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Privatisation of health care in Slovenia in the period 1992–2008

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ABSTRACT

Objectives: To discuss the background, nature and facilitating and hindering factors of the privatisation process in health care in Slovenia.
Methods: Descriptive analyses of legal and policy documents mapping the situation in Slovenia against an internationally established taxonomy and typology. Description of the scope and volume of the different types of privatisation.
Results: Determined by the political will, privatisation in health care in Slovenia has been a gradual process. In 2008, it applies to 30% of the primary care providers (GPs, paediatricians and school medicine doctors), almost 60% of providers in dentistry and about 20% of providers of outpatient specialist care. In the hospital setting, privatisation remained limited and there have not been significant private investments in health infrastructure. Privatisation of health insurance (including insurance to cover co-payments) has steeply risen to 15% of the total health expenditure (THE), while out-of-pocket payments reached 12% of the THE.
Conclusions: Slovenia's privatisation in health care is focused on primary health care and on health expenditures. Controversies over its extent kept privatisation contained and controlled. Today's share of private provision of health services remains at the conservative end of the European Union. Private expenditures for health services increased considerably, while privatisation of health infrastructure and management has so far been limited. Concerns about the future course of privatisation relate to the issues of equity, fairness and solidarity.

1. Background

Historically, private practice existed in Slovenia since the beginning of the organised medical profession in the 19th century. Until World War 1 most of the health care facilities were either private for direct payment or belonged to charities, with the exception of the state owned military facilities. In the period between the two world wars, developments went in two directions. At the primary care level, primary health care centres were established, which were mostly owned by municipalities. Certain key institutions, such as the school children primary health centre, the dispensaries for the protection of mothers and children, etc., were also owned by municipalities and physicians would be salaried. At the level of specialists, outpatient care private provision and ownership were most frequent, while hospitals were state-owned. After World War 2, private practice in Slovenia continued until 1947 when licenses were suspended and then banned completely in 1957. Between 1957 and 1992 private practice continued to a limited extent as a 'grey market' activity, predominantly among dentists. Physicians and dentists were keeping hopes that transition would lead to the legalisation of private practice. This resulted in a civil movement leading to the formation of the Medical Chamber of Slovenia (MCS) in 1991. Such a process did not run in isolation, but was rather symbolic of the transition processes in other former socialist countries of central and Eastern Europe. Privatisation became

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an important issue of the overall reforms. In 1989/1990 some republics of the former Yugoslavia (especially Slovenia and Croatia) saw privatisation as a political priority with the return of parliamentary democracy. In other central European countries, privatisation had also been in the forefront of political demands of health professionals. The main reasons for this were twofold: firstly, privatisation was seen as necessary for the implementation of the concept of physicians as free professionals and, secondly, it was expected that it would bring more efficiency and patient-friendly atmosphere into health care as a whole. There was another 'informal' reason for promoting privatisation—informal payments, which were very common in many of the central and eastern European countries. Privatisation was seen as means in overcoming informal payments' practices. Health care was suffering from managerial inefficiency, loss of motivation and financial losses, underinvestment, low salaries for health professionals and general under-funding. All of this contributed to health care becoming an important field for the implementation of privatisation policies. There had been a growing perception of health care as a commodity instead of a social benefit, which gave more influence to ideologies based on market forces. Political expectations went in the direction of explicit privatisation. Former state employees saw an opportunity of gaining independence through a self-managed single-handed practice. Once more professional and work independence were to be gained, there was, realistically, the wish to also increase their incomes. Overall, privatisation was seen as 'the magic cure' for the problems of the public sector, even as far as potentially providing solutions for understaffed posts in remote areas. Privatisation of health care investments was supposed to provide attractive options to stay in the country and work under independent management.

This paper poses four research questions in the exploration of the privatisation process in the Slovenian health care:

1. what were the reasons and the background of privatisation in Slovenia,
2. what was the nature of privatisation,
3. what was the extent of the privatisation process in numbers,
4. what were the influencing (facilitating and hindering) factors for privatisation.

At the beginning one of the proposed existing definitions of privatisation and its modalities in health care is introduced. We supplement it with an outline of the taxonomy and typology of privatisation in the health care sector. In continuation the developments in Slovenia are presented comparing them with the proposed definition. The nature and the types of privatisation as it unfolded in Slovenia are presented and put in the context of facilitating and hindering factors for privatisation. As an illustration of the extent of privatisation some statistical data are included. In conclusion, we present the controversies, which remain in view of the positions of stakeholders and their opposing views on the past and the future process of privatisation in health care in Slovenia.

2. Materials and methods

2.1. Defining privatisation

According to the European Observatory on Health Care Systems and Policies [1] privatisation is 'the transfer of ownership and government functions from public to private bodies, which may consist of voluntary organisations and for-profit and not-for-profit private organisations'.

In principle, privatisation defines the turning of public assets over to private ownership. An additional important issue of privatisation is the development of not-for-profit versus for-profit private delivery. For that purpose we have chosen for our study the taxonomical categories proposed by Saltman [2] (see Table 1).

We also compared the course of privatisation in Slovenia with the typology proposed by Maarse [3], where levels of privatisation can be structured as the different privatisations:

1. privatisation of health care financing,
2. privatisation of health care provision,
3. privatisation of health care management,
4. privatisation of health care investment.

The definition of privatisation, the taxonomy and the typology of privatisation were taken as a matrix against which the Slovenian situation is described, characterised and evaluated.

In order to analyse the information previously published on the background and on the reasons for privatisation, we carried out a search of nationally relevant documents through the Slovenian national bibliographical database (COBISS—http://www.cobiss.si), using the keywords 'privatisation of health care' and 'private work, health care'. We also carried out a search for 'privatisation, health care, Slovenia' in PubMed. The search for documents in the COBISS database yielded 25 hits with the keywords 'pri-

Table 1
A public/private taxonomy in the health sector.

Public		Private	
State	Public, but not-state	Not-for-profit (mission-driven)	For-profit (return-driven)
Ministry of Health (MoH)	Regional and local government	Community-based Religious Charitable NGOs	Small business
National Boards	Public corporations		Large corporations