Slovenian Experience on Health Insurance (Re)introduction

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A period of changes in what had previously been public health insurance began in Slovenia in 1992. A new legislation introduced a mixed public-private insurance, the share of GDP allocated for health care insurance in Slovenia equaled the EU average, and the financing of the public health insurance has been balanced up – until now. For the first time since Slovenia gained independence, the compulsory health insurance is planning a 6% reduction in its income. The way to the solution of the problem lies in a political consensus on the public health issues in Slovenia, but it is still unclear whether it can be reached. A successful political agreement on the adequate amount of health care, granted to the Slovenian citizens by the public health insurance, should secure its balanced financing, which is about to be disturbed.

Key words: delivery of health care; economics; health expenditures; insurance, health; health plan implementation; insurance, health, reimbursement; Slovenia

In most European countries, issues of equity, reinsurance, and clearly defined responsibility of the state in respect of health care are combined more or less successfully with a desire to contain costs and to ration systematically. Health insurance is an organized regulatory mechanism for acquiring funds on different bases to provide health care to people (1). By smart decision making and careful allocation process, a rational compromise between all the relevant health services and people who can benefit from them can be reached.

Slovenia chose a Bismarck-type of insurance system by introducing compulsory health insurance in the spring of 1992 (2,3). The reason for it was both political and economic. On the one hand, Slovenia adopted a type of health insurance similar to that in the countries in transition, on the other hand, a Beveridge-type of insurance was no longer feasible for historical reasons (3). Under the new system, the basic set of health care services has been provided by means of compulsory health insurance related to a specific source of monetary contribution. The new legislation required health care budget to be separated from the state budget, to avoid a flow of funds allocated for health care out of the health care sector (3). That way health care funds became more transparent and their primary intended use better ensured. This article offers a discussion on certain historical circumstances and other factors that have led Slovenian health insurance into the present situation.

Health Overview of Slovenia

Demographic Situation

The population of Slovenia was estimated at 1.99 million in 1998 (Table 1) and the most important demographic change seems to be further population aging. The proportion of people aged 65 years or more increased from 10.0% in 1985 to 13.7% in 1999. Over the same period, the proportion of children up to 15 years of age decreased from 22.0% to 16.4%. The overall number of live births between 1985 and 1998 decreased from 25,933 to 17,856 (31.1% reduction), while the number of deaths remained constant, around 19,000 (Table 1). Depopulation trend was recorded for the first time in 1993, when the number of deaths exceeded the number of live births. Bearing in mind the fact that depopulation accelerated in 1997 and 1998 (in 1998, the difference between the number of live births and number of deaths reached 1,183), we are predicting that the depopulation trend is going to stabilize in the future. Also, in the past decade, the long-term trend of birth rate and natural increase showed the relatively steepest decline (4).

The increase in the number of elderly people (the combined effects of top-down and bottom-up aging) changes the conditions under which children live and grow and poses major economic and health challenges.

Health Status Evaluation Based on “Health for All” Indicators

The difference between the average life expectancy in Slovenia and European Union was 3.1 years in 1985,
and 2.2 years in 1997. In 1998, average life expectancy at birth in Slovenia was 71.3 for males and 79.2 for females (75.3 for both sexes), meaning that Slovenia has achieved the goal set by the European health strategy, “Health for All”, by the year 2000 (5).

Infant mortality rate in 1997 was 5.2 per 1000 live births, which is below the EU average. The maternal mortality rate was 11.1 per 100,000 live births in 1997 and has been continually increasing since the beginning of 1990’s (5).

The overall mortality structure according to causes of death is similar to that in the EU and has been stable for a long time. The most frequent causes of death are cardiovascular diseases, followed by malignancies and external causes, such as injury and poisoning (4).

Deaths from external causes (injuries and poisonings) have a moderately decreasing trend. Although the number of deceased due to accidents has slightly decreased over the last years, Slovenia is still among the countries with the highest mortality rates due to external causes, and far above the EU average. Injuries and poisoning are also the most frequent causes of death in children and adolescents.

Over the last years, not a single case of congenital rubella, diphtheria, acute poliomyelitis, neonatal tetanus or tetanus in people younger than 50 years has been registered in Slovenia. Due to traditionally good immunization coverage, the incidence of vaccine-preventable diseases, ie, measles, mumps, and pertussis, has been low and recently decreased even further. Malaria has been long eradicated in Slovenia, thus the disease is registered only in isolated cases, ie, in people traveling to and from African or Asian countries (4).

Life Styles

In 1996, the new legislation prohibited advertising of tobacco products (6). According to the latest data obtained by the Slovenian public opinion survey in 1999, 71.8% of adults are non-smokers (7). There are significant efforts made to raise awareness of the people about the harmful effects of smoking. Concern for women and adolescents is growing because they are the main targets of very aggressive marketing strategies of tobacco industry today.

Drinking alcohol is a remarkably common problem in European Union. It seems to be culturally rooted and thus almost unavoidable. The increase in annual pure alcohol consumption in Slovenia (from 9.5 L in 1985 to 12.1 L in 1995) is disturbing, since it places Slovenia at the very top of the list of European countries with that problem (4).

Before 1989, illicit drugs use in Slovenia was quite limited. However, since 1989, use of all drugs, and particularly heroin, has rapidly increased. It is estimated that there are as many as 5,000 heroin users today (200-250 per 100,000) (4). The potential spread of HIV infection has added a new dimension to the illicit drug use problem and became a reason more for concern.

Health Care Resources and Utilization

The number of hospital beds is gradually but constantly decreasing due to the principles of health policy and changes in hospital care financing models. The number of hospital beds in Slovenia in 1998 (562 per 100,000 population) was below EU average in 1997 (687 beds). The number of physicians in Slovenia was 228 per 100,000 population or 1 physician per 439 inhabitants in 1998 vs EU average of 348 per 100,000 or 1 physician per 287 inhabitants in 1997. That fact has revealed a more conservative manpower policy in Slovenia. The average length of hospital stay in 1998 was 9.5 days (all hospitals), which was below EU average of 10.8 days in 1996 (5).

Health Insurance in Slovenia

Before and Immediately after Independence

Until 1990, the health care system in Slovenia had been managed through a complex self-management communities system. The federal constitution, passed in 1974, introduced a specific type of health insurance, with the “self-managing communities of interest in health” as the main source of funding. The self-management was an invention of the Yugoslav ideological system, according to which people themselves were able to define their needs and the ways in which they should be satisfied, without the intervention of the state. Local associations of people in one or more communities with at least 150,000 persons handled all insurance funds. Although the management of health insurance was left up to each republic, the federal government still influenced some health services through federal legislation and control of the republics’ budgets.

There were 65 local health communities, 9 health intercommunities (Celje, Koper, Kranj, Ljubljana, Maribor, Murska Sobota, Nova Gorica, Novo mesto, and Ravne) and 2 town health communities – Ljubljana and Maribor, in Slovenia in that period (8). Self-managing communities of interest in health had two houses - one representing health care staff and the other comprising elected health care users from the local area. The theoretical concept was an appealing one, but there were discrepancies between the idealized concept of worker’s self-management in all forms of production, including services, and the realities of daily management practice. The only effect of this experiment was a vast increase in bureaucracy in health care sector, which slowly took over the management of health care system. The slogan

Table 1. Vital indicators in Slovenia, 1985-1998a

<table>
<thead>
<tr>
<th>Year</th>
<th>Mid year population</th>
<th>Live births</th>
<th>Deaths</th>
<th>Natural increase</th>
<th>Birth rate</th>
<th>Mortality rate</th>
<th>Natural increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>1,973,151</td>
<td>25,933</td>
<td>19,854</td>
<td>6,079</td>
<td>13.5</td>
<td>10.4</td>
<td>3.1</td>
</tr>
<tr>
<td>1990</td>
<td>1,998,080</td>
<td>22,368</td>
<td>18,555</td>
<td>3,813</td>
<td>11.2</td>
<td>9.3</td>
<td>1.9</td>
</tr>
<tr>
<td>1995</td>
<td>1,987,505</td>
<td>18,800</td>
<td>18,968</td>
<td>12</td>
<td>9.5</td>
<td>9.5</td>
<td>0.0</td>
</tr>
<tr>
<td>1998</td>
<td>1,982,603</td>
<td>17,856</td>
<td>19,039</td>
<td>-1,183</td>
<td>9.0</td>
<td>9.6</td>
<td>-0.6</td>
</tr>
</tbody>
</table>

was “Health care is too important to be left to physicians” and the management of health centers was slowly handed over to non-medical professionals. As early as in 1978, the first serious deficiency of such a system was noted. Since the patients had almost unlimited rights (3), based on a combination of Beveridge and Semashko systems, to an unlimited set of available health care services, it became obvious that it could not be financed. Population as a whole, entitled to almost any type of service, with increasingly expensive health service on the one side and low economical efficiency on the other, had brought Slovenian Health insurance system to the edge of collapse at the end of 1990 (3).

In 1991, after the referendum on self-determination and adoption of the constitution, Slovenia declared independence. Consequently, the health care system underwent important changes in many aspects, a completely new system was introduced and a new health care legislation adopted (2,9). Alongside with the (re)introduction of health insurance, two of its variations were also set up, namely, compulsory and voluntary health insurance. Under the new legislation, Health Insurance Institute has been running the health care budget independently, since it was no longer a part of the state budget. This made the allotted money more transparent and ensured that it would be entirely used for maintaining health care system. The compulsory health insurance scheme provides the insured with the rights to health care services and cash benefits. Under the new system, the basic set of primary, secondary, and tertiary health care services is provided by means of compulsory health insurance, which is related to a specific source of monetary contribution. Through the purchase of voluntary insurance, additional services (ie, plastic surgery, adult dental services, particular drugs, etc.) are provided to the consumer above the basic level. Only in some cases, the insured do not pay anything (ie, certain diseases like cancer or diabetes, mother care related to pregnancy, and some age groups – children, students, etc.). The rights derived from compulsory health insurance encompass certain cash benefits: compensation for the loss of salary in case of disease-related absence from work, reimbursement of travel cost, ic, to and from a hospital, and funeral cost (3).

In 1991, Slovenian economy faced a severe blow caused by the loss of ex-Yugoslav market and Slovenian health insurance got in severe financial difficulties. To overcome that situation, in 1991, the national parliament approved the increase in the public-health allocations, which amounted to 18.5% of gross salaries, with employer and employee each paying half of that sum (Fig. 1) That measure liquidated all losses. Irrespective of the economic blow in the period 1991-1992, the health insurance succeeded in shaping stable conditions for the implementation of health care programs (3).

From 1992 until Present

Since 1992, six corrections of insurance contributions (“premiums”) have been effected. Irrespective of certain cost pressures, the rights of the insured that derived from compulsory health insurance did not undergo any significant changes in that period. Increase in GDP in 1994 amounted to US$ 9,708 (at current exchange rate) and enabled the Health Insurance Institute to propose public-health contributions to be reduced to 12.7% (3). In 1998, 7.5% of GDP (0.9% of voluntary health insurance and 6.6% of compulsory health insurance) was allocated to health care, which meant almost US$ 1,177 (in Purchasing Power Parity) per capita (Fig. 2). That amount was comparable to the amounts in some European countries (Fig. 3). The present contribution rate (13.2%) has been in force since February 1, 1996 (Fig. 1). We can conclude that, currently, the main pressures on the side of expenditures are: 1) increase in salaries of health care staff; 2) effects of the introduction of Value-Added Tax (VAT) (two levels – 19% and 8%); and 3) problems related to the regularity of payments of health insurance fees by some employers and the amount of unpaid contributions, which increased in 1998 as the Revenue Office did not manage to enforce regularity of payments (10).

In 1999, previously planned increase in salaries of physicians and dentists was effected. The raise had been included in the financial plans. However, there was an unplanned increase in nurses’ salaries because they threatened to strike (10).

The introduction of VAT had an important impact in the field of health insurance. The consequences of its introduction have been felt more since health care providers have not been able to refund the incoming tax on materials used (which amounts usually to 19%, compared to the previous 6.5%). In 1999, the calculated material costs on providers side increased by 4% and the depreciation costs by 13%, because of the new tax calculations.

With the new 8% VAT on medications and pharmaceutical services in pharmacies, (compared to the previous exemption from taxes), drugs expenditures amounted to almost US$200 million and have exceeded the planned amount by 3.7%. Compared with 1998, 10% more was spent on drugs, which represented a 4.1% real increase. In total, these costs represent 15.7% of total compulsory insurance expenditures. That is why their trends have an important impact on the whole compulsory health insurance. Drugs expenditures per capita also show high increases. In 1993, they amounted to 6.334 Slovenian Tolars (SIT) and in 1999 to 7.936 SIT, which was a 25.3% increase (11). Even after 1999, Slovenia has remained a country with relatively high

![Figure 1. Compulsory health insurance combined contribution rate (% of gross salaries) in Slovenia, 1992-1999. Source: Annual report of the Health Insurance Institute of Slovenia. Ljubljana: Health Insurance Institute of Slovenia; 1998:5-41.](image-url)
drug expenditures, higher than many other European countries.

**Challenges, Contemporary Solutions, and Scenario for Further Development**

**Challenges**

The most important factors, which have already influenced the future modeling of health insurance systems and will continue to do so, could be listed in the following categories: economic, demographic, epidemiological, socio-cultural, political, and health.

Under conditions of smaller growth in GDP, we have to count with a smaller increase in health expenditures and, consequently, with limited possibilities for the introduction of new health care programs. In Slovenia, we have managed to increase health care expenditures according to GDP growth rate (about 3% to 4% over the last years) and the inflation rate (about 8%; EU average: 0.5%-1.5%). Total health care expenditures have been increasing at a rate of 11%-12%. Our goal, however, should be to decrease the growth rate in health care expenditures to 3% or 4%, or even less, since that is our yearly GDP growth rate.

With aging of the population in Slovenia, hospitalization rates of patients 65 years old and older increased from 22.9% in 1992 to 28.4% in 1998. Health insurance will come under increasing financial pressure due to the higher expenditures caused by the unfavorable ratio of active and passive populations. The latter is represented by the higher share of the retired and handicapped, which increased from 17.8% in 1990 to 22.3% in 1995 and 23.3% in 1998. The classical solidarity-socialized health insurance system is therefore facing a serious challenge. An indicator representing the subsistence or dependency rate of the entire population (quotient of the number of active population and the number of passive population) has dropped from 1:1.7 in 1994 to 1:1.5 in 1999 (12).

For more than a decade, the need and demand for the treatment of chronic diseases, such as asthma, chronic bronchitis, degenerative arthritis, and neuroses, have been growing stronger and drawing particular attention.

The increasing awareness and importance of health in the society is also reflected in greater demand for certain preventive, therapeutic, and rehabilitation services. The overall expectations of the population are growing. Possibilities of influencing the course of diagnostic and therapeutic management on the side of patients themselves have become a highly ranked issue.

The political confrontation between the increasing demands for social programs due to the higher share of the elderly population on the one hand, and the demands for reduced social transfers on the other, will cause tensions in the health insurance system. Active and insured population will have to provide adequate level of social security to an increasing portion of passive population (13).

There will be further changes in the present systems of health insurance. In the context of a stagnating GDP, there will be hardly any room for a further increase in health care expenditures. There will be a clear trend of trying to squeeze out from the compulsory health insurance all those services in which the social component is dominant, as well as others that are not vital to the insured. The potential of a more positive attitude of the population toward the health promotion and increased awareness of one’s own health will have minor direct effects on the health care expenditures, but even then, these will occur only after several years of intense changes (14).

**Contemporary Solutions**

In the health insurance systems, there are many measures taken to ensure a balanced and co-ordinated financial performance in the field of the compulsory health insurance.

a) Measures in the field of partner and contractual relations with health care providers. At the primary health care level, a combined system of capitation (prevailing) and fee-for-service (limited) is in place. Such a system should encourage physicians to have fewer and more efficient contacts with patients. An additional stimulation to prevent inefficient care provided by primary
care physicians is payment of only 85% of price for the unaccomplished plan of services. In the field of hospital care, there is a fixed number of days of hospital stay and number of in-patients defined per hospital per year (a type of budgeting). If hospitals admit the planned number of patients, irrespective of the number of hospital days effected, they are fully reimbursed. With this approach, hospitals are stimulated to shorten the average length of stay and limit unnecessary hospitalization of their patients.

b) Measures to contain drugs expenditures. In April 1998, the Regulation on the Criteria for Formation of Gross Sales Prices of Drugs and Drugs Price Notification was adopted, according to which drugs prices should not exceed 85% of the reference prices in Italy, France, and Germany. The Regulation did not bring the expected reduction in expenses, since most producers did not respect it. That is why a new list of drugs was prepared, where drugs with higher prices were automatically ranked among those on the negative list, meaning that the compulsory health insurance did not reimburse them. That was an additional lever for obeying the Regulation as well as additional means of pressure on drug prices.

c) Activities for the management of problems in absenteeism. Employers and the compulsory health insurance allocate about 1.6% of GDP for sick leave compensations. Although national program was adopted (with the participation of the Ministry of Health, Health Insurance Institute, Medical Chamber, Chamber of Economy, trade unions, etc), no significant progress has been made in this field. However, an important drop in health-related absenteeism was observed in 1999, but whether the drop was actually a consequence of a more rational approach by GPs, who are in the first line of absenteeism management, is still to be confirmed. Probably some of it was due to the Health Insurance Institute’s measures for reducing longer sick leaves (under the authority of health insurance medical commissions) (10).

Scenario of Further Development

Slovenia is already facing certain development challenges and tendencies leading to increased demands for nursing care, treatment, and long-term care of the elderly and the chronically ill. In spite of all the queries about the future development of health insurance, it is almost certain that Slovenia will have to extend voluntary and commercial health insurance. In the field of health insurance in Slovenia, three scenarios are possible.

a) Permanent real growth of public expenditure on health care. That would mean a significant increase in the share of GDP allocated to health care and a potential increase in the number of employees in the health sector.

b) Stop further increase in the share of GDP allocated for health care by limiting solidarity. The necessary funds for certain programs would be placed in part or whole by private funds and insurance. That would mean a more radical reform of the system by which the absolute solidarity as we have known it for several decades would be abolished. This would allow defining the set of health rights in case of disease or injury more clearly. All the services and even some goods above that negotiated level would have to be covered from private funds. The public finances share allocated to health care services would remain unchanged, but the financing of additional programs and services beyond the basic set would be funded privately.

c) Managing the growing share of health care expenditures by differentiating between health care users according to their provisions and economic access to health care. An introduction of a certain census limit would differentiate the poorer from the richer. The former would still enjoy full basic coverage out of public funding, while the latter would have to choose one of the private or commercial insurances. The second option implies a differential approach in premiums and in the rights of the insured on the basis of their payments. That would limit the solidarity of the richer towards the poorer and would redefine solidarity in the health insurance system (10,11).

Conclusion

The centerpiece of the future public health insurance development is the fact that there will be less public financial resources. The Constitution of the Republic of Slovenia defines Slovenia as a lawful and social state and, in order to keep the social premise, all citizens should be allowed equal access to preventive and curative medical treatments and other rights issuing from the public health insurance. In that case, the people in charge of the state should re-evaluate the public health interests in the area of the public health insurance.

This is a critical review of the current rights as well as an attempt to establish whether certain rights can be limited or even completely erased from the public health insurance and transferred to the either voluntary or even direct and superstandard insurance. The latter should perform well, concerning the personal health interests of an individual.

Slovenia will work hard, though, not to trim too much the current level of health insurance. In order to achieve this, providers as well as the paying public will have to handle public financial resources in a responsible and economic way.

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