

Reform and Transitional Adjustment of the Health Care System in Slovenia

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Abstract

In the paper the authors analyse some unresolved issues regarding the health care reform that is under way in the Republic of Slovenia. They believe the reform is necessary due to the problems that have accumulated. So far the transition processes have not been undertaken in a systematic way by the public sector. With this in mind, the authors discuss the problems of compulsory and voluntary insurance, and the goals that can be achieved by enforcing the role of voluntary health insurance. The authors also examine areas that have important implications for the efficiency of Slovenian health care. Emphasis is primarily given to appropriate systems of incentives that affect the behaviour of health care providers, patients, insurers, and policy makers and then, to the management and governance of health care providers.

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1. Introduction

In 2003, the Ministry of Health of Slovenia initiated what is clearly the most extensive discussion about the health care system since the country's political and

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economic independence. As a starting point for this discussion, the Ministry published the 'White Paper' entitled Health Reform (*Zdravstvena reforma* 2003). Discussion of the reform quickly showed that, at least from an economic point of view, comprehensive health care reform is in fact currently necessary in Slovenia. Namely, despite the changes in the health care system in Slovenia during the 1990s, specific problems have been accumulated and still need to be addressed. However, it is important to note that data on the state of health among the Slovenian population show that the state of health is not critical and is better than in all transition countries and, in some cases, even developed countries that can devote more money to health care.

The need to reform the Slovenian health care system therefore stems from a different problem. Namely, the Slovenian health care system was only changed in a piecemeal way throughout the whole transition period in the 1990s. The health care system has thus been changed partially, without due thought and without clear social positions being taken on key dilemmas and characteristics that define health care systems around the world.

2. Slovenia's health care system problems and the transition process

What should be noted here is that the problems characterising the health care system in Slovenia in fact emerge in any transition process. This implies that the transition processes of stabilisation, privatisation, liberalisation, restructuring and institutionalisation also need to be addressed in health care (Balcerowicz 1994; Hoen, 1998).

Stabilisation is needed because of the losses of the social insurance fund, i.e., the Health Insurance Institute of Slovenia (see Table 1) which, with the present contribution levels on the one hand, and universal health care coverage on the other, cannot be cut without a major change in the financing of health care (*Zdravstvena reforma*, 2003: 64, 73).

Table 1: Financial results of the social insurance fund in EUR, million

Year	Social insurance		
	Revenues	Expenditures	Revenues - Expenditures
1999	1054.6	1051.4	3.2
2000	1182.0	1195.4	-13.4
2001	1333.6	1385.6	-52.0
2002	1505.0	1543.7	-38.7

Source: *Zdravstvena reforma* (Health Reform) 2003, p. 69

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These losses, together with both the ever-faster development of health care technology and ageing of the population, appear in a lack of services and poor correspondence between the structures of supply and demand for health care services. This is reflected in critical waiting periods, and sometimes also in long time lags in the introduction of more demanding forms of treatment.

Privatisation, as a typical transition process, was not carefully planned in Slovenian health care. It was never controlled, with municipal officials and state bureaucracy still making decisions about privatisation based on criteria that clearly do not include the efficiency of Slovenian health care. As shown in Table 2, the private sector is present mostly in primary health care.

Table 2: Number of providers by ownership status, 2003

	Number of providers			
	Public institutes	Private practitioners with concessions		
		Basic care	Dental care	Specialist care
Number	63	228	493	215
Share		24.36%	52.67%	22.97%

Source: Seznam izvajalcev zdravstvenih storitev (Register of Health Care Providers), Health Insurance Institute (<http://www.zzzs.si/izvajalci>), 25.8.2003

Due to the absence of a clear privatisation strategy the state's ownership interests are not clearly conveyed to the management of public institutes that operate under conditions of so-called soft budget constraints, whereby their losses created by their failure to limit themselves to the negotiated budget bring the Health Insurance Institute of Slovenia into loss.

Without any more decisive privatisation, liberalisation and increased competition have also not evolved in the Slovenian health care system. The opinion prevails among Slovenian physicians today that the market has no place in health care and that it is impossible to increase their efficiency by means of competition. Competition can appear in five areas in the health care system (Phelps 2002: 30). There is the relationship of health care providers to the buyers-users of their goods, the relationship among the providers themselves, the relationship between health care providers and suppliers, the relationship between health care providers and organisations of health care insurance, and competition among health care insurers. In Slovenia, it is certainly not clearly defined where competition and the market should operate in health care and what effects should be achieved with introduction of the market and increased competition. Access to the funds of insurance companies, especially insurance company providing compulsory health insurance, through tender offers, together with an increased number of health care providers, for

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example, can establish competitive relations between insurance companies and providers (Enthoven, 1985).

To a large extent, resistance to the market and competition in health care is a result of the fact that health care providers, as well as payers, have so far in Slovenia not been really restructured in the way seen for the rest of the economy.

In the health care system, the process of institutionalisation is also not completed so that it is often unclear who is responsible for what and to whom the provision of health care services should be entrusted. Physicians choose their own directors within public institutes and adopt management decisions in a self-management manner. In order for this to change, the state should withdraw from the management of public organisations. It is, however, important to note that the state's withdrawal from management should be accompanied with strengthened regulation of the entire health care system. State regulation is necessary in some fields within the health care system (Allsop, Mulcahy 1996). It is at least essential to regulate competition. Regulated competition is competition on the supply side only, with maintenance of a single source of public financing. Managed competition, though, is competition on both the supply side and the demand (funding) side (Maynard, Bloor 1995). The 'White Paper' does address this type of regulation, yet the issues are not discussed in any great detail (*Zdravstvena reforma*, 2003: 199).

It is, however, important to note that the transition processes must have as little effect as possible on solidarity, equality and justice (Rawls 1971). In some transition countries, these principles must even be introduced to a greater extent than the old centrally-planned state-owned health care systems were capable of assuring in the past.

3. Losses of the social insurance fund and the Slovenian type of voluntary insurance

Proof that the losses and growing indebtedness of the Health Insurance Institute of Slovenia are the most critical problem is seen in the Ministry of Health's clearly difficult struggle to eliminate voluntary health insurance. It is important to note that, in Slovenia, this type of insurance is voluntary insurance for the full coverage of co-payments. There is the belief that with the transfer of this type of voluntary insurance to social insurance it would be possible on one hand to improve the distribution of funds for health care and thus also at least partially to reduce waiting periods, and on the other hand, to obtain for the Health Insurance Institute of Slovenia the reserves and profits of both voluntary insurance companies and to thus cover the Institute's deficit without increasing the population's financial burden. As shown in Table 3, the losses of the social insurance fund could be compensated for by the surpluses of voluntary insurance companies that provide insurance for the full coverage of co-payments.

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Table 3: Financial results of compulsory and voluntary insurance companies in EUR, million

Year	Voluntary insurance			Social insurance			E+F
	Revenues from premiums (A)	Payment of claims processed (B)	A-B (E)	Revenues (C)	Expenditures (D)	C-D (F)	
1999	194.5	146.9	47.6	1054.6	1051.4	3.2	50.8
2000	216.6	175.1	41.5	1182.0	1195.4	-13.4	28.0
2001	251.4	214.5	37.0	1333.6	1385.6	-520.	-15.0
2002	290.0	236.2	53.8	1504.9	1543.7	-38.8	15.0

Source: Zdravstvena reforma (Health reform) 2003, p. 69

Although this would mean a higher contribution to the social insurance fund from employees and possibly also higher labour costs for employers due to employees' wish to protect their net wages through wage increases, individuals would no longer have to pay premiums for this type of complementary insurance. Since contribution levels are bound to salary levels, and premiums are the same irrespective of salary levels, the Ministry even believes that one of the basic principles of health care would thus be realised to a greater extent, i.e., the principle of equal access to health care.

Voluntary insurance for the full coverage of co-payments was introduced in 1992. At that time it became clear that public funds are insufficient for the coverage of all health care expenditures and this gave rise to the idea that the individual should also pay something from his own pocket for each service covered by social insurance. Since the share of such payments ranged between 5 and 15 percent of the price of the service and could also mean significant expenditure for the individual, the voluntary complementary insurance for the full coverage of co-payments scheme emerged. Individuals were in a way 'forced' to be included in this type of voluntary complementary insurance, since the risk would otherwise be too great. Ninety-four percent of those included in the compulsory insurance scheme also buy voluntary insurance for the full coverage of co-payments (Robinson 2002: 173, *Zdravstvena reforma* 2003: 70). The common role of co-payments in the world is to create incentives for health care users to make rational use of health care services. Since in Slovenia co-payments for health care services are universal and can be high, this required special additional insurance which some countries explicitly forbid. Insurance, namely, in this instance undermines the co-payments' function of rationalising demand. The proposal to eliminate such voluntary insurance is thus understandable since – among other things – it also enables the introduction of real forms of demand-side incentives. Also, with the exception of Slovenia and France, the market for voluntary health insurance to cover co-payments is not substantial in Europe (Mossialos *et al.* 2002: 59).

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However, the decision to transfer this type of voluntary insurance to social insurance leads to two issues, as the debate has also demonstrated. The first is the possibility of increased labour costs for employers. The transfer of the premiums paid by individuals to the contributions made by the employees does not increase labour costs macro-economically, but it may transfer the tax load to business. It would be very sensible for contributions to have the nature of income taxes (Normand, Busse 2002: 66). Health care would thus not only burden wages but also non-wage income. Namely, costs incurred to maintain or improve health are not the costs of labour but the costs of 'a person who spends both wage and non-wage income'. However, in Slovenia the feeling, justified during the period of socialism, that income only derives from labour still prevails.

The second issue is the role of voluntary insurance, provided mainly by privately owned insurance companies (see Kornai, Eggleston 2001: 74-5). The Ministry of Health has received the most criticism precisely because of the dislike of private insurance companies and the preference for a single organisation of social insurance.

4. Role of voluntary insurance in a system with predominant compulsory insurance

It is common around the world for social insurance to finance a specific benefits package, while individuals can take out voluntary insurance for all health care services not covered by social insurance. Such a combination enables the social insurance funds not to become too large and ungovernable, especially in the circumstances of a single social insurer. However, with the premiums of voluntary insurance being based on uniform prices of insurance irrespective of the social status of the individual, a closer link is created between the distribution and allocation functions of premiums. Conditions therefore become more similar to market conditions, without the loss of risk spreading in health insurance.

Even though the Ministry of Health proposes the elimination of voluntary insurance for the full coverage of co-payments this does not mean that it opposes voluntary health insurance. However, with a broad definition of a list of services guaranteed by compulsory health insurance it does limit the possibilities of its development. The theory that voluntary insurance will strengthen as new health care services develop in the future is weak since we can expect that precisely due to technology advances in health care in the coming years health care services will emerge whose payment would be even more suitably made by the Health Insurance Institute of Slovenia. In addition, even today this Institute's losses demand a narrower scope and extent of rights under compulsory health insurance. At the same time, providers seem to fill this benefits package with their offer more than patients and payers do with their needs.

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There is the conviction in the world that new services and new technologies in health care and ageing of the population in the coming years will quickly expand the basket of health care goods and services, irrespective of whether the payers are social insurance funds or voluntary insurance providers. However, voluntary insurance will take over at least part of the burden of social insurance, introduce greater incentives for the rational use of resources in health insurance and create some competition among payers of health care services. The reform in Slovenia will therefore have to take steps towards redefining the compulsory insurance benefits package in such a way that a narrower scope and extent of rights is guaranteed. It will also have to create conditions in which voluntary insurance companies constitute a normal part in the structure of payers for health care services in Slovenia.

5. Capital-funded versus pay-as-you-go systems of payment and ageing of the population

The most interesting part of the justification for the existence of voluntary insurance is connected with creating reserves for financing health care required due to the rapid ageing of the population. Health insurance is based on the principle of reducing risk among the sick and the healthy; seeking a balance between the sick and the healthy is common to all insurance systems. This balance can therefore be ensured also by budget financing and social insurance. There are, in principle, no significant differences between social insurance and the budget financing of health care since it is still a matter of a system of balancing between income and expenditure within one year or a specific time period. However, since illness is connected to age and the share of the elderly population is also increasing in Slovenia during the debate on the 'White Paper' there was a real stress on the need to adapt the insurance system to the ageing population. Health insurance, thus, should not just be insurance against the risk of illness but should also be insurance against the time of old age. Reserves for old age should be created. Private insurance companies, which are an example of a capital-funded system of payment in which 'you save today in order to be able to spend tomorrow' should enable such a form of insurance.

However, it is well recognised in economics that investments ex post equal savings. Whether by saving today we will really save for old age thus depends first on whether we really know how to invest savings in the economy, and then on whether the effectiveness of these investments really leads to an increase in the gross domestic product from which health care services will be financed in future decades. Voluntary insurance with the formation of reserves and the possibility of private investment certainly provides possibilities of achieving this goal. Social insurance and budget systems with their current balancing of income and health care expenditure, on the other hand, build up neither savings nor investment, nor a larger gross domestic product in the future. In strong economies with a large enough

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working and young population, pay-as-you-go systems are not worse than capital-funded systems. With the ageing of the population, unemployment and stagnation pay-as-you-go systems reach their limits (Henke, Borchardt 2003). However, this also limits the capital-funded systems. So the question of whether because of an ageing population we need capital-funded systems is in essence a question of whether voluntary private insurance companies are really capable of suitably encouraging economic growth and the efficiency of the economy and increasing per capita gross domestic product. It is also important to note that the formation of reserves would also be possible for social insurance funds. Since it is impossible to provide a final answer to this question, although we suspect that its role is more active than the role of social insurance, a combination of social and voluntary insurance has been adopted in the world.

6. Where can we find ways of boosting the efficiency of health care?

The discussion of claims in the 'White Paper' that the current extent of services under compulsory insurance can be maintained without changing the payment for them because there are reserves in the health care system particularly raised the question of the efficiency of the organisation, management and governance of health care providers. Something exists that could be called the 'illusion of management'. Namely, many of those taking part in the debate believed that improving the efficiency of providers can be achieved with a simple change of director, especially by replacing physicians acting in the role of director with professional managers, and by training senior management (*Zdravstvena reforma* 2003: 204). Lying in the background, there is the mistaken notion that greater efficiency can be achieved simply by changing the internal organisation, management and governance without changing the environment and external forces that influence provider behaviour. Since these outside forces in the economy are for the most part market-driven, then the mistaken notion is that the market should not be necessary in healthcare!

We must seek efficiency in health care from health care resources to health. Essentially, efficiency in health care is decided in six areas. First it all, competition is crucial. Competition is an entirely external force that rewards efficiency (Kornai, Eggleston 2001: 15-46). Second, there is no competition without private ownership. Efficiency in health care is thus also connected with the (partial) privatisation of state-owned health care organisations and the influence of competition amidst private providers. Competition between the state and private sectors in health care increases the efficiency of both. Third, competition and distinct ownership demand a special type of organisation which is fundamentally entrepreneurial. We therefore suspect that greater efficiency can derive from the businesslike organisation of providers, payers and partially even the state. Fourth, with an entrepreneurial organisation of health care organisations, the relation between the consumer, the

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intermediary – the insurer – and the provider becomes crucial and must include a suitable system of incentives. Incentives can either be in the form of demand-side or supply-side cost sharing. Fifth, the state regulates the entire system so the efficiency of this system also depends on state regulation. The latter must ensure suitable quality, accreditation of providers, provide instructions for procedures, regulate payers and regulate the relationship between providers and suppliers, especially the suppliers of pharmaceuticals. Sixth, health care services contribute to the ‘production’ of health. So there must be enough of them, they must be of high quality, and the patient must have the freedom to seek his own equilibrium as a consumer-user of health care services when he tries to maximise his utility.

7. System of incentives for health care efficiency

In seeking answers to the abovementioned dilemmas, two topics have been particularly highlighted in the current debate. The first is referred to as the level of integration between the health care provider and the payer. Currently in Slovenia there is a high level of integration of providers, organised as public institutes, and the Health Insurance Institute of Slovenia. However, the current debate has shown that it would boost competition if providers and payers were less integrated. This separation could be carried out in such a way that providers obtain funds through public official invitations to tender, whereby the payers obtain the possibility of selection among providers, and by introducing the principle ‘money follows the patient’ which initiates competition for patients among providers.

The second topic is reinforcement of pressures to manage the providers well by a suitable system of incentives and cost sharing in the payment for their services. There are four agents in health care (McPake *et al.* 2002: 49): health care providers, patients, organisations that finance health care, and sponsors. There are therefore many agents in health care so the question of incentives is crucial from the aspect of health care’s efficiency (Laffont, Tirole 1993). Demand-side incentives derive from the problem of moral hazard and are in the form of deductibles, co-payments or co-insurance (Kornai, Eggleston 2001: 80-1; Phelps 2002: 372). They are normally in fixed amounts since otherwise this type of incentive could lead to an overburdening of the individual (McPake 1993). Incentives reduce the demand for health care services but also increase the risk on the part of the user. Some studies suggest that elasticity of demand is around 0.2 (Newhouse *et al.* 1993: 121). Supply-side incentives are based on costs sharing on the part of providers when they provide specific services (Kornai, Eggleston, 2001: 84-5; Phelps, 2002: 376-429).

A market exists in the health care system in many cases, but it is complex and regulated. It is necessary to take into account the agent problem, regulation, oligopoly and monopolistic organisation of providers, monopsonist organisation of agents who allocate funds on behalf of final users and the obligation to provide funds

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either through taxes or social insurance (McPake *et al.* 2002: 183). These characteristics are recognised in the 'White Paper' and this is why it does not advocate complete market exposure. This is also why it outlines several dilemmas regarding payment systems within health care. The 'White Paper' very sensibly argues for a suitable introduction of co-payments, for example, for the first visit to the physician or the issue of a prescription, for the gatekeeping role of general physicians and for financing of the secondary level of health care through a capitation system at the level of general physicians and for introducing hospital financing in the form of prospective payment using DRGs. The Slovenian health care reform supports and encourages this type of hospital funding (*Zdravstvena reforma*, 2003: 120-5). The authors of the 'White Paper' assess this type of funding in a way similar to some other authors round the world (Gerdtham, Jonsson 2000). It is rational to continue the practice of capitation payment of primary health care since it can reduce costs; but it must be noted that it only operates suitably – reducing costs and ensuring the quality of services – in conditions of very strong competition and appropriate ownership, although some in the world believe that ownership does not have an influence on the effects of incentives. For basic health care, which is close to a club good, for example, capitation is the most appropriate system of funding and for private goods in health care a fee-for-service system is most suitable (Cornes, Sandler, 1986). It is necessary to take into account that certain authors consider health care services as private goods. According to them, the health care sector therefore publicly provides private goods (Stiglitz, 2000: 133, 136). Others believe that public goods in health care are present but to a limited extent (Hurley, 2000: 71).

One problem not highlighted enough by the 'White Paper' is the lack of physicians and their monopoly of the labour market. In Slovenia, the lack of general physicians estimated by the medical society is 130. This implies that there is a lack of competition among general physicians. A lack of competition can create conditions in which, for providers funded by capitation, there is a lack of incentive to ensure high quality. In such a case the capitation system is inappropriate (Feldstein, 2002: 345-78). Hence, the education of physicians and free access of foreign health care personnel to the Slovenian labour market is crucial and not sufficiently stressed in the 'White Paper'.

8. Restructuring and efficient organisation of providers

The other area that is crucial to the efficiency of Slovenian health care is the governance, management and organisation of providers, especially hospitals. Providers must meet specifically prescribed minimum conditions for the provision of specific services and specific products. These conditions are reviewed during the process of accreditation (Scrivens *et al.* 1995; Scrivens, 2003). According to the proposals of the 'White Paper' public institutes should also be reorganised as public

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companies. This particular proposal provoked the anger of many of those contributing to the debate, especially among health care personnel. At this moment, the 'model of the operating theatre' prevails in health care, which is not at all odd since surgeons often manage hospitals. Both governance and management functions are still – in a very self-management way – bound to physicians, who also choose the senior management. This points out the powerlessness of the actual owner – the state – and the need for at least partial privatisation in order to strengthen the ownership function. An organisational culture and a clear vision of hospitals cannot exist in current conditions since the organisational model does not allow it.

Hospitals in particular demonstrate a high level of integration between payers and providers. The losses of providers thus become the losses of the Health Insurance Institute of Slovenia. It is very often heard in the debate that the market and entrepreneurial organisation are unsuitable because a hospital might go bankrupt and close. In reality, precisely this fear would decisively influence the efficiency of hospital management. The legal status of hospitals should therefore be changed into public companies that operate in accordance with corporate legislation. Within management, the role of the business director must be stressed, and the role of a professional director should be similar to the role of a technical director seen, for example, in a manufacturing company.

The remuneration of physicians is non-stimulating so they very often work after normal hours for private health care providers. However, salaries are high, 111% above the average salary in the country which is more, for example, than in Austria, Finland and Sweden (Kornai, Eggleston, 2001: 167-9).

In order to create a more stimulating system, the public and market activities of health care providers could be distinguished. It would be possible to establish a special company for market activity owned by public – as well as partially privatised – health care providers and to thereby prevent the cross subsidising of public with market activities, which is forbidden in one way or another in the EU. It would be possible for employees in public companies to be employed on a full-time basis only to provide the services guaranteed by compulsory health insurance, and to be additionally rewarded for their work within market programmes. The salary of employees should depend on the quality of their work that is recognised by the market and on participation in the market activities and programmes of the public providers.

9. Conclusions

The outline of discussions surrounding the 'White Paper' confirms this paper's point of departure, i.e., that the problems characterising the health care system in Slovenia are in fact problems that appear in any transition process. Despite the fact that some problems are *similar to problems faced by the health care sector of any*

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developed country, several problems have emerged due to the fact that this sector was not addressed in any systematic way during transition. This is why it now requires a comprehensive reform that will result in a consistently designed health care system in Slovenia. The main findings are as follows:

a) Stabilisation of the health care system in Slovenia by eradicating the losses of the social insurance fund cannot be achieved through the elimination of voluntary health insurance for the full coverage of co-payments and its merger with compulsory health insurance. The only realistic and feasible solution is to reduce the scope of rights assured by compulsory health insurance. This would both annul the social insurance fund's losses and reduce the burden imposed on the business community. More importantly, this would create room for 'real' voluntary insurance. It is therefore imperative for social health insurance to assure the funding of and access to basic health care and state-of-the-art treatments and pharmaceuticals to all people facing any serious illness. Applying this criterion to the allocation of social insurance funds leaves space for voluntary insurance to cover those health care goods and services for which the strengthening of the allocative function of prices does not negatively affect the main ethical principles applied to health care, especially the equity principle. However, such decisions are always at least partly the subject of political debate.

b) Restructuring of health care providers should not be an administrative process governed by politically set rules and the politically influenced behaviour of health care providers' management. The latter, of course, has to be educated and trained for efficient management, but restructuring and increasing competition have to be achieved through constraints imposed by the market and appropriate incentives within the payment system. The overview of the health care system also shows that both gatekeeping and capitation payment are appropriate for the provision of basic health care. This supports the argument that the gatekeeping role of basic health care should be integrated to a greater extent with secondary outpatient care through the reimbursement schemes. In other words, some forms of outpatient care could be financed out of the capitation of general practitioners. The study of the health care system in Slovenia also shows that the implementation of co-payments as a form of demand-side incentives is necessary but can achieve its purpose only if they are paid out-of-pocket and insurance for full coverage of co-payments is made impossible. Further, prospective payment systems should be implemented for the funding of hospitals and cost-sharing agreements have to be put in place for health care providers. The employees of the latter could work on a full-time basis only to provide services that are guaranteed by compulsory health insurance, and additionally rewarded for their work within market programmes. The salary of employees must therefore also depend on the quality of their work that is recognised by the market and on their participation in market activities and programmes.

c) The efficiency of health care providers is also linked to increased competition. This is why privatisation and liberalisation should be a necessary part of the health care

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system reform in Slovenia. The case of Slovenia shows that an increase in the number of students and graduates of medical schools is particularly important for the future development of the labour market in health care. This is crucial for reducing barriers to entry for providers – especially in the fields of primary and outpatient secondary care – and for stronger competition among health care providers that could also contribute to quality improvements in health care provision. Appropriate government regulation, especially the accreditation of providers, is very important in these circumstances. In the health care sector there is in most cases no need to administratively regulate the entry of private providers. This also applies to voluntary insurance that has the nature of capital-funded insurance systems.

d) It is also important to look at institutional issues within the health care sector. In order for the market and incentives within the payment systems to play their appropriate roles the providers should be businesslike organisations with the kind of management and governance that is also fundamental for the success of any privately-owned organisation. The organisation of health care providers should be made more similar to the organisation of public enterprises and their managers need to be trained in line with modern principles seen in the fields of management and organisation. It is also necessary to establish certain governmental bodies with the purpose of regulating both the demand and supply sides of the health care sector.

e) The case of Slovenia and its health care system also shows that the social insurance funded mostly by income from labour is inappropriate. Considering the changes in the structure of transition countries' societies whereby capital income is gaining in importance, social insurance contributions should be based on the incomes of both labour and capital. It would therefore be appropriate for contributions and/or taxes for the financing of health care in the post-transition period to be in the form of income taxes. It is also reasonable to consider implementing certain elements of capital-funded payment systems.

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Reforma i tranzicijska prilagodba sustava zdravstvene skrbi u Sloveniji

Maks Tajnikar¹ and Petra Došenovič²

Sažetak

U ovom radu autori analiziraju određena neriješena pitanja glede reforme zdravstvene skrbi koja se provodi u Sloveniji. Mišljenja su da je reforma nužna zbog problema koji su se nakupili jer, dosada, javni sektor nije sustavno provodio tranzicijske procese. Uzimajući to u obzir autori raspravljaju o problemima obvezatnog i dobrovoljnog osiguranja i ciljevima koji se mogu postići provođenjem dobrovoljnog zdravstvenog osiguranja. Autori također razmatraju područja koja imaju značajan utjecaj na učinkovitost slovenskog zdravstva. Naglasak se najprije stavlja na odgovarajuće sustave poticaja koji utječu na ponašanje pružatelja zdravstvene skrbi, pacijenata i osiguravatelja, a potom i na upravljanje pružatelja zdravstvene skrbi.

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Ključne riječi: zdravstvena skrb, reforma zdravstvene skrbi u Sloveniji, tranzicija, osiguranje, učinkovitost

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