Privatization of Health Care in Slovenia

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This article analyzes the results of the hitherto privatization of health care in Slovenia based on statistical indices and public opinion data. The new legislation offered much more room for quasiprivatization than for real privatization. A greater room was left for privatization of financing than for the status of health care providers and infrastructure. The statistical data on private practitioners and the share of private resources in health care costs show that the privatization is relatively slow but irreversible process. Public opinion data revealed that the population of Slovenia accepted this process but some signs of distrust in private practice and new forms of health insurance were noticed. The new legislation leaves a high degree of regulation to the state in protecting citizens’ rights but there are some risks of unrestrained development of the market due to insufficient implementation of legislation.

Key words: assessment of health care needs; budgets; economies, hospital; health services administration; health system agencies; Slovenia

One of the most important trends in social policy since the beginning of the eighties has been a reassessment of the role of the state and the privatization of social services. Debates about the (dis)advantages of a market system as compared to a centrally planned system of social welfare result in the following questions: What is the most appropriate size and scope of the market?; What is the degree of regulation that is thought to be desirable?; and What is the degree to which government ought to intervene to enhance certain groups' ability to participate in the market and modify market outcomes (1)?

Even if markets are recognized as the most efficient means of allocating resources in most circumstances, there is a likewise accepted view that there is no room for unrestrained market activity in the provision of a social good like the health care. As Titmuss’s study (2) of blood donation in commercial markets showed, the consumer had less freedom to live safely and a little choice of determining prices, was more subjected to shortage of supply, had fewer opportunities to check and control consumption, quality and external costs, and was often exploited. This study also revealed that markets did not always produce better services and that it is difficult to measure efficiency in health, e.g., if it is the one that provides adequate service at minimal costs, or the one that most closely meets the needs of the consumers. Titmuss’s argument for treating medical care differently from other market goods rested on the high degree of uncertainty and unpredictability of consumption of medical care. He also stressed the lack of knowledge of consumers in this sphere and their reliance on professional advice. Johnson (1) also warns that markets in health and welfare may create greater inequality by excluding poor and disadvantaged people from its benefits, creating a two-tier services, affecting the distribution of services, and enabling more prosperous areas to attract better and more resources.

Therefore, questions related to the scope and regulation of market and the protection of vulnerable social groups should be solved in a way to hinder the imperfection of the health care market. Concerning the reliance on market mechanisms, the experts from the World Health Organization (WHO) (3) do not propose policy-makers less government activity in this sphere but different activity. The state should extend its role beyond traditional "command and control" measures by introducing flexible regulation that would achieve its goals by monitoring and evaluating outcomes rather than stipulating inputs. Consequently, the governments should increase their competence because it is professionally much more demanding job to supervise contracting and other market-based arrangements than to run services directly (3).

The above questions and their solutions are also of great concern for Slovenia that has made a significant progress in the privatization of social welfare, especially in health care. Namely, before 1992 there were no private funds for financing health care services at all and the private practice did not exist as an official institution after its abolishment in the late 1950s. The purpose of this article is to present the “renaissance” of the private health care institutions in Slovenia with a special attention to
the above mentioned questions. The concept of privatization indicates a transition of ownership (the right to dispose – to sell or purchase, the right to use and the right to appropriate) from the public to the private sector (4).

Other Countries' Reliance on Market in Health Care Sector
A variety of experiences related to markets is a significant feature of the Western European countries. According to the WHO experts (5), these countries have developed “diverse organizational patterns in the structure of their health-related services, facilities, institutions, and workforces”. They introduced market initiatives into different sectors of the health care system in health care funding, in different fields and stages of the production of health services (hospitals, nursing homes, physicians, social services personnel), and in allocation instruments that distribute funds to service providers. The same experts ascertain that “there is no single, simple concept of market that can be adopted for the use in a health system”. Every national health system has differently defined the scope and size of the market, which is reflected in the mix of public, quasi-public, statutory-regulated private, private non-profit making bodies. Each of the variation is a result of the country’s particular history, customs and culture, as well as the existing balance between political and economic power (5).

According to Johnson (1), models of welfare are useful analytical instruments for detecting variations in market provision among countries. A particularly helpful one is Esping-Anderson’s model of Welfare States (6) based on two variables: commodification/de-commodification and social stratification.

Esping-Anderson understood social citizenship and social rights as central components of the welfare state. He is convinced that the introduction of modern social rights implies the loss of the pure commodity status of people (under the industrial capitalism and its attendant markets, a principle was introduced according to which a survival of an individual depends exclusively on the sale of her/his labor and thus, her/his welfare is a function of the cash nexus). “De-commodification occurs when a service is rendered as a matter of right, and when a person can maintain a livelihood without reliance on the market” (6). Hence, de-commodification is the means by which the dominance of market is weakened.

In showing variations of the countries' dependence on the markets in health and welfare, Johnson (1) applied Esping-Anderson’s model of Welfare States which distinguishes three clusters of states (6): 1. Liberal-residual welfare states. In these states, the recipient of very low levels of benefits is dependent upon needs and means tests and the system stigmatizes those who use them. De-commodification is minimal and market provision is extensive. A dual system of welfare is developed: poorer people are dependent on state benefits, and those better-off buy services on the private market. State services are generally of poor quality, which stimulates the middle classes to buy services on the market. This cluster includes countries such as the United States and Canada.

2. The conservative corporatist model. There is a reliance on state insurance schemes, with benefits related to class and status. The de-commodification potential is reduced due to allocation of benefits upon contributions and work status. Representatives of this model are continental European countries, e.g., Germany, France, and Italy.

3. The social democratic regimes. In this case, high-quality services are provided on a universal basis. All social classes equally enjoy these rights. Market provision of health and welfare is of only marginal significance. A success of this regime is that the governments managed to win the loyalty of the middle classes by rising the quality of state provision to the levels demanded by the better-off citizens. The representatives in this cluster are Scandinavian countries, especially Sweden. It should be pointed out that universality of rights is not a single prerequisite for de-commodification. Universal system, such as that of the Beveridge type (National Health Service – NHS in the United Kingdom), offers only limited de-commodification, since services provided by the state are of lower quality than those offered on the market. Therefore, dependence on the market persists in the long run.

The United Kingdom has recently decided to pull back from the reliance on the competitive initiatives as the driving force for health care reform. This has been the impact of recession – a high level of unemployment that reduced people’s capacities to purchase private services. However, according to Johnson’s opinion (1), the private market still has a firm base in the United Kingdom and once the recession is over, it may begin to expand again at its previous rate. Besides, there is also a strong public support (7) for allowing people to choose between the state and the private market services. Which cluster in the model of Welfare State related to the market provision in health the Central and Eastern European countries, now in transition, are going to enter? Some authors have already made predictions; for example, Deacon (8) expects that Hungary and Slovenia will adopt regimes of the liberal Welfare State. The research to approve such predictions has so far been rare. A study made by Marrée and Groenewegen (9) drafts the current trends of health care reform in these countries. On the basis of the present experiences in five countries – the former German Democratic Republic,
Czech Republic, Slovak Republic, Hungary, and Poland, they found out that the background of their health reform was related to the previous history of these countries on the one hand and “reference” countries on the other. Before the introduction of the Semashko system (mainly in the fifties) all five investigated countries adopted the Bismarck system around the turn of the twentieth century, as their own health insurance systems, similar to many other Western European countries. After 1989, all countries under study exchanged their centralized and predominantly tax-funded system for a decentralized and partly privatized Bismarck insurance system (combination of social and private health insurance). Regarding the distribution of money to health care providers, these countries introduced the contract model (direct remuneration of providers by the third party) and allowing the extension of out-of-pocket model as well. These facts imply that Central and Eastern European countries are now much more on the way to the conservative corporatist model than to the liberal-residual model of Welfare State (9). What will be the impact of the Bismarck model on the future health care organization in the countries in transition and on their vital social subsystems, e.g., economy seems a very important question. The present governments of these countries are all facing the dilemma how to stimulate their economies and at the same time build up new system of social security, including health insurance. Apart from the problems inherited from communism they are also faced with the problems of continental European welfare states – increasing unemployment rates. The idea of social welfare based on the Bismarck model is founded on the presupposition of full employment of a considerable proportion of the population (9). Therefore, departure from this model in the future would not be a surprise.

Preparations for Launching the Process of Privatization in Health Care in Slovenia

The debate over reconstruction of health care system in Slovenia began in the second half of the eighties (it refers to other social services as well). At that time, there was a general consensus among professionals such as physicians, sociologists, and economists (10-13) that health care should be an appropriate combination of the public and the private sector. It was also obvious that the current health care system was in crisis (e.g., shortage of financial resources, low salaries, and low working motivation among health care employees and dissatisfaction of consumers). Some analysts believed that the situation could not be improved without the replacement of the quasi state monopoly over the health care services with a more pluralistic system of welfare. However, the supporters of a “quasi market” have yet to define a clear model for the accomplishment of this process in Slovenia. With the establishment of the Parliament of Slovenia, elected in April 1990 in the first free elections since the World War II, favorable circumstances for initiating the process of privatization in health emerged. The new government was charged with the task of reforming the whole system of social services. The general intention was to form a more efficient system of social services which would reflect the pattern emerging in Europe. The most important task was to prepare and implement procedures for drawing up new laws regulating the social services. The next task for the Ministry of Health was to prepare the Health Care Bill. One of the main challenges with which they were confronted was the re-constructing of the health care system into a more financially stable system. In addition, they were expected to tackle other challenges, such as the abolishment of public monopolies over the health care services, encouraging a more efficient production of health services, reducing administration, promoting better opportunities for individual choice, and making better use of the existing capacities. In short, a lot was expected from the introduction of private practice and voluntary health insurance.

Before and during the preparation of the Health Care Bill, some concerns about their extension and regulation were expressed (13-16). They were mainly based on the experiences of the West European countries where the private health practice and different types of health insurance already have a long tradition. Concerns were related first of all to the share of public and private sector in covering health care costs, the forms of health insurance, the position of private health practitioners (their organizational and professional autonomy), and the role of the state in regulating health care system. The answers to these issues were mostly general and abstract due to a deficiency of any preceding empirical analysis related to the privatization of health care in Slovenia. The proposals and instructions given to those drafting the bill can be summarized as follows:

1. The budget (taxes) and/or obligatory health insurance are the main resources of financing health care system in the majority of the developed European countries. They assure equal rights to the health care services for all citizens according to the principle of solidarity and reciprocity. Resources of the voluntary health insurance and “out-of-pocket” payments for health services represent only a minor share of all costs in health care. Commercial forms of health insurance are practically unknown in Europe.

2. Pure market relationships between a physician and a patient are very rare today in Europe. The
difference between public and private health system is perceived only by practitioners, but not by patients: an individual can receive medical help from a private and public physician, respectively, without any direct or only minor participation. In such a system, a private practitioner is reimbursed by the insurance company with which he/she has made a contract. Naturally, equal position of services in public and private sector implies that each of them have to be controlled by the insurance company in the same manner. Therefore a private practitioner has to be subjected to the numerous regulations of the public health system.

3. The regulative role of the state is confined only to those spheres of health care system which are financed by the public resources. For other spheres, the responsibility is under the domain of professional associations, for example, the chamber of physicians.

The only available empirical data from that period referring to the privatization of health care are the 1991 Slovenian public opinion data (17). In 1991, the data from the Slovenian public opinion survey No. 2 showed that three quarters of the Slovenian citizens would be willing to contribute more of their financial resources to health if services were of higher quality. However, only a minority of respondents (10%) were ready to give more money directly from their own pocket. The majority of respondents (50%) still strongly supported the old form of financing health care services: raising health care funds through a contributory amount of the employee’s gross income and the employer’s contribution. The rest of the respondents supported the mixed forms of financing: contribution of the employee’s gross income covers the basic health services. Other services are paid directly or through private insurance. The data from the Slovenian public opinion survey No. 1 (18), conducted in 1994, showed that only 8% of the respondents agreed that health care services should be paid by the citizens alone, 68% agreed that they should be paid by the state, and 24% of the respondents had no opinion at all. Unfortunately, there are no data on opinions, aspirations, motivations, and perceptions of those employed in the health care system about privatization in health care.

**Legislative Opportunities for Privatization in Health Care**

There is no doubt that the speed of privatization will be strongly influenced by the new health legislation. The following shows the room for maneuver that the new health legislation will offer.

Citizens of Slovenia and foreign citizens who fulfill all the conditions determined by law (19) are permitted to run a private health care practice. They are obliged to: (a) possess the appropriate professional education and the ability of autonomous work; (b) agree not to perform any other regular job; (c) have no legal bar to the performance of health care activity; (d) have suitable workplaces, equipment and co-workers if necessary; and (e) have a necessary approval from the Chamber of Physicians.

Private practice is possible in all the spheres of health care activities except in some parts of tertiary sector: the work of clinics and medical institutes, pharmaceutical activities, blood supply, storage and supply of human organs, hygiene, epidemiology, and pathology. All these activities should be performed only as a public service with a possibility of concession (it is given to a private physician with a license who made a contract with a public insurance company). Private practitioners are allowed to operate both within and outside the framework of the public health care service network. In both cases, permission of the regulatory body (The Ministry of Health) is required. The performance of private practitioners in the public sector additionally requires a concession (license for a contract).

This may be obtained by a consensus of the representatives of the county government (for the primary health care), the Republic government (for the secondary and tertiary health care), the Health Insurance Institute of Slovenia (HIIS) and the Chamber of Physicians. The concession is a prerequisite for a contract. The basis for a contract is an agreement signed by three parties: HIIS (on behalf of insured persons), the Ministry of Health (on behalf of the state), and providers of health care services with the HIIS, which is made with a highest bidder as a result of public tender process irrespective of the public or private status of the applicant. The amount and quality of services, their prices, the arrangements of payment, the control of the contract’s accomplishment, and all other obligations of contractual parties should all be precisely defined according to the Health Care and Health Insurance Act (20).

According to the above mentioned Act, all the citizens of Slovenia are entitled to obligatory health insurance. It reimburses the total costs of the health services for some groups of population (children, school children, and pregnant women), and some specially defined health services, such as obligatory vaccinations, treatment of occupational diseases, infectious (e.g., HIV) and some chronic diseases, services of nursing care and medical emergencies, health care related to blood and human organs supply, some medications, and prosthetics. For other services, however, cost sharing is required (from 95% to 50% of the total value of service) which can be reimbursed through the voluntary health insurance. This type of insurance is regulated according to the Insurance Act (21).
based upon commercial principles. This type of insurance is mainly reserved for covering the costs of health services which are not under the domain of obligatory insurance. The funding of obligatory health insurance comes from a percentage of the employee’s gross income and a percentage of the employer’s income. The only manager of these resources is HIIS, which has the status of a public organization. Resources are used according to the principle of solidarity and reciprocity. The voluntary health insurance funds are raised by the monthly premiums of insured persons. Contracts for voluntary health insurance can be made with HIIS or any commercial insurance company offering such an insurance. It is worth mentioning that the main holder of the voluntary health insurance is now HIIS, and that the most frequently used arrangement is compensation for services already partly paid by the obligatory insurance. (In 1995, 1,21 million people, out of a total population of approximately 2 million, made additional voluntary contributions for additional payment of health services.) Only 7,990 people were insured for medical services of a higher quality. In 1996, their number increased to 8,674 people. In the same year, a program of voluntary health insurance for those who travel abroad was introduced. The number of people insured by this insurance amounted to 8,076 (22).

The Health Care Plan of the Republic of Slovenia – Health Care of Slovenia to the year 2000 (23) is another document worth mentioning. It is derived from the previously presented legislation, and it even more directly influences the process of privatization. It defines the scope of the public health services network which will remain unchanged, as well measures for its implementation. According to them, the Health Center remains the basis of the health care organization and performance at the primary care level as it was before the implementation of the new legislation. It can be organized as a public institution or as a private institution of private health practitioners with concession, or as a combination of both. The inclusion of concessionaires in the public network will be determined by the need of the individual county which owns the accommodation and equipment of the Health Center on the primary level (the state is the owner of the accommodation and equipment on the secondary and tertiary level). There is already a need to include all the dentists in the private health care practice. For general and family medicine practitioners, respectively, the Plan anticipates gradual granting of concessions. However, no concessions are planed for the health care of children, school children, and youth, since it has a character of preventive and dispensary activity. It will remain exclusively a public service. The activities of specialists will be performed in clinics, private specialist’s dispensaries with concession, Health Centers, and in health resorts. Regarding the activities of hospitals, the Plan envisages only the public health care services. Nevertheless, it does not exclude the possibilities of its supply on the free market in the case of greater capacities of public health institutions.

The privatization of health care in Slovenia is most probably going to advance in two directions: as a quasi-privatization (only the right to use is transmitted to an individual), and as a true privatization (the right to dispose, i.e., the right to sell and to purchase, and the right to use is transmitted to an individual). Regarding the public health care network which remains the basis of the Slovenian health care services, it can be supposed that the quasi-privatization will be more extensive than the true privatization. It can be expected that the private sector will not be developed through the transition of ownership from the public to the private sector, but as an alternative and addition to the public health care services. It will be reserved for those who can afford it. It can also be observed that a greater room is left for the privatization of financing than for the status of health services providers and infrastructure. According to the permission of the Health Ministry (referring to the law), it is allowed to organize an out-of-pocket medical consulting in the Health Centers, clinics, and by private practitioners (concessionaires). This sort of medical consulting should include only the services of higher standard and unnecessary treatments which are not encompassed neither by the contract with the HIIS (obligatory health services) nor by the voluntary insurance (insurance for co-payment). However, jump the queue, which is not allowed, is often the case due to inefficient control by HIIS.

Main Conflicting Issues Concerning Legal Rules on Privatization of Health Care

During the legislative procedure, the main debate concerning the privatization in health care was focused on the so-called “paragraph on competition”, which prevented employees from having a regular job in the public sector and in the private sector at the same time. The opponents of that paragraph (mainly physicians) (16) argued that the paragraph required physicians starting private practices to immediately quit their regular jobs in public institutions. That meant starting from zero in a situation where they might not have accumulated any initial capital because of the low salaries, but where they were nevertheless forced to comply with the provisions of the working standards.

According to the Act, the founder of the public institution (the state) was responsible for equipment, accommodation, and funding, whereas the private practitioners had to be self-financing and self-providing, or hired at the market place. Therefore, most physicians supported the idea of a transitional period during which a regular job in a public institution and in a private practice would be permitted.
According to their opinion, this arrangement would allow a gradual acquisition of private patients, equipment, and working premises. Their arguments were not accepted. The Ministry of Health argued that the paragraph on competition made a distinction between regular and the so-called afternoon jobs and had the effect of reducing unemployment among health care workers and promoting competition, decreasing the work-load of health care workers, and increasing their professionalism. In addition, it was pointed out that the combination of a regular job and a private practice was not recommended by the World Health Organization (24). To arrive at a compromise, the Act included the provision that a professional might treat private patients in his/her domiciliary public health center (out-of-pocket medical consulting). However, the rules according to which such consulting should be performed have never been precisely defined. Nevertheless, the discussion on the “paragraph on competition” continues. There is a great interest among physicians for its abolition and in this respect, the Chamber of Physicians supports them. Their main argument is that the “paragraph on competition” is unreasonable due to honorary (non-regular, additionally paid) work of a great number of physicians who regularly work in public health institutions. Namely, according to the Health Care Act honorary work is not allowed. However, according to the Labor Relations Act they can work gainfully (but, for a limited number of hours). The opponents to the “paragraph on competition” argue that this discrepancy should be dismissed by the abolishment of the paragraph itself and changes regarding this matter could be very soon expected. The proposals by the Ministry of Health have recently appeared for relaxing the “paragraph on competition”: private practice will be allowed for top-specialists who are employed in public health institutions. The intention of such a proposal is to encourage experts to stay within one public health care sector.

After the new health care act was established, a severe conflict arose related to the tenancy of the public institutions’ capacities by the private practitioners. The act explicitly states that private practitioners (concessionaires) could secure his/her working places by this means. Nevertheless, the Ministry of Health did not provide any exact instructions on handling this issue (for example, what should be the level of tenancy). Because of this deficiency, the relationships between concessionaires and public health institutions (mainly the managers of Health Centers) were handled in very different ways. In some cases, the parties found a common interest (according to the information of HIIS, approximately 18% of all concessionaires have their working places in public institutions), but in other cases, a very intense disapproval by the management of a public institution appeared. This means that accommodations are left empty, and furthermore, these vacant spaces cannot be used by new physicians because of the prohibition of public health care network extension.

Results of the Privatization of Health Care
The scope and progress of privatization can be monitored through the number of private practitioners and share of private resources in the total health care costs. According to HIIS data (22), the number of private practitioners (concessionaires) has consistently increased (Table 1). In 1996, dentists had the greatest share, followed by general physicians and specialists (Table 2). However, the number of truly private practitioners is very small. The share of private practitioners in financial resources for health care services is 4.6%.

Table 3 shows that the share of private resources in the total health care costs has been increasing as well. The share of the health care costs in the total GDP is estimated at around 8% (13). This percentage includes the HIIS funds, resources for investments distributed by the state and counties, and resources of other insurance companies. However, this share could be even greater because the HIIS does not control resources collected in out-of-pocket consulting. It is too early to estimate the impact of the privatization process on the health condition of the population. However, data on the Slovenian public opinion from the survey No. 1 from 1994 (18) and No. 2 from 1996 (25) provide at least some indications of public experience with the private health practice and obligatory or voluntary health insurance.

The data show that Slovenian citizens are in general a bit cautious to the novelty introduced in the health care system and that the positive inclination to the new health care legislation observed by the fixed share of the respondents has been slightly decreasing since 1994 (Tables 4-11).

Table 1: The number of contracts in the period 1993-1996 (22). [view this table]
Table 2: The number of contracts with private practitioners by the activity in 1995-1996 (22). [view this table]
Table 3: Proportions among public and private resources of health insurance between 1992 and 1996 (22). [view this table]
Table 4: Slovenian public opinion related to the introduction of private health care practice – share of
respondents who believe private practice will positively affect the quality of health services (18,25). [view this table]

Table 5: Slovenian public opinion related to the introduction of private health care practice – share of respondents who already applied for private health services (18,25). [view this table]

Table 6: Slovenian public opinion related to the introduction of private health care practice – share of respondents who already applied for private health services and were more satisfied with private than public health services (18,25). [view this table]

Table 7: Slovenian public opinion related to the introduction of private health care practice – share of respondents who already applied to private health services and paid all the costs directly in cash (18,25). [view this table]

Table 8: Slovenian public opinion related to the introduction of private health care practice – share of respondents who already applied for public health services and paid all the costs through insurance arrangement (18,25). [view this table]

Table 9: Slovenian public opinion related to the introduction of private health practice – share of respondents who believe that fixed amount of rights from obligatory insurance will improve the quality of health services (18,25). [view this table]

Table 10: Slovenian public opinion related to the introduction of private health practice – share of respondents who believe that voluntary insurance will positively affect the quality of health care (18,25). [view this table]

Table 11: Slovenian public opinion related to the introduction of private health practice – share of respondents who believe that qualitative health services will not be available for poorer members of society who are not able to apply for voluntary insurance (18,25). [view this table]

A half of the respondents in 1994 believed that private practice would positively influence the quality of health services, whereas only 46% of them believed the same in 1966 (Table 4). In both studied years, the optimists were slightly more frequent among men than women, but significantly more frequent among younger than older age groups, among more educated than less educated, and among higher than lower social classes.

Nevertheless, the share of respondents who applied for private health services (Table 5) (unfortunately, the data do not allow a distinction between true private practice and concession) in the last twelve months prior to the interview has been increasing. In 1994, only 13% of the respondents applied for private services, compared to 20% in 1996. In both two years, women visited the private practitioner slightly more often than men. In 1994, there were only minor differences between the respondents regarding age, education, and social class, whereas in 1996, the differences increased: those who applied for private services were more frequently younger, more educated, and more often of a higher social class.

The data also show (Table 6) that satisfaction with private services slightly decreases: 83% of all respondents in 1994 and 74% in 1996 who already applied for the private services were very satisfied with them. In respect to this point of evaluation, there were very minor differences between men and women and between social classes. More variety was observed concerning the age and education level: younger age groups were more satisfied with private services than older age groups and those with medium level of education more than those with the lowest and the highest level of education. All costs of the services had to be paid directly in cash by 49% of the respondents in both two years (Table 7). There were again almost no differences between men and women. However, the differences appeared between some other social entities. Those who in 1994 paid all costs directly in cash were most frequently between 31 and 40 years of age and belonged to the middle social class, whereas in 1996 they were respondents younger than 50 years, more educated, and from a higher social class.

Meanwhile, in both 1994 and 1996, 37% of the respondents managed to pay all the costs of services at the private practitioner by means of insurance arrangement (Table 8). In this case, men slightly prevailed over women. In 1994, the respondents from the youngest age group prevailed among those who applied for the insurance arrangement, whereas in 1996, the respondents from the oldest one were predominant. Concerning the education level, less educated prevailed in both years, as well as the lowest over the highest social classes. Furthermore, in 1996, the difference between better and less educated and between the lowest and the highest social classes considerably increased.

Regarding the introduction of obligatory insurance, only 28% of the respondents in both years believed that the fixed amount of rights from obligatory insurance would improve the quality of health care provision and the health condition level of the population (besides, the majority of the
respondents were not sure what the outcome would be) (Table 9). In 1994, men were more confident in the obligatory insurance than women, older age groups more than younger, less educated more than better educated, and lower social class more than the higher social class. In 1996, the situation has slightly changed, especially regarding the age and the social class. The most positive opinions related to the introduction of obligatory insurance was most frequently found among the respondents aged 31 to 50 years. In respect to the social class, the situation was reversed compared to that in 1994.

The impact of the voluntary insurance on the quality of health provision and the health level of the population (Table 10) was estimated more favorably: 41% of the respondents in 1994 and 38% in 1996 anticipated improvements. Especially in 1996, men were more optimistic than women regarding improvements. In 1994, the highest share of the respondents confident in the voluntary insurance was reported by either the younger or the two oldest age groups, the respondents who graduated from a vocational school and university, and the two lowest social classes. In 1996, the situation changed: those who declared to be related to the middle or high social class were more confident. Furthermore, the difference between single social groups diminished. The enforcement of the rights from obligatory and voluntary insurance caused no problems in 95% of cases since May 1994 (when the survey was conducted) and in 83% since June 1996.

And finally, as Table 11 shows, more than a half of all respondents (54% in 1994 and 56% in 1996) expected poorer access to quality health services by the poorer members of society due to the new way of health care financing. In this case, there were almost no gender differences. Nevertheless, there were some variations regarding age, education, and social class. In 1994, the highest share of those who most strongly held such an opinion was related to the middle age group, and as well to ten years younger age group in 1996. Concerning the education level in both years, the most educated strongly differed from the other three groups. With respect to the social class, the respondents from the highest one were more aware or willing to express the opinion that the new system of financing health services would be less egalitarian compared to the old one.

Altogether, men, younger respondents, highly educated, and those declared to be related to the higher social class were more enthusiastic to the novelty introduced in the health care system and also more ready to accept the increase in social exclusion/inequality in the access to health care services than other groups of the respondents.

Discussion

Public opinion data can only provide a very general insight into the “consequences of privatization”. Other data are needed for a more precise insight. The full impact of the privatization on the health care system as a whole can only be evaluated using more efficient data-collection system. The current system does not provide complete answers to such questions as how privatization influences the quality of services, motivation for work, rational use of resources in public health institutions, and health of a population. According to the HIIS data (22), it can only be roughly estimated that private practitioners with concession are more scrupulous performers of contractual duties than those from public institutions, possibly due to their greater autonomy in providing certain services, employing their co-workers and smaller infrastructure costs as well. Regarding this matter, a question arises whether or not the Ministry of Health and the insurance company, especially HIIS, applied sufficient mechanisms in controlling the work of concessionaires. Thus, the expectations that private practice would stimulate more efficient production of health services on the basis of greater competition in the whole system have not been realized so far.

Undoubtedly, the above analysis shows that Slovenia has encouraged the development of a private market in health with legislative changes. The government altered the balance in financing health care by introducing voluntary health insurance and in health care provision by increasing opportunities for private practice. Statistical data reveal that only limited scope and size was left to the market, since the room was mainly given to the quasi-private and statutory-regulated forms of private practice. The state formed criteria and standards for controlling the entrance of physicians into the private practice according to the general social aims (to secure accessibility of health care services to all) and defined the most vulnerable social groups on the principle of solidarity. Therefore, Slovenia did not follow the liberal model of welfare state in its health care reform, but rather adopted the same one as other Central and Eastern European Countries did. This decision is more favorable for the proneness of the public opinion, still expecting a strong role of the state by ensuring their social and health care security.

Slovenian government took over the legislative solution of other (especially continental) European countries. On the basis of the present analysis (the main conflicting issues), this proved insufficient for a successful operation of the health system. Due to individual specificites of the country (e.g., the present patterns of behavior of providers and managers), more strict instructions for the
implementation of regulation should be given by the government, especially by the Ministry of Health. Otherwise, the risk of unrestrained development of the market will certainly increase.

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