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HEALTH INSURANCE SYSTEM IN SLOVENIA AND PREPARATIONS FOR THE REFORM

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ABSTRACT

The healthcare system is integrated in a broader social security system and a certain degree of redistribution and solidarity should be maintained. By doing so, the risk for a continuously decreasing reliance of the people on the principle of universality of healthcare and healthcare rights which may lead to a substantial reduction of readiness and social consensus for redistribution should not be ignored. And this particular consensus itself serves as a mechanism preventing the market principles to prevail in the field of healthcare. It will remain necessary to maintain a delicate balance between social solidarity, equitable access and interests of free enterprise. The healthcare system in the Republic of Slovenia therefore inevitably requires changes and improvements in the institutional, organizational and financial terms. Only with the data supported with and based on sound reform interventions in the social and economic foundations of the system, its organization and financing, improvements may occur in this field.

A series of attempts to reform the healthcare policy in the Republic of Slovenia, strategic and planning concepts and related initiatives failed to significantly change the concept as defined in late 1992. Under the leadership of the ruling political option in the Republic of Slovenia the healthcare policies have followed, since the Slovenia's independence, a pattern of reducing the role of the state by transferring different obligations to other - old and new - stakeholders involved in the system.

KEYWORDS health care, health care system, Bismarck model, health insurance

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1.1. Introduction

Slovenia has implemented a systematic process of modernisation of the health care system for decades in order to ensure stable financing and organisation of health care. Re-introduction of compulsory health insurance and introduction of voluntary health insurance were two of the most important reform strategies to improve the sustainability of the entire system. In recent years, the Health Insurance Institute of Slovenia (HIIS) put a lot of effort and knowledge into creating a stable and efficient system to rationalise and control the costs at the macro level of the health care system and at the same time provide the access to quality services for all insured persons. For this purpose, it has engaged trained personnel, established a good organisation and sophisticated information system.

The HIIS team of experts has extensive experience in the design and implementation of reforms of the health sector - especially in the expert areas related to the financing of the health care, cost sharing and cost management policies, health care information system and other related expert areas. In the last decade, the HIIS experts have strived to construct and enforce several projects and comprehensive strategies to promote a more rational and efficient system operation. The HIIS experts have extensive relevant experience in an international environment, particularly in Central and Eastern European countries, as they have implemented projects for various national and international agencies.[1]

Currently, the HIIS operates as a public institute which is legally obliged to ensure compulsory health insurance for all citizens and/or permanent residents of Slovenia (approximately 2 million). Until 1999, the HIIS implemented voluntary health insurance concluded by approximately 1.2 million policyholders. After the law was amended, the HIIS established an independent organisation for the mutual voluntary health insurance, called "Vzajemna". In the field of compulsory health insurance, the main task of the HIIS is the concern for efficient allocation of public resources in order to provide efficient health care for the population, based on a system of rights from the (compulsory) health insurance. The benefits package comprises the rights to health care services and the rights to several financial benefits.[2]

In the process of integration with the EU, Slovenia achieved the results that were considered as one of the best practices in sustainable financing of the health care system among the new EU Member States. In the field of health care financing, the HIIS has established special multidisciplinary expert project teams for the development, implementation and control of key areas of the (compulsory) health insurance: mobilisation and allocation of resources, processes of partnership negotiations, contracting, auditing, etc. To support these development activities, several projects have been successfully initiated and implemented; internationally most recognised was the project of the Slovenian health insurance (smart) card. The HIIS has put much effort into continuous education of its employees who needed professional training at a high level.[3]

The right to health care services includes services at the primary level of health care, including dental care, medical services in certain types of social care institutions and specialist outpatient services, hospital and tertiary services. It also includes the right to spa treatment, rehabilitation and transport by ambulance and other vehicles, medicines and technical accessories. According to the compulsory health insurance scheme, the policyholders are also entitled to various financial benefits (compensation for loss of salary during temporary absence from work, reimbursement of travel expenses, etc.).

[1] Slovenia - Health system review, Health systems in transition, 2009, p. 1-195.
[2] Slovenia - Health system review, Health systems in transition, 2009, p. 156.
[3] D. Stanimirović and M. Vintar, 2013, p. 4 (e-source).

The state guarantees the functioning of the social security institutions and creates conditions for private social work activities. It encourages and supports the development of self-assistance, charity work, programmes enabling a more independent life of persons with disabilities and volunteering. The rights to services and social security contributions are defined according to the principles of equal access and freedom of choice for all beneficiaries.

The state strives to prevent social exclusion, particularly by influencing the social situation of the population in the areas of taxation, employment and work and through grants, housing and family policy, health care, education and other policies.

For many years, specific preventive health care programmes for family planning, pregnancy and child care have been available in Slovenia. Practically all pregnant women and children younger than 5 years receive health care services (mostly at the level of primary care). These programmes provide special care during pregnancy and in the perinatal, neonatal and postnatal period, thereby providing a healthy environment for newborns and infants.

However, other health indicators show less favourable results. This is especially true for chronic diseases and injuries, although they could be prevented by selecting appropriate measures to prevent and control the risks. This occurs despite the fact that health care services perform screening tests for the early detection of head and neck cancer and breast cancer and for the detection of risk factors associated with cardiovascular diseases in persons older than 45 years. Moreover, the activities to promote health are gaining a growing importance in Slovenia with the aim of changing the lifestyles. The effect of health care services on the improvement of the health status of population is most evident in infectious diseases. Due to the high level of vaccination, their incidence is low.[4]

The principles of solidarity and equal contributions to social health insurance in Slovenia refer to individuals who have a regular income or receive pensions and disability benefits. All employees pay according to the same contribution rate. However, an element of potential injustice exists since some groups of insured persons (e.g. craftsmen and entrepreneurs) are free to determine the basis for paying contributions into the social security system. The current regulation for persons, who independently perform a commercial or professional activity as their sole or main occupation, provides the payment of the contribution for pension and disability insurance in the amount of 13.45% of the gross base which they choose by themselves.[5] They are entitled to this in accordance with the regulations on pension and disability insurance related to the compulsory health insurance and intended to the establishment of a simpler procedure for collecting contributions. The possibility of self-defining the base for pension and disability insurance is understandable since individuals thus also decide on the amount of pension they will receive after the fulfilment of conditions for retirement. Regarding the compulsory health insurance, this regulation tends to create inequality since the benefits are the same for all insured persons. In some cases, self-employed policyholders may completely avoid the obligation to pay the contributions. This indicates that there is an inconsistency in the implementation of the principles of solidarity, equality and equity. This mentality of self-employed persons will not change until a conceptual turnaround happens when the pension will not be perceived as a social transfer but will be based on an insurance relationship between the self-employed person and the state. It is necessary to establish this insurance aspect of pensions and thereby protect those pensioners who diligently paid the contributions and legitimately expect paid pensions. Only by strengthening the insurance

[4] according to A. Kraigher … [et al.], 2014, p. 40-42.

[5] Novelties in the payment of contributions to compulsory health insurance, 2013 (e-source).

principles in the pension system, a fair, transparent and, consequently, financially efficient pension system may be established. Equity of the system may be ensured by the fact that the amount of the pension depends on the amount of paid contributions in the fullest possible extent; the transparency of the system is provided by accurately informing the individuals about the amount of paid contributions through their work cycle and the amount of pension they can expect from the compulsory pension insurance after retirement. Only a fair and transparent system, that is simple by nature and understandable to an average policyholder and contains a clear link between the paid contributions and the amount of acquired rights, strengthens confidence in the system from the perspective of an individual, thereby increasing the motivation to pay the contributions since individuals know that their social security in old age largely depends on the payment of contributions to the pension system during their active period.

Moreover, difficulties arise in achieving solidarity in relation to insurance for injuries at work and occupational diseases. Employers are responsible for health and safety in the workplace. Therefore, it is expected that employers should bear financial responsibility for the prevention and rehabilitative actions in this field (e.g. treatment and rehabilitation of individuals who were injured at work or suffer from an occupational disease). However, in contrast to many other European countries, there is currently no specific insurance for this risk. The HIIS covers all costs (without any extra co-payments) of medical services and rehabilitation of people who are injured at work or suffer from an occupational disease. At the same time, the sickness benefit for temporary absence from work for more than 30 working days is provided from the compulsory health insurance.[6] This means that all insured persons cover a part of financial risks of injuries and diseases resulting from work in unsafe and unhealthy workplaces. Based on Article 13 of the Occupational Health and Safety Act, an employer is obliged to conclude a professional insurance for workers who perform particularly difficult and harmful work and workers who perform tasks that cannot be professionally performed after a certain age, according to regulations on pension and disability insurance. The employer's obligation according to the insurance for injuries at work and occupational diseases depends on the level of safety and health at work. The employer's obligation is determined by the Health Insurance Institute of Slovenia and Pension and Disability Insurance Institute of Slovenia according to the regulations on health insurance and regulations on the pension and disability insurance. The Health Insurance Institute of Slovenia determines the rate of contribution for injuries at work and occupational diseases according to Article 56 of the Health Care and Health Insurance Act.

Health insurance has a long tradition in Slovenia.[7] In the early 19th century, workers established "fraternal funds" based on solidarity and reciprocity. The first sickness fund in Slovenia was established in 1889 and was followed by similar providers of health insurance. Initially, the health insurance was compulsory only for workers but has gradually spread to other population groups.[8] Despite the changes in the organisation of health care, Slovenia has retained certain characteristics of health insurance through history, e.g. financing by contributions from employers and employees, autonomy and self-management. The health insurance system based on one public health insurance company which is responsible for universal access and several competing insurance companies which offer voluntary health insurance was fully restored almost immediately after the independence.[9]

[6] Compensation for loss of salary during temporary absence from work, 2015 (e-source).
[7] according to M. Novak and A. Cvetko, 2005, p. 54-55.
[8] according to S. Setnikar Cankar, J. Seljak, 2006, p. 147-195.
[9] J. Ceglar, 2004, p. 72.

Health legislation in Slovenia was subject to a major change in 1992. The new law created the basis for the current system of compulsory and voluntary health insurance, accelerated the process of privatisation of the health system and defined the role of key partners. The law has created a mixed public-private model of health care financing and introduced structural changes in the implementation of health services. These changes led to the partial privatisation of health care providers within the network of public services and introduced free choice of a doctor at the primary health care level. The second major Slovenian health care reform which introduced the pay model where money follows the patient was performed in 2003. In 2010 and 2011, another reform planned which addressed the problems of health care in Slovenia, such as inadequate allocation of capacities, lack of adequate information needed to make decisions, problems at different stages of the health care system management and challenges associated with the mission of the health care, but it has not been realised.[10]

All permanent residents of Slovenia are included in the compulsory health insurance. This provides two basic set of rights to policyholders: health care and money benefits or reimbursements. The system provides to policyholder the access to health services on the basis of partnership. Adequate access and quality of health services are key to the protection of policyholders. An essential component is equal provision of doctors and other capacities to the population.[11]

Slovenia has the highest health expenditure among all CEE countries. "In 2011, the share of total health care expenditure amounted to 9% of GDP, whereby the public share amounted to 71.4% (6.4% of GDP) and the private share amounted to 28.6% (2.6%). This data shows that the majority of the health care funding in Slovenia is provided from public sources. The system is fiscally balanced, especially due to the comparatively large resources (personnel and equipment costs are growing rapidly and are starting to cause major problems to the system)" (S. Setnikar Cankar and V. Petkovšek 2013, p. 221-234).

Compared with other countries, a significant proportion of health care expenditure comes from private resources, but in this case the majority of private resources are contributed by insurance companies that offer voluntary insurance (Slovenian Insurance Association, 2011). Other private expenditures include resources allocated to miscellaneous goods and medical services which people in Slovenia pay directly "out-of-the-pocket." Since the introduction of voluntary health insurance in 1992, the share of public expenditure on health care has declined in Slovenia, while private expenditure has increased with an intermediate fluctuation. The burden of additional health care financing has been transferred to personal expenses of the population.[12]

The access to health services is being increasingly obtained through direct payments. In 2011, direct expenditures of households represented 13.7% of total health care expenditure or 47.9% of total private health care expenditure. Currently, the increased level of private contributions is a major concern in Slovenia, but it does not undermine the universality of access to a significant extent (it undermines equality to some extent). The current aim of the development of health care in the future is to increase the share of public funding from 73 to 80% and to decrease private funding correspondingly. The latter is now composed mainly of premiums for complementary health insurance and direct payments.[13]

[10] according to S. Setnikar-Cankar and V. Petkovšek, 2013, p. 221-234.
[11] J. Ceglar, 2004, p. 6.
[12] Complementary health insurance and health care reform, 2011, p. 1-54 (e-source).
[13] E. Gregorič Rogelj, 2012 in J. Nemec, 2013, p. 228 (e-source).

After 1989, the state has re-established the monopolistic social health insurance system which has been supported by relatively functional schemes of private complementary insurance. In the near future, no major changes of this system are to be expected. The main strengths of this system are comparatively high level of resources, guarantees for effective access, functional private complementary insurance that provides system resources without limiting the universality of access and the limited size of the grey economy. All these features put it in juxtaposition with the most advanced health care systems in the world. It seems that the private complementary insurance schemes restrict equality of access, but this has already been reflected in the planned future government policies which also focus on issues of the private financing share and its effects. It may be stated that this positive situation is not only the result of the comparatively higher extent of available resources but also reflects better formulation of the health care policy in Slovenia compared to other CEE countries (at least in the early stages of reforming the health care).[14]

The health insurance system is divided into compulsory health insurance, voluntary health insurance for additional coverage and insurance for services that are not a part of the compulsory insurance.

1.2. background

Compulsory health insurance

The Health Care and Health Insurance Act (ZZVZZ) stipulates that insured persons are policyholders and their family members. Policyholders are determined in Article 15 of the ZZVZZ. Family members of policyholders and the conditions under which they acquire the rights of an insured person in the compulsory health insurance are specified in Articles 20, 21 and 22 of the ZZVZZ.[15]

Compulsory health insurance is provided by HIIS. All employed and self-employed persons and all pensioners who receive a pension from the Pension and Disability Insurance Institute of Slovenia are insured according to the aforementioned health insurance scheme. The status of an insured person may also be acquired by family members of a policyholder if they do not have the possibility to be included in the insurance scheme on a different basis and have a permanent residence in Slovenia (unless an international agreement provides otherwise).[16]

Children who are not policyholders themselves are insured as family members until they reach the age of 15 years or up to the age of 18 years if they are not insured in some other way; if they attend school after reaching this age, they are insured until the end of full-time education (but only up to the age of 26 years).[17] Compulsory health insurance does not always cover all health services and their full price. In the following, some services are listed, the costs of which are covered by the compulsory health insurance:

- all health care programmes for children and youth: diagnosis, treatment and rehabilitation after diseases and injuries suffered by children, schoolchildren, minors with developmental disorders and students while attending school;
- counselling in family planning, contraception, pregnancy and care for patients during childbirth;
- services related to the programmes of preventive care, diagnosis and treatment of infectious diseases, including HIV infection;
- treatment and rehabilitation of occupational diseases and injuries, cancers, diseases of muscles or muscle nerves, mental illnesses, epilepsy, haemophilia, paraplegia, quadriplegia and cerebral palsy, as well as progressive diabetes, multiple sclerosis and psoriasis;
- medical services related to donation and transplantation of tissues and organs, emergency medical treatment, including emergency transportations, visits of community nurses and treatment and care at home and in social institutions;
- long-term nursing care with home visits and provision of treatment and care in social care institutions, etc.[18]

[14] according to S. Setnikar-Cankar and V. Petkovšek, 2013, p. 221-234.
[15] T. Albreht, 2011, p. 37.
[16] Ibid, p. 31.
[17] see ZZVZZ, Article 22.
[18] according to U. Lipovec Čebron, 2011, p. 189-190.

Compulsory health insurance covers only a certain percentage of the full price of other services. The difference to the full cost is covered either by the policyholder himself or by the voluntary health insurance.

Voluntary health insurance

In order to obtain additional benefits, a voluntary/complementary health insurance may be concluded with an insurance company. It is advisable to be insured for the difference up to the full value of health services which are not fully covered by the compulsory health insurance scheme. Complementary health insurance is intended to everyone who has concluded the compulsory health insurance in Slovenia according to the law and is not subject to co-payments, except those who are expressly exempted from obligations of co-payments by the law. These are children, schoolchildren and students younger than 26 years in full-time education, children and adolescents with physical and mental developmental disorders, war disabled and civilian war disabled.

Slovenian health insurance system is based on cost-sharing between the public (i.e. HIIS) and private funds (comprised of co-payments). Co-payment is necessary for most services and is paid by the policyholder, unless a voluntary health insurance (VHI) is concluded to cover the risk. Although individual co-payments are not high, the total costs for patients with chronic diseases and those who require a more intensive medical treatment are relatively high. This is actually the main reason that a large proportion of the population is included in the complementary programme of the VHI.

During the attempt of reforms in 2003, there was a serious discussion regarding the scope of co-payments (White Paper).[19] It was argued that widespread co-payments would decrease the demand for health services. This argument is rebutted by the fact that virtually the entire population has concluded complementary health insurance. Therefore, co-payments do not reduce the use of health services. Moreover, insured individuals very rarely use legal options that entitle socially disadvantaged groups to the right to use health care services without co-payments. This applies to the following social groups: women in connection with pregnancy and childbirth, persons with diseases specified in the ZZVZZ, disabled and other persons with approved assistance, disabled persons with at least 70-percent physical impairment, persons older than 75 years, persons with the income lower than the income threshold and persons who exceed a certain amount of paid co-payments in a calendar year. Despite the listed contradictions, no evidence is available at the time of writing of this article that the system affects access to health services or that it causes discrimination in terms of providing health care based on the individual's financial situation.[20]

Co-payments are applied at the level of primary care in combination with the payment for specialised services in specialised clinics. The payment system based on Diagnosis-Related Groups (DRG) affects the secondary and tertiary levels of care. Thus, methods of payment in Slovenia are harmonised with those in many other European countries. First, it is assumed that the payment of health care providers depends on the performed work or number of treated patients. Private providers are paid according to this method and depending on the work performed under the contract with the HIIS, while the situation is different for the public health services.[21]

[19] D. Keber, 2003, p. 35.
[20] M. Česen, 2006, p. 63.

[21] T. Albreht, 2011, p. 96.

The income of the public service provider employees directly depends on the previously described method. The employees in these institutions are paid in the same way as all other public employees, namely in accordance with the provisions of the collective agreement negotiated between the unions and the government. Although these agreements contain stimulations for increasing the quantity and quality of work, there is no evidence that they actually lead to increased productivity. The employer has the possibility to allocate maximum 2% of the fund for pay to stimulate labour productivity. Some see this limitation as a reason for the relatively poor access to health services in certain areas. Due to this, the income of a doctor in a public institution at the primary level does not depend on either the number of treated patients nor on the extent of provided services.

1.3. Proposal of the new Health Services Act

In June 2013, the Ministry of Health presented a proposal for the new Health Services Act and opened a public debate on it. It was initially planned that the period of the public debate would be completed in early August, but it was extended until the end of the same month. The procedure to amend the Health Services Act[22] started in 2010.[23]

The proposal presented in June 2013 consists of the existing law, several amendments and some accompanying laws to be included in the final text of this legislation. In order to maintain the existing regulation of the health care system, it is based on the original text. The base of the system is represented by the network of public institutions supplemented by private providers to which concessions were granted and are included in public financing.

The main proposed change in the primary care is the establishment of coordinating entities at the regional or subregional levels, which would assume some functions that are currently in the domain of primary health care centres. This applies mainly to more expensive services and those that generally require a more complex structure. First, the number of 60,000 inhabitants was proposed as the lower limit for the coordination entity but this proposal was later withdrawn. Another new element of the proposed law stipulates that private providers are to be replaced by someone appointed by the responsible primary health care centre in the case of absence or leave. Furthermore, it is proposed that social care institutions also become providers of primary care for their residents (previously, these services were only provided by primary health care centres). In the secondary care, one of the major changes outlined in the proposed law is the possibility that a general hospital only consists of an internal and surgical department. Until now, general hospitals have also had to have a gynaecological and a paediatric department.[24]

The most important change proposed by the ministry concerns the procedure for granting concessions to private providers. This would be done through a public tender, while under the current law, the concessions are granted on request through the process based only on a review of requirements. The concessions would be limited to 15 years as opposed to the existing unlimited duration. Both, in relation to concessions and the topic of tasks and responsibilities of coroners, the proposed law contains a significant amount of details which could potentially be moved to the accompanying laws instead of remaining in the main law.

[22] ZZDej.
[23] Health Systems in Transition (HiT) profile of Slovenia, 2015 (e-source).
[24] Proposed Health Services Act, 2013 (e-source).

On 29th September 2015, the Ministry of Health published a revised proposal for amendments to the Health Services Act[25], which has encountered a sharp response from the professional public because the wider professional public did not participate in the preparation of the proposal. The proposed amendments to the Health Services Act abolish the competition between health care providers, since the Ministry of Health directs the Slovenian health care back to the path of the socialist system - state-regulated health care by the proposed amendment. I believe that the current proposal of the Health Services Act is certainly not in the interest of health care services users, since the availability of the chosen general practitioner to patients will be reduced upon the potential enforcement of the Act. The proposed law reduces the scope of health care concessions and limits their duration. Patients would have to find a new chosen general practitioner in a public institution if their current chosen concession doctor would not be re-awarded the concession or license. Thus, if patients are left without a chosen general practitioner or if these doctors remain without a concession, the patients will have to pay these services by themselves if they want to remain at the chosen doctor.

Goals of the health care system

Slovenia has a modern health care system comparable to the systems in the economically developed European countries. This claim can be substantiated by the state of the general structure of the health care system, level of the guaranteed rights of patients and health protection, health status of the population, organisation of health care services, method and sources of the system financing and its management. Achievements in this area are the result of a long tradition of implementation of public health care, the adequacy of the health insurance system and the commitment of people in Slovenia to the concept of solidarity in the event of illness or injury. Slovenian health care system has some peculiarities that are the consequence of certain historic structures and reflect different developmental paths of health care and health insurance systems in the country. These peculiarities can be seen in the scope of complementary health insurance and the fact that the majority of specialists provide services in public institutions. Moreover, the Slovenian health care system - in comparison with other EU Member States - is characterised by relatively limited capacities measured in terms of human resources or the number of hospital beds. Slovenia has also decided to have only one institution of compulsory health insurance, which implements a rational approach to the organisation of insurance in the state.

Coverage of health care costs and access to health care services

Slovenia has been facing challenges arising from new needs in health care, dictated by the ageing of the population and the consequent increase in chronic diseases. The increasing needs will require more funds and an increasing proportion of the GDP for the health care. It will no longer be possible to finance all needs from public resources or solidarity. New sources of financing health insurance will be needed in order to provide adequate health care to citizens in the future. Free access to health care services at the primary level is guaranteed to all citizens; but the access to the secondary and tertiary level, where the care is only provided to patients upon a referral from their chosen doctor, is limited. Limitations of the insurance coverage provided by the compulsory health insurance for the cost of medicines are regulated by the positive list. This also holds true for services that exceed certain standards under the regulations. These limitations apply to all insured individuals without exceptions or other distinctions.[26]

[25] Proposed Health Services Act, 2015 (e-source).
[26] according to T. Albreht, 2011, p. 122-123.

The actual access to health services and possibilities related to the reception of benefits are important according to the provisions of the aforementioned Act. Access to general practitioners and other professionals (e.g. paediatricians and gynaecologists) is almost universal at the primary level, with the exception of some remote rural areas where the lack of doctors sometimes occurs. Access to dental care for adults is more difficult due to the lack of dentists. At the level of primary care in Slovenia, this is the only area of health care with waiting lists. Waiting periods last from one to three years.[27]

All insured individuals have guaranteed access to health care at the secondary level in emergencies or if doctors decide that a delay of treatment would cause irreparable damage to the patient's health. There are waiting lists and waiting periods especially in the field of orthopaedics (hip and knee replacement), open heart surgeries, coronary angiography and balloon dilation, cataract and thyroid gland surgeries and also some advanced diagnostic tests (e.g. magnetic resonance imaging). Since this includes patients with chronic pain and older patients, these two groups face waiting periods which represent a barrier to their access to health care services. For procedures with long queues, additional insurance or even direct payments are available. To abolish or shorten the queues, the Ministry of Health and the HIIS have taken various measures, including increased funding of health care providers in the fields where queues occur. As a result, long queues have been partially shortened but the problem is far from being solved. Data related to waiting lists is based on estimates since national registers of queues have not yet been introduced and also no analysis of the causes of waiting periods has been performed. The HIIS strives to regulate the problem of waiting periods by contracts with providers. Until the completion of this article, this approach has not yet produced the desired results. Therefore, the Ministry of Health, HIIS and the management of health care providers, particularly hospitals, must resolve many issues in this field.[28]

There are different opinions why the waiting periods extend. The health care providers argue that this is due to insufficient funding, while some hospitals say that the reason is the lack of health care personnel, space and equipment. Each of these factors affects access to health care services, but so far there is no concrete evidence to show that one of them is a major cause of long waiting periods. The comparison of hospitals with similar work conditions shows that in some hospitals waiting periods are very long while in others they are insignificant. Another important factor is the organisation of work and productivity of employees in individual institutions offering health care. This is associated with enthusiasm and efficiency of management and its impact on health care personnel for achieving a higher quality of work and assuming an increased work load. The result of these factors are variations in the access to health care services at the secondary health care level in different areas.[29] In 2007, a pilot on-line approach to finding a solution was developed and launched, which should have given an insight into the situation in terms of waiting periods for the most common procedures of diagnosis and treatment.

In terms of financing, there are slight differences between certain services, which are mainly the result of differences in the level of human resources available in certain areas (e.g. anaesthetists and radiologists) and not the result of a decision on the method of financing health care providers. Regarding the provision of services of the primary health care, the differences between the regions are small; however, at the secondary level of health care, it is difficult to measure whether the provision of certain services is too large or too small since insured individuals use health care services not only in their home region but also in other regions. Capacities of an individual region are not only intended to meet the needs of its inhabitants.

[27] Waiting periods and consulting hours, 2015 (e-source).
[28] M. Fortuna, 2012 (e-source).
[29] according to A. Čufar, 2007, p. 35-36.

Inequalities in the access to health care services between regions could be solved with a systematic and long-term effect if the solution was based on a strategy or plan of the development of health care, which would involve key stakeholders and decision makers. Since the government does not have such a plan, these issues are being solved only on short-term basis with annual negotiations between health care providers and payers (municipalities or the HIIS). According to financial capabilities, certain amounts of assets are reallocated in order to increase the health care capacities in the areas where the access to services is most problematic. The planning of health care services is based on the projected progress and the growth of health care capacities. An exception are programmes that enhance the health of the population and preventative services based on the identification of the most serious and most common diseases and options of their control and changing life habits.

1.4. results and discussion

The Resolution on National Health Care Plan,[30] which was proposed for public discussion in June 2015, provides the abolition of the complementary health insurance and regulation of concessions. The Health Insurance Institute of Slovenia will lose its role in determining the rights and the management of hospitals will be given more powers. The resolution has outlined the direction but not the solution in terms of changes of the system of financing the health care system, which would preserve the health care package of rights and its adaptation to new technologies.

The financing of the health care system in Slovenia is problematic due to excessive dependence on revenues from the contribution rate of employees, which was proved to be inadequate during the economic crisis when the revenues of the Health Insurance Institute of Slovenia (HIIS) decreased due to an increase in unemployment. The resolution proposes the payment of compulsory health insurance from all types of revenue of an individual, e.g. rents, dividends and annuities. The reduction of disparities in the contribution rate is also proposed, where full-time employees are most burdened.

The current form of complementary insurance is not based on the principle of equity since premiums are regressive and represent a disproportionately greater burden for the socially vulnerable population. The premiums for complementary insurance are too high with regard to paid indemnifications or health care services since insurance companies profit by savings measures in health care. Instead of the complementary health insurance, the Ministry of Health proposes a new financing model but it has not been designed yet.

The Ministry of Health has also been preparing amendments to the Patient Rights Act and intervention measures to reduce waiting periods to an acceptable level, whereby the expert managements of selected hospitals shall be directly involved.

The changes in long-term care are also to be made, whereby the Ministry of Health cooperates with the Ministry of Social Affairs. Initially, the area of primary health care and geriatrics shall be developed. A solution for financing this area is to be found.

Only realistic health economy with realistic prices will enable competition between public and private health care providers. The change in the calculation of participation will lead to a market-oriented health insurance that will cover the services which are not covered by the compulsory insurance. Health care institutions should be autonomous and independent from politics, both in their operations and staffing.

[30] Resolution on the National Health Care Plan 2015-2025, 2015 (e-source).

The health care reform and establishment of a system that will encourage users and health care providers must consider public health care as a solidarity system of public financing. Health policy must operate widely and to the benefit of all citizens, not just of an individual provider, which can only be achieved by professionalism, responsibility and effective control of the Ministry of Health. A good health system means that people have access to good health care where basic services are completed. Before offering a complete care to someone, we must ask ourselves what the complete care really means. A basic public health care system must exist; it is not possible to be without it. Everyone should have access to basic care that enables them to remain healthy and covers potential costs of treatment. For all other services that go beyond the basic care, it is reasonable to let in the market.

Policyholders should become major players and decision-makers who offers them more for the collected money. Competition would also be stimulated by private provision of health care services at the primary and secondary levels. Slovenian health care system is characterised by a low share of private providers, which is in stark contrast to most health care systems in Europe. In 2013, the HIIS concluded agreements on the financing of the provision of services with 1781 providers, namely 225 public institutions and 1556 private providers with concessions. The share of private providers with concessions amounted to almost 14% in financial assets.[31]

For the reform and establishment of a system that is in accordance with the incentives of users and providers and in line with solidarity and public health care, if the public health care is understood as a solidarity system of public financing but not necessarily as a means of implementation through public institutions, it is necessary to promote changes in the field of expertise of health policy, regulation and control which must be professional, timely and active, reorganisation of the HIIS to a health fund, introduction of competition in the field of compulsory health insurance and liberalisation of the provision of health services at the primary and secondary levels. Of course, the reform cannot be implemented over night. It is a process that takes a longer period of time and requires active participation and collaboration of experts, primarily from the practice. There will be no reform if regulations are changed or amended. The changes must be considered by a project group within the Ministry of Health which will be responsible for the timely preparation and implementation of the reform proposals. The state must establish a system that will be professionally, financially and organisationally autonomous and capable of functioning.

If the Ministry of Health understands how the health system works, where are its shortcomings, what is its proper role and what the ministry should not interfere with, this is a good way towards the adoption of the reform. From the existing situation of the health care system in the Republic of Slovenia, the following conclusions can be deducted:

1. The health insurance system on the Republic of Slovenia must be updated. Insurers, either private or public, can be successful only in the case of improving and maintaining the health of their policyholders. It is true that insurers are not responsible for health, but they provide financial security to policyholders. Currently, insurance plans want to create a competitive advantage by selecting healthy policyholders, reducing services, negotiation of higher discounts and imposing increasing costs to policyholders. Regulations to end the discrimination based on coverage and prices must be introduced, which is based on health risks or existing health problems. Moreover, the insurance plans are required to measure and report on the state of health of the insured persons. Such reporting will help consumers to choose health

[31] M. Kranjec, 2015 (e-source).

plans based on reports and prevent the insurers to be stingy with costly services, such as preventive examinations. Health insurers that compete in this way, will add value to the system much more effectively than it could be done by health insurers that have a state monopoly.

2. Employers must be retained in the insurance scheme. Everyday interactions with their workforce enable employers to create value by developing a culture of well-being, enabling effective prevention and examinations and directing employees to where the high value health care is provided. Employers can also enhance the competitiveness and general improvement of the system in ways that government entities cannot imitate. The insurance system already provides the material security of employed workers and their family members and is an inseparable part of social security since it consists mainly of contributions from personal and economic insured risks. These are services and contributions from health insurance, pension and disability insurance and unemployment insurance. These are also the branches of social insurance. The laws in this field determine insured social cases, group of persons who are subject to compulsory insurance, insurance conditions and types and scope of rights. These are the so-called statutory insurance since the insurance relationship or compulsory insurance arises independently of the will of the insured person. A characteristic of social insurance is a combination of social criteria reflected through the ability of the insured person to contribute to the insurance and observance of the principle of proportionality between the contributions paid, duration of paying the contributions, amount of duty and the specific method of financing, where the costs of insurance are covered both by employees as insured persons and their employers. Sometimes the state also contributes and thus impacts the economy and the situation in the labour market.

3. To ensure the availability of individual insurance, large regional insurance funds are needed in the state in order to distribute risks and facilitate contracting for coverage and premiums equivalent to or better than those covered by the largest insurance plans at the level of employers. Regional funds instead of a centre-national fund will encourage greater responsibility towards insured persons and closer interaction with regional insurance networks, which will enhance competitiveness on the basis of value. A reinsurance system is also needed, which evenly distributes the costs of insurance of people with very serious health problems within the regional funds at the level of employers.

The health care system in the Republic of Slovenia certainly has several positive qualities and can be compared with other European systems according to its development achievements. In recent years, the whole system has not been adjusted to the changed circumstances; therefore, it has come into a retarded position from which there are several exits. I shall analyse the objectives that will provide the most comprehensive health care of the population. The guidance shall be obsolete health legislation, accessibility and quality of health care programmes and services, definition of public health care service network, responsibility for the management and administration of public health care institutions, division of work between different levels, effective control of current and investment spending and quality of implemented services and demarcation between public and private in the health care system.

Slovenia lacks some types of personnel in the health care sector, i.e. family medicine specialists, paediatricians and gynaecologists. To ensure a sufficiently large number of family doctors, paediatricians and gynaecologists in clinics for women, additional 808 doctors and teams (nurses and other required personnel) would be needed according to the professional medical standards and the HIIS estimate made in

the first half of 2015.[32]In the context of the preparation of the document Resolution on National Health Care Plan 2015-2025, a systemic analysis of the needs for medical doctors in Slovenia and the plan for education of additional health care personnel were made. Changes in the education of medical specialists, additional funding for the scarcest medical personnel and measures to further promote the graduates of the Faculty of Medicine to perform specialisations in these fields are announced.[33] Enrolment in faculties educating for careers in health care is large but many of them are not employed in their profession after graduation. Work in these professions is strenuous, working conditions are poor, payment is generally too low considering the input. Top experts go abroad since the system do not impede them there and they can focus more on the profession. They are not burdened with trifles and bureaucracy. What will happen if we do not employ young doctors and nurses in our country? Everything will only go downwards.

Special story is voluntary health insurance in Slovenia. We know that compulsory health insurance does not cover all services in their full price; therefore, almost everybody has concluded a voluntary insurance of such risks in order not to cover the potential high price differences. The system itself literally forces people to conclude such an insurance. Such forms of voluntary health insurance as in Slovenia are not known in Europe. How can there be a lack the money for health care while voluntary health insurance companies have huge profits? A much more sensible approach would be to establish a direct co-payment for health care services to the provider itself as it is in Sweden. There, health care services are paid directly "out-of-the-pocket" but legislation restricts these co-payments up to a certain amount. If a patient spends this amount before the end of the year, he has right to free visits for the rest of the year. Certain high-risk groups of the population are exempted from these co-payments.

The introduction of co-payments for visits to medical professionals and health care personnel would make patients aware about the fact that health care is not free. Thus, greater responsibility for their own health would be given to patients. It is necessary to consider the implementation of co-payments for unjustified access to emergency medical departments since emergency clinics are visited by patients who, due to the appointment with the chosen general practitioner at an emergency clinic, jump queues and receive a comprehensive treatment immediately. The introduction of co-payments would represent a commitment of health care professionals to perform the service.

[32] summarised from the Response of the ministry to the shortage of doctors: First improvements next year, 2015 (e-source).
[33] Resolution on the National Health Care Plan 2015-2025, 2015, p. 46 (e-source).

1.5. CONCLUSION

The reform of the health care system in Slovenia, as well as at the level of the entire EU, is urgently needed, which is reflected in the reduced role of the state in the field of health care.

The health care system in the Republic of Slovenia certainly has several positive qualities and can be compared with other European systems according to its development achievements. In recent years, the whole system has not been adjusted to the changed circumstances; therefore, it has come into a retarded position from which there are several exits. I have analysed the objectives that have provided the most comprehensive health care of the population. I have focused on the following issues: obsolete health legislation, accessibility and quality of health care programmes and services, public health care service network, responsibility for the management and administration of public health care institutions, division of work between different levels of the health care services, effective control of current and investment spending and quality of implemented services and demarcation between public and private in the health care system. Undoubtedly, changes in the institutional field are necessary, which would allow different framework for the functioning of the health care.

Regarding the rights that will remain in the social health insurance, I believe that it is necessary to continue to maintain universal access and also to differentiate the degree of solidarity. The highest level of solidarity among all insured persons will have to be sustained by those categories of insured persons who should not be impeded in accessing health care services due to their material position and medical and social indications. For those rights under the current social security system, to which it is necessary to ensure non-discriminatory access for all and everyone, a combination of payments from public funds and individual co-payments, against which an individual can be insured, is an already established and well-functioning arrangement in Slovenia. For those rights from the compulsory programme, which are increasingly differentiated according to the standard of treatment, the most suitable form of financing is a combination of co-payments and extra payments. In the complementary health insurance, which is so widespread in Slovenia that it is almost universal, it is necessary to increase the equality of treatment for all insured persons. The access of the insured persons to this insurance must remain non-discriminatory in the future. A premium within one insurance company must remain the same for all insured persons and the inclusion into the insurance must not be in any way conditioned by the medical condition. The complementary insurance should be paid from public funds for those insured persons who have concluded compulsory social insurance but have not concluded the complementary insurance due to their material position. Complementary and compulsory health insurances should jointly hold effective control over the implementation of an insured person's rights and obligations under the health insurance. Complementary health insurance increases access to health care for those who are able to pay the corresponding premium, while it is very likely to disable the access to health insurance especially for the elderly, people with poor health and those with low incomes. Due to the latter, many countries have been increasing their role in the direction of greater regulation of private insurance, easing the burden of paying for voluntary health insurance against co-payments for socially most vulnerable groups or in the form of restrictions on the amount of medical expenses for which a reimbursement is granted to an individual by the state.

Public health care is not a commercial activity and not subject to supply and demand or market prices for health care services. I believe that market competition between the private and the public health care must not be allowed and that they must be strictly separated. This is the only way to organise the public health care as an efficient and effective system based on the principle of solidarity, which guarantees equal rights to

health care for all citizens, which is the goal that is precisely defined in the constitution of the Republic of Slovenia. Legal demarcation of the public and market health care is necessary. Additional money to reduce queues in the private sector only increases the cost of the public health care. This means that additional funds without systemic organisational measures adversely affect the performance of the public health care. Changes for increasing business efficiency and competitiveness of the public health care and changes in the financing of public health services are also necessary. All these changes could significantly improve the Slovenian health care system. It is more important to get the correct answer to the question "what" than to the question "when". If the current initiative for the health care reform is limited only to the issue of insurance coverage without paying a serious attention to cost control and coordination of the health care, the "crisis" in the health care will also affect us in the coming years.

Upon reforming of the health care system, the Slovenian Ministry of Health should consider the following:

- Prerequisites for successful reform are knowledge (technical capacity), strength (institutional capacity) and political will (political capacity).
- There is a negative correlation between public financing and total expenditure for health care.
- Compared to other systems of the social policy, health care is under a strong influence of service providers. High-cost health care system means higher incomes for the economic sector.
- Limitation of cost is easier when the state is owner of medical facilities and service providers are rewarded in the form of salaries.
- Where the provision of services is predominantly private, the state plays the key role in designing the standards of the health care and regulating the reward system.
- States that leave the decision on the financing of the health care to individuals are not in a better position regarding the control of the health care costs than states that directly intervene in the health policy.
- Neoliberal reforms fail when there is no appropriate administrative capacity to control the market.
- The prospect of greater effectiveness on the basis of the reforms based on the market has never been realised.
- Innovation at the micro level (e.g. efficient hospital sector) does not constitute a reliable basis to achieve greater efficiency and better quality health care system in general.

The reform of the health care system in the Republic of Slovenia will contribute to the improved efficiency of the health care, better use of resources in the health care, improved quality of health care services and easier access to health care services for the entire population.

It is necessary to introduce a system that will facilitate the access to health services, especially from the perspective of citizens, shorten the queues, enable greater efficiency and innovation and good practice. This can be achieved by a smaller role of the state and its organs upon the simultaneous enlargement of the scope of regulation. Based on the analysis, I have established that a more precise demarcation between the public and the private system is required in Slovenia. The public system must allow the private health system to provide health care services, provided that it does not interfere with the reduction in business volume of the public health care. Both systems must cooperate since the competitiveness of health care services and their quality will thus increase. To achieve the financial stability of the system, it is necessary to transform the rights under the compulsory health insurance. The HIIS has no more funds from previous years which would cover the budget deficit; therefore, austerity measures are needed, which are based on the concern of the population for their own health. The possibility to reach the set goals in the Slovenian health care mainly

depends on the growth of gross domestic product which is lower in Slovenia than the average of the EU Member States. A redefinition of the health benefit package which should fully cover all key health services is also required. When the health care system is adapted to the changes of the population, social development and development of technology in medicine, better performance of health care services, better use of resources in the health care, improved quality of health care services and easier access to health care services for the entire population can be expected.

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