privatisation of both types, independent contracting as well as pure private practices, was intense. In 2006 55% of all dentists were in private practice and one fifth of them (11% of the total number) were working in purely private practices without a concession. A similar trend can be observed with outpatient specialists.

5.3.5. Facilitating and hindering factors

Privatisation has not been running as a continuous process and depended on the political setting. There has been interplay of factors, which are all summarised in Table 4. Political setting was the most important factor influencing the development of privatisation in health care delivery. Attitudes with respect to facilitating privatisation differed depending on the specific political preferences of different governments.

There are a number of controversial issues still open in privatisation of health care. Some authors like Toth [27] challenge the excitement of various policymakers ad-
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Advocating a more aggressive approach to privatisation and warn against the lack of transparency of a developing mixed system. A series of interviews published in a Slovenian journal reflected the diversity of opinions as expressed by the different stakeholders, where a clear contrast appears between the positions of the professional associations and insurance companies and those institutions, which should defend the public interest [28]. One of the key issues that also remain unresolved is how to delimit between the ownership of infrastructure and the rights to health care typical of a public system [29].

Table 4. Facilitating and hindering factors in each of the areas of privatisation in Slovenia.

<table>
<thead>
<tr>
<th>Area of privatisation</th>
<th>Facilitating factors</th>
<th>Hindering factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Privatisation of health care delivery (private practice)</td>
<td>Political setting (favouring privatisation) Professionals’ motivation</td>
<td>Political setting (not favouring privatisation) Lobby of public providers</td>
</tr>
<tr>
<td>Privatisation of health insurance</td>
<td>Introduction of co-insurance (health care and health insurance act)</td>
<td>Absence of a particular legal solution</td>
</tr>
<tr>
<td>Privatisation of health facilities</td>
<td>General approach to privatisation in different sectors</td>
<td>No final political decision and no final legal solution to this date</td>
</tr>
</tbody>
</table>

5.4. Discussion

Legal enactment did not follow the political will, proposals and intentions of the government to privatise health care facilities in the first half of the 1990s. There was no background for the privatisation of these facilities as it had depended on the adoption of a general framework for the entire state-owned sector. In 2008, there are indications that private investments in establishing new private providers would be encouraged in order to supplement the existing public providers through the optimisation of private investments. Development of public–private partnerships has so far been an exception, even if they could provide solutions for smaller hospital and primary care in certain environments.

As far as the taxonomy, our analysis of privatisation in health care delivery shows that predominantly primary care (including pharmacies serving outpatients) and the specialist outpatient services were the foci of privatisation. The State continues with its role as the key owner of hospital facilities, while private facilities for in-patient care are scarce. In primary care, the provision has transformed into a service shared between public and private providers leading to the present 25% share of private providers amongst all. According to the Saltman’s taxonomy, Slovenia introduced a for-profit type of private provision, predominantly as small single-handed businesses, which are mainly return-driven. While most private providers work as independent practitioners under contract funded by public funds (HIIS), the potential surplus achieved remains at full disposal of the owner. Purely private providers focus on selected services, such as health and spa resorts for medical rehabilitation,
dental care for adults and some smaller in- and out-patient specialised facilities. The role of charities in health care is, at present, very limited.

The decision to enhance and attract additional private funds resulted in a growing proportion of private expenditures in health. Some of these developments (such as the introduction of the co-payment insurance) resulted in adding regressive elements to the health care system [5]. In European comparisons the present private expenditure for health is not extreme with 27% of the THE. But it has surpassed the 25% margin, which had been seen by some Slovenian authors as an unofficial 'limit'. Some services and some providers remain outside of any publicly financed arrangement. In contrast with the declarative health policy aims and limitations to privatisation, the out-of-pocket expenditures have risen to an important share. In health care provision, the most privatised service is dentistry at the primary level, where almost 60% of all went into private practice. This is certainly due to two important facts:

1. Co-payments are important in dentistry (in prosthetic treatments up to 60%),
2. In dentistry some materials and treatment procedures are entirely excluded from the compulsory health insurance package,
3. Traditionally, dentistry was a service where the willingness-to-pay, as measured through opinion surveys, has been much higher and,
4. Because of the resource restrictions in the entire publicly financed systems causing waiting lists.

Since 2005 there have been several new providers in the field of outpatient interventions, such as outpatient and day surgery, including cataract surgery. These providers supplement the existing network of publicly owned specialist and hospital services. Shares of private practitioners in GP practices are comparable to those in Sweden or Finland, but much lower than in the neighbouring countries, regardless of their previous development. This is mostly due to a much slower pace of the privatisation process in Slovenia than in most other transition economy countries. Its closest neighbour Croatia decided to effectively privatise the entire primary health care delivery already in 1993, which led to the disintegration of health centres and to the privatisation of individual offices [30]. Authors reported sharp reductions in the number of home visits and preventative visits in primary care settings in Croatia. In Slovenia the number of home visits increased by 10% at the beginning of the 21st century. The number of curative visits remained stable at around 9 million per year (90% of all primary care visits, 4.5 per inhabitant). Preventative programmes for early detection of risk factors for cardiovascular diseases and for cervical cancer provided incentives for a more preventative-oriented primary care and reached good coverage rates (over 70%). In the Former Yugoslav Republic of Macedonia (FYROM) rapid privatisation of primary care took place in 2006/2007 and now virtually all primary care physicians are private practitioners [31]. At the same time in Serbia a parallel completely private system was established in the absence of a consistent and co-ordinated control of the transformation. A more comprehensive process of priva-
Slovenian health care in transition took place in the Czech Republic in the 1990s [32], while in Slovakia this occurred after 2001 [33].

The political setting was a decisive factor, both facilitating as well as hindering in the privatisation of health care provision and in the privatisation of health care facilities. This is not surprising as the State kept the decisive role in managing public institutions in health care, while on the other side appointing municipalities to manage private provision in their territory and shifting the responsibilities for managing private providers to the fully empowered chambers (such as the Medical and the Pharmacists’). The fact that the State in 1994 was not able to decide on a generic policy on privatisation of all forms of public ownership meant a postponement for health care. This causes public and private providers to run in parallel and in some cases demonstrates the shortcomings of the State and/or municipalities to responsibly manage their respective provider networks. Privatisation of health insurance is an option only to the extent that private providers working for private insurance schemes would buffer the undersupply in the public system. The formal comprehensiveness of the compulsory health insurance and the rising expenditure in the area of supplementary insurance which covers co-payments further limit possibilities for private health insurance. These developments are rather specific for the situation in Slovenia and reflect the policy preferences. Health care management remained largely in the domain of the medical profession as a medical degree was required from candidates for managerial posts in publicly owned health care institutions. This meant that initially professional background had a higher priority than the demonstrated managerial skills. Local political preferences influenced the course of privatisation in primary care and resulted in differences of the extent to which privatisation took place.

5.4.1. Methodological issues

We developed our analysis of the privatisation process in the Slovenian health care around the strategic policy documents and health plans as well as the legal documents, defining the health system in Slovenia. These were supported by the statistical data on the pace and the extent of the privatisation of health care delivery and the survey data on the population’s perceptions of the process, including their satisfaction with private providers. As explorative and analytical literature on the topic is rather scarce, we included all the references, which we managed to identify in the process of literature review. This had been done using the international and national reference databases we believe to have identified the valid documents. Based on the explorative work on the documents described, we were able to identify the most important facilitating and hindering factors for privatisation.

5.5. Conclusions

Slovenia underwent a process in which elements of entrepreneurship have been introduced into health care. Contrary to this widespread approach and trend, the ownership of the national and local publicly owned health care providers has not
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changed. Some of their services were taken over or were supplemented by independent providers, contracted through public funds and mostly working in single-handed practices. In dentistry and in some specialist services also purely private practices developed. Most of the system remains controlled through the inclusion of independent providers in the contract-bound reimbursement schemes of the HIIS as part of the public network of health care providers. Health financing transformed from a purely publicly financed system into a mixed system with an important level of partly regressive private expenditures. At the same time, privatisation of investments and infrastructure in health care so far remains modest. There has been clear preference for privatisation with providers in primary care and dentistry and in selected diagnostic and specialised services, while the overall shares of private providers remain moderate. Contrary to the other countries in transition, the process of privatisation has been gradual and contained. The future developments will depend strongly on the political preferences as the system remains in control of the extent of privatisation at all levels. As private expenditures surpass the level of 25%, the public’s attitude toward privatisation in Slovenia has become more reserved about the potential challenges to fairness, solidarity and equity in the health sector. These concerns are likely to remain present for the foreseeable future and the role of the State in controlling the process of privatisation in all its different types is expected to remain strong.

5.6. References


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Privatisation of health care in Slovenia in the period 1992-2008


[27] Toth M. Privatizacija v zdravstvenem varstvu v Sloveniji – napredek ali naza
dovanje? (Privatisation in health care in Slovenia – progress or a step back?). Bilt org ekon inf 2006;22(September (3)): 76–82.


[29] Hočevar F. Poreklo lastnine zdravstvenem infrastrukture v javnem zdravstvu ne sme vplivati na uresničevanje pravic v področju zdravstvenega varstva (The ownerslip of infrastructure in a publicly financed health care should not influence the execution of rights to health care). Bilt org ekon inf 2006;22(September (3)):85–6.


