Slovenian health care in transition: Studies on the changes in the Slovenian health care system from 1985 until 2010
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In a period of complex social, political and economic changes health care system reforms played a prominent role over the past decades on the policy agendas in Central and Eastern European countries. Slovenia was no exception to this widespread reform wave. It followed a cautious path of slow changes and several segments of the organisational structure of the old system remained. This thesis describes and explores reforms and change processes on six different topics of the health care system over the past 20 years, putting them in the context of socio-economic trends and regional developments.

Chapter 1 serves as the general introduction to the thesis. It presents a brief outline of Slovenia’s geographical and economic characteristics and of its historical development in health care. It then continues with the description of different health care and health insurance systems, in order to provide a framework for selecting the six topics explored in the thesis and presents the three central research questions:

1. What were the developments in 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)
On each of the individual six topics - health workforce planning, primary care organisation, public health infrastructure, privatisation of health care delivery, hospital care reimbursement reforms and health policy developments - the three research questions are addressed. But in doing so, also additional topic-specific research questions are raised and addressed.

Chapter 2 looks at medical workforce planning and presents a detailed description of the contextual framework, quantitative data on medical workforce development, results of interviews with representatives of key stakeholders and outcomes of a study of relevant policy documents. The contextual framework is based partly on the legal setting of the system and partly on the study of relevant policy documents. Quantitative data illustrate the developments in medical workforce over time and reflect the different policy approaches taken. The State reduced its influence through the delegation of a number of tasks to other stakeholders and disagreements appeared on how to pursue the future medical workforce planning. This became of increasing importance given the arising shortages of medical doctors in Slovenia. A solution to this problem was proposed by forming a national body linked either to the Ministry of Health or to the National Institute of Public Health, which would be responsible for the co-ordination of activities in the field of medical workforce planning in Slovenia. This would be of particular importance in order to address the remaining interregional differences in health care provision. A looser state control over the educational and health care systems, together with the independent position of the professional groups, may lead to imbalances over a longer period.

In Chapter 3 changes in primary health care centres (PHCCs) over the transition period are explored. This is done by means of a survey carried out amongst the managers of PHCCs. 57 questionnaires representing PHCC catchment areas covering 93.7% of the Slovenian population were obtained. The position of municipalities’ versus PHCCs was reinforced but their role remained ambiguous. While the number of employees in PHCCs was reduced by one third and the scope and volume of services shrank, the capital investments were still ongoing. While PHCCs survived well the transition process both structurally as well as functionally, much has been left to local solutions as national guidance has hardly been provided. This is particularly true for the unstructured approach to system changes in primary care, a poorly managed process of privatisation and creation of a monopoly position of the HIIS. All of these gave rise to tensions at the local level, where problems should normally be resolved. PHCCs will need to focus on facing and addressing future challenges, most importantly preserving and expanding their public health functions, increasing efficiency and establishing clearly defined relations with private providers.

Processes in the restructuring of the public health infrastructure are discussed in chapter 4. While at the beginning of the health care reforms, public health was supposed to be one of the foci of the reform process, it was later decided that it should remain intact. The chapter presents the results of an in-depth analysis of legislation,
policy documents, research reports and other health policy papers related to the public health infrastructure in Slovenia. Findings were validated through consulting three external experts on public health in Slovenia. Changes in the public health infrastructure were very limited; only few new services were added and health promotion was developed as an institutionalised field. Much effort was devoted to finding alternative sources of finance, instead of reinforcing national budget funds or improved governance. New developments mostly focussed on the building of additional capacity, such as in health promotion, which raised hopes that some investment will take place to orient Slovenia’s public health infrastructure more to the New Public Health agenda. Contrary to most other central and Eastern European countries, Slovenia did not choose to restructure its public health infrastructure, but rather gave it a face lift. This means that public health institutes will still require attention on increased efficiency, professional workforce development (nationally and internationally and including networking) and better responsiveness to public’s and health policy needs.

Chapter 5 deals with privatisation of health care in Slovenia over the period of almost two decades following the political changes. In this study background and nature as well as the facilitating and hindering factors of the privatisation process in health care in Slovenia are analysed. As one of the key priorities of the overall political changes and as an important ambition of organised health professionals, it received a lot of attention by the general public as well as amongst professional circles. What happened in Slovenia was a gradual process in which elements of entrepreneurship have been introduced into health care. The analyses are based on an internationally accepted taxonomy against which the situation in Slovenia was analysed based on available legal and policy documents. Similarly a description of the scope and volume of the different types of privatisation was made. As the focus in privatisation was on primary health care (in 2008, 30% of private providers in GP, primary paediatrics and school medicine services) and health expenditures, controversies continued over its extent. Privatisation of delivery of dental care was much more intense since 60% of all providers were private in 2008. Against the background of public debate on privatisation of health care delivery the increase in private expenditures for health services reached 27% of the total health expenditure in 2007. Privatisation initiatives were strongly politically motivated and depend on the political will either locally (with municipalities for primary care) or nationally (with the MoH for all other services). Privatisation of the public health infrastructure and management has so far been marginal. On the other hand, there are strong concerns about the future course of privatisation, especially related to equity, fairness and solidarity.

In chapter 6 hospital care is studied, specifically focussing on hospital capacity and overall performance measures. This study describes the organisation, management and developments in the volume and types of care and explores the consequences that two policy interventions – introduction of case-based payments and the diag-
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diagnosis-related groups (DRGs) had on the average length of stay. For this study, routine statistical data prepared by the National Institute of Public Health, as well as strategic and planning documents of the health care reforms were analysed. The two major reimbursement changes were taken as milestones, which split the observed time frame into three distinct periods. The latter were compared by carrying out a regression analysis. After 20 years of a process of reforms, privatisation of health care delivery and its diversification, hospital care remains state-owned and controlled. There are only a few smaller private in-patient providers with a limited number of diagnostic and therapeutic procedures (mostly those that can or may reduce waiting lists!). Capacity in terms of hospital beds shrunk considerably as hospitals had to face several reimbursement reforms. With a reduction of hospital beds of around 20% and with a simultaneous increase in the number of cases by almost 18%, a significant move was made towards more efficient and more performance oriented hospital care in Slovenia. This resulted in a shorter average length of stay (ALOS) and in an increased turnover of patients. While some believe that this has still not been enough, it can be seen as an important achievement of a still totally publically owned subsector in health care. All of this significantly contributed also to the reduction in waiting lists, especially for the procedures that were favoured by the health policy priorities. However, all hospitals and all their departments (except one!) still remain in place and no initiative to limit the scope of services of any hospital has ever been successful. Comparing the period 2001-2003 with the period 1997-2000 five variables (diagnosis of a complication, male sex, death of patient, clinical hospital, general hospital) were predictors of a reduction in the ALOS, while in the comparison between the period 2004-2007 and 2001-2003 only male sex and death of patient predicted the reduction of the ALOS. The two reimbursement (case-based payments and DRGs) reforms contributed to these processes to an important, yet not decisive, degree. This comes partly as a surprise since the introduction of DRGs had been promoted as a significant step towards more efficient hospital care, contributing to shortening of waiting lists, among other outcomes. Some of the outcome indicators, such as the ALOS or the hospital throughput, definitely show significant improvements, greater than those previously elaborated and it has all been achieved in an almost exclusively public system.

Chapter 7 discusses how health care policies in Slovenia over the past two decades tried to balance equity and efficiency. 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. Focussing 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 period observed are also presented, while the broader policy context
was assessed through participatory observation and the use of semi-structured interviews with key national health policy makers in 2001 (the latter serving as a sort of a mid-term review). In spite of the different national policy processes running concomitantly (some of which were not favourable to health expenditures!), Slovenia managed to keep sustainable health care financing at around 8.5% of GDP. However, this has been done at the expense of a declining trend in share of public funding, which was in part compensated for by the supplementary health insurance and, in part, by the rapidly increasing out-of-pocket expenditures. The latter two categories clearly introduced regressivity to the system. This was corrected by subsidising some preventative and health promotion programmes from the national budget, by the introduction of risk-equalising schemes into supplementary health insurance and by subsidising supplementary health insurance to the least well-off. All of these processes were nurtured by a period of favourable economic development that enabled system’s stable financing and elasticity for additional private expenditures. In the 1990s one of the key measures was in restricting the capacity of health care providers and reinforcing the strong role of the single central insurer. There were fewer pressures on the system also due to the improved general conditions for population health. It is evident that the present financing scheme is unlikely to be sustainable due to demographic trends and other drivers, which are increasing unmet needs. Slovenia’s health care transition took place during a period of favourable economic developments, which enabled stable financing and by restricting the capacity of health care providers. Such an environment assisted in improving the general conditions for population health, thus reducing the pressures on the new system. The previous system transformed into a mixed social health insurance based system, based on the single central insurer, supplemented by a number of insurers, who offer insurance against co-payments or, the supplementary health insurance.

In the last chapter, Chapter 8, the Discussion puts the findings of the research process in the context of the three research questions. The main findings could be summarised in the following points:

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 was 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.

Slovenia was able to achieve significant advances in the population health status during the process of intense socio-political and economic changes. It went through
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a process of health care system transformations, which were the result of political preferences, which in turn defined their limited scope and depth, especially in comparison with other countries going through a process of socio-economic transition. This brought about a more moderate process of change, less difficulties in the functioning of the public arm of health care providers and in the gradual development of the private sector working under public funds, thus preventing some of the adverse effects of privatisation known from other countries. Such developments were particularly important in view of restrictions imposed by the health workforce shortages, shortages in public funding of health care and in solving long-term sustainability of the publicly financed health care.

One of the key political and health policy development issues is the harmonisation of relations across the key actors in the system. As much as delegation and devolution of powers and competencies followed the overall trends in Europe, they caused important difficulties in processes of the day-to-day functioning of the health care system. The central conflict in that respect is the conflict between the public interests expressed by the official state policy (MoH) and the organised health professionals represented by the various professional associations.

Shortages of health professionals, inadequate co-operation of key actors in managing primary health care delivery, unclear aims of the privatisation processes in health care delivery and expenditures, insufficient transformation of public health institutions and the need for further improvement in hospital care efficiency are all issues that remain unfinished after the first two decades of the transition and health reform process in Slovenia. As they form cornerstones of any health care system they will need to be revitalised and restructured for a more efficient and successful health care system in the next decades. While significant improvements could be identified in the field of hospital performance and primary care functioning, health policy makers were slow and undecided in responding to the challenges of privatisation, health workforce shortages and redefinition of the public health organisational structure. Given these challenges, Slovenia's future health policy will have to clearly position its long term strategic goals in order to be able to sustain a continued development of a modern health care system for the advancing and more demanding needs of its population.