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

B ackground: Slovenia’s health reform from 1992 had five goals - introduction of a social health insurance system and a system of co-payments for a range of services, introduction of private practice in health care, devolution of planning and control functions from the State to professional associations and municipalities and the introduction of licensing and recertification for health professionals.¹

M ethods: With a focus on financing a descriptive and explorative analysis of the general demographic, economic and health financing data and the reported data on financing structure was carried out. The general population health indicators for the entire observed period are also presented. The broader policy context was assessed through participatory observation during the whole period and the use of semi-structured interviews with key national health policymakers in 2001, which served as a mid-term review.

R esults: Slovenia’s transformation of its health care system led to sustainable health care financing at around 8.5% of GDP. This was done at the expense of a declining trend of public funding, partly compensated for by the supplementary health insurance and partly by increasing out-of-pocket expenditures. Private expenditures

introduced regressivity to the system, which was corrected through risk-equalising schemes and by subsidising supplementary health insurance to the least well off.

Conclusions: Slovenia’s health care transition took place during a period of favourable economic development, which enabled the system’s stable financing and restricting the capacity of health care providers. This environment assisted in improving the general conditions for population health, which reduced a part of pressures on the new system. The previous system transformed into a mixed social health insurance based system, based on the strong central insurer. The present financing scheme is unlikely to be sustainable due to demographic trends and other drivers increasing unmet needs.

Keywords: health system reform, health care financing, health insurance

7.1. Background
Slovenia’s transformation of its health system over the past 18 years followed a reform framework developed in 1992. Over the years, this was followed by a series of health policy reform attempts, strategy and planning designs and related initiatives, which did not bring significant changes to the ideas from 1992. Steered by the political arena, health policies followed the pattern of reducing the role of the State through delegation of different tasks to other - old and new - stakeholders in the system. The specific goals of the 1992 reform were in the following (see also Table 1.):

1. Introduction of a Bismarckian health insurance system with a single insurer for compulsory health insurance (CHI)
2. Introduction of co-payments for a range of services, subsequently covered by the compulsory insurance to a varying extent
3. Legalisation of private (independent) practice for health professionals
4. Devolution of a set of planning and control functions of the State to the professional associations ('Chambers') and to the municipalities
5. Introduction of licensing and compulsory continuous education of health professionals

Each of these actions had its own pace and its own - desired and undesired - effects in the health system. Experience from the previous system defined the political choice to move away from a model of a predominant state control towards a system with the delegation of the most important powers and tasks to different stakeholders in the system. The principles of these processes were:

1. To protect the budget allocated to health care from the direct intervention by the Government,
2. To involve key partners in the system (payers, professional associations, providers associations) in the negotiation process, assuming own responsibilities in the contracting process,
3. To liberalise the entire process of health care delivery.
The main aim was in increasing transparency of the system and in ensuring that key decisions were to be taken by consensus by those directly involved in health care delivery. At the same time, less of a direct State involvement and more entrepreneurship were expected. Following the political process, the role of the State was to be reduced to the level of co-ordinating some of the planning and control mechanisms within the health sector. The State would maintain its stewardship role and giving away many managerial - and even regulatory - functions. This was done through the supervisory role over the stakeholders to whom the State appointed its previous tasks. These options followed the predominant pattern of reforms across the central and Eastern European area.

Table 1. Organisational changes taking place in the course of the 1990s.

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<tr>
<th>Process</th>
<th>Responsible institution</th>
<th>Regulation</th>
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<tr>
<td>Health care budget holder</td>
<td>Ministry of Health (MoH)</td>
<td>Health Insurance Institute of Slovenia (HIIS)</td>
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<tr>
<td></td>
<td>– Natl. Adm. for health care</td>
<td></td>
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<tr>
<td>Additional payments/insurance</td>
<td>MoH – ‘participation fees’</td>
<td>HIIS + commercial insurers until 2001 and later only specially regulated commercial insurers</td>
</tr>
<tr>
<td>Registration of providers</td>
<td>MoH</td>
<td>Public – MoH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Private – Professional Chambers</td>
</tr>
<tr>
<td>Private practice</td>
<td>Non existent</td>
<td>Physicians and dentists – Medical Chamber of Slovenia (MCS)</td>
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<td></td>
<td></td>
<td>Pharmacists – Chamber of Pharmacy of Slovenia (CPS)</td>
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<tr>
<td></td>
<td></td>
<td>All other professionals – MoH</td>
</tr>
<tr>
<td>Postgraduate training</td>
<td>MoH</td>
<td>Physicians and dentists – MCS</td>
</tr>
<tr>
<td></td>
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<td>Pharmacists – CPS</td>
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This paper focuses and is limited to the developments in the field of health care financing in Slovenia analysing the areas of compulsory and supplementary health insurance and their implementation between 1992 and 2008. We formulated the following research questions:

- What were the key issues related to the introduction of social health insurance in Slovenia?
- What were the issues and problems related to the introduction of co-payments and then supplementary health insurance (SHI) in Slovenia?
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– What are the present benefits and shortcomings of the goals set by the reform of 1992 in health care financing and how are they related to the equity and efficiency of the system?

7.2. Material and methods
1. Background data on general demographic and health indicators (infant mortality, life expectancy; data on the number of providers) for the period 1990-2008
2. General economic data (health accounts and the financing structure data) and indicators for the observed period, focusing on the period 1995-2007.
3. Report on social issues prepared for the entire area of expenditures in the social sector by the Institute for Macroeconomic Analyses and Development in 2009
4. Participatory observation over the whole period and a series of semi-structured interviews with representatives of the main national institutions involved in policy- and decision making processes in 2001.

Background data were taken from the databases, reports and national indicator databases of the Institute of Public Health of the Republic of Slovenia and the WHO Health for All databases. In 2001 a series of interviews was carried out with the representatives of key stakeholders at the national level and the material obtained was used in the preparation of this analysis as a ‘mid-term’ review of the system changes. Finally, financial data from health accounts for the period 2002-2005, together with some basic financing structural data for the period 1995-2004 were used to assess the changes occurring in the most important streams of health expenditures in Slovenia during the observed period.

We performed an explorative assessment, based on the data available from the routine statistical databases as well as those provided by the special annual reports on CHI (with the Health Insurance Institute of Slovenia) and by the task force on health accounts set up in 2005 in order to implement the OECD methodology for health accounts [1] in Slovenia. Wherever available we focused on the comparison between the data from the start of the reform and the situation in 2007/2008. Financial data were unstable before 1995 due to the high inflation rate (over 20% annually) and the health accounts data are available only for the period after 2002. The first author of this paper lives in Slovenia and was in a position to observe the policy debates over the whole period.

7.3. Results
7.3.1. The context

The main laws of the period were prepared in 1990/1991[2],[3],[4]. Studying the accompanying materials and from the interviews, we identified the following aspects as crucial in guiding the direction of these laws:
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- responsibility of all citizens and inhabitants of Slovenia, employers and the State to actively contribute to health care costs through a CHI scheme, based on the principles of social health insurance,
- health care and health insurance, which is compulsory by law and ensured to the entire population, is a public and not-for-profit service,
- introduction of supplementary (SHI) and voluntary insurance for increased risks going beyond the legally described rights of the compulsory insurance,
- a negotiation process among the representatives of equal partners determines the extent of programmes of health services at all levels and types of care – ‘the partnership model’,
- CHI to be managed by a public institution and administered by representatives of the insured, certain interest groups (e.g. pensioners, disabled) and employers,
- Retaining all the important achievements of the past and gradual introduction of the principle of cost sharing between public finance and private sources.

7.3.2. Developments in economic and demographic indicators – the socio-economic background

Between 1990 and 2002 there was only a minor reduction in the total population size. This trend changed since 2004 with a constant increase in the total population due to immigration and, most recently, a rise in fertility, attributable to the fertility of ‘baby-boomers’ grandchildren. The total fertility rate was in decline between 1990 and 2003 (dropping from 1.46 to 1.20) and increased back to 1.38 in 2007 [5]. The most recent increase in birth rates brought the first net natural increase after 1993. GDP per capita in PPP$ reached an estimated 26,910 in 2007 (rank 46 according to the World Bank [6]) and already by the time of Slovenia’s accession to the European Union surpassed the mark of 70% of the EU average. Health expenditures per capita reached PPP$1800 in 2005, three times the amounts in Bulgaria or Romania and roughly 50% more than in the Czech Republic or Hungary. These data, together with a steep increase in the share of young people enrolled in the tertiary education, brought Slovenia to the rank 26 measured by the value of the Human Development Index (HDI) - 0.923[7]. The extension of life expectancy at birth was due both to the reduced infant mortality and to reduced adult mortality (Slovenia lagging behind the average of EU-15 in life expectancy at the age of 65 by 1.41 years in 1985 and by 1.09 years in 2005). The gap in life expectancy between Slovenia and the average of the new EU member states widened in favour of Slovenia in less than 20 years (3.6 years in 2005 compared to 1.6 years in 1987). Premature mortality remains an important public health problem in Slovenia with the probability that one male in four and one female in ten will die before the age of 65 [8].
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<tbody>
<tr>
<td>Infant mortality</td>
<td>13.08</td>
<td>8.36</td>
<td>5.53</td>
<td>4.90</td>
<td>4.15</td>
<td>2.78</td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>72.19</td>
<td>73.99</td>
<td>74.79</td>
<td>76.27</td>
<td>77.58</td>
<td>78.53</td>
</tr>
<tr>
<td>Life expectancy at 65 years (years)</td>
<td>14.81</td>
<td>15.66</td>
<td>16.14</td>
<td>16.97</td>
<td>17.60</td>
<td>18.46</td>
</tr>
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</table>

From mid-1990s onwards Slovenia had a rather consistent growth of GDP per capita and at the same time also of life expectancy. Figure 1. shows the correlation between the two variables. Figure 2. shows the relationship between trends in THE growth and real GDP growth. There is a widening gap between the two developing after 1999. Between 2000 and 2007 the growth in THE was of 63.8%, while the growth of GDP per capita was of 56.6%. In the same period the number of employed in health care grew only by 15%.

Slovenia also shows a low level of social inequality as measured by the Gini coefficient. Slovenia has maintained a relatively low level of inequality with its value of 24 in 2005 - compared with 26 for Austria, 23 for Sweden, 28 for Germany and 30.9 for the Netherlands [10].

Figure 1. Correlation between GDP per capita (EUR) and life expectancy at birth (years), 1995-2007. Source: Statistical Annual of the Republic of Slovenia, 2008.
7.3.3. Reform goals, processes and outcomes

The reform process was running through the five goals, but in this paper, we focus only on the two concerning CHI and SHI. These were the specific issues related to the two health insurance developments:

1. Full population coverage by a uniformly prescribed compulsory insurance
2. Replacing a state-run and state-dominated decision making system by partnership negotiations within the Bismarckian health insurance scheme
3. Increased transparency of insurance contributions through linkages between employment and/or social status and entitlements
4. Increased share of own (private) participation in health care costs through the introduction of a supplementary health insurance

7.3.4. Introduction of a Bismarckian health insurance system with a single insurer for CHI

Reinstituting the Bismarckian social health insurance system was one of the cornerstones of the reform of 1992. It was intended to preserve equity and accessibility, while at the same time ensuring transparency of obligations for payment of contributions. This way Slovenia followed the pattern of other countries of central and Eastern Europe (CCEE). Health professional associations were also hoping they would disentangle an important part of the negotiation process on tariffs and budgets from the political level [11].
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The Health Insurance Institute of Slovenia (HIIS) is legally defined [3] as the sole provider of CHI since 1992 and started contracting providers from 1 January 1993. The contributions rates for the active population (i.e. those actively contributing to the CHI from their gross incomes) are split in a typical Bismarckian fashion between employers (paying off the total payroll sum) and employees (paying off their gross salary). The old deficits and debts were consolidated by setting the total contribution rate initially and temporarily (for one year) at 18.25%. Table 3. shows trends in the total contribution rates over the period of 16 years (rates from 2002 are still in force), while Figure 3. shows trends in incomes and expenditures of the HIIS compared against the growth in GDP.

There were serious concerns about a Bismarckian system becoming negatively selective against all those population categories, which show difficulties in coping with complex administrative systems. In spite of these concerns, the system provided for a large degree of universality as in 2008 only 7570 persons [12] (0.37% of all eligible) were not integrated in the compulsory health insurance system and thus were formally not insured (compared to around 26,000 in 2003[13]).


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<tbody>
<tr>
<td>Total</td>
<td>18.25</td>
<td>13.80</td>
<td>13.25</td>
<td>12.78</td>
<td>12.70</td>
<td>13.25</td>
<td>13.45</td>
</tr>
<tr>
<td>Employees</td>
<td>n/a</td>
<td>6.60</td>
<td>6.36</td>
<td>6.14</td>
<td>6.10</td>
<td>6.36</td>
<td>6.36</td>
</tr>
<tr>
<td>Employers</td>
<td>n/a</td>
<td>7.20</td>
<td>6.89</td>
<td>6.64</td>
<td>6.60</td>
<td>6.89</td>
<td>7.09</td>
</tr>
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In comment to Table 3., we need to stress that the split is not 100% equal between the two sides due to the following reasons: Employees and employers pay a similar percentage for coverage against diseases and injuries out of work (employees 6.36% versus employers 6.56%). However, employers additionally have to pay 0.53% off the payroll for coverage against injuries at work and occupational diseases.

Demographic transition is one of the important long-term pressures on the CHI as pensioners and their family members in 2008 represented 26.6% of all the insured. Other factors were less predictable, such as: increases in salaries of health professionals between 1996 and 1999, increases in pharmaceutical expenditures and the introduction of VAT for medicines and medical aids (reflected in the increases of 2001). The Parliament consequently decided to increase the contribution rates from 1 January 2002 by 0.2%. Over the next years the share of CHI in GDP started to decline (see Figures 4. and 5. below). The trade-off was supposed to be in optimistic outlooks for the GDP growth.

The setting of the CHI from 1992 has several issues and challenges:

1. Equity concerns – raised by the fact that co-payments were introduced, partly reduced due to maximising of co-payments at an annual level.
2. Specific protection against personal costs lies in the full coverage for certain population groups at higher risk - e.g. children and youth, women for all services related to reproduction - and for certain diseases - e.g. diabetes, cancer, communicable diseases.

3. The Health Care and Health Insurance Act (HCHIA) introduced co-payments for all medicines (except for those directly related to point 2.) at the levels between 25 and 75% (depending on the classification into different lists).

4. All emergency services and treatments for life threatening conditions are excluded from co-payments.

Figure 3. Annual growth of incomes and expenditures of the HIIS and the respective growth of GDP between 1997 and 2001. Source: Annual report of the HIIS for 2001, p. 42.

Figure 4. Share of the health care expenditure by source of finance of the total GDP. Source: Annual report of the HIIS 2008.
The clear downward trend in public expenditures for health care can be seen from Figure 5. below. Between 2003 and 2006 the average nominal annual growth of health expenditures was of 5.7%, while the GDP rose at an average of 7.3%.

Figure 5. Percentage share of CHI in Gross Domestic Product in Slovenia between 1993 and 2007. Source: HIIS and the Ministry of Finance of the Republic of Slovenia.

Figure 6. Categories of CHI coverage and the resulting share of co-payments in the price of services. Source: Health Care and Health Insurance Act, 1992.
7.3.5. Introduction of co-payments for a range of services, covered to a different extent by the compulsory insurance

An important characteristic of the system of 1992 was the introduction of co-payments for a range of services. This controversial idea was meant to enhance private expenditure and in this way contribute to a different distribution of health expenditure sources. Co-payments existed before 1992, when a system of ‘participation fees’ yielded only around 2% to the THE\[14\]. As we can see from Figure 6. above, the range of co-payments spans from 0% to 50%. There are no co-payments for certain conditions where the law ensures full coverage – communicable diseases including sexually transmitted diseases, cancer, diabetes, some neuro-muscular disorders, etc. High co-payments would apply only to non-acute services, such as rehabilitation and physiotherapy services, or dental prosthetics, for the rest they account for 5 to 25% of the service fee. The legislator provided for two additional buffers based on population categories - children, who are free of charge for all diagnostics and treatment (including medicines), and the elderly over the age of 75 years. Co-payments were supposed to deflect some of the ‘unnecessary’ use of services and were originally uninsurable. Concerns about its impact on equity in charging the sick lead to a small legal niche in the HCHIA providing for the introduction of a supplementary health insurance (SHI) (also called ‘voluntary’) against co-payments. Successful promotion in favour of this insurance resulted in the inclusion of a vast majority of the eligible population in the supplementary insurance schemes. Between 1992 and 2001 these were run only by two insurance companies; the first, a department of the HIIS, was dealing exclusively with SHI, while the second was a branch of a commercial insurance company. In the first years, most insured did not feel the burden of the premiums. At first employers were paying individual premiums (even in the public sector!). In 1994, the Court of Accounts (Slov. Računsko sodišče) issued an audit report [15], which in the case of the National Institute of Public Health, clearly stated that it employer’s paying of SHI for its employees in the case of a public institution paid out of public funds would be against the principles of sound management of public funds. After this ruling of the Court of Accounts all the employed in the public sector had to pay own premi

The introduction of co-payments and the subsequent co-payment insurance schemes had two important consequences – cream-skimming that began in 2002 (which was stopped upfront by the establishment of risk equalising schemes in the HCHIA) and, the redistribution of expenditures in favour of private and out-of-pocket. After the separation of the SHI from the HIIS, three companies dominated the market. As we have seen in the graph above, the share of GDP for SHI remained rather stable. The increase in the share of private expenditures in the THE from 22.3% to around 28% was the result of a decline of CHI share in GDP [16]. Insurance companies offering SHI are not bound to invest in the provider infrastructure as they do not commission services from them but reimburse their insured. Furthermore, SHI companies produced surpluses over the last 5 years [17] without rethinking the premium levels, which is
partly the result of an obligatory reserve that they had to create by law. Waiting lists are still an important issue to date and as a political priority and they are being resolved within the publicly financed providers with public funds. It is true that waiting lists have virtually been resolved in cataract surgery where to date waiting time has been reduced to less than a month (used to be over 2 years in 2002 – data of the MoH) or in acute cardiac surgery. But other problem areas remain, for example, different outpatient consultations with over 6 months waiting time and major orthopaedic surgery, such as hip replacement with over one year, and knee joint replacement with over two years waiting list (latest data of the MoH and Institute of Public Health of the Republic of Slovenia).

7.4. Discussion

7.4.1. ‘Health and wealth’

In contrast with the experience of other countries in socio-economic transition, in Slovenia economic changes assisted positive developments in population health status, such as in positive changes in life expectancy (both at birth and at age 65). Even if Slovenia was able to reduce the gap to the EU-15 to a greater degree than other new member states, there are other warnings against complacency. As Jagger et al.[18] report, Slovenia stands behind EU-15, Cyprus and Malta and has a smaller relative share of healthy life years in life expectancy at the age of 50 than Poland. This may be related to the fact that Slovenia has one of the lowest effective ages at retirement for both women and men in the EU (55.2 and 59.5 years respectively) [19]. Maintaining health through the middle period of life becomes important for the future. Improved wealth may have also had a positive impact on the recent increased birth rates.

The cost of health workforce (60% of the THE) financed from the public sources grew much faster than the overall GDP. The widening of this gap grew bigger since 1999 very rapidly. This was a result of salary increases in health care in response to the physicians’ strikes in 1996 and 1999. These changes led to the restructuring of the health expenditures. From the available data and other explorative research we could not conclude with certainty that patients’ access to services has been limited as a result. This may have been more related to the under-supply of physicians observed in the same period as Slovenia remains one of the countries in the EU with the lowest physician/population ratios. This may become a limiting factor for the future delivery of health care and cause problems beyond presently observed stagnation in primary care [20].

7.4.2. Introduction of a social health insurance system and of additional sources of funding

Social health insurance seemed as the best or, in practice, as the only realistic option for all the key actors. It was introduced through a single central insurer and provided for good population coverage due to its universality. Initially, a lot of crit-
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icism existed around the creation of a 'monopoly' with only one provider granted this status by law. Still, the introduction of the CHI in Slovenia and its combination with SHI is regarded as an important achievement [21]. Slovenia certainly avoided some of the problems of fragmentation of the health insurance markets experienced in some other countries (e.g. Poland [22], Czech Republic [23]). Stability of health care funding offered room for reimbursement of new services and new drugs reasonably quickly. However, on the downside several controversies remain – strong state control over the HIIS, the power that the HIIS has in all negotiation processes and the tiresome process of achieving a compromise over tariffs in the annual contracting process. Other partners consider that annual negotiation for contracting purposes in minute details year in year out an unnecessary process. So far, Government has been closing almost all the open issues in such negotiations (as prescribed in such cases). The State decides on the budget cap for the overall yearly budget of the HIIS as the Ministry of Finance defines for them the same terms as for the national budget.

It was very important that the principle of fairness in income distribution and the related social contributions was applied to the area of CHI. Given there is no upper limit to the contributions the insured have to pay, CHI remains progressive. The sustainability of CHI became challenged by the adopted introduction of a new salary system in September 2008 (including all salaried personnel in health care) and by the deepening of the financial crisis, which is already causing a rapid decline in employment. This is worsened by the declining trend of public finance over the past five years in the THE. Financial crisis will in turn decrease the incomes of the health insurance and increase the expenditures both in health as well as in the social sector. As at present the age at retirement is still rather low, the Government is already planning measures to extend it to a minimum of 60 years of age. This is becoming inevitable in view of the forthcoming quickly advancing ageing projections. Future management of these issues at the national level will define what their impact on financial stability of health care may be. To preserve the current rights, the total contributions to the CHI will have to be increased - either through a higher contribution rate or, through additional sources, such as raising them on all types of personal income under the same conditions as salaries. Otherwise, the only way of coping with the increased needs may be through higher private and co-insurance solutions. Another option would be in redistributing spending through mixed financing schemes for long-term insurance, similarly as it had already been done for voluntary pension insurance, and consisting of a compulsory and a voluntary part.

Introduction of co-payments for health care services from the CHI turned into a very important issue and added a significant regressive component to the system. This regressivity was partly reduced by virtue of an almost full adherence of eligible adults to the SHI - the last official data from 2008 show that around 90% of the eligible adults hold a valid supplementary insurance. This insurance nevertheless remains a source of inequality and regressivity. Supplementary insurance against co-
Slovenian health care in transition payments, which exists also in some other countries (e.g. France [24] or Denmark [25]) provided for a solution to prevent excessive direct expenses. In the Health Reform of 2003 this situation was to be resolved by the gradual inclusion of supplementary insurance into the CHI. The State managed to keep inequalities, at least partly, under control as it introduced risk-equalising schemes to curb the overt cream-skimming [26]. In 2008, about 15% of the THE (or 1.3% of the GDP) was linked to the supplementary (‘voluntary’) insurance.

Contrary to the highly regulated area of co-payments and supplementary insurance schemes, the area of out-of-pocket payments remains unregulated. In the beginning of the 1990s these payments were estimated as ‘minimal’, which was due entirely to the lack of a monitoring system to structurally capture these data. As a percentage of GDP these expenditures have not changed over the last five years. The last report on the social situation in Slovenia from 2009 [27] shows that personal and household expenditures for health and health care are in decline when expressed in relative terms and there is no significant gradient across the three of the four income classes. There are several reasons for the nominal growth of these expenditures. One is in the unregulated area of long-term care, where shared responsibility exists between the health and the social care sector. As there is no long-term care insurance enacted yet, patients and their relatives depend partly on cash benefits and partly on own out-of-pocket expenditure. Another reason for private expenditure is the rising offer of services for direct payment (e.g. queue jumping for outpatient specialist visits). This is a result of active cost shifting to private expenditures, but also a result of inefficient resolving of waiting lists, where private providers fill in the gaps.

7.5. Conclusions

Slovenia’s story of the health care financing reforms following the socio-political and economic changes of the end of the 1980s and the beginning of the 1990s bears resemblance and differences to other countries in the region. We studied the changes in the financing of healthcare over the period of almost twenty years. In spite of the fact that this research was limited by the difficulty to obtain good integrated and high quality data, our main conclusion can be that Slovenia has successfully introduced a sustainable and equitable social health insurance system. This has insured stability to the functioning of the health care system and functioned in a favourable socio-economic context. In parallel with the CHI with its progressivity and strong state control over expenditure, the system owes a certain level of stability also to the development of the SHI, which is a regressive component in the Slovenian health insurance setting.

The main challenges for the future remain in the doubtful prospective sustainability of the present combination of funding sources. The continued trend of a decreasing public share in financing of health care is unlikely. This may be the result of the ongoing financial crisis and additional sources of equitable funding will be necessary. The alternative may be in shifting certain costs to the supplementary insur-
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...ance that may result in the classical vicious circle of increased premiums and consequent opting out of the insurance due to high premium costs. Additional increases in out-of-pocket payments are not likely to be socially and politically acceptable, especially as they may become a particular burden to the quickly growing population of the elderly.

A new reform process has been launched in 2009. This is the right moment to reflect on the best solutions for the future. A mixed public and private system of health care delivery, where transparencies of its efficiency, effectiveness and equity are ensured, seems the most likely preferred option. Higher throughput of the system, which is expected by the citizens and patients, will depend on the efficient management of all resources.

7.6. References

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