Analysis of the health system in Slovenia

Summary and Key Findings
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Introduction

The Government of Slovenia is implementing a fiscal consolidation package aimed at controlling and restructuring general government expenditure through structural reforms to improve efficiency and performance. In parallel, in 2014 the European Commission released Country Specific Recommendations (CSRs) for Slovenia in respect of macroeconomic imbalances, sustainability of the health system and regulating long-term care. During this process, the European Commission presented the need for an analysis of expenditure on health care in order to inform changes and reform processes.

Domestically, pressures on the health system will continue to grow as demand and costs for health care pick up with the stabilization of the economy, continuous introduction of new technologies, a growing burden of non-communicable diseases and a rapidly ageing population. Indeed, Slovenia is among the European Union (EU) member states projected to sustain one of the largest increases in aging-related public spending by 2060. Health spending is projected to rise by between 0.5 to 2.6 percentage points of GDP over the period 2010-2060, while long-term care is set to rise from 1.4 percent of GDP in 2010 to between 2.8 and 5.6 percent of GDP in 2060.¹

In response to these challenges, the Ministry of Health of the Republic of Slovenia commissioned a team of international exerts from the WHO Regional Office for Europe and the European Observatory on Health Systems and Policies, to work in conjunction with national experts from a variety of government and stakeholder bodies to complete a Health System Review of Slovenia. The objectives of the Review were to address European Commission concerns about sustainability raised in its CSRs and to inform the Minister on the performance of the health system. A new Health System in Transition profile of Slovenia, which provides a comprehensive description and analysis of the way the current health system is governed and financed, forms part of the package of work undertaken for the Health System Review. It will be published in the Spring of 2016 and provides the organizational context from which future reform proposals depart. The other major components of the Review include reports on:

- Health System Expenditure Review;
- Assessment of Health System funding;
- Purchasing and Payment Review; and
- Optimizing Service Delivery

Aided by the results of the Health System Review the government aims to develop, seek parliamentary approval and implement reform measures to improve service delivery and efficiency in the health sector and to enhance the fiscal sustainability of the health system given growing costs and aging demographics, while preserving and continuing to improve health outcomes.

The Slovenian health care system from an international perspective

Comparing the Slovenian health system to its counterparts in Europe, especially those in Central and Eastern European (CEE), on some key structural characteristics provides an encouraging picture. The Slovenian health system performs relatively well on some key indicators, often between the EU15 and EU13 averages, and on some indicators among the best. Below, various macro-level indicators are explored, including on health status, organization, financing and delivery, that together provide some background that contextualizes the findings of the Health System Review reports.

Health status
Two of the most important indicators used for health status are life expectancy and infant mortality. Since 1990, Slovenia has been steadily closing the gap between the ‘new’ Member States (EU13) and the ‘old’ Member States (EU15) of the European Union (Figure 1). With regard to infant mortality, an indicator often used because it is seen as being related to the effectiveness of a health system, Slovenia improved from somewhat above the EU15 level in the early 1990s, to among the very best in Europe (see Figure 2).

Fig. 1 Life expectancy at birth, selected countries

Source: WHO Regional Office for Europe, 2015

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**Organization**

The Slovenian health system operates a single payer social health insurance system with General Practitioners (GPs) as gatekeepers. With this set-up, Slovenia has had a model in place that has become the standard in most CEE countries, the notable exceptions being the multi-payer (but gatekeeping) Czech Republic and Slovakia. Interestingly, the comparably small countries from the Baltic region, i.e. Estonia (1.4 million), Latvia (2.0 million), Lithuania (3.0 million), adopted the single payer model after a great deal of experimenting with multiple insurance pools. They found that the latter led to inefficiencies due to fragmented financing and too small risk pools, especially given their small population size.  

Most CEE countries also adopted gatekeeper system. International agencies such as the World Health Organization and the World Bank played key roles (through advice and loans) in the adoption of the family doctor model, often modelled on the United Kingdom and Dutch systems. Yet training doctors and changing the attitude of the population need time and many of the gatekeeper systems in the CEE countries are still comparably weak. An international research project into the strength of primary care, the Primary Health Care

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3 WHO Regional Office for Europe. European Health for All database, 2015.
Activity Monitor, assessed 77 indicators (from 2009-2010) that among others, covered governance, workforce development, accessibility, continuity, coordination, and comprehensiveness. It found that Slovenia’s gatekeeping system is comparably strong, and stronger for example, than neighbouring countries (see Figure 3).

**Fig. 3 Strength of European primary care systems**

Source: Kringos et al. 2012

**Financing**

In terms of spending, Slovenia offers no aberrations to comparable countries. Since the mid-1990s, spending per capita (in PPP$) has remained firmly between the EU15 and EU13 averages (Figure 4). This is a position in line with Slovenia’s economic performance, which also is between EU15 and EU13 level. Looking into more detail on how health funds are spent, there are again no surprises. As in most countries, the majority is spent on hospital care followed by ambulatory care and retail sales and medical goods, i.e. pharmaceuticals (see Table 1). It is worth noting that Slovenia, in contrast to some other CEE countries such as Hungary and Lithuania, does not suffer from excessive pharmaceutical spending, which in these countries is mainly caused by the high relative prices of pharmaceuticals and utilization patterns.

Furthermore, out-of-pocket expenditure is low and not a significant barrier to accessing health care in Slovenia. This is confirmed by EU-SILC data, where Slovenia consistently has among the lowest (if not the lowest) levels of unmet health care needs in Europe for all

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income groups. In 2013, for example, 99.8% of the population declared no unmet needs, which to a great extent is due to the broad range of entitlements covered by compulsory and complementary health insurance.

**Fig. 4 Per capita health spending (PPP$), selected countries**

Source: WHO Regional Office for Europe, 2015

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7 WHO Regional Office for Europe. European Health for All database, 2015.
### Table 1 Health care expenditure (%) by provider, selected countries (2011)

<table>
<thead>
<tr>
<th></th>
<th>Hospitals</th>
<th>Nursing and residential care facilities</th>
<th>Ambulatory healthcare</th>
<th>Retail sale and medical goods</th>
<th>Administration of public health programmes</th>
<th>General health administration and insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Czech Republic</td>
<td>44.1</td>
<td>1.6</td>
<td>25.9</td>
<td>21.5</td>
<td>0.2</td>
<td>3.4</td>
</tr>
<tr>
<td>Germany</td>
<td>30.0</td>
<td>7.8</td>
<td>31.0</td>
<td>20.9</td>
<td>0.8</td>
<td>6.0</td>
</tr>
<tr>
<td>Estonia</td>
<td>46.7</td>
<td>2.8</td>
<td>21.4</td>
<td>24.1</td>
<td>2.5</td>
<td>2.3</td>
</tr>
<tr>
<td>Latvia</td>
<td>39.7</td>
<td>3.5</td>
<td>23.9</td>
<td>28.6</td>
<td>0.0</td>
<td>3.3</td>
</tr>
<tr>
<td>Lithuania</td>
<td>37.4</td>
<td>1.5</td>
<td>23.4</td>
<td>29.1</td>
<td>0.6</td>
<td>2.0</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>32.9</td>
<td>15.7</td>
<td>26.2</td>
<td>11.2</td>
<td>0.4</td>
<td>1.4</td>
</tr>
<tr>
<td>Hungary</td>
<td>30.2</td>
<td>3.0</td>
<td>23.5</td>
<td>36.8</td>
<td>2.8</td>
<td>1.4</td>
</tr>
<tr>
<td>Netherlands</td>
<td>33.6</td>
<td>24.1</td>
<td>19.3</td>
<td>14.1</td>
<td>1.3</td>
<td>4.8</td>
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<tr>
<td>Austria</td>
<td>38.9</td>
<td>9.0</td>
<td>24.0</td>
<td>16.7</td>
<td>0.6</td>
<td>3.9</td>
</tr>
<tr>
<td>Poland</td>
<td>34.4</td>
<td>1.6</td>
<td>29.2</td>
<td>25.9</td>
<td>1.4</td>
<td>1.7</td>
</tr>
<tr>
<td>Portugal</td>
<td>38.7</td>
<td>1.6</td>
<td>32.6</td>
<td>22.9</td>
<td>0.1</td>
<td>1.8</td>
</tr>
<tr>
<td>Romania</td>
<td>36.2</td>
<td>2.7</td>
<td>14.2</td>
<td>30.9</td>
<td>2.6</td>
<td>1.9</td>
</tr>
<tr>
<td>Slovenia</td>
<td>41.5</td>
<td>5.7</td>
<td>23.7</td>
<td>23.3</td>
<td>0.7</td>
<td>3.5</td>
</tr>
<tr>
<td>Slovakia</td>
<td>25.8</td>
<td>0.0</td>
<td>28.5</td>
<td>38.0</td>
<td>1.2</td>
<td>3.5</td>
</tr>
</tbody>
</table>

Source: Eurostat 2013⁸

**Physical and human resources**

Slovenia has been on the EU15 average in terms of acute care beds since the early 1990s. This is in sharp contrast with CEE countries with a stronger Soviet legacy in their health system as these countries had to strongly reduce their numbers of acute care beds (Figure 5). Taking an in-depth look at some often-used hospital efficiency indicators provides a similar picture. The average length of stay in acute care was on the EU15 average in 2013 (Figure 6). Other indicators, such as numbers of discharges and outpatient contacts, are on the EU15 average.⁹ An exception is the relatively low occupancy rate in acute hospitals (Figure 7). However, as the large fluctuations in the data perhaps signal, caution is needed with interpreting these data or to make any firm statements about efficiency in Slovenian hospitals. In terms of physical resources, Slovenia has a similar profile to that of the United Kingdom, that is, comparably low numbers of physicians and an average number of nurses. Many CEE countries usually have also low numbers of nurses (Figure 8).

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⁸ Eurostat 2013.  
⁹ WHO Regional Office for Europe. European Health for All database, 2015.
Slovenia has been (and still is) right on the EU15 average.

Source: WHO Regional Office for Europe, 2015

Also other efficiency indicators such as numbers of discharges and outpatient contacts are comparable to EU averages.

Source: WHO Regional Office for Europe, 2015

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10 WHO Regional Office for Europe. European Health for All database, 2015.
Fig. 7 Bed occupancy rate (%), acute care, selected countries

Occupancy rate seems low, but caution with data is needed

Source: WHO Regional Office for Europe, 2015

12 WHO Regional Office for Europe. European Health for All database, 2015.
Source: WHO Regional Office for Europe, 2015

Conclusion
From a macro perspective, the Slovenian health system performs well on many indicators. Health status indicators are good and among the best compared to EEC countries or even EU15 countries in the case of infant mortality. Spending levels seems to be appropriate given the size of the economy and out-of-pocket payments are comparatively low, providing good financial protection to residents. Hospital efficiency indicators are mostly on the EU15 levels while the number of physicians and nurses are similar to that of the United Kingdom and somewhat better than most CEE countries. The health system’s set up, with a single payer social insurance system, performs comparatively well in terms of financing and seems appropriate for a small country. Moreover, the country does not have an overabundance of hospital beds or a lack of primary care like many of the other countries in the region. Overall, these are good structural indicators for a health system to have. This does not, however, mean that there is no room to improve the system and make important efficiency gains.

13 WHO Regional Office for Europe. European Health for All database, 2015.
Summary of Health System Review Reports’ Key Findings

Expenditure review

Since the onset of the financial crisis, Slovenia has taken strides to improve the sustainability of its health system by implementing measures to generate additional revenues and reduce expenditures. Efforts over the last five years have included increasing contributions for the self-employed, requiring contributions from student employers, restricting entitlement to free services, increasing coinsurance rates, and reducing prices of medicines and health services.

Under the Council of the European Union Country-Specific Recommendation (CSR) in 2014, urging the government to take steps to address its excessive public deficit, a comprehensive review of health expenditures was called for to support fiscal consolidation. This recommendation comes despite the fact that the Health Insurance Institute of Slovenia (HIIS) – the primary financier of health care in Slovenia – cannot itself contribute to public debt. Since 2004 when the public treasury bailed out the health insurance fund, HIIS has been funded almost exclusively through the yearly contributions of its members, and unlike other areas of the public sector, is prohibited from recording annual losses. Nevertheless, given the financial pressures associated with the rising costs of health care and an ageing population, a review of revenues and expenditures in the Slovenian health sector is an important and timely exercise.

The Health Expenditure Review provides actionable evidence on how resources for health are generated and spent to assist the Slovenian government in identifying and implementing reforms so that the health system achieves better value for money and can secure long-term sustainability. The review provides a detailed assessment of current funding levels, resource allocations, trends and projections to support an overarching evaluation of the performance of health system resources.

Key Findings

- Health sector revenues are very susceptible to labour market fluctuations. Overall, the recent economic crisis led to significant reductions in contributions to the HIIS due to rising unemployment, slower wage growth, increases in the share of inactive enrollees who make comparatively low monthly contributions, high unemployment and insufficient counter-cyclical arrangements of the health financing system. Macroeconomic forecasts indicate that the labour market will not return to pre-crisis levels in the near term, which implies that the health sector will continue to face financial pressures going forward. The aging population exacerbates the problem, since
pensioner contributions to HIIS are significantly lower than average contributions from the employed.

- The slowdown in revenue growth for HIIS was more pronounced than growth in total government revenues – between 2005 and 2013 total government revenues as a share of GDP increased by 1.8 percentage points, while HIIS revenues increased by only 0.3 percentage points. Health care spending by central and local governments remains low by EU standards, despite slight increases in spending in recent years. Therefore, a key aim would be to diversify HIIS revenues and put in place countercyclical financing mechanisms so that there is some regularity to health system resources. Without steady, reliable revenue streams, it is difficult for both HIIS and providers to plan budgets beyond 6 months to 1 year and ensure access to quality health care. Nearly all other health systems in Europe, including those traditionally thought of as social insurance systems (e.g. France, Lithuania, Czech Republic, etc.) receive significant funding from general tax revenues.

- Health care expenditures are linked closely to HIIS revenues, since HIIS must be financed without any borrowing from the central government and without increases in insurance contribution rates. Nevertheless, despite fewer resources, the mix and volume of services purchased has not changed notably throughout the last few years.

- Savings measures by the HIIS were adopted with the aim of preserving the level of health-care programmes and accessibility of services. To keep within available funding and pre-contracted volumes of services three main strategies have had to be used: decreasing prices, delaying payments, or shifting costs onto complementary health insurers.

- As a result, reductions to HIIS revenues have arguably most adversely affected providers, leading some public providers to incur financial losses and a small number of public hospitals to require financial assistance from the Ministry of Finance.

- HIIS pays for a number of budget items that it did not fund in years prior to the crisis, such as provider training and medical specializations. This represents a significant cost, comparable to the total operating costs and profits of Complementary Health Insurance (CHI), and could be shifted back to Central government budgets.

- While there are a number of unappealing characteristics of CHI (e.g. high administrative costs compared to HIIS, private profits) it has served an important role throughout the crisis, both by protecting households from incurring high coinsurance payments, as well as to a limited extent, by partially subsidizing the provision of services, as private insurers pay providers for the coinsurance portion of services rendered even after HIIS contracted volumes have been met for the year. These factors contribute to maintaining access to health services and offer financial protection to households.

- The complementary health insurers have remained profitable throughout most of the crisis, though the profits amount to only a small share of total health expenditures, around 0.3% of total health expenditures in 2014.
• Health worker salaries are not particularly high overall, but this is generally due to low salaries for nurses and other non-physician workers; there are concerns regarding overtime payments, and while these are fairly high, they make up only a small share of expenditures.

• According to current baseline forecasts, ageing is expected to lead to larger increases in health and long-term care expenditure relative to GDP as compared to the EU-28 average. In the long-term, due to increasing demand and slow growth in revenues from social insurance contributions, there will be a need to either find alternative sources of revenue, to reduce the basket of services provided by HIIS, or to cut prices continuously to maintain volume and quality of care.
Assessment of health system funding

Financing of the health system in Slovenia is based largely on compulsory health insurance funded primarily through payroll contributions, with private financing for complementary health insurance (CHI) premiums and out-of-pocket payments. Given the almost exclusive reliance on labour force contributions, long-term financial sustainability may be at risk under this financing approach, and diversification of the revenue sources for the health system may be required. In addition, the CHI system largely exists to finance public sector co-payments and is funded through flat rate premiums requiring complex risk-equalization across insurers to prevent cream skimming and generating high administrative costs relative to the compulsory health insurance system.

In addition, the consequences of a patchwork approach to financing are most salient in long term care (LTC), where services are currently funded from several sources: compulsory pension and disability insurance; compulsory and complementary health insurance; the national budget and the budgets of municipalities; and out-of-pocket contributions from service users. A more unified and sustainable approach to financing LTC is needed, particularly given changing demographics.

The analysis for this part of the project has resulted in three separate reports:

- **Evaluating health care financing in Slovenia** – which gives an overview of options for funding of the health system. It aims to identify how more equitable and efficient funding systems could be designed to deliver quality healthcare services that are sustainable in the long term.

- **Making sense of Complementary Health Insurance (CHI)** – which considers the role of complementary health insurance within the health financing system, provides options for alternatives and evaluates the potential effects on equity, efficiency and financial protection.

- **Evaluating long-term care needs and financing** – which explores the organizational and funding arrangements for long-term care and what will be required for a less complex and sustainable basis for the future provision of long-term care (LTC) services and benefits.

### Key Findings

**Evaluating health care financing in Slovenia**

**Key features/Problems**

- Public spending on health is heavily reliant on payroll taxes. This will become an even greater challenge in future, as the population ages and dependency ratios change. Diversification of funding sources is needed.
• The current system of financing does not have a sufficiently robust counter-cyclical mechanism to mitigate the potential adverse effects of revenue fluctuations due to economic cycles. A more stable system of funding sources is needed.

• The system has performed well in relation to both the equity of financing and access. While there has been some cost-shifting on to private sources, the CHI system, with almost universal enrolment, has meant that almost no households have been exposed to damaging out-of-pocket payments. Hence, equity of access has been preserved with remarkably little unmet need. However CHI premiums are regressive.

• The funding of long-term care is a growing problem which needs additional funding.

International Lessons

• France presents an interesting and imaginative example to broadening the financing base of the health care system beyond payroll taxation. In France, a diverse range of taxes are utilised to make public funding more stable and boost social insurance funding. The French authorities levy social insurance contributions on income as opposed to wages. Sources of government budget support for Social Health Insurance include a tax on pharmaceutical companies. In addition, large companies are taxed on their turnover. There are also levies on the polluting activities of all companies. Finally, revenue from an unpaid working day (the solidarity day) for the French working population, is earmarked for long-term care and support services for the elderly and those with disabilities.

• Lithuania has an elegant counter-cyclical contribution mechanism which it uses to stabilize social health insurance funding. First, the health insurance fund accumulates reserves. Second, the government makes transfers from its budget on behalf of the unemployed and those economically less active. Third, since 2007, these transfers have been based on average gross wages in the year two years prior to the transfer, which helps to prevent sudden drops in health insurance revenue in economic crises.

The Benefit Package

• Universal health coverage (UHC) requires a broad health care package and Slovenia has historically done well in this regard, particularly because cost shifting on to CHI has protected the population against user charges.

• While affordability within public financing will always be an issue it is recommended that the package continues to be as broad as possible to facilitate equity of access. Evaluating and ensuring best practice quality of care within the current package may be a more effective focus for decision-making and subsequent resource allocation than revisiting and potentially restricting the publicly provided benefit package.
## Options for stabilisation and improved counter-cyclical funding for HIIS

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Description</th>
<th>Impact</th>
<th>Impact on financing objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher effective rates for pensioners (with the additional amount paid by the state)</td>
<td>20% increase for pensioners</td>
<td>Extra €73 million per annum (3.2% revenue growth)</td>
<td>Allows diversification of funding sources and in turn sustainability of health financing. Generates significant additional revenue with the potential of adjusting further if needed in the future.</td>
</tr>
<tr>
<td>Government budget transfers on behalf of children</td>
<td>€20 per month per child paid by the state</td>
<td>Extra €89 million per annum (3.8% revenue growth)</td>
<td>Improves diversification of funding sources and in turn sustainability of health financing. Generates significant additional revenue.</td>
</tr>
<tr>
<td>General across the board increase</td>
<td>3% increase in premiums for all groups</td>
<td>Extra €69 million per annum (3.0% revenue growth)</td>
<td>Does not address the fundamental challenge of overreliance on payroll contributions, but generates significant additional revenue.</td>
</tr>
<tr>
<td>Extend levy base for health insurance contributions to all income</td>
<td>Additional 2% non-payroll income taxation earmarked to health</td>
<td>Extra €15.8 million per annum (0.7% revenue growth)</td>
<td>Improves equity in financing and sustainability of the health financing system. Generates a little more revenue for health, but could be expanded.</td>
</tr>
<tr>
<td>Equalization of rates between employed and unemployed</td>
<td>Contribution for unemployed to double from €104 to €203 per month</td>
<td>Extra €4 million per annum (0.2% revenue growth)</td>
<td>Very modest effect on generating additional revenue, but improves counter-cyclicality.</td>
</tr>
</tbody>
</table>

## Reflections on policy options

- Health financing in Slovenia has a heavy reliance on payroll contributions which may not be financially sustainable. There is also a long term problem through a shift of the population into lower contribution categories for social insurance. Further, there are dangers in promoting further cost-shifting on to the private sector because of regressive financing and the potential for growing transaction costs.

- It is in this context that additional general taxation support to HIIS looks inevitable to help deal with economic cycles and the ageing population.

- There is some scope for revising the contribution rates and payments into HIIS. The rates for pensioners paid by the state pension fund are very low and could be supplemented by funding from general taxation revenue. State funding of children’s premiums may also be helpful. Contribution rates for the employed and unemployed
could also be equalized to improve counter-cyclicality. There may be some scope for proceeds from non-payroll income and property taxes to be earmarked for health care.

- Further use of user fees is not recommended without regulated CHI cover.
- The current benefit package should not be restricted or divided but there could be a renewed focus on quality of care and appropriate pathways within the benefit package.

Making sense of Complementary Health Insurance (CHI)

CHI in Slovenia achieves very high coverage of the population and premiums appear to be largely affordable. It provides financial protection to households from co-payments and a safety valve for public financing during financial crisis. By international standards, the voluntary health insurance market in Slovenia performs well. Nevertheless, it is complex and regressively financed while transactions costs and insurer profits have risen. It is also lacking in transparency.

SWOT Analysis of CHI in Slovenia

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CHI protects people against the negative effects of user charges which would otherwise be substantial</td>
<td>1. CHI premia are flat rate and hence regressive. Poor households pay as much as rich households. Larger households pay more.</td>
</tr>
<tr>
<td>2. CHI allows the public sector to shift costs on to the private sector in a way that does not create unmet need</td>
<td>2. CHI incurs transaction costs associated with insurer profits and administrative costs and, indirectly, the costs of government regulation.</td>
</tr>
<tr>
<td>3. CHI premia appear at present to be largely affordable by the vast majority of the population</td>
<td>3. There is some evidence of oligopolistic pricing which is inefficient</td>
</tr>
<tr>
<td>4. CHI administrative costs are low by international standards</td>
<td>4. Current risk equalisation mechanisms do not remove the incentive to risk select.</td>
</tr>
<tr>
<td>5. The current risk equalisation scheme helps reduce risk selection.</td>
<td>5. CHI makes the system more complex and there is currently little information and transparency on its performance.</td>
</tr>
<tr>
<td>6. CHI may remove an incentive for HIIS to control costs/ create efficiencies</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Could the CHI market be reformed to ensure CHI provides good financial protection for all households and is financed more equitably?</td>
<td>1. If the public system continues to shift costs on to the private sector:</td>
</tr>
<tr>
<td>2. Could the resources consumed by CHI transaction costs be lowered?</td>
<td>a. The financing of the system may become more regressive (as a larger portion of the overall funding comes from flat-rate premia)</td>
</tr>
<tr>
<td>3. Could the market be more transparent for regulatory authorities and consumers?</td>
<td>b. The increasing flat rate premia may become less affordable to poorer households who then drop cover and face user charges.</td>
</tr>
</tbody>
</table>

2. CHI transaction costs may continue to rise over time reducing the administrative...
Options for CHI

- Option 1: Better regulation and oversight of CHI
- Option 2: Replacing CHI with public compulsory pre-payment
- Option 3: Abolishing user charges
- Option 4: No change

Better regulation and oversight of the CHI market (option 1) would help mitigate the weaknesses of CHI while preserving its strengths. Investing in policy-relevant analysis, improving reporting requirements, introducing a minimum claims ratio and strengthening risk equalisation would enhance transparency, help to lower transaction costs and ensure that the market operates more efficiently. With better analysis and information, the government would also be able to introduce effective policies to make CHI financing more affordable and equitable (such as taxing CHI to pay for the CHI premiums of the poor).

CHI does very well in covering gaps in publicly financed coverage. However, it may be useful to see whether the CHI market could be encouraged to provide cover for other health care activities that incur significant out-of-pocket payments, such as dentistry. Dental costs are one of the few causes of unmet need and hardship in Slovenia.

If the government feels better regulation is not feasible then it could consider removing the need for people to buy CHI covering user charges. This could be done by replacing CHI with a public compulsory prepayment option (option 2) or by abolishing user charges (option 3).

Both of these options have merit – they would lower transaction costs at a system level, enhancing administrative efficiency. Depending on how they were implemented, they could also improve transparency and equity in financing (by linking payment to income). However, they both present significant political risks in comparison to option 1, by provoking opposition from private insurers (and others). They also raise additional challenges for the government.

- A major impact on the CHI market, probably resulting in large job losses, though option 3 could be phased in to allow an adjustment period.
- Bridging the funding gap – of around €400 million – created by the demise of CHI covering user charges (option 2) and the abolition of user charges (option 3).
- If additional public funding cannot be found to fully bridge this gap, and costs are shifted onto households, health system performance is likely to suffer.
Because of these additional political risks, and because decisions about increasing public spending may be largely beyond the control of the Ministry of Health, better regulation and oversight can address the shortcomings of the CHI market.

Other roles for Private Insurers
One option that has been put forward is to change the role of private health insurers to become active purchasers of all health care services and so to introduce competition for purchasing HIIS benefits. While it may seem at first sight that there could be potential benefits to be had by introducing competition into the health care purchasing process the evidence argues against tangible benefits from this option. Introducing purchaser competition – especially if purchasers are private insurers with little or no experience of purchasing – will most likely lead to a rise in transaction costs and may also lead to cost escalation, inequity, inefficiency and less transparency.

Evaluating long-term care needs and financing

- LTC expenditure in Slovenia represents only a small component of GDP, and is much lower than health care spending, but is growing much more rapidly. Even on optimistic assumptions about the levels of disability, the effects of demographic change will be to more than double expenditure on LTC by 2035.
- There are four main public funding sources for LTC, but nearly half of the public LTC spending is by the Health Insurance Institute of Slovenia (HIIS).
- The HIIS will see the largest absolute growth in LTC spending because of its focus on LTC for older people. The Ministry of Labour will see only a smaller increase given the focus on LTC for non-elderly people.
- Private spending on LTC is almost all out of pocket spending by recipients and this has been growing significantly. On current policy and practice, this would increase rapidly (given that the services paid for privately are likely to grow rapidly) and this might not be sustainable.
- There is unnecessary complexity in the current public funding of LTC that leads to confusion about entitlements, difficulty in brokering access to combinations of services needed by users, and this may be a factor in the over reliance on residential care.
- Consideration should be given to reducing the complexity of (particularly the public) funding of LTC. This might be achieved either by shifting responsibility to a single government department and/or agency, or by mechanisms that aim to co-ordinate the spending and entitlements between the different funding organizations.
- The full report shows that LTC spending, under various scenarios, is likely to grow rapidly, and that the rate of growth will vary hugely between the different public funders of care. With a much longer time scale it would be possible to derive more precise estimates of the changing costs to the different funders, but the current calculations display clearly the patterns of likely change.
Purchasing and payment review

Purchasing and paying systems play a key role in making health system affordable and promoting efficiency. Yet in Slovenia there is important scope for improvement and several problems have been identified. This Report looks more closely at how health resources are allocated from payers to providers in Slovenia. Its various elements are organized around the basic question of what constitutes an effective and strategic approach to purchasing, so that available resources can be used optimally. The Report has five components:

1) Looking at the greater use of cost-effectiveness evidence - through Health Technology Assessment - to inform decisions on what goes into the health benefit package
2) Review of the care purchasing process and its governance
3) Review of payment methods for health services
4) Review of payment methods for physicians
5) A final part looks at the preconditions that would be necessary for introducing any eventual Pay-for-Performance (P4P) schemes to reward providers for their quality and/or extra efforts.

Key Findings

Purchasing and payment are integral parts of strategic purchasing, which is the main instrument for promoting quality and efficiency in the use of health funds. It includes (1) which benefits should be purchased, (2) How should these be purchased (purchasing process), and (3) What payment methods should be used.

In terms of ensuring that general governance measures are in place to carry out purchasing and payment functions efficiently, the government should consider:

• Assessing whether the institutional set-up, as well as expertise and staffing levels, are sufficient
• Improving the National Health Plan (NHP) and legislation so that they define roles and responsibilities and can be used to hold actors accountable
• Improving information systems so that they mandate, collect and make available meaningful information for use by all stakeholders to enable effective purchasing

Benefit basket and HTA

In Slovenia, there is no explicit listing of covered services (except for few areas, e.g. pharmaceuticals), with the result that providers have substantial latitude in what they can bill to insurance. The effectiveness and/or cost-effectiveness of different services is not taken into account in determining the benefit basket.

Priorities for benefit setting:

• The government could consider establishing a clear mechanism, with explicit definition of roles and responsibilities, to determine which benefits (incl. technologies) are to be covered;
• Health Technology Assessment (HTA) should be further institutionalized as part of a clear mechanism to determine covered services. An independent non-for-profit HTA body should be established and clear criteria to guide assessments should be defined. Traditionally, effectiveness, safety and costs (or cost-effectiveness) are the criteria most frequently employed.

Related considerations include:
• From a methodological perspective, experience can be drawn through collaborating with more experienced countries, for example in the context of EUnetHTA.
• Coverage decision-making processes need to be transparent and the reasoning behind decisions needs to be clear and readily accessible. Stakeholder involvement is vital in this respect and may also help counteract professional resistance towards an HTA-based approach. Furthermore, transparent and inclusive deliberative processes can mitigate concerns about the political cost of difficult decisions.

Purchasing
The review finds that many problems facing the purchasing process relate to inadequate governance; therefore, a large scale assessment would establish whether the institutional set-up as well as expertise and staffing levels are sufficient to meet the demands to design, regulate, run and monitor an effective purchasing process.

Priorities for the purchasing process
The government could consider the following measures:
• Clearly describing roles and responsibilities in establishing a public network of providers, a centralized concession system, and population health need.
• Fixing General Agreement (GA) and contract negotiations so that they are concluded within a predefined timeline and include patient groups. This will not only provide clarity to providers but the inclusion of patient groups could also help to focus the discussions on quality of care instead of financing and shortfalls.
• Revising the duration of the GA and contracts and require HIIS to develop strategic (3-5 year) and operational (annual) purchasing plans in line with the NHP.
• Strengthening the purchasing role of the HIIS by i) reassessing the government’s role in arbitration, ii) considering the introduction of selective contracting and iii) introducing hard HIIS-enforced budget constraints.
• Making contracts much more specific to and/or include quality assurance mechanisms and quality indicators and clinical guidelines (the latter two need developing)

Payment of health services and physicians
The problems associated with the payment of inpatient (hospital) care include: insufficient institutional support for keeping the DRG system up-to-date, the use of imported (and potentially inadequate) cost weights for DRGS and weak incentives for increased efficiency within hospitals.

The problems identified with the payment for outpatient (specialized ambulatory) services are: malfunctioning institutional arrangements for revising and updating the fee-for-service (FFS) catalogue (Green Book) and weak incentives for efficiency.
The main weaknesses identified in the payment of primary care are: inadequate age weighting of capitation payments and limited incentives for service provision and quality of care.

The main problems identified with the payment of physicians include: the rigidity of the civil service pay scale that also applies to physicians, insufficient incentives for productivity and quality and insufficient remuneration of primary care physicians.

**Priorities in payment methods**
- Clearly assigning institutional responsibilities for developing payment systems (DRGs, FFS, and capitation) and for maintaining these systems up-to-date.
- Improving payment adequacy by increasing the availability of cost data (for the calculation of DRG weights, FFS points, and capitation payments), adjusting the FFS catalogue, recalibrating capitation payments, and redefining the salary scale.
- Providing stronger incentives for efficiency (and quality) by changing the relative importance of different payment systems (increased relevance of DRGs and FFS), and potentially (in the long run) introducing P4P.

**Related considerations include:**
- Financial incentives will have relatively little effect in motivating change if provider (hospital/local public health care institution) management has only limited autonomy to make decisions on staff and equipment and if the ultimate financial risk of providers is borne by the treasury.

**Rewarding performance: pre-conditions P4P**
Introducing P4P schemes prematurely, without the means to monitor activity and quality reliably, risks rewarding the providers that are best at gaming the system and undermines the primary policy objectives of rewarding legitimate extra effort and improving quality of care.

**Priorities in considering the introduction of potential P4P schemes:**
- Any introduction of financial incentive/Pay-for-Performance (P4P) schemes needs to take a step-by-step approach, starting as a small-scale pilot programme that is evaluated before national roll out;
- Any introduction of P4P scheme should be *preceded* by amendment of current payment systems for primary care providers and hospitals to establish properly functioning and transparent payment methodologies.
- Strengthening the development and enforcement of the current quality management framework, namely adopting a national program of clinical guidelines, and enforcing the regulation of quality monitoring responsibilities within individual health care facilities/institutions;
- Establishing an institutional framework that is responsible for overseeing quality management and improvement policies (possibly through a coordinating unit within the NIIS);
- Developing appropriate indicators/performance metrics in both the primary care and hospital sectors, and co-ordinate their collection and evaluation;
• Operationalizing a system of *quality reporting* and public dissemination of results as a preliminary basis for developing more robust quality monitoring activities.
Optimizing service delivery

The overarching aim of the Report on Optimizing Service Delivery is to describe current service delivery patterns in Slovenia and to identify key facilitators and barriers towards optimizing the interfaces between primary and secondary care, and between health and long-term care. Drawing on examples of good practice but also on ‘failures’, the analysis seeks to derive lessons that can inform addressing key bottlenecks as well as opportunities to optimize service delivery in the Slovenian health system.

The analysis comprises three components focusing on (i) the primary-secondary care interface; (ii) pathways for people with multiple care needs; and (iii) the interface between health and long-term care. Specifically, the report provides:

1) an analysis of the key facilitators and blockages for better coordination at the primary-secondary care interface through
   (i) assessing key indicators of ‘avoidable’ hospitalizations across Slovenia and over time; and
   (ii) exploring the day-to-day challenges experienced by health care providers in the management of chronic disease, using diabetes as a case study.

2) an assessment of the main challenges faced by people with multiple care needs as they pass through the system through
   (i) exploring the core challenges and experiences of good practices in the management of people with multiple care needs as perceived from different professional perspectives; and
   (ii) assessing processes and procedures for discharge planning implemented by hospitals with a focus on people with multiple care needs and from the perspectives of a range of providers and agencies in three regions in Slovenia.

3) a description of the current long-term care arrangements that are in place in Slovenia.

Key Findings

_Slovenia has a strong primary care foundation to address the changing health and health care needs of the population but faces the challenge of fragmentation of service organization and delivery._

- Similar to many other countries in Europe, Slovenia is facing the combined challenges of an ageing population coupled with a rising burden of chronic diseases, growing expectations and technological advances against a background of increasing financial constraints and the need to ensure that resources are spent efficiently.
- Slovenia’s primary care system has been rated to be strong and to provide a promising foundation to address these challenges. At the same time, a core concern for the Slovenian health system remains fragmentation of service organization and delivery,
which poses particular challenges given the changing demographic and health profile of the population.

- There is a need to strengthen the coordination and collaboration between different providers and across organizations and institutions along the care pathway, from prevention and early detection to the management of multiple care needs by bridging health and long-term care.
- The report aims to identify key facilitators and barriers towards optimizing the interfaces between primary and secondary care, and between health and long-term care.

**Trends in potentially avoidable hospital admissions for selected chronic conditions during 2009-2013 as an indicator of the performance of primary care in Slovenia point to improvements in some areas.**

- Decreasing rates of hospital admissions for chronic obstructive pulmonary disease (COPD) likely reflect declining trend in adult smoking prevalence following introduction of smoking restrictions at the workplace and in public spaces in 2007 while there is also some evidence of earlier detection and treatment of COPD through family medicine ‘model practices’ from 2011.
- Decreasing rates of hospital admissions for hypertension and a small increase in the rates for congestive heart failure (CHF) likely reflect policies introduced in 2002 as part of a national programme for the primary prevention of cardiovascular diseases. There is evidence of improved control of hypertension in primary care between 2002 and 2008 while available data also suggest lack of awareness of and knowledge about CHF in general population in Slovenia and need to strengthen understanding among health professionals in particular among nurses who deliver patient education.

**Focus groups with key stakeholders revealed a range of barriers towards better coordination at the primary-secondary care interface in the Slovenian system.**

- Using diabetes care as a case study for addressing chronic disease in Slovenia, discussions with registered nurses, specialist physicians in family medicine, community nurses, diabetologists and local patients’ associations revealed a range of factors that were perceived to prevent health care providers to deliver good quality care in line with the 2011 national diabetes guidelines.
- Perceived blockages to implementing best practice in diabetes care were: time (*high volume of patients in primary care*), capacity and infrastructure (*lack of appropriate information technology*), organizational constraints (*lack of clarity about roles and responsibilities; of access to specialist services, of continuity in primary care; of communication between primary and secondary care; and of professional autonomy of community nurse*), and environmental constraints (*reimbursement structure* perceived to incentivize acute health problems and interventions over advising or counselling patients).
Interviews with providers at the different tiers of the system on providing quality care for people with multiple care needs identified several opportunities to build upon promising examples of good practice.

- The day-to-day management of service users with multiple care needs was perceived to pose a range of challenges as reported by health care professionals in different health care settings in three regions in Slovenia (Ljubljana, North West and North East).
- Providers reported a perceived lack of standardized processes and procedures for the handover of patients between providers and care levels and shortcomings in the way the different levels shared information in terms of content, structure and mode of transfer. More integrated information systems were seen to be core to strengthen coordination between care levels, which was believed to be particularly important to enhance the quality and safety of patient care, in particular for those with multiple care needs.
- There was a perceived need for better guidance and protocols to help better meet the multiple needs of complex older patients although there was recognition that implementation of such guidance might be faced with professional resistance. Based on the (international) evidence, it is appears to be important to consider seeking staff views during guideline development in order to enable ‘buy-in’ and promote implementation and adherence.
- Identified examples of good practice at the primary care level included the family medicine ‘model practice’ models as a promising step in enhancing care for those with multiple needs as they allow for a more systematic multi-disciplinary team approach to patient care. Participants also cited the experience, in the North East region, of consultations with a clinical pharmacist consultant for patients who use more than 8 medications, as an example of good practice to enhance the management of drug side effects, drug interaction, and polypharmacotherapy more broadly.
- At the secondary care level, interviewed providers referred to the ‘care continuum and coordination nurses’ introduced in the North West region (see below) as one example of good practice. The Institute of Oncology in Ljubljana was mentioned as an example of the routine sharing of results from patient consultations with specialists with the patient’s family physician.
- The creation of protocols and checklists according to the principles of orthogeriatric collaboration in Ljubljana, which has been found to significantly improve outcomes for older people with hip fracture.

Surveys of provider groups in Ljubljana, the North West and the North East on discharge planning processes and procedures highlighted a lack of standardization of processes and procedures as the key challenge to enhancing continuity at the interfaces between care levels.

- Discharge planning may control costs and improve patient outcomes through for example, influencing the length of hospital stay and the pattern of care within the community by bridging the gap between hospital and home.
- Surveys of doctors and nurses working in hospital, staff working in community health centres (community nurses, family physicians and nurses working in family medicine ‘model practices’), nurses in long-term care institutions or retirement homes and patient representatives reported a perceived lack of standardization of discharge papers, which
was seen to pose considerable challenges in ensuring continuing care especially for vulnerable people who are being discharged from hospital.

- There was agreement among respondents that ‘care continuum and coordination nurses’ as implemented in the North West region fulfilled an important function in coordinating a given patient’s discharge from the hospital and as a case manager who takes on wider responsibilities in the coordination of different services to address the patient’s needs.
- Evidence suggests that a more strategic approach to discharge planning and support in the Slovenian context, such as that adopted in the North West region may go some way towards enhancing patient outcomes.

**Long-term care is provided through different routes across the health and social care sectors, with different entry points and different procedures concerning the assessment of entitlements for supplements to support long-term care needs.**

- The provision of long-term care has been described to heavily rely on medical and curative approaches in institutional long-term care settings while there is less emphasis on rehabilitation and prevention.
- Available evidence points to a lack of transparency because of different entry points and different needs assessment procedures. This creates conditions that risk unequal treatment of people in need of long-term care services.
- Different oversight and regulatory mechanisms are suggested to impede on better coordination of service provision between the health and social care sectors.
- The Government draft resolution on the national health care plan 2015-2025 seeks to address several of these issues through creating a “unified way to access services, integrated implementation of activities in various forms and an uniform method of financing”.