Health Care Systems in Transition

Slovenia
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Slovenia

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RESEARCH AND KNOWLEDGE FOR HEALTH

By the year 2005, all Member States should have health research, information and communication systems that better support the acquisition, effective utilization, and dissemination of knowledge to support health for all.

Keywords

DELIVERY OF HEALTH CARE
EVALUATION STUDIES
FINANCING, HEALTH
HEALTH CARE REFORM
HEALTH SYSTEM PLANS – organization and administration
SLOVENIA

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Foreword

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Care Systems.

The Observatory is a unique undertaking that brings together WHO Regional Office for Europe, the Governments of Greece, Norway and Spain, the European Investment Bank, The Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.

The aim of the HiT initiative is to provide relevant comparative information to support policy-makers and analysts in the development of health care systems and reforms in the countries of Europe and beyond. The HiT profiles are building blocks that can be used to:

- learn in detail about different approaches to the financing, organization and delivery of health care services;
- describe accurately the process and content of health care reform programmes and their implementation;
- highlight common challenges and areas that require more in-depth analysis;
- provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in the different countries of the European Region.

The HiT profiles are produced by country experts in collaboration with the research directors and staff of the European Observatory on Health Care Systems. In order to maximize comparability between countries, a standard template and questionnaire have been used. These provide detailed guidelines.
and specific questions, definitions and examples to assist in the process of developing a HiT. Quantitative data on health services are based on a number of different sources in particular the WHO Regional Office for Europe health for all database, Organisation for Economic Cooperation and Development (OECD) Health Data and the World Bank.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health care system and the impact of reforms. Most of the information in the HiTs is based on material submitted by individual experts in the respective countries, which is externally reviewed by experts in the field. Nonetheless, some statements and judgements may be coloured by personal interpretation. In addition, the absence of a single agreed terminology to cover the wide diversity of systems in the European Region means that variations in understanding and interpretation may occur. A set of common definitions has been developed in an attempt to overcome this, but some discrepancies may persist. These problems are inherent in any attempt to study health care systems on a comparative basis.

The HiT profiles provide a source of descriptive, up-to-date and comparative information on health care systems, which it is hoped will enable policy-makers to learn from key experiences relevant to their own national situation. They also constitute a comprehensive information source on which to base more in-depth comparative analysis of reforms. This series is an ongoing initiative. It is being extended to cover all the countries of Europe and material will be updated at regular intervals, allowing reforms to be monitored in the longer term. HiTs are also available on the Observatory’s website at http://www.observatory.dk.
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The current series of Health Care Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Care Systems.

The European Observatory on Health Care Systems is a partnership between the WHO Regional Office for Europe, the Governments of Greece, Norway and Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

The Observatory team working on the HiT profiles is led by Josep Figueras, Head of the Secretariat and the research directors Martin McKee, Elias Mossialos and Richard Saltman. Technical coordination is by Suszy Lessof. The research director for the Slovenian HiT was Josep Figueras.

Administrative support, design and production of the HiTs has been undertaken by a team led by Myriam Andersen, and comprising Anna Maresso, Caroline White, Wendy Wisbaum and Shirley and Johannes Frederiksen.
Special thanks are extended to the Regional Office for Europe health for all database from which data on health services were extracted; to the OECD for the data on health services in western Europe, and to the World Bank for the data on health expenditure in central and eastern European (CEE) countries. Thanks are also due to national statistical offices which have provided national data.
Introduction and historical background

Introductory overview

Slovenia is a small country located between the Alps, the Pannonian Plain, the Mediterranean and the Balkans. It borders Austria and Hungary in the north, Italy in the west and Croatia in the southeast. Formerly a constituent part of Yugoslavia, Slovenia declared independence on 25 June 1991.

Slovenia is mountainous with heavily forested areas and covers 20,273 km². The climate is mixed, with a sub-Mediterranean climate on the coast, alpine climate in the northwest and continental climate with mild to hot summers and cold winters in the plateaus and valleys to the east. The population in mid-1998 was estimated at 1,978,334; 65% lives in urban areas. The capital is Ljubljana, with 270,481 inhabitants.

Slovenes are a Slavic ethnic group and comprise about 88% of the population (1991 census). Hungarians and Italians are considered indigenous minorities with rights protected under the Constitution. Other ethnic groups are Croats, Serbs, Bosniaks (Muslims), Yugoslavs, Macedonians, Montenegrins and Albanians. Between 250,000 and 400,000 Slovenes (depending on whether second and subsequent generations are counted) live outside Slovenia, mostly in other continents and in European Union (EU) countries. There are Slovene indigenous minorities in Italy, Austria and in Hungary. The official language is Slovene, a South Slavonic language. It is written in the Roman alphabet and has many dialects. In ethnically mixed regions, the official languages are also Italian and Hungarian. Most of the population is Roman Catholic, although there are some small communities of Protestant Christians, Muslims and Jews.
Government administration

Slovenia has a democratic political system with a parliamentary form of state power. The system is based on a tripartite division of powers between the legislative, executive and judicial branches.

Its 1991 constitution guarantees universal suffrage for all Slovenians over 18 years of age; freedom of religion; freedom of the press; and other civil rights. Political parties represented in the National Assembly with 90 members (the parliament also has a National Council with 40 members) after the elections of 15 October 2000 are: the Liberal Democracy of Slovenia (LDS); the Social Democratic Party of Slovenia (SDS); the United List of Social Democrats (ZLSD); Slovene People’s Party (SLS/SKD); New Slovenia – Christian People’s Party (NIS); Democratic Party of Pensioners of Slovenia (DeSUS); Slovene National Party (SNS) and the Party of the Slovene Youth (SMS). The National Assembly also has one representative of the Hungarian minority and one of the Italian minority.

The National Assembly adopts laws and the National Council proposes laws or requests reconsideration in the National Assembly. National Assembly members serve 4-year terms and are elected directly by secret ballot according to a proportional voting system. The National Council members are

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1The maps presented in this document do not imply the expression of any opinion whatsoever on the part of the Secretariat of the European Observatory on Health Care Systems or its partners concerning the legal status of any country, territory, city or area or of its authorities or concerning the delimitations of its frontiers or boundaries.
representatives of social, economic, professional and local interest groups and are elected for 5 years by the elected representatives of special-interest organizations and local communities.

The Government of the Republic of Slovenia is the executive body and the supreme body of state administration. The executive function involves mainly preparing legislation, proposing the national budget and national programmes and implementing laws passed by the National Assembly. The government consists of the Prime Minister, the head of government who is elected by the National Assembly for a 4-year term, and the 15-member Cabinet of Ministers. The government ministers are appointed for the following areas: finance; internal affairs; foreign affairs; justice; defence; labour, family and social affairs; economy; agriculture, forestry and food; culture; the environment and spatial planning; transport; education, science and sport; health; and information society. The government also includes a minister without portfolio responsible for European affairs. The government must be approved by the National Assembly. The government generally endorses all health care reforms and, within its fiscal limits, secures the necessary material basis for health care services.

Judicial authority is exercised by judges; they are appointed for life. The Supreme Court is the highest court in the judicial system. There are district and circuit courts; the high courts are appeal courts. The Constitutional Court has been strengthened since the new constitution was introduced in 1992.

The President of the Republic represents the Republic of Slovenia and is the supreme commander of its armed forces. The President is elected for a maximum of two 5-year terms by direct elections.

The human rights ombudsman is responsible for protecting human rights and fundamental freedoms in relation to state bodies, local administrative bodies and all those with public jurisdiction. The ombudsman is proposed by the president and elected by the National Assembly for a period of 6 years.

When Slovenia gained independence, a new constitution gave municipalities a form of self-governance and anticipated the possibility of integrating municipalities into wider, self-governing communities. The activities of any larger self-governing communities are financed by the municipalities that created these communities. The constitution explicitly transfers the mandate for taking on responsibility for local matters to municipalities, and when all municipalities agree, a given responsibility of the state may be transferred to them if the state provides the financial means. Pursuant to the Act on the

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2 In this document, self-governing communities is used to define both single municipalities and units of several municipalities that have been merged to form actual self-governing communities. Strictly speaking, only 30% of all communities are actually operating as self-governing communities.

Slovenia
Establishment of Municipalities and Determination of their Territory in 1994, Slovenia was divided into 147 municipalities. The number of municipalities increased to 192 in 1998.

The highest decision-making body in a municipality is the municipal council, the members of which are directly elected. A mayor also is directly elected. So far, Slovenia has no intermediate level of government between the municipality and the state. The Act on Regions, which is still being prepared in 2001, is expected to define this intermediate level: the region.

**Socioeconomic development**

According to estimates by the US Central Intelligence Agency for 1999, industry provides 35% of Slovenia’s gross domestic product, agriculture 4% and services 61% (1). The main industries include manufacturing of food and beverages, electronics, electrical machinery, metal processing and metallurgy and motor vehicles. The agricultural sector is dominated by dairy farming and stock breeding. The main crops are corn, barley and wheat. With its natural beauty, varied climate and geographical and cultural diversity, Slovenia has great potential for tourism. Slovenia’s natural resources include brown coal and lignite in abundant quantities as well as lead, zinc, mercury, uranium, silver, natural gas and petroleum.

Following independence, Slovenia adopted a number of economic reforms including a bank reform, market reform and privatization. A reform of the pension system has been introduced to adapt to demographic, economic and social circumstances and to be able to provide long-term social security.

The balance of trade (1999) is US $8545 million for exports and US $10 083 million for imports. A total of 66.1% of exports are sent to EU countries and 68.9% of imports come from EU countries. Slovenia exports intermediate goods (47.0%), consumption goods (40.4%) and capital goods (12.6%) (2).

In 1991 a new currency, the tolar, was introduced at a fixed exchange rate to the German mark (218 tolars were equal to 1 euro in October 2001). Slovenia joined the International Monetary Fund in 1993, and the tolar became convertible in accordance with the standards of the Fund in 1995. Slovenia has created solid foreign-exchange reserves in recent years.

Since 1992, Slovenia’s gross domestic product (GDP) has increased steadily, and the growth rate was 4% in 1999 and 4.5% in 2000 (1). In 1999, the GDP per capita was US $10 078, and the estimate for 2000 is about US $12 000. This growth has not translated into increased employment. The standardized unemployment rate has been increasing since 1992 and amounted to 7.6 in 1999 (7.3 for men and 7.9 for women). It has been stagnant since 1994.
The economic and social position of the regions is imbalanced. The Statistical Office of Slovenia calculated various social and economic indicators between 1995 and 1997. These indicators show a favourable picture for the Ljubljana urban region, which was above the national average according to nearly all indicators, whereas other regions of Slovenia fall significantly behind the EU average (the GDP purchasing power parity per capita equalled 57% of the EU average). This is also reflected in a wide variation in unemployment rates between regions. The highest unemployment rate in 1999 was registered in the Podravje region, amounting to 21.2%, compared with 10.8% in central Slovenia in the same year (3).

The Human Development Index for Slovenia in 1998 was 0.864, and Slovenia ranked number 28 in the world.

**Demographic trends and health status**

The main demographic characteristics in Slovenia are a low birth rate, a low fertility rate and a low rate of population growth.

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>1985</th>
<th>1987</th>
<th>1989</th>
<th>1991</th>
<th>1993</th>
<th>1995</th>
<th>1997</th>
<th>1999</th>
<th>2001 (estimate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–14</td>
<td>22.0</td>
<td>21.4</td>
<td>20.9</td>
<td>20.0</td>
<td>19.1</td>
<td>17.9</td>
<td>17.2</td>
<td>16.1</td>
<td>16.5</td>
</tr>
<tr>
<td>15–64</td>
<td>68.0</td>
<td>68.2</td>
<td>68.4</td>
<td>68.8</td>
<td>69.2</td>
<td>69.5</td>
<td>69.3</td>
<td>70.0</td>
<td>69.4</td>
</tr>
<tr>
<td>65 and above</td>
<td>10.0</td>
<td>10.2</td>
<td>10.6</td>
<td>11.0</td>
<td>11.7</td>
<td>12.5</td>
<td>13.1</td>
<td>13.9</td>
<td>14.1</td>
</tr>
</tbody>
</table>


Slovenia’s population is aging (Table 1). The birth rate decreased from 13.1 per 1000 population in 1985 to 8.8 in 1999. The total fertility rate of 1.2 in 1999 was far below the replacement level. Natural population growth has been negative since 1997, −0.7 per 1000 population per year. The crude death rate of 9.5 in 1999 increased only slightly during the transition compared with other transition economies and quickly recovered its relatively low level (2).

The main characteristics of the falling birth rate are a decreasing number of women with three or more children; decreasing differences in the number of children within different social classes; and changes in the spacing of births during the period of women’s life when they are fertile.

Life expectancy at birth in Slovenia in 1999 was estimated to be 71.3 years for males and 78.8 years for females (2). Healthy life expectancy, measured by the disability-adjusted life expectancy index, is about 7 years less. The difference from the EU average was 2.5 years in 1997. Life expectancy, morbidity and
mortality data show disparities between regions that correspond to indices of relative poverty. The difference between the lowest and the highest life expectancy in the regions is more than 7 years. The correlation coefficient between income and life expectancy across Slovenian municipalities is 0.7, indicating a strong correlation. The correlation between life expectancy and education is slightly lower but still statistically significant (3).

The morbidity and mortality data show that Slovenia experiences the same morbidity and mortality characteristics as other European countries in western and central Europe. Diseases of the cardiovascular system are the most common cause of death in Slovenia, causing almost half of all deaths. These are followed by cancer, injuries, poisoning, respiratory diseases, diseases of the digestive system and others.

Mortality by age and sex groups shows a pattern similar to the EU average. The infant mortality rate fell to below 10 per 1000 live births in 1988 for the first time and was 4.5 per 1000 live births in 1999 (2).

The most frequent diseases are diseases of the respiratory system, followed by mental disorders, musculoskeletal disorders and digestive system disorders.

In men, the most common type of cancer is lung cancer (88.3 cases per 100 000 population), followed by cancer of the colon and rectum; skin cancer; and cancer of the larynx, pharynx and mouth. In women the most common type of cancer is breast cancer. The incidence of breast cancer among women increased between 1985 and 1997.

Communicable diseases in Slovenia are not a prominent cause of morbidity. In recent years in Slovenia there have been no registered cases of diphtheria, acute poliomyelitis, neonatal tetanus, tetanus or congenital rubella among people younger than 50 years of age. Because immunization coverage has traditionally been good, the incidence of vaccine-preventable diseases, such as measles, mumps and pertussis, has been low and has decreased further recently. Malaria has been eradicated in Slovenia, and thus only isolated cases of malaria imported from African or Asian countries are registered (nine cases in 1999). The incidence of syphilis has continued to decline since 1975 except from 1994 to 1998 (from 0.9 per 100 000 in 1992 to 2.77 in 1995). The incidence in 1999 was 0.2 per 100 000 (4).

From 1986 to 1999, the annual reported incidence rate of acquired immunodeficiency syndrome (AIDS) varied between 0.05 and 0.7 per 100 000 population. A cumulative total of 84 AIDS cases, 73 in males and 11 in females, had been reported by 31 December 1999. In addition to AIDS cases, a cumulative total of 71 cases of human immunodeficiency virus (HIV) infection without developed AIDS, 55 in males and 16 in females, had been reported by 31 December 1999 (4).

Slovenia
Slovenia’s suicide rate has been among the highest in the world for over two decades: about 30 per 100 000 inhabitants per year. National data have shown for years that suicide is most common in the marginalized parts of society. This takes into account the specific suicide rates for individual population categories: workers with only primary education, (semi-)skilled workers, unemployed people and alcoholics. This trend shows that the population most at risk is the segment living in social poverty (5).

External causes of injuries and poisonings are also a major public health problem in Slovenia. Injury and poisoning are the leading causes of death after the age of 1 year and represent the main causes of death until about 45 years. Even though the number of deaths caused by injury or poisoning decreased slightly from 105 per 100 000 population in 1986 to 63 in 1997, Slovenia still has one of the highest rates of this kind of mortality in Europe, exceeding the EU average by 100% (6).

Despite a slight trend towards a decline in the death rate caused by chronic liver diseases and cirrhosis among men and women, Slovenia still exceeds the average of the EU countries and has one of the highest mortality rates from diseases caused by alcohol abuse in Europe. Slovenia has more than 30 deaths per 100 000 population per year from liver diseases. Alcohol consumption in Slovenia is among the highest in Europe (10.38 litres pure alcohol per person per year in 1998) (6).

Oral health has improved, as assessed by the average number of decayed, missing and filled teeth at the age of 12 years (DMFT index), with a decline from 5.1 in 1987 to 1.8 in 1998, which places Slovenia among the European countries with the lowest caries prevalence (7).

**Historical background**

**The period from 1899 to 1945**

Prior to the First World War, Slovenia was a constituent part of the Austro-Hungarian Empire. The health care system, level of services and epidemiological situation were comparable to those of other parts of the Empire. Health care was delivered on the basis of private practice. The first development towards a health insurance system was at the time of the adoption of the Miners Act in 1854, which enacted fraternal funds providing compulsory insurance to miners and foundry workers. In 1858, insurance covering illness was extended to railway workers, and in 1869 their insurance was enhanced through insurance...
against injury. Compulsory insurance against injury was enacted in the Austrian part of the Hapsburg monarchy through an act adopted in 1887, which followed the Bismarck model. In 1888, the insurance scheme was extended to incorporate health insurance. Two thirds of the health insurance funding was contributed by workers and one third by their employers.

The first actual sickness fund for compulsory health insurance was established in Ljubljana in 1889. The first district fund was established in Ljubljana in line with the German social insurance model, followed by similar funds established in Slovenian towns across the country. The role of the sickness funds was to protect the worker’s social rights during illness and the rights to health care services. Injury insurance was an autonomous branch, insuring workers against work-related injuries, with contributions solely paid by employers. By the end of 1889, 65 district health insurance funds had been established in the Upper Carniola and Lower Styria regions with about 15,000 people insured. They continued operating until the Austro-Hungarian monarchy collapsed at the end of the First World War. Social insurance for workers was reinstated in 1918, and an association of the health insurance funds on Slovenian territory was founded in 1919.

From 1918 to 1945, Slovenia was a member state of the Kingdom of Yugoslavia. During this period, steps were taken toward the development of social medicine through the establishment of a regional social hygiene institute for prevention, primary care centres and a central institute for hygiene and medicine. Both a Medical Chamber of Slovenia and a Slovene Medical Association existed at that time (the latter dating back to the previous century). In 1937, pension and disability insurance programmes were established.

**The period from 1945 to 1991**

In 1945, Slovenia became a part of the Socialist Federal Republic of Yugoslavia. Until 1954, the model of social insurance had prevailed as a system for health care funding. In social health insurance, all workers and pensioners together with their family members were included in the obligatory scheme. At that time farmers, self-employed people, craft workers and other professional groups had no coverage. These groups were also gradually included, so that the entire population was covered by the mid-1970s.

Social insurance was introduced for workers and public employees but not for other groups of the population. This social insurance combined pension and disability insurance, health insurance, maternity insurance and some other social charges. It was carried out by regional social insurance branches financed by the contributions of employers and employees; the public budget contributed

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*Slovenia*
only certain funds for the rights of soldiers and war veterans. It was administered by the state or by regional peoples’ committees. Because of economic and demographic differences between the regions, reinsurance was introduced between regional social insurance institutes to cover above-average risks and was implemented at the level of the republics.

The basic system of social health insurance has changed gradually because of several political changes. Especially the development of a socialist political framework influenced how the health care system was managed. Health care facilities became state-owned. Private practice was not allowed and all physicians were salaried employees of the state. Primary health care was delivered through health centres, which included general practice, paediatrics, health programmes for schoolchildren and adolescents, occupational medicine, pulmonary care, gynaecology, dentistry and other services. General practice declined, as all other specialties in primary care were considered superior.

Specialist outpatient and hospital activities were carried out in hospitals, which were all public. The era after the Second World War was also a period in which hospitals that were under-equipped or outdated were renovated. This lasted into the 1970s, with the funds being provided partly by the republic budget and partly (in later years) by the providers of health insurance. Some of the funds were collected from individual contributions.

On the regional level, an institution for social medicine and hygiene monitored the epidemiological situation. Large-scale prevention programmes were prepared, and the Institute of Public Health (IPH) in Ljubljana carried out public health disease-prevention measures. Regional hospitals were established and some other health care services, such as physical therapy in spas. The Medical Chamber of Slovenia was abolished.

Following reforms in 1954 and 1955, health insurance was separated from social security. Separate types of insurance were established for workers, public employees, craft workers and self-employed people, and later also for farmers, who acquired some minimal rights (such as emergency treatment in hospitals, treatment of infectious diseases and preventive health care). The providers of these health insurance policies were community health insurance institutes, administered according to the Bismarck model by the representatives of employers and insured people. Contribution rates were different for individual types of insurance (workers, craft workers and farmers). Slovenia had 15 insurance institutes in 1965. In 1972, a referendum was held that resulted in full equality in the insurance rights of workers and of farmers, which provided the conditions for universal insurance of the whole population.

According to the federal constitution of 1974, newly adopted health insurance legislation made “self-managing communities of interest in health”
the main source of funding. This involved local associations of people in one or more communities totalling at least 150 000 people and managed all insurance funds. In addition, health centres were introduced at the regional level, encompassing hospitals, primary health centres, pharmacies and the respective regional institutes of public health. These centres were to provide a full range of preventive and curative services. Although this principle was appealing in theory, the centres came to be associated with loss of cost control and an ever-growing bureaucratization of health care.

During the four decades of socialism, Slovenia experienced periods of financial stability. However, because of a lack of sustainable economic policies, there were also periods of high inflation, economic fluctuation, losses and large budgetary debts in health care institutions. Health sector salaries, similarly to other economic sectors, were considerably lower than those paid in other European countries. There was also a general lack of experience in health care financing, management and administration. The development of the system in the 1970s and 1980s was accompanied by continuous financial difficulty. It was characterized by a broad and expanding range of health care rights, growing health provider capacity and promotion of access to health care services. By 1990, the health care system in Slovenia was on the verge of financial collapse. Even today, a conflict remains between the expectations and economic capacity of the system, as continuing to finance the provision of the rights to which Slovenian citizens were entitled under the previous health system is a challenge for the public sector.

In the years preceding the reform in 1992, Slovenia’s health care system exhibited certain weaknesses in securing the main resources, financing and efficiency. These problems did not merely reflect the accumulated general problems of the former state but resulted from weaknesses in the system itself. In the early 1990s, the system experienced serious financial and liquidity problems in securing money for health care services. These problems and the immense positive energy involved in the processes of rapid modernization of the overall social structure led to the rapid adoption of new health care legislation in 1992 and opened the way to an integral overhaul of the health care system.

The period from 1991 to the present

In 1991, Slovenia became an independent state and began the process of economic transformation to a market economy. The transition from one socioeconomic paradigm (predominantly a collectivist social philosophy) to another paradigm (predominantly an individualistic social philosophy) placed great pressure on the organization and functioning of the health care system in Slovenia. The socioeconomic relationships changed; the centres of power were
distributed differently; and the ownership, financial resources and administration of health care institutions were redefined.

In early 1992, health care legislation was changed to introduce a compulsory and a voluntary health insurance system. At the same time, private practice was reintroduced. The goal of Slovenia’s health policy has since been to draw from its previous experiences, specifically to maintain and improve the effective components of the former system and to change, step by step, those that had proven ineffective. The new legislation (1992) has brought major changes in the following three aspects of the health care system:

- structural changes in health care financing – (re)introducing health insurance;
- structural changes in the delivery of health care services, including privatization within the public health network and introducing free choice of physicians; and
- new roles and a new focus in the system – the partnership model and contracting.

The central topic of modernizing the health care system was financing. The first big novelty was reinstating compulsory health insurance and the second introducing voluntary health insurance. In this way, besides the prevailing public resources (mainly compulsory insurance), new important private resources (mainly voluntary insurance) have been introduced in the health care system to fund health care programmes since 1992.
Organizational structure and management

Organizational structure of the health care system

The main organizational features of the Slovenian health care system, the key actors and their relationships are derived from the historical development of the system and are further based on legislation introduced in 1992 (Fig. 2). The Law on Health Care and Health Insurance (8) laid the basis for the present system of compulsory and voluntary health insurance, permitted privatization of health care and transferred many administrative functions to the Medical Chamber of Slovenia and the Slovenian Chamber of Pharmacy.

The state is responsible for ensuring the conditions for a healthy environment and healthy living as well as for the implementation and functioning of preventive public health programmes and health promotion.

The state and its legislative and executive bodies (ministries, state agencies and offices) have administrative and regulatory functions. These are carried out by preparing and passing laws, bye-laws, standards and other acts by which the state ensures the prevention of contagious diseases, a healthy environment and safety and health at work; establishes special programmes of preventive activities, including for the most vulnerable groups; and in general determines health care policy. Important among these are public health care tasks, planning health development and establishing priorities. Further, the state owns and administers public health facilities at the secondary and tertiary level. These tasks are implemented by the National Assembly, the government and its individual ministries.

National Board of Health

The National Board of Health is an advisory body to the government and has been responsible for maintaining health on the agenda in government and parliamentary procedures. As defined by the Law on Health Care and Health

Slovenia
Fig. 2. Organization of the health care system

LEGEND:
- hierarchical/administrative relation
- contractual level
- professional supervision
- advisory relation
- national level
- regional level
- local level

PARLIAMENT

Committee on Social Affairs, Work, Family Matters and Health

GOVERNMENT

National Board of Health

MINISTRY OF HEALTH

- Health Inspectorate
- Office for Medicinal Products
- National Chemicals Bureau
- WHO Liaison Office

Health Council

Medical Chamber of Slovenia
Slovenian Chamber of Pharmacy
and
Nursing Chamber of Slovenia

Health insurance
Compulsory HIIS
Adriatic Insurance Company

Clinical centres and institutes (tertiary level)

Institute of Public Health
Regional institutes of public health (9)

Regional HIIS branches (10)

Health care centres, pharmacies
Private health care facilities with a concession

Self-governing communities

Local HIIS branches (46)

Regional HIIS branches

Health care centres, pharmacies
Private health care facilities with a concession

Private facilities without a concession

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Insurance from 1992 (8), the Board’s role is to promote health policy by monitoring the effects of the social and physical environment on health; it assesses development plans and legislative drafts from the viewpoint of health. For this purpose, it cooperates with the administrative bodies and coordinates among them the work related to health issues. The functioning of the Board is currently being reviewed owing to the need to clarify its accountability. According to the National Health Care Programme of the Republic of Slovenia – health for all by 2004 (9), the Board will coordinate intersectoral investment in health and will coordinate government activities that affect public health, including determining tax policy, defence and food policy, defining sports and cultural programmes, introducing new technologies, promoting road traffic safety and protecting health at work. Herein it has only an advisory role: that is, it can only indicate problems but has no decision-making power.

**Parliamentary Committee on Social Affairs, Work, Family Matters and Health**

The Parliamentary Committee on Social Affairs, Work, Family Matters and Health prepares legislative proposals and other materials for parliamentary discussion. The Committee seeks to obtain a social consensus on all laws and legal matters undergoing parliamentary consideration.

**Ministry of Health**

The tasks of the Ministry of Health are to prepare legislation for health care and health protection and to ensure regulation and supervision of the implementation of legislation. The activities of the Ministry relate to health matters at the primary, secondary and tertiary level, including the financing thereof. The Ministry furthermore monitors public health, prepares and implements health promotion programmes and ensures the conditions for people’s health education. Health promotion and disease prevention activities are predominantly related to drug dependence, infectious diseases and HIV infection, food and drinking-water safety, nutrition policy and environmental health. Activities further focus on supervising the production, trade and supply of medicines and medicinal products and the manufacture of and trade in illegal drugs. The Ministry is also in charge of implementing international agreements on social security. The Ministry is furthermore responsible for developing the strategic plan for the development of the health care system. Strategic plans prepared by the Ministry are submitted to the parliament for approval. The plans specify all major points of health policy as well as priorities and short-
and long-term strategies for development and implementation. Specific strategies include:

• developing policy on health insurance (both compulsory and voluntary);
• developing a public-private mix in health care financing with regulated competition;
• planning and managing public health care institutions;
• developing public health and quality of care, including consumer rights and the rational use of drugs; and
• educating physicians and other health care professionals.

The Ministry is also responsible for establishing hospitals and public health institutions at the national level. In this role, it approves the policies of an institution, provides financing for specific expenses such as investment (the Ministry finances investment at the secondary and tertiary levels, which by law are the responsibility of the state, whereas capital investment for primary care facilities are the responsibility of the self-governing communities) and plays an active role in nominating the directors of health institutions. The Ministry has four offices: the Health Inspectorate, the WHO Liaison Office, the Office for Medicinal Products and the National Chemicals Bureau.

The Health Inspectorate controls the implementation of legislation, other regulation and general acts regulating sanitation, hygiene and the ecological protection of the public and monitors environmental health.

The work of the Office for Medicinal Products is determined by the Law on Medicinal Products and Medical Devices, the Law on the Organization and Working Areas of the Ministries, and other regulations adopted by the parliament. The Office for Medicinal Products implements the national policy on drugs and medical devices, issues permits for the manufacture of medicinal products and medical devices and approves market authorization for medicinal products.

The National Chemicals Bureau, established in 1999, enforces the legislation on chemicals and prepares and implements laws and regulations relating to chemicals. Its further activities are: maintaining a list of chemicals; manufacturing conditions for, trade in and use of chemicals; activities related to classifying, labelling and packing chemicals; and monitoring the implementation of the Convention on Chemical Weapons and the Law on Chemical Weapons.
Health Council

The Health Council is a special advisory body to the Ministry of Health that was set up in accordance with the Law on Health Care and Health Insurance with the responsibility of assisting the Ministry in its planning tasks. The Council is formed for a 4-year term; its members are nominated by the Minister for Health and confirmed by the parliament. The Council consists of the representatives of national specialty expert groups, including representatives of the Faculty of Medicine of the University of Ljubljana, the Ministry of Health, the Medical Chamber of Slovenia and the Slovenian Chamber of Pharmacy. The Health Council serves as the highest professional body with the responsibility of reviewing proposals for the development of health policy and questions of ethics and doctrine.

The Council can summon expert advice through the national specialty expert groups. National specialty expert groups are established within each medical specialty and are composed of recognized experts. Besides participating in the Health Council, they also provide doctrines for each specialty, encourage the auditing of medical practice and participate in expert audits.

Specific duties of the Council include:

• monitoring systematic, developmental and personnel questions in health care and proposing measures and defining priority tasks;
• monitoring health requirements in Slovenia and proposing health programmes;
• cooperating in preparing the health care plan and personnel and working norms;
• monitoring the supply of medicines and proposing measures; and
• dealing with other important questions of health care.

The Health Council, in cooperation with the Faculty of Medicine of the University of Ljubljana and other institutions, proposes and monitors the implementation of:

• a programme of preventive health care for individual population groups;
• a programme of development research tasks in health care that are important for the Republic of Slovenia as a whole;
• a programme of social medicine, hygiene, epidemiological and health ecological activities to be performed by the national IPH; and
• a programme of total health education and health advisory activities for the population.
Other ministries

Apart from the Ministry of Health, other ministries with competence in health services include the following.

• The Ministry of Finance reviews and approves the budget of the Ministry of Health. The Ministry of Finance and the parliament approve the basic principles and the shares of the state budget, budgets of local authorities, mandatory health insurance and mandatory pension and disability insurance through a budget memorandum each year.

• The Ministry of Education, Science and Sport supervises activities related to medical and health professional education and some health promotion programmes. It is also responsible for matters related to basic research and technological development and for university and postgraduate education of junior researchers. In its internal cooperation activities, the Ministry is working on participating fully in EU activities and is participating in its Fifth Framework Programme of research (of which a number of projects are related to health).

• The Ministry of Labour, Family and Social Affairs together with the Ministry of Health coordinates the provision of homes for elderly and handicapped people. They are also responsible for negotiating bilateral conventions on social security that are of a multisectoral nature.

• The Ministry of Environment and Spatial Planning cooperates with the Ministry of Health in the field of environment and health.

• The Ministry of Internal Affairs, Ministry of Defence and Ministry of Justice pay for health care for police and military personnel while on active duty and for prisoners.

The Health Insurance Institute of Slovenia

Following the 1992 health care reform legislation (the Law on Health Care and Health Insurance), the Health Insurance Institute of Slovenia (HIIS) was created as a public and not-for-profit entity strictly supervised by the state and bound by statute to provide compulsory health insurance to the population. The statute of the HIIS is subject to approval by the Ministry of Health.

The HIIS is the sole organization responsible for providing compulsory health insurance. Its tasks include: issuing compulsory insurance; concluding health contracts with health care providers and suppliers of technical aid; supervisory and administrative tasks; providing legal and other professional assistance to insured people; and managing a database and statistics on health
The HIIS has the task of representing the interests of insured people in negotiations with the partners concerning health services programmes and their implementation and determining prices. The HIIS makes proposals on the contribution rates. Because the Slovenian population is small, the HIIS is the only major compulsory insurance centre, whereas other insurance companies also offer voluntary insurance. The HIIS is governed by an assembly made up of representatives of employers and the insured people that independently administers the activities of the HIIS. The director of the HIIS is nominated by the assembly and appointed with the agreement of the parliament. The priorities of the HIIS must be coordinated with those of the state in representing the interests of insured people. The HIIS has 56 branch offices altogether, including 10 at the regional level and 46 at the local level. Regional councils in the regional branches of the HIIS have more of an advisory nature and cannot decide on issues concerning health insurance.

Institute of Public Health

The Institute of Public Health of the Republic of Slovenia (IPH) has nine regional public health institutes and was founded in December 1992 by a government decree to cover the fields of social medicine, hygiene, environmental health, epidemiology, informatics and research activities. In these fields, the national IPH carries out research, education and publishing activities.

The most important activities of the national IPH are to implement the national programme of preventive medicine, to collect and analyse data on the health of the population and health care services and, based on reliable data, to prepare health policy documents and suggest measures to improve and protect health.

Health care delivery system

The health care delivery system is defined by the Law on Medical Services (10). Apart from public health care services, there are also private health care facilities as part of the public health network (having a contract with HIIS) or not (without a contract for reimbursement).

Health care capacity is structured at three levels.

The primary professional level includes practitioners, such as general practitioners, paediatricians, school physicians, occupational medicine specialists, gynaecologists, dentists and home care nurses, and other health, social and local personnel in public and private outpatient clinics and health
centres. A health centre is a public health institution with organized primary health care activity for the people of one or several communities striving in principle towards a proactive approach for individual target population groups (such as children, schoolchildren, women or workers). Health care at this level is directly accessible.

The secondary level includes specialist health care in specialist outpatient departments and hospitals with suitable medical and nursing personnel for the needs of the population within a region. As a rule, patients are referred to this level by primary health care.

The tertiary care level includes medical activities located at the national level for organizational or technological reasons. These can be highly specialized services such as organ transplants or less specialized services such as basic cardiovascular surgery.

Local governments

Local governments of self-governing communities have not yet begun to play as active a role in decision-making in the health care system as envisioned by the health care reform legislation of 1992. They are currently mainly responsible for granting concessions to private health care providers who wish to work within the publicly operated primary health care system. They are in theory also responsible for planning, establishing and managing primary health care facilities, which is in part reflected in their responsibility for capital investment in public primary health care facilities and pharmacies. However, despite the target population coverage of at least 8000 inhabitants per self-governing community, many have a smaller population coverage (up to a population of 450), so that, in early 2001, only about 30% of them were self-sufficient in capital investment in primary health care facilities.

Unions and professional associations

The Medical Chamber of Slovenia, responsible for physicians and dentists, and the Slovenian Chamber of Pharmacy were abolished in 1945 and re-established in 1992. Some public powers, including supervisory and administrative functions, were transferred to the chambers. The Medical Chamber of Slovenia and the Slovenian Chamber of Pharmacy are responsible for specialization, licensing, developing and issuing a code of medical ethics and supervising professional practice. Membership in the Medical Chamber of Slovenia and the Slovenian Chamber of Pharmacy is compulsory. The Medical Chamber of Slovenia has become an influential body that has taken over some responsibilities that were traditionally within the scope of the Ministry of Health.
The Nursing Chamber of Slovenia was established more recently. There are also proposals to establish new chambers for other health professions.

There is some discussion about the scope and functions of health professional chambers in the publicly organized health care system. Some of the concerns are related to a lack of funds. Fully delegating public roles that were previously the responsibility of the state would require considerable funds.

The Slovene Medical Association, a voluntary nongovernmental association of physicians, discusses professional issues and advises the Medical Chamber of Slovenia. The Association publishes a monthly medical scientific journal on medical issues in Slovenia (Zdravniski Vestnik).

Several trade unions represent the interests of health professionals: FIDES – the Slovenian Union of Physicians and Dentists; the Slovenian Health Service and Social Service Union; the Federation of Slovenian Free Unions (Health Care and Social Care Union Department); and the Union of Health Care Workers of Slovenia.

Public health institutions are members of the Society of Health Institutions of Slovenia, which individuals may also join. This society is one of the partners that represents the interests of those employed in these institutions in negotiations with the payers of services.

Voluntary organizations

The role of nongovernmental organizations in health care is beginning to emerge in Slovenia. Nongovernmental organizations can implement the role of public participation in proposing and carrying out the changes (reforms) in the organization and system of health care. In principle, a nongovernmental organization can secure a small share of public financing from the state budget if it meets certain budgetary requirements. The Law on Organizations, passed in 1995, introduced certain conditions for such public interest organizations. The respective ministries are authorized to determine the criteria that must be met by the organization if it is to obtain the status of a public interest organization.

Slovenia has several self-help groups. The most prominent are alcoholics anonymous groups and self-help groups for people with chronic diseases such as diabetes, cardiovascular diseases and osteoporosis.

The Slovene Consumers’ Association has several projects related to out-of-court reconciliation, including for health-related issues.
Parallel health services

The Ministry of Defence owns and employs its own first aid health care facilities within its military premises. First aid care is usually provided by a military physician salaried by the Ministry of Defence. For more complex primary health services, a general practitioner under contract with the public health insurance fund is often consulted. All services for the people performing military service are paid through the state budget.

Planning, regulation and management

The Slovene health care system has characteristics of both the integrated and the contract model of health care systems.

At the secondary and tertiary care level, the employees have the status of public employees. They are paid in accordance with the collective agreement. The state provides funds for investment, and services performed are paid by the HIIS based on the contract between HIIS and the hospital institution.

Most primary care providers are contracted by the HIIS, and most practitioners at this level are still employed in public health centres, but some work in private practice. The self-governing communities provide funds for investment in public health centres.

Planning

According to the 1992 legislation, the Ministry of Health is responsible for strategic planning and health policy development and its implementation through the development of a planning framework. The Ministry is also responsible for adopting regulations and legislative policy and earmarking financial resources for these tasks. The Ministry is responsible for planning secondary and tertiary health care facilities and capital investment for hospitals. Capital investment planning for primary health care facilities was delegated to the self-governing communities. However, the pace and extent to which the communities have taken up this task differs.

The health care system is predominantly oriented towards treatment. Comprehensive and demanding new activities are difficult to carry out because of deficiencies in the capacity of public health care professions, which are most marked in management, strategic planning, health care supervision (surveillance) and preventive health care. Setting up suitable professional conditions in this field will probably require establishing an accessible study

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and research environment (a school of public health), which will enable postgraduate studies and the continuous training of qualified experts in public health. Establishing the study environment will require relying primarily on the already developed national infrastructure while establishing broad international cooperation.

The planning framework of the Ministry of Health has been set out in the National Health Care Programme of the Republic of Slovenia – health for all by 2004 (9) adopted by the parliament in May 2000. The plan integrates the WHO health for all policy. The objectives of the plan are: to set out strategic directions, priorities and targets for health system development; to build healthy policy; to tackle health inequality; to modify lifestyles harmful to health; to improve the quality of the physical environment; to improve the quality of health care services; and to promote research in public health. The plan represents the framework for action to tackle mental health, alcohol, tobacco, nutrition, the quality of health care and environmental health protection.

The previous national health care plans spelled out targets for the level of certain health care factors, such as the number of hospital beds; the number of physicians; the number of dentists; the number of qualified nurses; and the overall number of health personnel employed in the public health system in Slovenia. National population-based planning standards for primary health care facilities are expected to be included within the plan of the public health care network (under development). Self-governing communities are involved in designing the primary care network and in projecting the necessary capacity. These standards would then serve as a framework for implementing the public health care network.

The planning of capital investment is coordinated with the directors and managers of the responsible institutions. In early 2001, the Ministry of Health targeted approximately a 1% annual decrease in hospital beds in the following 5 years as well as a decrease in the number of hospitals or hospital departments. The decrease in hospital activities and public health professionals is to be balanced with an anticipated gradual increase in private practice activities.

There is no explicit planning policy on the introduction of medical technology that requires high capital investment. In 2000, the Health Council made decisions related to the acquisition of capital investment-intensive medical technology. As the members of the Council are acknowledged medical specialists, decisions tend to be more oriented towards their specialty than taken within a broad public policy perspective.

Additional planning functions are carried out through annual negotiations and contracting in compulsory health care insurance.
Regulation

The health sector is regulated at various levels and by several organizations. The government and the parliament set the limits and policies on the macro-economic level. These limits are coordinated and respected by the annual planning process of the HIIS. The annual financial plan for compulsory health insurance prepared and accepted by the HIIS assembly is thus the framework for the partnership negotiating process for each year. The Ministry of Health, which is also a member of the partnership negotiating process, has a role in balancing health care needs with available public resources and priorities. It must also fulfil the mandates of the government and parliament. The Health Council, as specified by legislation, advises the Ministry of Health and addresses specific problems related to health and medicine. The Medical Chamber of Slovenia, the Slovenian Chamber of Pharmacy and the Nursing Chamber of Slovenia are responsible for controlling professional advancement, including professional auditing of physicians, dentists, pharmacists and nurses. Other professional associations (such as medical societies and sections) have also an important role in organizing professional training, adopting professional guidelines and checking professional work. Health care providers are further governed by internal regulations of institutions according to the public health network and contracts between third-party payers and health care providers. The local governments of the self-governing communities are responsible for regulating primary health care services.

The director and managers of the national IPH, in cooperation with the Ministry of Health, are responsible for managing the activities of the national IPH and coordinating the regional institutes of public health as defined by law.

Directors manage hospitals and health centres under the supervision of the Ministry of Health in secondary and tertiary care and the self-governing communities in primary care.

Citizen participation

Citizen participation in planning and managing health care services is a new development in the health care system and so far only takes place indirectly. Citizens may participate directly in public debates held in the parliament on the health care plan and in regional-level committees of insured people, which have been established to provide an opportunity for the citizens to actively participate in planning and managing the health insurance system. Citizens may also participate indirectly through their representatives in the parliament, in the HIIS assembly, in the council of the HIIS and in health-related associations.
and nongovernmental organizations. A health forum is considered to be lacking as a neutral place for wider discussions on how to resolve health-related issues that require at least relative social understanding and consensus prior to enactment.

**Consumer protection**

Consumer protection is a new field in Slovenia, and the link between insured people and consumer interests is just being established. For example, the Ministry of Health has established a complaint board. The board advises consumers further on the institutions from which they could seek assistance, by referring them, for example, to the Medical Chamber of Slovenia, Slovenian Chamber of Pharmacy or Nursing Chamber of Slovenia. In some cases consumers are also referred to the centres for social work and to other ministries. When the modification of the organization of health care activities was being prepared and adopted, the ombudsman intervened several times in the discussions with proposals for improving consumer protection.

In terms of consumer protection, the relatively widespread occurrence of the various forms of alternative medicine needs to be regulated in relation to the legal basis, economic aspects and health care aspects.

**Decentralization of the health care system**

The Slovenian health care system remains relatively centralized, and the self-governing communities still have limited responsibility. The state has the task of planning health care for the entire area of the state and for the entire health care system. All administrative and regulatory functions of the system take place at the state level; the lower levels have mostly executive duties. Compulsory health insurance is also centrally managed and administered; only executing the tasks and activities adopted at higher levels is delegated to the local levels. The professional chambers and organizations also operate at the state level or through their regional branches.

Local governments are also said to make limited use of the autonomy they gained in planning health services. Thus, the de facto degree of devolution in planning primary health services from the national government to the self-governing communities cannot be determined yet.

Privatization, which developed towards terminating the public employment of physicians and other health care workers and opening their own practices, is
taking place gradually and to a constantly increasing extent. Here most practitioners secured the possibility of performing their services by obtaining concessions and hence financing from the compulsory insurance funds, and thus they returned to the network of public health care service. Those who have no concession can offer services to clients who pay out of pocket.

Of the 1458 professionals licensed for private practice since 1992, 959 are contracted by one of the 10 regional social insurance funds. Insurance funds reimburse most of their services, and some rent public premises for their practices. Only about 500 physicians, mainly dentists, operate outside the public system, and their services are mostly covered by direct payments from the patients. No information is available as to the share of total health care expenditure contributed via direct payments by patients. However, according to anecdotal evidence, patients are increasingly making out-of-pocket payments for visits to such physicians in private practices who do not obtain a concession and for purchasing services not included in the benefits package.

Voluntary insurance, which was introduced in 1993, covers part of the co-payments levied on certain services. Voluntary insurance financing in Slovenia, however, represents the public interest because it serves as a regulated form of supplementary funding for the publicly financed segment of the system and was therefore heavily promoted by the government when it was introduced.

Very few private for-profit hospitals exist in Slovenia outside the public network: for example, a plastic surgery clinic. There is also the opportunity for private investment in new hospitals, although this has not yet taken place.
Health care financing and expenditure

Main system of financing and coverage

Slovenia maintains a Bismarck-type health care system, which was introduced for workers as an extension of a compulsory accident insurance system in 1888. The insurance system experienced many changes. The 1992 Law on Health Care and Health Insurance forms the legal basis for the current system. The law laid the basis for a centralized compulsory health insurance system to be administered by the HIIS. By statute, the HIIS is the sole provider of compulsory insurance. The HIIS operates autonomously and is governed by elected representatives of employers and insured people. In its capacity as the founder of the HIIS, the state has retained some main levers to manage and control operation, such as involvement in determining the contribution rate and the scope of rights and resolving other important issues arising in the provision of public health insurance.

Contributions towards statutory health insurance constitutes the major system of financing health care in Slovenia, providing more than 90% of funding. Virtually the entire population with permanent residence in Slovenia is covered under the sole compulsory insurance scheme either as a mandatory member or as a dependant. Coverage is also provided to citizens of almost all EU countries through arrangements governed by bilateral conventions.

Slovenia has 21 categories of insured people, with two main groups. The first comprises white- and blue-collar workers whose contributions depend on income and not risk and include non-earning spouses and children without any surcharge. The contributions are proportional to the individual’s income and shared between the employer and the employee. The parliament determines the contribution rates based on a proposal by the HIIS each year. Since February 1996, all employers and employees have paid a total of 13.25% of gross income: 6.36% by employers and 6.36% by employees, plus an additional 0.53% by employers to cover occupational injuries and diseases.

The second group comprises people contributing fixed amounts. The HIIS determines these fixed contributions independently. The National Institute for
Employment pays such a fixed contribution for each registered unemployed person. Other people with no income are registered in self-governing communities, which are obliged to pay a fixed contribution into the national fund. Pensioners pay a contribution of 5.65% of their gross pension. Farmers and craft workers contribute substantially less. Self-employed people, the fifth largest category of insured people in Slovenia, pay contributions according to a fixed proportion of their after-tax income.

Those who pay most regularly tend to be employed in the public sector. Some people argue that some categories (such as self-employed people, farmers and craft workers) are not paying a high enough proportion of their income.

The HIIS is responsible for invoicing contributions, determining the terms of payment, collecting interest on overdue payments, writing off bad claims and imposing penalties subject to special regulations governing the settlement of taxes and contributions. In practice, the HIIS has delegated these tasks to certain government agencies (the agency of public accounting and the tax administration). The HIIS also determines the criteria and conditions for the potential reduction or write-off of contributions by specific groups of insured people (such as farmers following a drought).

The HIIS may also require additional contributions from employers to adjust for health care claims that are excessive compared with the average for the sector because of occupational diseases and injuries.

The state budget covers capital investment for all secondary and tertiary health care facilities. Budget financing also covers expenditures for the national public health programme, which includes the traditional national prevention programmes as well as some new health promotion programmes, medical education and training, research, the national health information system, cooperation between sectors and health care coverage for specific groups such as soldiers, prisoners and refugees.

The self-governing communities collect revenue at the local level to allow capital investment in primary health care facilities. They provide for all public services and decide locally how much to invest in health. For reasons explained previously, the proportion of funding generated by self-governing communities cannot be specified because the self-governing communities differ in the extent they use their autonomy in practice to collect taxes and to invest this in health care. Some of the differences are explained by very different populations covered between the self-governing communities.

Special funds are available from the state budget for developing self-governing communities, and some funding is available from the Ministry of Health for developing emergency units.

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Health care benefits and rationing

In Slovenia, there are three dimensions to the population’s rights to receive health care. The first right is expressed in the constitutional responsibility of the state to develop economic, environmental and educational policies and appropriate social, fiscal and infrastructural measures, thereby establishing the necessary conditions and incentives for an individual to exercise responsibility for his or her own health.

The second involves mainly employers, who are responsible for safeguarding the working environment. According to 1992 legislation, employers’ responsibilities include maintaining health in the workplace, preventing occupational diseases and injuries, providing first aid, ensuring preventive, periodic and special preventive health check-ups of employees, paying benefits to employees on sick leave for up to 30 days and analysing the health impact of technological processes.

The third dimension refers to compulsory health insurance. These rights are defined by the Law on Health Care and Health Insurance and more specifically described in the special regulations on compulsory health insurance accepted and revised by the HIIS. The law and the regulations specify the entitlements of insured people to benefits that are acquired through contributions to compulsory health insurance. The compulsory health insurance provides all insured people with two types of rights. The first type is entitlement to health care services delivered in Slovenia at the primary, secondary and tertiary levels, including drugs and technical aids. The second type comprises specific cash benefits, such as compensation for salary for absence from work exceeding 30 days and the costs of travel. The benefit package of the compulsory insurance scheme covers a full range of benefits, some of which are subject to co-payments. The following services are covered in full:

- all health programmes for children and adolescents: diagnosis, treatment and rehabilitation of diseases and injuries suffered by children, schoolchildren, minors with developmental impairment and students, as long as they attend school;
- counselling in family planning, contraception, pregnancy and childbirth care to women;
- services pertaining to programmes of preventive care, diagnosis and treatment of infectious diseases, including HIV infection;
- treatment and rehabilitation of occupational diseases or injuries, malignant diseases, muscular or muscular nerve diseases, mental diseases, epilepsy, haemophilia, paraplegia, quadriplegia and cerebral palsy, as well as advanced diabetes, multiple sclerosis and psoriasis;

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• health care services related to the donation and transplantation of tissues and organs; emergency health care, including emergency transport; nursing care visits; and treatment and care in the home and in social institutions; and
• long-term nursing care as home visits and treatment and home nursing in social care institutions.

A specific form of cost-sharing and co-payments was introduced into the system by law. As services for specific groups and patients are fully covered by the system of compulsory insurance, other services are covered only as a certain proportion of the total value of the service. This proportion has been introduced with further clauses of Article 23 of the Law on Health Care and Health Insurance determining the services and respective percentages of costs to be covered by compulsory insurance. These services thus require co-payments varying from 5% to above 50%. For example, in 1993, the year in which voluntary insurance was introduced, the proportions covered by compulsory insurance were defined as follows:
• at least 95% of the cost of services in connection with organ transplantation and the most demanding surgery, treatment abroad, intensive therapy, radiotherapy, dialysis and other very demanding interventions (co-payments less than 5%);
• at least 85% of the cost of treatment of reduced fertility, artificial insemination, sterilization and abortion; specialist surgery; the non-medical portion of care and spa treatment in continuation of hospital treatment except for non-occupational injuries; the treatment of oral and dental conditions, orthopaedics, orthodontics and hearing and other aids and appliances (co-payments less than 15%);
• at least 75% of the cost of medications from the positive list and specialist, hospital and spa treatment of injuries that are not work related (co-payments less than 25%);
• a maximum of 60% of non-emergency ambulance transport and medical and spa treatment that is not a continuation of hospital treatment (co-payments 40% or more); and
• a maximum of 50% of the cost of ophthalmological devices and orthodontic treatment of adults; and medications from the intermediate list (co-payments 50% or more).

Thus, compulsory health insurance covers the full prices of health care services only for preventive measures and measures defined in a specific national programme, services for treating injuries at work and occupational diseases,
services for children, pupils and youth, services of birth and maternity counselling, emergency treatment, treatment at home and treatment of specific diseases such as cancer, diabetes, multiple sclerosis, epilepsy, haemophilia, paraplegia and several others. For all other services and population groups, the compulsory health insurance covers certain percentages of the full prices. The remainder must be paid out of pocket or through private voluntary co-payment health insurance.

It is believed that, besides the reduction in the services available without co-payments by patients and the reduction in spa treatment, health services have not been rationed in Slovenia. The benefit package has not been limited to a core of essential services, nor are priorities determined based on age or income.

**Complementary sources of financing**

The regulation of compulsory health insurance, which presumes co-payments in the system, opened the way to wide affirmation of the voluntary health insurance scheme. This scheme was introduced in 1993, the year after the new legislation was passed. Two providers were competing: the HIIS, which was obliged to introduce voluntary insurance for co-payments by law operating as a not-for-profit public insurance company, and a private for-profit insurance company. In a very short period, more than 1.4 million inhabitants of Slovenia signed up for voluntary health insurance. At present, 95% of all insured people have voluntary health insurance, insuring themselves against the risk of out-of-pocket payments. In addition to this basic insurance package, the insurance companies now market other insurance policies as well, such as non-standard services and insurance for travelling abroad.

Statutory insurance is the most substantial source of financing by far. Financing through the state budget plays a minor role. From year to year the private resources have increased. The largest source of private financing is voluntary insurance (Table 2). It rose from 1.5% in 1991 to 8% in 1994 and 11.6% in 1998. However, information on the amount of direct payments not reimbursed through voluntary insurance is not available.

**Out-of-pocket payments**

Out-of-pocket payments in the form of co-payments for services under the compulsory insurance system are said to be largely reimbursed through voluntary insurance arrangements.
However, people are also said to increasingly make out-of-pocket payments for visits to physicians in private practices who do not obtain a concession and for purchasing services not included in the benefit package of the compulsory insurance system. No information is available on the magnitude of these payments.

It is speculated that informal payments were previously made in certain instances, such as to shorten the waiting time for specialist and dental care. Later there were efforts to formalize these payments, with the main objective of reducing the waiting lists generated under the social insurance contract. Previously informal services were practically legalized by allowing the practitioners to provide certain services in public premises outside office hours. The health institution at which the service took place and not by the practitioner receives the income from this activity.

**Voluntary health insurance**

Voluntary health insurance was introduced in 1993 and designed to supplement the resources for health care accumulated through compulsory health insurance. The population cannot opt out of the compulsory scheme, and thus there are no voluntary full-coverage schemes.

Voluntary insurance comprises mainly two types of policies: those for co-payments within the compulsory system and those for additional (non-standard) health care rights or services. The vast majority of the population is included in the supplementary voluntary insurance for co-payments in the system. In the years of introduction (1993–1994), many large employers purchased voluntary insurance for co-payments collectively for their employees. But after a more precise systemic approach, it was recognized that individuals should have choice in voluntary insurance, so today insurance schemes have individual insurance policies. Insurance premiums are set by the insurers and can vary.

In view of the novelty of voluntary health insurance in Slovenia, there were initial fears that a two-tier system would be promoted. Nevertheless, arguments

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*Table 2. Sources of health care financing (%)*

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</thead>
<tbody>
<tr>
<td>Public</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taxes</td>
<td>98.5</td>
<td>2.6</td>
<td>2.8</td>
<td>3.4</td>
<td>3.4</td>
<td>3.3</td>
</tr>
<tr>
<td>Statutory insurance</td>
<td>88.5</td>
<td>86.9</td>
<td>85.7</td>
<td>85.2</td>
<td>85.1</td>
<td></td>
</tr>
<tr>
<td>Voluntary health insurance</td>
<td>1.5</td>
<td>8.9</td>
<td>10.3</td>
<td>10.9</td>
<td>11.4</td>
<td>11.6</td>
</tr>
<tr>
<td>Direct payments</td>
<td>Unknown</td>
<td>Unknown</td>
<td>Unknown</td>
<td>Unknown</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

Source: Health Insurance Institute of Slovenia.
that this system would end the limitless claims of the compulsory health insurance system by generating additional resources were stronger.

The preparation of legislation dealing with the introduction and regulation of voluntary insurance projected that 40 000 people were expected to take out policies in 1993, the first year of operation. However, an intensive campaign before the new system was introduced persuaded most Slovenes to become voluntarily insured. In 1993, 1 200 000 people took up voluntary insurance with the HIIS, and an additional 150 000 opted for supplementary insurance with the Adriatic Insurance Company. Today about 1.4 million inhabitants have voluntary insurance for co-payments: almost 95% of those who otherwise would have to pay cash co-payments have decided to enter into one of two alternative voluntary insurance schemes.

Formally, cream-skimming in voluntary health insurance for co-payments has not been allowed; the law from 1992 prohibited it. But in practice from the outset there were problems with risk selection and organizational and systemic problems. These trends provoked the need for better regulation of voluntary health insurance. According to amendments to the Law on Health Care and Health Insurance in 1998, the HIIS founded a new voluntary insurer Vzajemna (which means mutuality), which is independent from HIIS and was established as a mutual not-for-profit health insurance company. It became the largest provider of voluntary insurance. Vzajemna offers voluntary insurance in four areas: coverage of co-payments; coverage of non-standard services (higher quality materials, more convenient procedures, more services in hospitals or health spas); coverage of services not included in the benefit package offered by compulsory health insurance; and coverage of people not eligible to be insured by the compulsory health insurance system.

The second largest insurer is the Adriatic Insurance Company, a commercial provider, and several other providers of voluntary health insurance provide niche products, such as travel health insurance.

External sources of funding

Slovenia has participated in many international technical programmes, including the EUROHEALTH programme of WHO and the Phare Programme of the EU. As Slovenia has a relatively high per capita GDP compared with other central European countries and a relatively equal income and expenditure balance in the compulsory health insurance system, external sources have had a very marginal role. Since 1993, some external financing has co-financed legislative activities and institution-building within the process of Slovenia’s accession to membership of the EU.
In this regard, the EU has generated the most significant resources, whereas financial contributions of WHO, the World Bank, the United Nations Development Programme and other United Nations organizations have been devoted to specific tasks (such as regulating illicit drug control) and do not play a major role in financial terms.

**Effects of the 1992 reform on funding**

The introduction of compulsory and voluntary health insurance in Slovenia has had several beneficial effects. An important achievement is the financial sustainability of the health care system. Introducing voluntary insurance improved the generation of resources, but the funds generated through compulsory health insurance contributions still represent most of the total public budget. There are some other national and local budget sources, including capital investment and the national programme of public health. Most private funds derive from voluntary insurance premiums, which have thus gradually replaced direct payments and other forms of private funding.

Co-payments and enhancement of the range of voluntary health insurance services have allowed progressive restructuring of the ratio between public and private funds to finance health care programmes. From the initial share of 1.5% in 1992, the share of private funds flowing into the health care system through voluntary health insurance increased to about 13.5% in 2000. The structure of sources of health care financing makes the system a mixed public-private system, in which, however, compulsory health insurance has retained a prevailing contribution in ensuring fundamental health security.

The new structure of financing sources is consistent with the strategic macroeconomic objectives of containing the growth of public health care financing below the rate of growth of the GDP. In recent years, Slovenia has reduced the proportion of GDP used on health care from about 7.7% in 1993 to 7.6% in 1999. Public health care funding has remained at about 7% of GDP (7.1% in 1993, 6.6% in 1999). The balance is mainly voluntary health insurance funds.

**Health care expenditure**

Total public expenditure on health care in Slovenia has been increasing in current prices since 1992 because the general price level has increased rapidly. Measured in constant prices (1992), public health care expenditure increased gradually until 1997 (Table 3).
Public expenditure on health care, 1992 to 1997

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer price index</td>
<td>100</td>
<td>133</td>
<td>161</td>
<td>182</td>
<td>200</td>
<td>217</td>
</tr>
<tr>
<td>Total public health care</td>
<td>73 500</td>
<td>104 900</td>
<td>132 200</td>
<td>152 500</td>
<td>175 400</td>
<td>198 800</td>
</tr>
<tr>
<td>Public health care</td>
<td>73 500</td>
<td>78 900</td>
<td>82 100</td>
<td>83 800</td>
<td>87 700</td>
<td>91 600</td>
</tr>
<tr>
<td>expenditure in constant</td>
<td>7.2</td>
<td>7.3</td>
<td>7.2</td>
<td>6.9</td>
<td>6.9</td>
<td>6.8</td>
</tr>
<tr>
<td>as a percentage of GDP</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

Sources: Health Insurance Institute of Slovenia and Office for Macroeconomic Analysis and Development.

Public health expenditure decreased as a proportion of GDP after 1996 mainly because the proportion of private funding increased through co-payments levied on certain services. In addition, GDP has risen more rapidly than has public health expenditure.

Except for the decline in 1991, Slovenia has maintained a funding level comparable to those of neighbouring countries throughout the 1990s (Fig. 3, 4).

The public share of total health care expenditure was 86% in 1999; this is between the level of some countries of central and eastern Europe and EU countries (Fig. 5).

Expenditure estimates for 1999 include 237.8 thousand million tolars (6.6% of GDP) spent through compulsory insurance, 6.23 thousand million tolars through budgetary resources (0.17% of GDP) and 3.05 thousand million tolars through local resources (0.08% of GDP).

Structure of health care expenditure

Table 4 presents certain categories of health care expenditure as a percentage of the total. Pharmaceuticals have been fluctuating during the 1990s between a low of 13.5% in 1991 and a high of 16.4% in 1994, which may represent a gradually increasing trend. The table also reveals a low proportion of total spending allocated to investment during the 1990s.
Fig. 3. Trends in health care expenditure as a share of GDP (%) in Slovenia and selected European countries, 1990–1999

Table 4. Health care expenditure by categories, as a percentage of total health care expenditure, 1993–1998

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Expenditure on compulsory health insurance</td>
<td>91.0</td>
<td>88.4</td>
<td>86.9</td>
<td>85.7</td>
<td>85.2</td>
<td>85.1</td>
</tr>
<tr>
<td>2. Expenditure on voluntary health insurance$^a$</td>
<td>6.7</td>
<td>8.9</td>
<td>10.2</td>
<td>11.0</td>
<td>11.5</td>
<td>11.6</td>
</tr>
<tr>
<td>Total current expenditure (1 + 2)</td>
<td>97.7</td>
<td>97.3</td>
<td>97.2</td>
<td>96.7</td>
<td>96.7</td>
<td>96.8</td>
</tr>
<tr>
<td>Of this:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital care$^b$</td>
<td>31.3</td>
<td>27.8</td>
<td>30.3</td>
<td>31.2</td>
<td>31.3</td>
<td>30.8</td>
</tr>
<tr>
<td>Pharmaceuticals$^c$</td>
<td>14.8</td>
<td>16.4</td>
<td>15.4</td>
<td>14.4</td>
<td>15.0</td>
<td>15.8</td>
</tr>
<tr>
<td>3. Investment (by the state and municipalities)</td>
<td>2.3</td>
<td>2.7</td>
<td>2.8</td>
<td>3.3</td>
<td>3.3</td>
<td>3.2</td>
</tr>
<tr>
<td>Total expenditure (1 + 2 + 3)</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Health Insurance Institute of Slovenia.

$^a$ Excluding voluntary health insurance through the Adriatic Insurance Company.

$^b$ Expenditure on compulsory and voluntary health insurance excluding insurance through the Adriatic Insurance Company.

$^c$ Prescriptions only.

Slovenia
Fig. 4. Health care expenditure as a percentage of GDP in countries in the WHO European Region, 1999 or latest available year (in parentheses)

Source: WHO Regional Office for Europe health for all database.
Fig. 5. Health care expenditure from public sources as a percentage of total health care expenditure in countries in the WHO European Region, 1999 or latest available year (in parentheses)

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albania (1994)</td>
<td>51.1</td>
</tr>
<tr>
<td>Bosnia and Herzegovina (1991)</td>
<td>56.8</td>
</tr>
<tr>
<td>Bulgaria (1994)</td>
<td>75.3</td>
</tr>
<tr>
<td>Croatia (1996)</td>
<td>76.3</td>
</tr>
<tr>
<td>Romania (1998)</td>
<td>76.4</td>
</tr>
<tr>
<td>Kyrgyzstan (1992)</td>
<td>76.5</td>
</tr>
<tr>
<td>Kazakhstan (1998)</td>
<td>76.6</td>
</tr>
<tr>
<td>Belarus (1997)</td>
<td>76.7</td>
</tr>
<tr>
<td>Luxembourg (1998)</td>
<td>76.8</td>
</tr>
<tr>
<td>Ukraine (1995)</td>
<td>76.9</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>77.0</td>
</tr>
<tr>
<td>Slovakia (1998)</td>
<td>77.1</td>
</tr>
<tr>
<td>Lithuania (1998)</td>
<td>77.2</td>
</tr>
<tr>
<td>Belarus (1997)</td>
<td>77.3</td>
</tr>
<tr>
<td>Luxembourg (1998)</td>
<td>77.4</td>
</tr>
<tr>
<td>Ukraine (1995)</td>
<td>77.5</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>77.6</td>
</tr>
<tr>
<td>Slovakia (1998)</td>
<td>77.7</td>
</tr>
<tr>
<td>Lithuania (1998)</td>
<td>77.8</td>
</tr>
<tr>
<td>Belgium (1998)</td>
<td>77.9</td>
</tr>
<tr>
<td>Slovenia</td>
<td>78.0</td>
</tr>
<tr>
<td>Iceland</td>
<td>78.1</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>78.2</td>
</tr>
<tr>
<td>Estonia</td>
<td>78.3</td>
</tr>
<tr>
<td>Sweden (1998)</td>
<td>78.4</td>
</tr>
<tr>
<td>The former Yugoslav Republic of Macedonia</td>
<td>78.5</td>
</tr>
<tr>
<td>Norway (1998)</td>
<td>78.6</td>
</tr>
<tr>
<td>Denmark</td>
<td>78.7</td>
</tr>
<tr>
<td>Latvia (1998)</td>
<td>78.8</td>
</tr>
<tr>
<td>Ireland</td>
<td>78.9</td>
</tr>
<tr>
<td>Spain (1998)</td>
<td>79.0</td>
</tr>
<tr>
<td>Hungary (1998)</td>
<td>79.1</td>
</tr>
<tr>
<td>France (1998)</td>
<td>79.2</td>
</tr>
<tr>
<td>Finland (1998)</td>
<td>79.3</td>
</tr>
<tr>
<td>Germany</td>
<td>79.4</td>
</tr>
<tr>
<td>Switzerland (1998)</td>
<td>79.5</td>
</tr>
<tr>
<td>Israel</td>
<td>79.6</td>
</tr>
<tr>
<td>Poland</td>
<td>79.7</td>
</tr>
<tr>
<td>Turkey (1998)</td>
<td>79.8</td>
</tr>
<tr>
<td>Austria</td>
<td>79.9</td>
</tr>
<tr>
<td>Netherlands (1998)</td>
<td>80.0</td>
</tr>
<tr>
<td>Italy</td>
<td>80.1</td>
</tr>
<tr>
<td>Portugal (1998)</td>
<td>80.2</td>
</tr>
<tr>
<td>Greece (1998)</td>
<td>80.3</td>
</tr>
<tr>
<td>Malta</td>
<td>80.4</td>
</tr>
</tbody>
</table>

Source: WHO Regional Office for Europe health for all database.
The main efforts to contain costs in the 1990s focused on the pharmaceutical sector. The national IPH reported increasing expenditure on pharmaceuticals, which was partly attributed to increasing consumption of medicines in hospital and outpatient care in parallel with relatively uncontrolled price increases for medicine. In 1995, the government intervened to control the drug prices in the wholesale and retail sectors by establishing a new agency (the Office for Medicinal Products) and taking control over price-setting.
Health care delivery system

Primary health care and public health services

Both public and private providers of care deliver primary health care. Public providers include health care centres and health stations. The locations of health care centres correspond to the seats of former self-governing communities (from before 1995), and the locations of health stations correspond to important local centres, which are small towns, hamlets or villages. In 1999, there were 64 health care centres and 69 health stations. Health care centres bear traditions from the ideas of Andrija Stampar, a Croat public health professional who lived from 1888 to 1958, and the first one in Slovenia was established in 1926. The original idea that has survived was that delivery of primary health care should be brought to the local communities and various types of care integrated and targeted to specific population groups. Today, by law and in practice, a health care centre is an institution that provides, as a minimum, preventive and curative primary health care for different target groups of inhabitants, notably many of those who are at higher risk from a public health viewpoint. The types of care include: emergency medical aid; general practice or family medicine; health care for women, children and youth; home nursing; laboratory and other diagnostic facilities; preventive and curative dental care for children and adults; health aids and appliances; pharmacy services; physical therapy; and ambulance services. In the past, the outreach of different types of care was facilitated by the organization of dispensaries for all these types of care. Some of this is still carried out, especially for children and youth. In addition to the services listed above, there were also anti-tuberculosis and venereal disease dispensaries that later slowly declined as the importance of these diseases did. Some of these services are still organized but as purely supplementary outpatient specialist services. A health station provides as a minimum: emergency health assistance, general practice or family medicine and health care for children and youth, family medicine and basic diagnostic services.
services and is linked to the nearest health care centre for other activities described by law.

Health care centres are established by one or more self-governing communities, which also have to ensure their regular functioning, take responsibility for administering them and provide adequate funds to maintain the premises. These important obligations and rights are derived from the fact that one or several self-governing communities own a health care centre so that health care centres are publicly owned. All the employed are salaried according to the terms of the general contract for employees in the non-industrial sector and a special contract for health care. Physicians and dentists have, however, obtained the right to have a special contract, which means a separate negotiating position that introduces special supplements to their salaries.

Apart from public health care there is also private care by either individual health professionals acting as providers or by group practices with various combinations of services and specialties. The self-governing community grants concessions for private primary health care providers (based on the consent of the Ministry of Health). Such a concession is a public contract, which ensures inclusion into the network of publicly financed health care providers. It is agreed for an indefinite period, and each party has the right to withdraw from it (with certain limitations and restrictions). A concession is necessary only for the services practitioners want to have reimbursed by compulsory and/or voluntary health insurance. Once a concession has been granted and the contract signed, the HIIS is approached to define the terms of the contract for the provision and extent of services and reimbursement. The contract with the HIIS gives the private provider of health care the same rights as any public provider. The only difference is that a private provider cannot apply for public funds for capital investment.

Three processes that marked the initial phase of the introduction of private provision of care were:

- an unclear policy on the further development and even existence of health care centres;
- fragmentation of self-governing communities; and
- lack of a clear national strategy on the approach to private health care and the objectives that should be reached in achieving the adequate or acceptable mix of the two.

There was a range of attitudes to the further existence of health care centres. They actually collapsed and functionally ceased to exist in several parts of Slovenia while still developing and being well integrated into the new concepts in other parts of the country. Such diverse attitudes resulted in differences in
physical access for people in different parts of Slovenia. Part of this problem was also the long unsolved issue of publicly owned premises and their availability for (potential) private providers of health care. As no national guidelines were prepared for this problem until late in the process, many private providers left the publicly owned premises and started developing their own. Two main problems arose. Considerable dedicated and custom-built infrastructure was losing its main purpose, but the effective costs of maintaining such structures as health care centres became very steep when many profitable services left the publicly owned premises. The central issue was the question of rent. Only late in the process were some successful solutions found to overcome this problem.

In 1999, 134 private health centres were providing various types of services. There were 178 general practice offices (about 15% of the total) and 286 specialist offices (about 75% of those not directly attached to hospitals). Dentistry is the most privatized of all, since there were 550 private general and specialist dental offices (about half of the total). There were also 26 privately practising field nurses and 80 physical therapists (about one third of the total).

A private practitioner who does not obtain a concession may practice, but the patient must pay for services out of pocket. Private practitioners also practise independently in homes for elderly people, other social institutions and pharmacies.

The health care legislation of 1992 limited the capacity of the primary health care network to the level of 1992. This was further reaffirmed in 2000 when the National Health Care Programme of the Republic of Slovenia – health for all by 2004 (9) was adopted. This policy has achieved relative stability in the health care system, and the number of physicians has not grown by more than 0.5% per year ever since. Such a policy also constrained the possibilities and opportunities for private provision of care, which can be publicly financed in an area only if the restrictions on the number of professionals are respected. A concession and the resulting contract are therefore a means of controlling provision. It can be granted only if there is considerable certainty that the new provider will not enlarge the health care network in the area and the region. One of the equity principles promoted by the National Health Care Programme focuses on possible deviations from the national averages – for human resources, these deviations cannot exceed 10% on either side. Such an approach means that there is little flexibility and movement of personnel, so potential private providers often simply remain in the area in which they had practised previously and take their patients along with them. The physical accessibility of primary health care services needs to be improved, as shown by the fact that new providers can be established in the areas with shortages of services and/or personnel.

Slovenia
The privatization process made the system more dynamic, despite being nothing more than the introduction of private health care. There is now a challenge in achieving both more services and better quality. Careful evaluation of the future location of the new provider and determining the extent of services to be provided and the office hours can ensure access for each individual provider and type of service. Overall patient satisfaction with private providers remains high, although the share of those favouring the private provision of care has gradually decreased in surveys. Private provision introduced competition as a largely unknown (until then) phenomenon in health care. Although private practitioners with contracts with the HIIS work alongside the publicly employed physicians, competition arises by virtue of the competitive process associated with winning a contract.

The personnel delivering primary health care include: general practitioners or family physicians, dentists, nurses, pharmacists, physical therapists, speech therapists, occupational therapists, psychologists or psychiatrists, midwives and other health professionals necessary to carry out the work of the health centre. Social workers are not based in the health centre. Community nurses are independent but based in the health care centre. Specialists generally work in health centres part time based on a contract with the health care centre. They may be employed full time according to need.

The general practitioner and the nurse compose the health team, which provides the initial contact with the patient for curative and preventive care. The physician is the team leader and responsible for medical decisions regarding the patient. General practitioners provide care primarily to adult patients. Paediatricians and school medicine specialists are involved in health care for children and youth. Primary health care gynaecologists provide maternity care and preventive gynaecological services. There are also occupational specialists providing general practice and preventive services to workers in factories.

Community nurses support the recipients of nursing care through health promotion, prevention, treatment and palliative activities. They provide health care services for various groups, including adolescents, healthy elderly people, chronically ill and disabled people, pregnant women, infants and mothers after they have given birth.

Pharmacists supply over-the-counter and prescription drugs and may provide related patient education.

The average number of patients per general practitioner is about 1800 (which normally includes only up to 10% of all children since their care is usually organized through primary care paediatricians). General practitioners provide general medical care, minor surgery and home visits when necessary. Physical, occupational and speech therapists provide rehabilitation. A gynaecologist
provides family planning and prenatal and postnatal care. A community nurse also makes home visits for prenatal and postnatal care. Emergency services are available around the clock.

Paediatricians provide care, including immunization for young children, preschool children and schoolchildren and youth. Nursing staff and community nurses provide health promotion and health education services.

The rules of compulsory health care insurance entitle patients to select their own physician in primary health care: in the health care centre or in private practice having a contract with the HIIS. The personal physician is in principle a general practitioner, but in urban areas and in some small towns children would have a paediatrician or a school medicine specialist as their personal physician. This selection is made for a period of at least 1 year. In 2000, about 95% of insured people had selected a personal physician. A similar situation applies to dentists.

The 1992 legislation allows women to choose a personal gynaecologist. Generally this gynaecologist must be in a health centre or a private gynaecologist in a hospital or clinic having a concession and contract with the HIIS. Children also have to have a personal physician and a dentist, selected for them by their parents or guardian.

Personal physicians represents the entrance point to the system (gatekeeper). They follow the health status of their patients, treat and prescribe medicines and maintain files and records. The personal physician may certify up to 30 days’ leave of absence because of temporary working incapacity. Under certain circumstances, the personal physician of a sick child can certify a parent’s leave of absence to care for the child.

Where such treatment is needed and respecting the gatekeeper function of personal physicians, the personal physician may refer the patient to particular specialist outpatient or hospital diagnosis and treatment. The personal physician may advise the patient as to which specialist or which institution he or she would recommend, but the patient may choose from a range of existing public or private providers of health care. Patients selecting a private provider who does not have a contract with the HIIS must pay the full cost of services.

Referrals by the personal physician to specialists can include consultation, diagnostic procedures and/or treatment. When treatment is included in the referral, the specialist must provide the patient with all services needed, including the relevant prescriptions and control visits. Slovenia established a typical gatekeeper system so patients have the right to be treated by a specialist only when their personal physician has established this need. The only exceptions are chronic diseases when long-term treatment by certain specialists is needed. In such cases, personal physicians can transfer some of their authority.
to other consulting specialists or to hospitals. When that occurs, the relevant specialist or hospital has to report back to the personal physician about the patient’s progress on a regular basis.

The concept of the personal physician was introduced to improve the quality of relations between patients and physicians and to provide continuity of care. This system reflects the confidentiality obligatory on both sides and encourages mutual respect of rights and duties. It contributes to better treatment of patients, as personal physicians who follow patients over a longer period of time and are familiar with their medical records can also provide better and more effective treatment. Further, such a system can be used as an excellent basis for preventive activities and action since general practitioners and their patients have a much closer relationship.

A primary health care facility (health care centre or health care station) is available within 20 kilometres from almost all locations in Slovenia. In rural areas, a physician’s practice is more that of a family physician and a physician may have as many 3000 patients, whereas in Ljubljana a physician may have as few as 750 patients.

A national coordinator for quality assurance works within the health care system in accordance with WHO policies and procedures. The Standards and Metrology Institute of the Ministry of Education, Science and Sport is also concerned with quality. A nongovernmental organization, the Union of Consumers of Slovenia, is concerned with patient rights, satisfaction and the quality of health care services.

The Slovene Public Opinion Poll was most recently carried out in 1999 and included a section on health and health care. A significant majority of the population was satisfied with their general practitioners and their pharmacists, but they were slightly less satisfied with the specialist outpatient and dental services. The causes for dissatisfaction involved primarily waiting times and complicated administrative procedures, and the people who have not visited one of the health professionals doubted that their personal physician would actually do everything possible to improve their health. The consensus of the respondents was that introducing private practice will improve the quality of health care, and those treated by private practitioners demonstrated a higher level of satisfaction than those treated by publicly employed physicians. Over the past 5 years, the percentage of people who consider private care to be superior in quality to the care provided by public providers has declined. Nevertheless, the organization of work in primary health care does not yet fully reflect the importance of this service within the national provision of health care. The degree of utilization of working hours, cost awareness and management of health institutions require a special focus within health policy.
The introduction of private care through independent practices has accelerated in recent years, especially in primary health care. The situation differs for specialist outpatient and hospital care, where considerable perplexity remains as to the nature and the extent of private provision of care.

Challenges for primary health care services include:

- to reduce differences in professional development among physicians throughout all regions of Slovenia and to support high-quality education for all types of health professionals;
- to preserve and further improve the present organizational structures, services and all aspects of the health care system that have proved effective;
- to develop and implement an equitable solution for integrating the public and private sectors; and
- to emphasize health promotion as the main health priority in accordance with the National Health Care Programme of the Republic of Slovenia – health for all by 2004 (9).

The role and position of physicians, dentists and pharmacists have been changed by two processes. One was started with the basic legal framework from 1992 with the adoption of the three basic laws and empowerment of the Medical Chamber of Slovenia and the Slovenian Chamber of Pharmacy to exercise public authority in certain areas. That authority and the respective responsibilities of physicians and dentists were further developed through the Law on Medical Services (10) adopted at the end of 1999. This Law empowered the medical profession and the Medical Chamber of Slovenia to exercise a high level of self-regulation and autonomy in all matters concerning the postgraduate training of physicians and dentists, administration of continuous medical education and licensing of physicians and dentists.

Fig. 6 shows the number of outpatient contacts per person per year for European countries. With 7.4 contacts, Slovenia is still below the average for central and eastern European countries of 7.9.

Public health services

One of the objectives of the 1992 legislation was to change the philosophy of health care from being oriented towards disease to being oriented towards promoting health. Developing the basic policy documents took quite some time, however, especially the National Health Care Programme of the Republic of Slovenia – health for all by 2004 (9) as a long-term strategy. It took 8 years to prepare and was subject to excessive political and narrow influences. It is
Fig. 6. Outpatient contacts per person in countries in the WHO European Region, 1999 or latest available year (in parentheses)

<table>
<thead>
<tr>
<th>Country</th>
<th>Contacts per person</th>
</tr>
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<tr>
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Source: WHO Regional Office for Europe health for all database and OECD (11).

Slovenia
therefore a compromise document, and achieving a more long-term strategy beyond 4 years requires a completely new document. The concept of directing more resources into preventive care and health promotion is supported by the Health Council of the Ministry of Health, which was established as an advisory body at the national level.

The 1992 legislation clearly defined the role of the national Institute of Public Health (IPH). It integrates the daily practice, research, education and postgraduate training functions covering all areas of public health. Traditionally, public health in Slovenia has had three main branches: social medicine, hygiene and epidemiology. Over the last two decades, rapid development and integration of several fields led to the development of another discipline, environmental health. An important component of all these fields (except for social medicine) is well equipped public health laboratories, some of them serving as reference laboratories. The IPH covers three important areas through small professional teams: health care organization, health economics and health informatics. The latter two are also developed in several other institutions, especially the HIIS. A very important function of the IPH is also to maintain several important national health statistics databases, including the national death register, hospital statistics database, outpatient statistics database and database on national health care providers and health professionals. In 2000, a new legal framework was adopted that assigns the IPH and some other institutions to host health registers for their work. It is also the first time that a legal basis was established to allow different health data to be linked through some common personal identifiers.

The Health Council of the Ministry of Health, in cooperation with the Faculty of Medicine of the University of Ljubljana, clinics, broader professional colleges and other institutions, proposes and monitors the implementation of the programme of preventive health care and health education for the population. Part of these efforts is also the national programme of social medicine, hygiene, epidemiological and environmental health services, which is implemented by the national IPH and regional institutes of public health. The national IPH is responsible for environment and communicable disease control, in cooperation with the relevant health care providers, ministries and other health care institutions.

Several initiatives are being taken to strengthen health promotion, especially by the Ministry of Health and the national IPH. The Ministry of Health is coordinating an extensive survey to obtain better data on the prevalence of chronic diseases and lifestyles to improve the planning of health promotion in the coming years. Recently the Minister for Health appointed a new state secretary to coordinate multisectoral activities that can promote and sustain health at the national level. A special department for health promotion will
also be established at the national IPH. The main problem encountered in connection with health promotion, as in other countries, is convincing politicians and political decision-makers of the importance of health promotion in the future development of the health system.

Health promotion and education programmes are also implemented in primary health care by nurses and by other health care professionals working in health care centres. Programmes with several years of working in cooperation with WHO, such as the countrywide integrated noncommunicable diseases intervention (CINDI) programme, health-promoting schools and others have disseminated from their starting local environments and have become national initiatives operating in local communities, cities and schools.

A completely revised prevention programme for primary health care was set up in 2000. It defines several fields of activity and specific services to be provided to the entire population, extending the framework of more formally defined services to the active adult population.

Fig. 7 shows the percentage of children immunized against measles in Slovenia and other countries in the WHO European Region. Measles immunization was at 96% in 1999 and Slovenia is on the average of the countries of central and eastern Europe and the newly independent states.

**Secondary and tertiary care**

Specialist secondary outpatient care is performed in hospitals, spas or private health facilities. Hospitals provide about 75% of secondary care, either as inpatient or outpatient care. Clinics and institutes provide more complex tertiary health care services. The personal physician directly (or sometimes in cooperation with the specialist) refers patients to these services.

Specialized ambulatory medical services are provided at the polyclinics affiliated with hospitals or in community health centres contracted through a clinical specialist or consultant. Since private care was introduced in Slovenia, these services have also been carried out at private offices, where specialists can practice either based on a contract with the HIIS or without a contract (with no reimbursement by the HIIS).

Specialists who hold a concession have the right and responsibility to bid for contracts in the public tenders announced annually by the HIIS. The contract with the HIIS clearly specifies the scope of the contractual work, its monetary value and the price of specific services. Specialists without a concession can set their own prices for services (not reimbursed).
### Levels of immunization for measles in the WHO European Region, 1999 (or latest available year)

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
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</thead>
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<td>Finland</td>
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</tr>
<tr>
<td>Tajikistan</td>
<td>90</td>
</tr>
</tbody>
</table>

Source: WHO Regional Office for Europe health for all database.
As of 2000, most hospital polyclinics worked within the public network of health care services. There are also a few purely private health care providers of specialist care and diagnostic services, but most work on contract with the HIIS. These polyclinics also organize outpatient consultation for self-paying patients under regulations certified by the Ministry of Health. In terms of time and staff, these areas represent non-standard services paid out of pocket. The fees are divided between the physicians, who perform the services outside regular working hours, and the employing institution. Slovenia has no combined public-private polyclinics yet, but the medical and dental professions aspire to move in that direction.

There are 26 hospitals, including nine regional and three local general hospitals and the main tertiary and teaching hospital, the Clinical Centre in Ljubljana. In addition, there are 12 specialized hospitals, which provide orthopaedic, pulmonary, gynaecological and psychiatric care as well as care for children and youth with severe chronic diseases and disorders. Apart from the Clinical Centre in Ljubljana, there are two other national tertiary institutions, the Institute of Oncology and the Institute for Rehabilitation.

All hospitals are state owned, but there have already been some initiatives for private hospital care. Private hospitals may be established out of the network of publicly financed providers. There is also an opportunity for private investment in new hospitals, although this has not yet taken place. The bed capacity of hospitals in Slovenia is considered adequate, and the geographical distribution is pretty even over the whole country. The number of beds is relatively rational compared with the neighbouring countries and the EU.

Over the past decades, cooperation between primary and secondary care left much to be desired. In recent years, increasing resources have been devoted to primary health services to implement all the prescribed programmes of prevention activities. Currently there are plans to develop home care in close cooperation with hospital health services and primary health care services.

Primary health care services and hospitals mainly cooperate on referrals and exchanging test results. Hospitals also provide postgraduate training courses for physicians working in primary health care.

Tertiary clinics and institutes provide the most demanding services that cannot be provided by other institutes and private health providers or services that have been centralized in a single locality for reasons of cost-effectiveness. Patients can be referred to such an institution by the personal physician or by a specialist who has treated the patient upon referral from the personal physician.

Treatment in spas can be suggested by the personal physician or by a physician in the hospital who is treating the patient. The medical committee of the HIIS can either approve or reject the suggested treatment. The insured
person may also be present at the deliberations of the committee. If the treatment is approved, the committee refers the insured party to the appropriate spa for treatment. If the professionally based evidence favouring treatment in a spa is considered inadequate the proposal is rejected, but the insured party can appeal to a higher-level committee.

The number of hospital beds declined from 5.0 per 1000 in 1990 to 4.6 in 1998 (Fig. 8, 9). This is the result of a policy of moving from inpatient to outpatient care implemented mostly by reducing resources but is also expected to change further with the forecast changes in the hospital reimbursement system. There will also be a further shift to day hospital facilities and a more integrated approach to home care for various patient categories. Slovenia is substantially below the average for central and eastern Europe. Fig. 8 shows the relatively lower bed numbers per 1000 population compared with other countries.

In this intermediate reform period, the HIIS also provides certain incentives to reduce the duration of hospital treatment, such as payment for a bed that is not occupied. This payment is made in bed–days up to a maximum of 1 day less than the average length of stay. The average length of stay has been declining very gradually in recent years: from 12 days in 1987 to 10 in 1997. This figure compares favourably with western European countries, many of which have

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**Fig. 8. Hospital beds in acute hospitals per 1000 population in Slovenia and selected European countries, 1990–1999**

Source: WHO Regional Office for Europe health for all database.
Fig. 9. Hospital beds in acute hospitals per 1000 population in central and eastern Europe, 1990 and 1999 (or latest available year)

Source: WHO Regional Office for Europe health for all database.
CEE: central and eastern Europe.

Slovenia
longer lengths of stay. Slovenia had 16.2 inpatient admissions per 100 population in 1997; this had consistently increased since 1987. Compared again with western European countries, this figure is relatively low (Table 5).

In any case, all these changes have influenced the length of stay and the number of hospital beds. The annual negotiations (defining the service contracts) between the HIIS, the Medical Chamber of Slovenia and the Ministry of Health have resulted in agreement that hospital beds and staff must be reduced by 1.0–1.5% annually. However, hospitals attempt to fill the excess bed capacity that thus arises through alternative arrangements such as accommodating patients covered by voluntary insurance and marketing non-standard services. The HIIS saves some of its resources, which are then directed toward primary health care, long-term care and other types of non-hospital care.

Social care

Community nursing services are based in the health care centre. Such services are organized with all primary health care centres around the country and work simultaneously with the general practitioners or family physicians in the self-governing communities. The community nurses have picked up all the tasks of district nurses over the past years, including those previously exclusively provided by midwives. Homes for elderly people and disabled people provide long-term health care.

Slovenia has many homes for elderly people that are slowly becoming providers of specific kinds of health care. Nearly all these homes are public.

Because the Slovene population is aging, there are two options for what to do about this and increase the public availability of services. One follows the attempts to find financing and reimbursement niches to solve the superfluous bed capacity. These superfluous beds will be offered as extended-stay departments for publicly owned institutions to reduce the waiting period for acceptance into homes for elderly people. On average, every year up to two new homes for elderly people are opened. Because this trend cannot be maintained financially, nursing care facilities and treatment in the home must be introduced as soon as possible. Long-term care is accessed through the local community social agency based on the recommendation of the physician.

A permanent physician on the staff provides health care in the homes for elderly people in cooperation with registered nurses. Based on need, clinical specialists are also consulted or called in. The level of care for chronically ill and incapacitated patients is relatively high in these institutions. There are,
Table 5. Utilization and performance of inpatient services in acute hospitals in countries in the WHO European Region, 1999 or latest available year

<table>
<thead>
<tr>
<th>Country</th>
<th>Hospital beds per 1000 population</th>
<th>Admissions per 100 population</th>
<th>Average length of stay in days</th>
<th>Occupancy rate (%)</th>
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Source: WHO Regional Office for Europe health for all database.


Slovenia
however, plans to enable a bridge between a hospital setting and home care for the people who are expected to recover well in the short term. This should especially apply to patients recovering after surgery, who would be discharged sooner from a regular department and quickly receive rehabilitation treatment and nursing care at a nursing department. Such departments should be opened at several general and clinical hospitals to reduce costs and more rapidly rehabilitate certain categories of patients.

Providing for the needs of the growing number of elderly people presents new challenges. Enabling them to maintain self-sufficiency and an optimum quality of life at home as long as possible is a major task requiring attention in the future.

**Human resources and training**

The level of human resources in health care is considered to be well controlled and adequate, considering the specific situation of the health care system. The present policy is directed towards maintaining the present situation. Nevertheless, prospective analysis of demographic data for physicians and that of the general population indicates potential shortages of physicians in certain regions. Currently, there is no unemployment among physicians, and there are already substantial problems in ensuring the coverage of certain areas. It will be necessary to consider recruiting some health care workers from outside Slovenia. Fig. 10 shows trends in the number of physicians in Slovenia and selected European countries. The policy of the last few years has been reflected in a markedly slower rate of growth in the number of physicians in Slovenia. Growth has also been slowed in the past few years in other countries with previously high growth rates. Slovenia still has many fewer physicians per capita than most EU and central and eastern European countries. Only the United Kingdom has fewer among EU countries and only Romania and Albania in central and eastern Europe.

Fig. 11 shows trends in the number of nurses per 1000 population in Slovenia and selected European countries. The situation with nurses in Slovenia is somewhat different than with physicians. Their numbers show relatively constant growth and at a higher level than Austria or Croatia. Slovenia has more nurses than most central and eastern European countries. A high proportion of nurses work in outpatient settings, both in primary and secondary specialist care, whereas there are relatively somewhat fewer nurses in hospitals.

Fig. 12 compares the numbers of physicians per capita for countries in the European Region. Slovenia has 2.3 physicians per 1000 population, which is
Fig. 10. Number of physicians per 1000 population in Slovenia, selected European countries and the EU, 1990–1999

Source: WHO Regional Office for Europe health for all database.

Fig. 11. Number of nurses per 1000 population in Slovenia, selected European countries and the EU, 1990–1999

Source: WHO Regional Office for Europe health for all database.
lower than the average for each of the three groups of countries. Slovenia has 6.8 nurses per 1000 population, which exceeds the average for central and eastern Europe of 5.9 but is less than the average for the newly independent states of 8.0. Slovenia has more nurses per 1000 population than the average in western Europe.

Basic medical education takes 6 years. After graduation from the School of Medicine of the University of Ljubljana there is an obligatory internship of 6 months, which is then extended into an obligatory postgraduate training programme lasting for an additional 18 months. It is semistructured with optional components. If it is completed in a predetermined fashion, it can provide credit for about half the general practitioner postgraduate training. However, it can also be interrupted at any point if and when a junior physician takes up a specialization. Dentists have an internship period of 12 months, which also completes their obligatory postgraduate training period.

Physicians and dentists who work in health care and practice their profession with patients have to become members of the Medical Chamber of Slovenia and need to be licensed. Every physician and dentist must undergo an examination every 7 years to renew his or her licence. Postgraduate courses are organized to accommodate the range of specialties and give special points required for admission to the re-certification examination (which can then be also skipped if the number of credits is sufficient). Most courses are intended for general practitioners. General medicine has transformed gradually into family medicine and is taught as a subject in the undergraduate programme of study.

The Faculty of Medicine of the University of Ljubljana has a Department of Family Medicine with a well defined teaching staff. To be granted a full licence to practise in the field, general practitioners have to specialize in a 4-year programme, which also includes a comprehensive programme of public health (social medicine). In the context of this transition, additional training is envisaged for physicians now exclusively treating children and young people. Since 1999, all postgraduate specialist training has been reformed. Some new specialties have been introduced, and the older core curricula have been thoroughly revised and harmonized according to the guidelines of the European Union of Medical Specialists for each respective specialty.

Undergraduate training in public health is limited to the modest introduction received by medical, pharmaceutical and nursing students. An exception is the programmes for public health for health inspectors.

The Faculty of Medicine of the University of Ljubljana has a Department of Public Health. This Department offers various programmes for professional and research training in collaboration with the national IPH.
Fig. 12. Number of physicians and nurses per 1000 population in the WHO European Region, 1999 or (latest available year)

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<th>Country</th>
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Source: WHO Regional Office for Europe health for all database.

Slovenia
There is a well developed medical specialty in epidemiology, hygiene and social medicine, requiring 3 years of training beyond the medical degree. There are also training programmes (postgraduate courses for two semesters and 400 hours) in social medicine, occupational medicine, health care for children, youth and women and dental public health. The graduates can continue their studies at the Andrija Stampar School of Public Health in Zagreb.

The minor part of this programme (credit points) is also acknowledged as a part of the postgraduate studies in biomedicine at the University of Ljubljana. The courses are founded by participants themselves or by the institutions where they are employed.

No schools of public health are functioning under that name in Slovenia. Preparations for founding a school of public health within the University of Ljubljana have been initiated.

Training in nursing is provided at the secondary school, high school and university levels. Additional training is required for community nurses. There are two schools for health professionals – one is part of the University of Ljubljana and the other one of the University of Maribor. They provide university training for nurses. A new curriculum for nurses, which began in 1993 at the University of Ljubljana, is based on the principles of primary health care with strong emphasis on health promotion and prevention, and includes health education as a course of instruction. There are several lines of study: general nursing, health education, midwifery, physical therapy, occupational therapy, sanitary engineering and dentistry, including orthodontics and prosthetic dentistry. The importance of nursing has grown immensely in recent years. There are plans to organize and establish nursing as a special occupation within health services. Nursing professionals in Slovenia are currently taking master’s and doctoral degrees with the support of their colleagues in other European countries.

The distribution of health care personnel is considered to correspond quite well to the distribution of institutions, hence there are no plans to change the current numbers of health personnel. Enrolment at the Faculty of Medicine of the University of Ljubljana is limited to maintain the same number of physicians. Nevertheless, based on the analysis mentioned above and on the recommendation of the Ministry of Health and the Health Council, the Faculty of Medicine decided to increase the number of admissions by 15%.

There are no unemployed physicians in Slovenia. However, the health sector faces problems with health care personnel, which can be linked to poor utilization of working time and insufficient training, especially in management.
Pharmaceuticals and health care technology assessment

Regulations

The framework law in pharmaceuticals is the Law on Medicinal Products and Medical Devices adopted in 1999 and harmonized with the pharmaceutical *acquis communautaire* of the EU. Drugs are registered by the Office for Medicinal Products, which was founded in 1996 and operates within the Ministry of Health. Its main objective is to implement the national policy on drugs and medical devices.

A medicinal product may only be marketed after marketing authorization by the Office. The import of serum, vaccine, blood products and radiopharmaceuticals is subject to specific authorization procedures. A national register of medicinal products is published in cooperation with the national IPH. The register also contains the prices and recommends to physicians that, among a selection of equally effective drugs, the less expensive ones should be chosen. A register of medical devices is being developed. The Office issues permits for the manufacture of medicinal products and medical devices according to good manufacturing practices and recently ISO 9001 and approves market authorization for medicinal products. The procedure employs a modified approach for specific groups of products that have already been approved for marketing in the EU according to a centralized or decentralized procedure (for example, for orphan medicinal products and others). Companies may manufacture medicinal products only after they have been authorized.

Prices are controlled by basing pricing criteria on reference prices, negotiations or cost-effectiveness.

The medicinal products committee of the Office evaluates medicinal products and medical devices, for example, by commissioning clinical trials. About 100 clinical trials are performed annually in Slovenia. Most are multi-centre, international clinical trials. The clinical testing of a drug requires ministerial approval of clinical tests based on an examination of documents relating to the test.

The Institute of Pharmacy and Drug Research, a public institute founded in 1955, is responsible for controlling the quality of medicinal products, and the Standards and Metrology Institute is responsible for certifying and standardizing medical devices.
The special interdisciplinary commission of the HIIS (according to legislation on classification and pharmacoeconomic criteria) classifies drugs covered by obligatory health insurance on positive and intermediate lists. Medicinal products on the positive list are reimbursed 75% by compulsory insurance, and 25% is paid by voluntary insurance or out of pocket. Medicinal products on the intermediate list are reimbursed 25% by compulsory insurance. A negative drug list contains products with no reimbursement. For children, youth and certain diseases, the law mandates that the compulsory health insurance pay all drug costs. The use of generics in Slovenia is not promoted. In practice, co-payment for medicines is mainly covered by voluntary health insurance.

**Prescribing and distribution**

Control is exercised over all prescriptions. Each physician has a prescribing number, and the type and volume of the drug the physician prescribes is recorded. In 1996 a bar coding system was introduced to monitor drug prescriptions.

Drugs are distributed through wholesalers or private importers, who obtain drugs from domestic production or through imports and sell them to public or private pharmacies. Two firms represent Slovenia’s pharmaceutical industry, Lek in Ljubljana and Krka in Novo Mesto, both of which are private corporations. Most of the domestic pharmaceutical manufacture is export oriented. Slovenia has no restrictions on private ownership.

Pharmacies are reimbursed by a fee-for-service system according to a list of pharmaceutical services, including checking the data from prescriptions, instructing patients, preparing magistral preparations (custom-mixed pharmaceuticals) and galenicals (preparations with organic ingredients) and others. All these standard services are assigned pharmacy fee points by the same measures as other health care services. The point values also include material costs and pharmacist’s wages. The manufacturer’s price, wholesaler’s margin and pharmacy fee together form the price of the drug.

**Consumption**

Slovenia has relatively high drug consumption. The money spent on pharmaceuticals is not exactly known, because the consumption of medicinal products in hospitals and those dispensed without a prescription in pharmacies are not recorded at the national level.
The data gathered from prescriptions are more accurate. Prescription pharmaceuticals started to be monitored in 1974, when the automatic processing of prescriptions was launched. Since then several improvements have been made. Now physicians are informed periodically of the volume of drugs they prescribe.

Consumption of pharmaceuticals according to age groups is generally highest for groups older than 60 years, younger than 1 year and 1–3 years. Over the last decade, the most frequently prescribed drugs were those for circulatory diseases, followed by drugs for parasitic and infectious diseases and drugs for respiratory diseases. These three groups account for one third of all drug prescriptions in Slovenia.

The consumption of prescription drugs has grown in recent years (Fig. 13). In 1991, an average of 5.5 prescriptions per person were issued. The number increased until 1994, peaking at 6.8. This trend continued into early 1995, prompting measures to limit the number of prescriptions physicians were permitted to write. Thus, the number declined to 6.3 in 1995.

In 1997 the largest category of prescriptions was for cardiovascular disease medicines, amounting to about 26% of all prescription costs.

**Fig. 13. Number of prescriptions issued per capita per year, 1990–2000**
The HIIS has faced increasing pharmaceutical costs in recent years because consumption has increased and because the price of medicines has increased rapidly (Fig. 14). In 1995 the government intervened under special legislation to control drug prices in the wholesale and retail sectors by determining the prices. As a result, the rate of increase slowed substantially.

The number of drugs on the positive list was reduced in 1997, but the number on the intermediate list increased. Since the share of co-payment is higher for the intermediate list, this greatly increased the medication expenditure in voluntary health insurance. Thus, the final outcome of the years 1997 and 1998 was a considerable increase in pharmaceutical expenditures beyond the planned level.

In 1996, the Ministry of Health published prices in the drug register along with a recommendation to physicians that, among a selection of equally effective drugs, the less expensive ones should be chosen. There are plans to implement intensive measures to control imports and the use of all types of drugs.

Perspectives

Despite the measures taken to date, the situation remains unsatisfactory. Comparative data show that drug consumption is still relatively high compared with other European countries. The general health status and needs of the Slovenian population do not warrant such a level of drug intake. The pharmaceutical sector must therefore be carefully reviewed in the future and necessary action taken.

Fig. 14. Cost of an average prescription in Slovenia in US dollars, 1990–1999
The introduction of electronic prescriptions (a health insurance card issued to almost all insured people) will make the drugs prescribed for each insured person more transparent. Unnecessary drug prescribing will be prevented as well as incompatible drug combinations.

Physicians do not have enough information on drugs, especially not on prices. An electronic database of medicinal products that will be accessible to all physicians is being prepared, including drug codes, registered names, nonproprietary names, ingredients, indications, side effects, doses and prices. The database will contribute to solving this problem.

Together with the Ministry of Health, the Slovenian Chamber of Pharmacy and the Medical Chamber of Slovenia, the HIIS is preparing comprehensive and comprehensible information for presentation on radio or television and in print about proper drug use and the harmful consequences of use without professional medical justification. Medical and pharmacological experts should agree and decide about the most rational way to use drugs.

Measures to harmonize with the *acquis communautaire*

Within the scope of the national programme for the adoption of the *acquis communautaire*, Slovenia is harmonizing its pharmaceutical and medical devices legislation with EU legislation. Legislation related to the pharmaceutical sector is mainly transposed by amending and modifying the Medicinal Products Act, which has been complemented by at least 30 regulations. These additional provisions regulate how certain parts of national legislation are to be changed when the EU legislation comes into force when Slovenia becomes a member. Another activity is harmonizing procedures for obtaining marketing authorization for drugs already distributed in Slovenia. According to the Department of European Integration of the Ministry of Health, most harmonization measures had been accomplished by the end of 2000.

Legislation related to medical devices is being harmonized in cooperation with the Ministry of Science and Technology and the Standards and Metrology Institute.
Financial resource allocation

Third-party budget setting and resource allocation

Each year the Ministry of Health (representing the state), the Medical Chamber of Slovenia (representing health care providers) and the HIIS (representing the third-party payer) negotiate over several months to agree on the services to be included in the insurance benefit package and determine the total cost of the health care programme to be paid by compulsory insurance (a budget ceiling). This agreement describes the services and defines the total capacity, needs and extent of services based on the general framework of the public finances for that year. As an instrument for defining the ceiling for state funding, the agreement for 2000 maintained the public budget at about 6.5–7.0% of GDP, a measure also intended to contribute to achieving the acquis communautaire for accession to the EU. Funds on health care spent in excess of 7% of GDP are to be covered by supplemental sources.

Annual negotiations and contracting in compulsory health insurance begin at the state level. Individual contracts with health care providers (public health centres, hospitals and private practitioners) are then drawn up. The contracts detail the type and volume of services to be provided as well as the prices of programmes or services, the method of calculation and payment, the supervision of the implementation of the contracts and the individual rights and responsibilities of the contracting parties.

Fig. 15 illustrates the financing flows between the insured people, third-party insurers and providers. Fig. 16 illustrates the process of negotiation between the main parties.
Fig 15. Financing flow chart

[Diagram showing financial flows and budget allocations in the health care system of Slovenia, including contributions, taxation, and investment flows.]

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Fig. 16. Process of partnership negotiations

**Representatives of the Ministry of Health**

- Representatives of HIIS*
- Representatives of providers

**Negotiations on:**
- Programme of health services
- Capabilities for the implementation of the programme
- Funds required
- Starting point for sharing the cost of the programme and services
- Régulation of mutual arrangements regarding implementation of the program

**Consensus or arbitration (government)**

**AGREEMENT**

**Invitation for offers**

**Offers of providers**

**HIIS regional units of HIIS**

**Negotiations on:**
- Contents of the programme
- Calculated elements of the contract
- Value of the programme of services
- Office hours and other obligations of providers to insureds
- Method of mutual arrangements or relations (sanctions, supervision, etc.)

**Consensus or arbitration**

**CONTRACTS**

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* HIIS: Health Insurance Institute of Slovenia
Payment of hospitals

Hospitals (as well as health centres) receive most of their funds through contracts with the HIIS. They are paid prospectively, each year, based on a combination of bed–days and special fees for high-cost services (but within the limits defined by the prospective budget).

The process of negotiations has two steps. In the first stage, the partners negotiate the agreement determining the budget ceiling for each broad class of services in hospitals (and services in health centres). In accordance with the agreement, the HIIS pays a flat rate to hospitals per bed–day, with exceptions for certain more expensive services and materials. For example, admissions for high-cost services such as heart surgery, transplants and dialysis are paid at higher flat rates. In addition, hospitals that reduce their average length of stay can receive an incentive payment for empty beds.

The second stage of the negotiations involves two parties, the HIIS and each provider. Based on the agreement reached above, the HIIS issues a public tender for contracts with each provider.

If the HIIS and a hospital cannot agree on the content of the annual agreement, they face arbitration. If arbitration fails, the dispute is settled by the government, but this is extremely uncommon.

The HIIS pays the contractually agreed amounts regardless of whether the hospitals achieve higher efficiency, such as hospital throughput, average length of stay or admission rates. If hospitals suffer losses, they usually have more staff and consume more materials than are stipulated in the contract.

As the reform continues, important changes are taken place since 1999 in the reimbursement schemes that might intrigue an observer. The next step will be to link interventions to specific patients by providing case-related formulas. The future steps depend to a large degree on the Ministry of Health and the key decision on how to finalize the reimbursement of hospitals.

Payment of physicians

As explained earlier, physicians in primary care may practice: under employment, privately with a concession and under contract with the HIIS or privately independent of a contract.

Employed physicians are salaried by the health centres and health care stations. Physicians at health care stations are paid a combination of capitation and fees for services by a regional health insurance fund.

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Private physicians without concessions and contracts are paid through out-of-pocket fees or voluntary insurance and the prices are not regulated. Again, no data are available as to the proportion of services reimbursed through voluntary insurance.

According to the health policy, private practitioners were permitted in the public network of health centres, to motivate competition. This motive is reflected, at least in theory, in the assumption that private practitioners (both private contractors and completely private) will compete with each other and with the public health centres to obtain contracts with the HIIS. However, the degree of competition in this scenario has not yet been assessed empirically.

The contract with the HIIS is a block contract defining the scope of the contractual work, its monetary value and the price. The salary levels of hospital physicians are negotiated between the Medical Chamber of Slovenia, the Ministry of Health and the HIIS. The salaries may vary by 15–20% because of performance incentive payments as determined by the hospital management.

In 1994, physicians’ average earnings were 88% higher than the average salary of all white-collar employees. A nurse’s average salary was about 20% higher than the average salary of all professions. Compared with 1990, the physicians’ earnings differential declined from more than twice the average, whereas the differential for nurses increased from 14% higher than the average in 1990.
Health care reforms

Aims and objectives

As described, the most important health care reform was introduced in 1992, with the main purpose to ensure sustainable financial resources, and to restore and sustain greater financial stability in the health care system. A key issue was the modernization of the health care system. In line with these aims, the 1992 reform changed three specific areas:

- macro financing reform: structural changes in financing, including defining the public and private sources for funding health care: the public-private mix in funding health care;
- resource allocation reforms: new roles and subjects (along with a partnership model and contracting); and
- reform of the delivery system: structural changes in the delivery of health care services: privatization within the public health care network or a public-private mix in health care delivery, free choice of physicians and introducing a gatekeeping function in primary care.

A central theme of reform was organization and financing. The first great novelty was reinstating compulsory health insurance and the second introducing voluntary health insurance – indeed a new concept in the health care system. In this way, since 1992, most health care has been funded through compulsory and voluntary health insurance.

Such modernization has produced several results. Looking back on the reform effects from the present perspective, the reform is generally assessed as a success. The most important result is the fact that the reform and the modernization of the system did not suspend the general trend of the improving state of health of the population. Nevertheless, the main achievement of the reform most frequently mentioned is the financial and general stability of the system. This is a direct effect of the improvement of the structure of funding sources,
which, even today, provides a foundation for stable financing of health care programmes. The funds raised through compulsory health insurance contributions comprise the largest part of the total public health care budget but are not the only source. In addition to the compulsory health insurance funds, national and local budgets cover such expenditure as operating the ministerial health care services, capital investment and the national programme of public health. Voluntary insurance and direct purchasing of specific goods and services are the sources of private funds.

This structure of funding sources implemented the strategic objectives pursued by legislators and promoters of the reform in 1992: to maintain the growth of public health expenditure at or below the growth of GDP. In recent years, Slovenia has used in the range of 7.7% (in 1993) to 7.6% (in 1999) of the total GDP on health care. Public health expenditure has been about 7% of GDP (7.1% in 1993, 6.6% in 1999), the balance mainly comprising voluntary health insurance.

Despite success, Slovenia already faces new challenges and problems, similar to other industrialized countries in the WHO European Region. These arise from the aging of the population and the corresponding changes in the patterns of health and disease, dramatic development in medicine and pharmaceuticals and the corresponding severe pressures on costs. The public health care and health insurance systems have special difficulty in counteracting the trends arising from a developed market, industrial and service environment, not only in Slovenia but throughout Europe. These have been and may well be the most challenging issues facing the future regulation of public health care systems across Europe.

The Slovenian health care system, which has traditionally been frequently exposed to dynamic changes, will continue to upgrade and advance in response to such trends, including the regulation of long-term care and occupational health and safety. Nevertheless, radical changes should not be expected in the fundamental model of health insurance, which will remain basically oriented towards following the principles of social benefits and solidarity. Health care will still require gradual and «soft» upgrading and amending and, in particular, being equipped for a more dynamic response to new challenges (including the ones generated by the market). The development trend points towards amendments with market elements rather than towards retrograde strengthening of the authority of the state, although development is always greatly influenced by political ambitions, options and, in some countries, practice.

Within this framework, Slovenia is in the process of adapting the health care system to the requirements associated with EU accession. In contextual terms, no real problems are expected because the system is already being
modernized. Paradoxically, effective coordination and cooperation at the EU level require vast administrative and technical capacity. This capacity includes managerial staff at the macro level (the state, the Ministry of Health and public health insurance providers), meso level (management teams of hospitals and other public health care institutions) and micro level (heads of clinics or departments and individual specialists responsible for important business decisions). Any successful management indeed can only stem from excellent managerial expertise and skills.

This, together with the need to change the reimbursement system in health care supported by a better organized and harmonized information system to support decision-making, led the government to borrow money from the World Bank to restructure the top level of the health care system. The Health Sector Management Project will run from 2001 to 2004 in its first phase. The following changes are planned: an implementation plan for a pilot-tested reimbursement system for health care and introduction of the European health informatics standard to standardize the most important definitions of data and to define the data set to be included in the data interchange enabled through the National Health Information Clearinghouse. The main focus of these activities will be hospitals, which will be the first to be restructured as the shortcomings in information support and management skills are assessed to be greatest there. In addition, a programme of health management is expected to be set up both to train health care managers in the short term and to provide a solid base for the future undergraduate and postgraduate education, training and the adoption of skills at different faculties and settings.

Except for the expected increased administrative capacity in the health care sector, adopting the *acquis communautaire* is not likely to have any major consequences for the Slovenians. Except for some specific high-end services available through the scheme of treatment abroad, the supply of health care services to the population is accessible and of relatively high quality. With the possible exception of minor cross-border migration of patients in the border regions, it is not expected that many Slovenian citizens would seek services abroad, and because the prices are similar, patients from EU countries are not expected to seek services in Slovenia. Since 1992, the material circumstances of health care professionals has advanced sufficiently that significant movement of health professionals from Slovenia to EU countries is not expected.

**Health for all policy**

WHO provides support to the Ministry of Health and to the health care sector in developing health policies in accordance with the strategy for health for all.

*Slovenia*
WHO promotes the exchange of knowledge and collaboration between Slovenia and other Member States within the framework of WHO and other entities such as the EU Phare Programme.

Health for all represents an important aspect of health policy in Slovenia. National coordinators have been appointed to work towards specific targets. Within the medium-term programme agreed with WHO, the coordinators monitor and coordinate activities with respect to specific targets.

**Accession to EU membership**

Following independence in 1991, Slovenia accelerated the reforms needed to transform the economy, the constitutional and legal systems and state administration. A parliamentary declaration in 1996 set the objective of being prepared for EU accession by the end of 2002. The accession conference between Slovenia and the EU on 31 March 1998 commenced negotiations for EU entry and sped up the process towards full membership. Slovenia aims to complete negotiations by the end of 2001 and has set the objective of being internally prepared to assume the obligations deriving from membership by the end of 2002. The bodies dealing with EU accession in Slovenia have mainly been established for legislative measures: the government Office for European Affairs, which coordinates preparations for Slovenia’s integration into the EU and the related management of interdepartmental preparations for negotiations with the EU. The negotiating team for accession was set up in 1998 as a group of ten experts. The team is responsible for negotiating 31 chapters of the *acquis communautaire* that the candidate countries have to adopt and implement by the time of accession to the EU. The Department of Negotiations is responsible for coordinating and supporting the negotiation process. The government invited the social partners and nongovernmental organizations in Slovenia to actively participate and initiated a tripartite social dialogue.

To harmonize with EU legislation and the *acquis communautaire*, Slovenia has passed substantial social policy legislation. There has also been substantial legislative activity related to: occupational health and safety; disability insurance; a reform of the pension system; equal opportunity policy for gender; and labour law. National programmes were adopted on poverty and social exclusion and on social security. A programme on parenthood and family income was going through parliamentary hearings in 2001. Slovenia has already temporarily closed negotiations for the chapters on social policy and employment, environment and the free movement of goods and fields relevant to public health and health protection.

Future social policy issues will include coordinating social security for
migrant workers. Bilateral accords between several EU countries and Slovenia already guarantee that Slovenian citizens and citizens of the EU countries will be treated comparably in acquiring and maintaining social security rights.

Social affairs are being dealt with comprehensively in Slovenia with the help of the EU Phare Programme, but most health-related activities towards EU accession are within sectors. Much work is being devoted to preparing legislation in areas such as manufacture, trade and use of chemical products and pharmaceuticals; food safety; and blood supply. Slovenia is participating in four disease prevention and health promotion programmes of the EU: health promotion; combating cancer; preventing drug addiction; and preventing AIDS and other communicable diseases.

Slovenia has completed most of the administrative action related to the free movement of goods, services, people and capital. Adequate administrative capacity in health care is a precondition for coordinating and implementing the present and future EU common standards. Slovenia set up a special intersectoral project under the auspices of the EU Phare/Consensus Programme. One of the main objectives is to strengthen administrative capacity in health care and to facilitate coordination and cooperation at the EU level.

Reform implementation

After the new legislation was adopted on 1 March 1992, the HIIS was founded and compulsory and voluntary health insurance were introduced, thus offering citizens the possibility of purchasing complementary health insurance. At the same time, preparations for introducing private practice were initiated.

Increasing the contribution rate was one of the measures taken to improve the financial viability of the health care system. The favourable effect of the inflow of new funds was reflected in a relatively stable trend in the proportion of GDP spent on health care since the mid-1990s.
Conclusions

The Slovenian health care system provides universal and comprehensive health care access for all Slovenian citizens regardless of income. The health care reforms of 1992 in Slovenia were prompted mainly by the need to increase transparency in the financial flows of the health care system, mobilize supplementary funds for health care purposes and regain control of escalating health care costs. In addition, the changes introduced attempted to maintain the positive features of the system achieved under the former regime, specifically equity in health care and ensuring a comprehensive range of services to the entire population. The main means selected to achieve this involved introducing a system of compulsory social health insurance, introducing complementary voluntary insurance and privatizing physician practices in primary health care.

Some powerful signs of the success of these reforms became apparent in the early course of implementing reform. Perhaps the most successful feature of the reforms was that additional funds could be rapidly mobilized for health care by switching from budgetary financing to earmarked employer and employee contributions via the newly established health insurance fund. Thus, when many health care institutions were incurring losses and were heavily indebted to suppliers in the 1990s, the reforms succeeded in securing an increasing proportion of the GDP. In addition, far larger segments of the population purchased voluntary insurance than originally anticipated, thus further increasing the total resources available for health care.

An important achievement is the fact that, after the reform, the trend towards improvement in the health status of the Slovene population has continued. Opinion polls have also shown for several consecutive years that about 80% of the people are satisfied with health care and health insurance. The extraordinarily large number of people purchasing voluntary insurance indicates a large degree of solidarity among the population and the fact that they have enthusiastically received this novelty. The original high standard of health care for the population with high health care capacity and extensive rights among Slovenia
insured people has been preserved while public health expenditure as a proportion of GDP did not increase.

Cost-containment and efficiency-promoting efforts in hospitals have involved developing such practices as the HIIS paying hospitals based on prospective budgets and contractual agreements aiming at reducing beds and staff paid by the HIIS. More attention is currently being paid to revising the rates per bed–day plus a system of fees for special services towards a case-based payment system similar to diagnosis-related groups.

Some minor problems remain in the form of waiting lists for diagnostic and surgical procedures in hospitals; dissatisfaction of physicians and nurses with working conditions; dissatisfaction of patients with waiting lists and the quality of services; and prices for pharmaceuticals that are relatively high compared with neighbouring countries.

The Slovene Public Opinion Poll was most recently carried out in 1999 and included a section on health and health care. More than half the people surveyed were satisfied with outpatient, specialist and dental care and perceived the system as being equitable. Causes for dissatisfaction involved primarily waiting times and complicated administrative procedures. The consensus of the respondents was that introducing private practice was expected to improve the quality of health care, and those who underwent treatment by private practitioners reported greater satisfaction than those treated by publicly employed physicians.

Nevertheless, public participation in developing health policies is rather limited for such a small country. It might be worthwhile to consider actively stimulating the public debate and to increase the understanding of policy-makers of how the public perceives the health care system and their expectations towards it. For this purpose, the role of the regional boards as advisory bodies of governments of self-governing communities, for example, might be exploited to increase the participation of interest groups in policy-making.

An immediate challenge is to complete the work harmonizing legislation with EU legislation, which tends to consume resources that are not available to invest in further developing the health care system. Such developments, for example, are envisaged in the long term in increasing regional capacity to implement health policy and the development of insurance for long-term nursing care for the aging Slovene population.

The implications of the reforms of the 1990s on the future direction of the Slovenian health system are uncertain. The measures initiated, such as cost-
containment measures including the introduction of co-payments, the shrinking benefit package and private supplementary insurance for people who can afford it, threaten to undermine the equity achieved under the former system.

Fears have been expressed that this may be a possible scenario, as relatively affluent people obtain access to more and higher-quality services by paying out of pocket or better coverage through voluntary insurance.

Slovenia faces dilemmas and uncertainty in the development of health care, but these do not differ essentially from those encountered in most European countries and other industrialized countries. These include the questions of how to preserve health and social security in the aggravated conditions ahead that will be even more marked by the problems of an aging population and related increase in chronic degenerative diseases and growing needs and requirements for health care services. This will require more investment in health care and more effective management of health care expenditure. This prompts several questions that need to be addressed.

• Can further privatization and competition among providers contribute further to reducing costs?
• Do the rights to health care related to social solidarity need to be decreased or increased, and in which areas?
• To what extent can the public be expected to pay privately for better standards and better access to health care services?
• How should national economic and individual interests in financing health care be coordinated?
• Should health care be primarily directed towards social solidarity or should it be partly or increasingly subject to market forces?
• What effects will the various options have on the health status of population?
• How can Slovenia implement under such conditions the objectives of WHO related to health for all in the twenty-first century?
• Will only the economic aspects be decisive?
• How can the proper balance be struck between opportunities and needs?
• How can individual people be encouraged to take responsibility for their own health?

All these are the challenges within which Slovenia is being integrated into the overall global endeavours for better health as a means to improve people’s quality of life.

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