Slovenian health care in transition: Studies on the changes in the Slovenian health care system from 1985 until 2010
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In this chapter, the developments of the transition process in the Slovenian health care system will be discussed based on the findings presented in the previous chapters. In the first subsection, findings along the lines of the three central research questions and the conclusions from each separate chapter will be brought forward. This will be followed by a discussion of the methodological aspects and limitations of the overall thesis. The third subsection brings an interpretation of the findings, while the final, fourth, subsection discusses the implications for the stakeholders in health care in Slovenia and lessons that can be drawn for other countries in the region of south-Eastern Europe and in the area of Central and Eastern Europe.

8.1. Main findings

The thesis is composed of six studies addressing six topics, which represent three branches of health care organisation - primary care, hospital care and public health - and three governance functions in health care in Slovenia - human resource planning, privatisation of health care provision and health policy. Each of these topics was related to the three central research questions:

1. What were the developments in the Slovenian health care over the period of the last two decades? (the descriptive analyses)
2. What were the relationships between key actors in the system, their interactions and co-operations and their key decisions influencing the health system transformation? (the explorative analysis)
3. What were the consequences of the main developments in health reform and health policy in Slovenia? (the impact evaluation and analyses)

Answers to the first research question were provided in all six chapters where changes in the Slovenian health care system over the past 20 years were described. The changes were in part launched before the political changes in 1990, but most of them occurred between 1992 and 2000. The guidelines and the blueprint for the reforms were prepared at a national health strategy conference in 1990. Health policymakers opted for moderate changes without a major restructuring of the health care system or its components. Foreign authors and consultants saw the Slovenian health care system as a rather well functioning one but with potential for optimisation [1]. On the other end of the spectrum we have those who see changes as far too extensive and criticise - in particular - privatisation and rises in private expenditures. The latter are a focus of criticism from the Association for civil control over health care (in Slovene – Združenje za civilni nadzor nad zdravstvenim varstvom), who are explicitly opposed to further privatisation of any kind in health care and have influence within the biggest political party of the present government (2008-2012), the Social Democratic Party (www.socialnidemokrati.si).

Different factors influenced Slovenia’s health care reform. As proposed by Saltman and Figueras in an analysis of strategies applied in European health care reforms as codified in the Ljubljana Charter[2][3]1 Slovenia shares both of the contextual factors – the centrality of values and the macroeconomic context. Political and social changes of the end of the 1980s brought about a significant change in values. Moving away from collectivist principles and nominal solidarity, they became more individualised, both from the patient as well as from the provider side. Health policy and some key actors, such as the organised medical profession, were striving to have a health system driven by more individualistic values, including more private interests and initiatives. The economic crisis of the 1990s was threatening to endanger the foundations of a solidarity-based health care system. Public health challenges of that period included relatively high cardiovascular disease mortality and morbidity, successfully addressed by a nation-wide screening programme for cardiovascular risk factors starting in 2002[4]. Additionally, problems of injuries (especially traffic-related [5]) and the alcohol-related disease burden are still ranking high among public health problems. Due to the continuous and sustained rise in Slovenia’s health expenditures, doubts were arising about its sustainability and about the impact on the macroeconomic stability. This was a result of high increases in salaries of health professionals triggered by their dissatisfaction and strikes as well as of the inefficiencies in the delivery of health care. Such a conclusion is in line with the findings of Wagstaff and Moreno-Serra[6], who found an increase in the total health expenditures in countries with social health insurance (SHI), but a limited or no impact on general health indicators. Slovenia’s health care system, prior to the changes introduced in

1 Ljubljana Conference on Health Systems organised by the WHO European Office in Ljubljana, Slovenia, June 1996.
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1992, used to be a mixture of different models. Dominated by public funding, ownership, as well as by public delivery of health care, it had most features of a national health service with local and regional health authorities playing a key role in the system. Nominal user fees, then called ‘participation fees’, existed in the previous system and were seen as transferable into the new one.

Slovenia followed the patterns of the reforms in the region, but its economic advance was much faster and also much greater. These circumstances facilitated the creation of a rather generous social health insurance system, which gradually got more and more expensive in terms of nominal expenditure. In spite of such a trend, the public share started to decline as a result of macroeconomic demands for stability and based on the assumption that economic growth would nurture the demand for health care and potential of private co-payments. This fact was in line with the experiences in the neighbouring countries, e.g. Croatia (see also Vončina et al.).

Many so-called transition countries were exposed to external pressure, including different proposals on how to reform their health care systems. Others actively sought for foreign experiences and examples to be taken up. Slovenia was less exposed to foreign consultancy and external aid in the health sector reform in the 1990s, so the external impact on the developments in health care was minimal. The proverbial Slovenian self-sufficiency also played an important part. Most of the concepts and solutions were therefore the result of national decision making processes, starting from the strategic blueprint from 1990. The course of the reforms seemed to have been positive as Slovenia quickly showed better results than its neighbours [7]. The period explored in this study was marked by the following characteristics:

1. Politically motivated decisions in health policy.
2. The absence of a comprehensive health care strategy (in particular clearly specified goals and aims with defined targets and indicators).
3. Previously unrecognised shortages of medical doctors, dentists and nurses.
4. Privatisation as the most politicised topic at the expense of a more consistent definition of goals to be achieved in the process.
5. A public health infrastructure that has not transformed in line with the “New Public Health” ideas.
6. Improved hospital care as demonstrated by general indicators and a gradual reduction of the hospital capacity.

Changes in the relationships between the main actors in the system, which were the focus of the second research question, were described in Chapter 2, where the repositioning of the key actors in the health care system was the main focus, in Chapter 3 where the lack of co-ordination among actors was evident, in Chapter 5 where privatisation brought on board new actors to the system and in Chapter 7 where overall health policies and strategies were discussed. As the setup of the health care system had changed, so did the relationships between the main actors. The previous system was characterized by the crucial role of the MoH, while the relatively
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weak professional associations had a mere consultative role. A transformation took place towards a system with redistributed functions and a re-allocation of responsibilities. The medical profession ensured a prominent part in designing some of the core functions, such as the regulation of postgraduate training, planning of medical posts, medical supervision and audit and licensing of medical doctors and dentists. The change from a National Health Service system into a social health insurance system meant that the control over the health care budget moved away from the MoH. The State continued to keep the key levers for its overall control and planning. The Ministry of Finance at present controls and caps the overall budget for compulsory health insurance and by doing so influences also the supplementary health insurance. But the internal distribution of funds now belongs to a complex mechanism of partnership negotiations. These are composed of the HIIS, the association of public providers of health services, the professional associations, and the association of social care institutions, the association of spas and the MoH as an observer and moderator. The power of each of these actors/partners depends on their legal status, obligations and position in the system where the HIIS and the Medical Chamber are the strongest. The MoH keeps a lot of legal weight to monitor, influence or even overturn some of the decisions taken by these two important key actors, but that does not occur often. As a consequence of the difficulties in the mutual relationships between actors problems manifest themselves in the following areas:

1. overall health care strategies and priority-setting,
2. medical workforce planning,
3. hospital care financing,
4. primary care arrangements,
5. health policy formulation

The MoH clearly shows shortcomings in its ability to successfully define national health care strategies and explicit priority setting. This is a serious handicap as the country in 2010 has no long-term strategy for health care neither a comprehensive strategy for the human resource planning in health care.

The Medical Chamber of Slovenia (MCS) was given the authority to manage postgraduate training by the MoH. This came as another empowerment on top of those for medical audit, continuous medical education (CME) and licensing. The MCS is therefore the strongest actor in determining the development of medical workforce in individual specialties, the number of new medical specialists (thus influencing the overall numbers of medical doctors) and the level of requirements for CME and licensing. As a consequence shortages in medical manpower exist and are foreseen to remain in the near future and will have an impact on the development of all domains of health care. Availability of health professionals will be limited and there will be provider competition to attract them.

Hospital care financing and reimbursement mechanisms have been in the focus of health policy makers for more than a decade. Two major reimbursement reforms
have been carried out, the introduction of case-based payments and the introduction of DRGs. An Australian modification of DRGs was adopted and after the initial experiences it is clear that this system needs to be refined and uniform pricing only needs to be implemented. This should help resolve the imbalances that exist between Australian and Slovenian weights that are system-specific and reduce imbalances between hospitals, which now derive from the persistent differences in weights for the same DRG.

Primary care is under the authority of the municipalities, while the MoH keeps the role of moderating the process and securing additional funds for on call services, ambulances and incentives for demographically challenged areas of the country. The MoH tried to reconsider the responsibilities that municipalities have for primary care. Due to the strong lobby of mayors and their political weight, together with the legal interpretations of primary health care as an authentic responsibility of municipalities, the MoH left the regulation of primary care in place. Problems occur mostly because of the different approaches to privatisation where PHCCs are not seen as a rather unique and functional set of intertwined services, but rather as an obstacle to privatisation. This has led to important variations around the country, to marked conflicts between the MCS and the Association of public providers of health care (APPHC) with some municipalities taking sides, depending on the political setting.

After 2000, the shortage of medical doctors was recognised as objective and actions were started to mitigate it. Most notably this relates to the adoption of policies leading to increases in the number of medical doctors in Slovenia through either import of medical doctors from neighbouring countries or in establishing a second medical faculty in the country. In the end, a mixture of the two occurred. The import of doctors was not a state-led long term process, but a more ad-hoc response by providers in trying to overcome shortages of medical doctors.

One of the factors contributing to a weakened MoH was the insufficient development of the public health infrastructure. This is illustrated by the policy and health system support that these institutes could have provided had there been enough analytical power for estimation of epidemiological transition, proposing forecasts and monitoring the developments in health care. The public health institutes could not respond adequately to the challenges and opportunities and it has remained a sub-sector with the least formal changes over the past 25 years. There was a sustained effort to keep the status quo, with no real comprehensive transformation into ‘the New Public Health’ as discussed elsewhere. It was mainly the public health community itself who resisted the changes. There were some gradual and contextual changes, confined to selected areas, such as health promotion, monitoring of the health system and some initial efforts in health economics. A successful bridging of public health and health services was achieved through developing health promotion activities within the PHCCs as a service open to the whole population of its respective catchment area.

The third research question was answered through the exploration of the consequences of the health reform in Slovenia. Similarly as with the first research ques-
tion, elements of the answer to the third research question can be found in all chapters – in Chapter 2 the consequences of the lack of a co-ordinating body to steer the different strong actors in health workforce planning resulting in problems in reaching consensus between the key actors, primarily between the MoH and the MCS – these problems limit the flexibility of the system in responding to shortages of medical doctors, in Chapter 3 again a lack of operational co-ordination of primary care services resulting in difficulties in arranging replacements, on-call and night duty services in some areas of Slovenia – privatisation of primary health care delivery was promoted by the MCS as a solution for less attractive areas, but this has not materialised; Chapter 4 shows the two sides of the consequences of a lack of restructuring the public health infrastructure resulting in its slow adaptation to the principles of the New Public Health, insufficient professional development and shortages in policy support provided to the MoH; Chapter 5 studies the privatisation process and its consequences; while the process is characterized by moderation given the restrictive approach taken by the health policy makers, it still continues; Chapter 6 presents outcomes of the two policy interventions to restructure hospital resource and performance management, which had an impact on performance as measured by patient turnover and the average length of stay, and Chapter 7 deals with the reform effects on equity and efficiency in the health care system showing that overall the Slovenian health care system is both efficient and equitable although the latter might change given the present developments.

The most important new key actor since 1992 is the HIIS, which even if under the state control and supervision, acts rather independently on the state’s behalf. They hold a monopoly set by law for the compulsory health insurance (CHI) which was instituted to divert market fragmentation. The state continues exerting a tight control over the CHI budget as the Ministry of Finance involves and commits the HIIS in the preparation of the comprehensive national budgets. The void created by the shrinkage in public financing of health insurance was filled partly by the supplementary health insurance (SHI) and partly by pure out-of-pocket expenditure. These developments were in line with the trends in other countries (e.g. Croatia and Estonia see paragraph 8.3). SHI was introduced as effectively an insurance against co-payments (similar concepts exist only in Denmark and France). Slovenia was faced with another challenge – the overt cream-skimming attempts in the field of supplementary health insurance. This was reversed through the establishment of risk equalisation schemes [8]. The other problem that still remains is the lack of a cap on co-payments, which makes SHI almost ‘compulsory’ for chronic patients as they could still face significant costs.

An area that has clearly not been resolved yet is long term care. While some countries have since long tried to address this challenge in a sustainable way, Slovenia kept postponing a legal solution involving a separate social insurance system for long term care.

Primary care remains a priority for health policy makers in Slovenia. This is definitely in line with the international health policy developments on primary care.
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concepts [8] and policy [9]. An important conceptual change was the introduction of the selected personal physician or GP. This enabled patients (and all other citizens) to select their own personal physicians based on their own choice. The introduction of a personal physician concept together with his/her gate keeping role was well accepted [10]. Reforms of hospital reimbursement schemes led to shortening of the average length of stay and to quicker discharges of patients with a transfer of care to the primary level and an increased workload. However, primary care was not financially rewarded for these changes.

If we look at the outcome measures, especially at the healthy life expectancy at 50, which has recently been elaborated [11], we can see that Slovenia stands in the forefront of the new member states and lies, especially in the case of women, around the average of the EU. The interplay of different determinants influencing healthy life years at that point in life has been positive in Slovenia. Other generic outcome indicators, such as life expectancy and infant mortality clearly show a constant improvement. From studies of life expectancy we can see that the gap between Sweden and Slovenia got reduced in males from 6.25 years in 1993 to 4.33 years in 2007. Also in females similar improvements could be seen – 4.99 years between France and Slovenia in 1994, dropping to 2.55 years in 2006. In infant mortality in 2007 Slovenia was third after Sweden and Finland.

Slovenia avoided mass privatisation both in the general economy as well as in the health sector. Contrary to some other countries, the political situation was dominated by political forces, which preferred a more state- and publicly-owned infrastructure and financing based on solidarity through a state-controlled social health insurance system. Looking at the relationship between privatisation and unemployment and adult male mortality 1992-1994, we can see that Slovenia has not been significantly affected, even more; it lies below the average for the effects of privatisation [12]. One of the limitations of making too strong inferences based on that period lay in the fact that privatisation was still in its infancy at that point. Controversies continue over its pace and course. Most of the public’s attention is dedicated to the ways of how private delivery of services, especially the part which is financed from public funds, is going to be monitored, evaluated and audited. This concern is shared by external observers and analysts as well [13]. On the other hand, the rising share of private expenditures for health is clearly showing a growing trend. This is certainly a matter of concern, especially since the bigger out-of-pocket and other private expenditures on health are clearly regressive [14] and represent a major challenge to the solidarity in the Slovenian health care system.

8.2. Methodological aspects

This thesis was developed around three sub-segments of health care and around three important topics for health system development in Slovenia over the past two decades. There has been a shortage of studies that comprehensively address health system changes in Slovenia in the period of political and socio-economic transition
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(in the 1990s and in the 2000s). In this sense, this thesis is trying to contribute to filling this void. Several segmental and sub-sectoral analyses were carried out, mostly dealing with financing, reimbursement and privatisation of health care delivery. The context of the changes and the actual transformations in each of the sectors is also described in detail in the series ‘European Health Systems in Transition’ [15], where the author of this thesis acted as the key author of the book on Slovenia.

In this thesis a number of different methodologies have been used for data collection. Firstly, one of the cornerstones of this research is a study of legal, policy and policy related documents. Analysis of the legal documents was an important activity in the exploration and description for this thesis and it has been used in all six studies. Some policy goals were defined more through legal acts than through a health care strategy, which followed only much later (the National Health Plan – Health for All by the Year 2004). In some cases the legal framework had only been a precondition, while in others it served as the backbone of its setup and functioning and, consequently, of the analytical framework used in the study. The socio-political setting and policy documents completed the picture of the different identified periods in which reform processes were unfolding.

Secondly, a survey was carried out amongst managers of PHCCs consisting of closed, combined and open-ended questions. The survey provided also some quantitative data on workforce and service development. Thirdly, semi-structured interviews with key stakeholders were used, a method employed in the study of medical workforce planning (Chapter 2) and in health policy and health reform developments (Chapter 7). In both of these two studies interviews were used as a research method. They provided the source for positioning of each stakeholder and to study their inter-relationships. This way interviews contributed to the validation of the contextual analysis.

A particular issue was the author’s personal involvement in some of the activities otherwise studied in this PhD research work. This could have led to potential biases, which were addressed in several different ways:

1. Where possible routine statistical data were used to provide a solid quantitative background to studies in this thesis such as on the developments in health workforce (Chapter 2) and the efficiency of hospital treatment (Chapter 6).
2. Surveys and interviews were used as information base (Chapters 2, 3 and 7).
3. Validation of the findings in explorative work was sought through the involvement of external reviewers, experts, who provided additional feedback, criticism, comments and suggestions, especially in Chapters 4 and 7.
4. An existing taxonomy and typology was used for the study on privatisation (Chapter 5).
5. Health policy reform changes were analysed by combining routine health and economic statistical data, reports on the developments in the social sector and through participatory observation of the processes, including semi-structured
interviews with representatives of all key stakeholders in the health care system in Slovenia (Chapter 7).

Several limitations should be noted with respect to the different studies presented in this thesis as well as changes occurring after studies were published:

1. The particular period of study, such as was the case of the health workforce study, where no clear policy preference existed for the potential solutions to the management of health workforce at the national level.

2. In the case of survey data we were limited by exploring only the side of the management of PHCCs themselves and not the positions of their counterparts in the system – the municipalities, independent practitioners and the HIIS.

3. We excluded the financial performance data from the public health infrastructure study, which would show a clearer picture of the transformation of services and the big variation in public funding. However, this was done by other authors previously and their findings were referenced in the research shown.

4. Changes in the hospital care were observed using the only dataset that ran for more than ten years and provided for an insight into rather delicate changes in certain periods. Due to the richness of data and the enhanced motivation of providers, it would be useful to be able to analyse the same period with the DRG data, but that particular dataset covered just a few years’ time (only after 2003).

5. Finally, all analyses that included some general population health indicators and some economic indicators were at the same time limited by their availability.

8.3. Slovenia’s similarities and differences in comparison with the other countries of central and Eastern Europe (CCEE)

In comparing Slovenia with the other CCEE, we can see the following similarities:

1. Adoption of the social health insurance model
2. Reducing the capacity of the hospital sector
3. Redefining reimbursement of providers
4. Privatisation of health care delivery
5. Devolution, delegation and decentralisation

In Slovenia the adoption of the social health insurance model was linked to its long history dating back to the 1890s when the Austrian Empire adopted the social health insurance soon after Germany. In a recent article Rechel and McKee [16] analyse health reforms in the entire area of central and Eastern Europe, including the former Soviet Union. Through the presentation of the basic population health indicators, we can see large disparities across the entire region, Slovenia mostly performed as the best in the region. This is in line with the large gap in health expenditure per capita (HE per capita) in 2007, where Slovenia was ahead of Croatia, Czech Republic or Hungary by more than 60% and Slovenia’s HE per capita was more...
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than 6 times that of Romania. Life expectancy followed the economic power of countries, except in some well known cases (e.g. Albania). In the same year inverse rankings were recorded in the case of infant mortality, where Slovenia and Czech Republic were best with 3.3 and 3.2 infant deaths per 1,000 live births respectively. Hussey and Anderson [17] discuss options for reform through a comparison between single- and multi-payer health insurance systems. They clearly stress advantages of single-payer health insurance systems in those countries where tax systems are well-functioning. They have an advantage in the efficiency of collecting revenues, overall cost control and the capacity to subsidise health care for low-income individuals. These also formed the basis of the rationale for a single-payer health insurance system also in Slovenia.

Slovenia’s first neighbour from the Yugoslav federation, Croatia, established a very similar system of social health insurance, based on a strong single central insurer, which, in their case, also controls the complementary health insurance [18]. Their share of health expenditure in GDP is higher than that of Slovenia and other countries in the region. On the other hand, health expenditures were under a lot of pressure by the IMF, which resulted in a reduction of nominal health expenditures by 9% between 2000 and 2002. Croatia nevertheless preserved a higher percentage of publicly funded health expenditure than Slovenia. Contrary to Slovenia, Croatian complementary health insurance accumulated high losses due to adverse risk selection. On the other hand, Slovenia’s containment of public expenditures for health care resulted in a slightly declining share of health expenditures in the GDP, which were presented in Chapter 6.

Comparing expenditure trends with the developments in Estonia, we see some similarities between the two countries. The most important among them is the declining share of public sources of financing, in both countries due to a decline in the social health insurance’s share. The main difference between the two countries lies in the bigger share of taxes in the total health expenditure in Estonia. In all three cases, we have comparable countries with one central insurer (‘Fund’) for compulsory health insurance. Because of its smaller size, Slovenia did not follow the idea of opening the market for compulsory health insurance. The downside of this approach - otherwise taken up also by Estonia, Lithuania, Croatia, Romania and Bulgaria – is in the creation of a strong stakeholder, which is also financially powerful and develops into an independent policy making force within the health care system. This in turn requires health policy makers to concentrate on controlling these entities more vigorously.

As we have seen in the chapter on hospital care, the capacity of the Slovenian hospitals was not as large as in other CCEE and, consequently, no major reform has taken place yet. Developments in hospital reform in central and Eastern Europe were dealt by Healy and McKee [19], but they did not choose to discuss Slovenia in their analysis. They present a number of conceptual issues, especially those related to the development of democratic decision making processes in these countries, as well as
the changes carried out in the hospital sector in the 15 countries studied. Contrary to the strong role of the central authorities in the countries of the region, in Slovenia the state’s role was influenced by the strong political pressure of the local authorities. This was particularly clear in their interests to prevent the closing down of hospitals or even departments. This is in clear contrast with the reforms in Estonia, where there was strong political will to rationalise the formerly inflated hospital sector [20]. As Slovenia had not introduced a regional administrative structure it could not follow on the reforms, such as the one in Slovakia in 2003, where the management of a large part of public hospitals was transferred to the regions [21]. Slovenia also did not have such a large hospital capacity as some other central and Eastern European countries. Hungary is a good example of the inherited situation with more than 10 beds per 1000 population in 1990 [22]. This gradually reduced through a process of regionalisation, where regions were made accountable for their own hospital sector.

Reimbursement of providers is a frequent topic of health policy discussions. In terms of the entire health system, there were two principal changes – introduction of weighted capitation in the primary care and introduction of case-based payments and, later, of DRGs into hospitals. As Slovenia adopted the gate-keeping concept in primary care, capitation seemed a natural choice for reimbursement. It was not so much about preventing a higher number of visits as these are comparable with the EU-15 countries. Other challenges surfaced on the provider side – one was in outsourcing of laboratory and other diagnostic tests to the outpatient specialist services and the other in hospitals, where a solution was sought to replace the previous system of bed-days, which resulted in long and unnecessary hospitalisations. DRGs were introduced through a top-down process on the initiative of the MoH. Advance warnings about the adverse effects of DRG introduction later materialised in coding issues where hospitals found ways of curbing the system through inappropriate coding practices (the so-called ‘DRG creep’). This was clearly a problem also in some other CCEE, as Moreno-Serra and Wagstaff [23] explain, mostly in those who adopted simultaneously a DRG system and reimbursement of GPs by capitation. Systematically, ‘DRG creep’ was studied only in Hungary [24].

Privatisation is another common feature of all countries going through the socio-economic and political transition process. It is a process which was intended to reverse the effects of nationalisation and expropriation of private property in the former socialist countries. In Slovenia the issue of privatisation has always been an important political battlefield of health policy makers. While there was a rather broad agreement that compulsory health insurance would have to remain under full public management and control, there was less consensus over the privatisation of health care delivery. Privatisation remained focussed on primary care and outpatient specialist care. The extent and aims of this process have remained undefined and a source of controversies. While some authors considered privatisation an option for less interesting medical posts, others regarded any type of state interfer-
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ence in this ‘market’ as inappropriate or even not permissible. Overall, privatisation of health care delivery in Slovenia is modest compared to countries like the Czech Republic, Slovakia or Estonia. When comparing only primary care delivery with the countries in south-eastern Europe, higher percentages of private providers are present in Croatia and Macedonia (between 70 and 85%).

Transfer of powers from the MoH to other actors in the system was not an exclusive or unique feature of the health care reform in Slovenia. It was present in other CCEE, most importantly in those coming from the experience of centrally planned models of health care. As Yugoslavia had completely devoluted and decentralised its health care system in the 1970s, Slovenia brought this experience as its heritage into the independent state. Primary care in Slovenia is in the hands of municipalities, both in terms of control and distribution as well as in financing its infrastructure in public institutions, such as the PHCCs. There were concerns expressed over the course of devolution when there was a rapid fragmentation of the former municipalities as their number rose from 65 to 210. It was clear that the smallest among them would not be able to meet the challenge of administering these services and would be unable to attract health professionals into certain rural areas. A common and one of the most controversial issues is the delegation of some of the former state functions to the respective associations and chambers. This is the case of the transfer of postgraduate training of medical doctors to the Medical Chamber of Slovenia where the MoH kept only a minor regulatory role in the process. This phenomenon is not limited to Slovenia, but is strongly present also in other countries, such as the Czech Republic or Slovakia and in the area of former Yugoslavia.

Which are the differences between Slovenia and the countries in the region?

1. Primary care reform
2. Public health development
3. Size of the health workforce and the resulting interventions

In contrast to the central planning model of the countries of the Warsaw pact, Yugoslavia introduced a strongly decentralised model, based on an important role of municipalities. One of the important features of this system was the concept of the primary health care centres (PHCCs), which originated in the 1920s. The other important difference was in the setting up of a new concept of a generalist physician with a structured training for GPs emerging in Slovenia and Croatia. Both were conceptually different from the polyclinics and physician profiles developed under the Semashko concept. PHCCs were following principles of health education and health promotion and were putting them into practice in a different economic, social and historical context. There was no immediate strive for a comprehensive reform of primary health care as for example in the Baltic states [25], in particular in Estonia[26],[27] and in Lithuania[28]. In Estonia a complete restructuring of primary care took place, including the new concept of a family physician, new payment methods and service contracts for family physicians. In Lithuania the change fo-
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cused on the re-training of all physicians in primary care, especially the district paediatricians, who lost most of their roles to two processes – the demographic changes and the new paradigm in primary care. The comprehensive GPs in Yugoslavia were promoted through PHCCs. Slovenian and Croatia became the first countries to introduce structured specialty training for GPs [29], later to be picked up by Yugoslavia as a whole. In the 1990s in Serbia the primary care reform had several phases [30] with the basic infrastructure remaining preserved, including the concept of different specialists for target populations (e.g. paediatricians for children, gynaecologists for women, etc.). PHCCs brought paediatricians and gynaecologists to the primary care level and required the typical organisation PHCCs. Continued formal support from health policy for the further continuation of PHCCs raised controversies with the MCS. They believed that PHCCs as public institutions were ‘obsolete’ and should be replaced by clusters of single-handed practices merged by common interests. The other conflicting issue was the development of GPs as family physicians, limiting the influence of both paediatricians and gynaecologists. These two dilemmas remain unresolved to date and are highly politicised.

Developments in public health in Slovenia have so far been more similar to those in the area of former Yugoslavia than in other central and Eastern European countries. Most of the pre-transition structures in the public health institutes remained in place. Changes and new concepts, such as health promotion and health interventions in the local communities, have been successfully launched. These actions were steered by the MoH and supported by additional funding from the national budget, but it still took 8 years to pass between the launch of the health promotion as a concept until it got institutionally supported by the MoH. Interventions were focussed on promoting lifestyle changes and on setting up of screening programmes (cardiovascular risk factors, breast and colon cancer). The role of the national institute was co-ordination of activities and conceptualising interventions, while regional institutes worked on the practical implementation. This is where successful co-operation between the regional Slovenian public health institutes and the network of PHCCs was established.

Health workforce and its shortages, especially in the case of medical doctors, dentists and nurses, is a feature where Slovenia differs from almost all countries going through the process of transition. Contrary to the countries coming out of the Semashko’s health care system and contrary to most of the former Yugoslav republics, Slovenia kept a tight control on the number of admissions to all faculties educating health professionals. Depending on the movements of health professionals from other parts of Yugoslavia, Slovenia experienced additional shortages with the outbreaks of war conflicts in Croatia and Bosnia and Herzegovina. Slowness in response to this challenge is still felt through widespread shortages of physicians and dentists. Though an important share of health professionals currently practicing in Slovenia got their degrees abroad, the approach to solving shortages was in securing sufficient numbers of health professionals through domestic production. Immigra-
Slovenian health care in transition was significant in the period 1996-2005, after which it shows signs of gradually slowing down. Health policy implications of the shortages and of the approach to solving them reflect in the following problems:

1. Difficulties in filling medical, dental and some nursing posts in primary care and in some general hospitals.
2. Increasing demands on providers to actively search for innovative solutions on securing certain services through subcontracting and outsourcing, mostly with individual specialists (e.g. shortages of radiologists cause outsourcing needs in securing the continued service)
3. Pressures on salaries due to a bigger workload, particularly in smaller environments, such as smaller PHCCs and smaller clinical departments in general hospitals. These pressures resulted in significant increases in salaries in the period 1996-1999 and again in 2008-2009.

When dealing with human resource planning and lacking a health care strategy, there were concerns related to the accession to the EU due to the possibilities for mobility of health professionals [31]. There are several projects currently underway (e.g. Health Prometheus2), which are going to objectively explore the extent of health professional mobility in Europe. Health Prometheus showed that almost 22% of currently active medical doctors and dentists in Slovenia graduated outside of Slovenia (mostly in one of the countries of former Yugoslavia) and the majority of them immigrated into Slovenia before 1992.

8.4. Implications for stakeholders in the Slovenian health care
Findings presented in the six chapters hold a number of implications for the different stakeholders and they are presented below separately for each of the stakeholders.

8.4.1. Implications for the Ministry of Health (MoH)
The MoH has become a handicapped driver in the driving seat of the health system in Slovenia. It has been clearly incapable of protecting its governance and stewardship roles, while powers were transferred over to different, old and new, stakeholders in the system.

1. Today the MoH has a rather limited role in intervening in the issues and policies dealt with in this thesis. This is particularly true for medical workforce planning policies, which are currently one of the key issues of the health system (in)stability.
2. The MoH in its governance position needs to keep its regulatory role in preventing two adverse effects of inadequate medical workforce planning policies – delays in accessing care and equity considerations due to inadequate distribution of health professionals in the country.

2 Health Prometheus, a project running between 2009 and 2011 with the co-funding of the DG Research of the European Commission
3. The MoH should intervene when an insufficient number of specialty training posts is causing delays in accessing care. The self-regulatory role of the MCS includes its responsibility for securing all the required types of medical specialists for the needs of the publicly financed system. But this is often perceived as too limiting and often also too self-centred.

4. Primary care delivery is the second area where the MoH’s influence is limited as this is the function and responsibility of municipalities. But in protecting an adequate distribution and equitable access across the country, the MoH has the responsibility of correcting inadequacies occurring because of inappropriate decisions by the municipalities.

5. Remodelling of the hospital reimbursement systems is a rather successful story, where the MoH could take up a leading role due to the almost exclusive State ownership of almost the entire hospital care infrastructure.

8.4.2. Implications for the health insurers

1. The only public insurer, the Health Insurance Institute of Slovenia (HIIS) has responsibilities, which enable it to have a considerable impact on the functioning of the health care system in Slovenia.

2. Through their budgetary planning activities they directly and indirectly define the extent of the health professional workforce in the country as professionals are mostly salaried and financed predominantly through public funds.

3. Primary care, which is a continuous health policy and health system priority, can only prosper if adequate funding is secured for an evenly distributed service across the country. The HIIS is less concerned with the micro regulation of health care provision at the primary care level since this is a task for the municipalities and, ultimately, for the MoH.

4. Even as being a public entity they impact the relationship between public and private providers at the primary care level as they commission contracts from both groups of providers. This way the HIIS assumes also the responsibility for the preferences expressed through selective purchasing. This is still in its initial phases in Slovenia, but it may become an important influencing factor in the near future.

5. Insurance companies, which sell supplementary insurance, need to be aware of their public mission [32]. As supplementary insurance is an insurance against co-payments, it means that it is closely linked with the compulsory health insurance. The latter determines the full effective price and thus influences directly the expenditures on the supplementary insurance side.

8.4.3. Implications for health professionals

Long term shortages of health professionals, especially medical doctors, dentists and nurses are foreseen.
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1. In the case of medical doctors, the relief will arrive through increases in admissions to the first medical faculty in Ljubljana and through graduates of a recently established second medical faculty in Maribor.

2. A rapidly growing network of nursing schools is in place as deficits of nursing professionals were affecting the normal functioning of the health care system, especially in hospitals.

3. A significantly increased role of the professional associations in the health care system was important due to their new self-regulating role and became comparable to the neighbouring countries (especially Austria and Germany). This issue is now being reconsidered due to the controversies about the power and influence of the professional associations (‘Chambers’).

4. With the MoH having a limited role in solving shortages of medical doctors and their inadequate distribution in the country, currently the main levers to steer these processes are with the MCS.

5. The regulated professions gained the possibility of moving into an independent status, which enables them to get a contract with the compulsory health insurance. Even if this process has been slower in Slovenia than in some other CCEE, it has still led to some important shifts in the delivery of health care services, especially making it more flexible in outpatient specialist care.

8.4.4. Implications for the public health institutes

The failure to structurally reform public health institutes (PHIs) had a number of consequences:

1. PHIs have only slowly adopted some of the recent concepts of the New Public Health agenda, which has limited their adaptability under the new health care system.

2. As PHIs have policy support and development as one of their mission, their slower adaptability has led to inefficiencies at the health policy level (also with the MoH).

3. The NIPH will need to redefine its strategy and give priority to the changed needs and expectations of all users of services, from the MoH to citizens.

4. Regional PHIs will have to further develop their co-operation with the PHCCs as they have the leverage for coordination of health promoting and preventative activities.

8.4.5. Implications for the health care providers

There are three types of health care providers after the reform of 1992 – public providers, private providers working for public funds under a concession and private providers, which are for-profit and working predominantly for private funds. Challenges that the new system poses are grouped accordingly:
1. Public providers are facing competition for the same funds, though the whole system is regulated through limited expansion in the number of providers. At the local level they typically depend on the local political situation – sometimes they are favoured by the policymakers, sometimes handicapped.

2. Private providers working for public funds got possibilities to compete for these sources of finance through a high level of regulation. In the outpatient specialist services this shift from for-profit to a not-for-profit system has been quite significant.

3. Private providers working only for private funds are mostly present in dentistry, but also in some specialist outpatient care services. Primary care is not attractive for purely private providers due to its full coverage under compulsory health insurance. Providers are generally facing several challenges:
   1. The strong role of the HIIS as the only financier of the publicly funded health care.
   2. Shortages of health professionals, especially medical doctors and dentists, but currently still nurses. This is particularly demanding for providers in remote areas and those who have limited possibilities of providing additional incentives.
   3. Publicly owned providers are rather rigidly controlled by their owners, either state or municipalities. The levers of modernising management are still very limited.

8.4.6. Implications for citizens

Involvement of citizens and patients in the development of the health system and health policy reforms in Slovenia was quite limited. The problem lies in the rather limited representation of citizens and patients in the decision making bodies of individual stakeholders and key actors of the health care system. All key actors claim they play a role in representing citizens and patients or, at least, in defending their rights.

1. The HIIS has an assembly with the representation of the insured where 25 out of 45 are occupied by the insured. Most of them are nominated by the trade unions, patient organisations, organisations of pensioners and the handicapped. In that sense ‘user’ or ‘consumer’ interests are represented in the highest decision making body of the compulsory health insurance.

2. The MCS claims to defend patient rights through its own complaints’ procedures. But in some of the recent situations these procedures have not proven to be really independent, but strongly motivated by the interests of the medical profession.

3. Finally, the MoH claims to defend the interests of patients and citizens as it is required to secure equal access to health care both in terms of geographical dis-
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Distribution as well as in economic terms. Given their limited influence these missions are proving to be increasingly difficult.

Even such a varied structure proved to be insufficient to protect patient interests, which is why the Patient Rights’ Act was adopted. It defines in particular patient involvement in the decision making processes that concern their treatment. Given all problems with complaints procedures with all key actors and at all levels, it is important to stress that a ‘non-fault’ complaint procedure was instituted. Involvement of patients in the development of guidelines remains an unfinished task.

8.5. Implications for other countries in the region

1. One of the most important lessons based on the study of the transition and the transformation of the Slovenian health care system is in the rather successful changes, introduced without a complete dismantling of the old system.

2. Slovenia approached shortages in human resources for health by seeking solutions that would stabilise its workforce market through domestic production. Foreign doctors were an important addition to the system between 1997 and 2005.

3. Stability of primary care services was ensured partly through the preservation of the network of the PHCCs, which proved its vitality by taking up tasks related to health promotion in the community and thus redefining their mission. It would have been surprising if they had been eliminated simply to satisfy the ideas of a system of fragmented single-handed practices, based on the dominant role of medical doctors.

4. Public health infrastructure rigidity may not serve as the best example but it does provide some positive experiences in introducing elements of the ‘New Public Health’ agenda, such as health promotion in the community and interventions in improving lifestyles at the regional and community levels.

5. Privatisation is a topic where Slovenia has been more cautious than most other central and Eastern European countries. With its limits to privatisation of health care delivery it shows how the system can remain rather stable and affordable through mixed provision.

6. An important privatisation lesson for the countries in the region is that Slovenia left very little room to for-profit providers with the exception of dental care providers. This way it avoided the setting up of a parallel system of for-profit providers.

7. Hospital care was transformed by combining gradual restructuring and changed reimbursement mechanisms, which still yielded significant improvements in terms of shorter ALOS and bigger patient turnover and a shift to day treatments.

8. Due to its recent history and previous system characteristics shared with the area of former Yugoslavia, Slovenia could serve as a potential role model for these
countries’ reforms. A number of positive experiences could potentially be used. This is particularly true of the solutions in health promotion in primary care, innovative solutions in the reimbursement of primary and hospital care and in addressing the topic of human resource management at the national level.

Slovenia reformed its health system in a gradual way through a slow transformation of the primary care setting, stepwise privatisation of health care delivery, reform of hospital reimbursement systems, while responding slowly to the shortages of health professionals and incompletely reforming the public health services. The past developments can be evaluated as successful, but in future there will be a need to adopt a long term health care strategy, including a health workforce planning mechanism, in order to ensure the an equitable and efficient health care system and its sustained functioning and financing in order to preserve its positive trends from the past 20 years.

8.6. References
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