Health Systems Characteristics Survey 2016

Slovenia

Please note: The comments provided below should be read in conjunction with the responses provided in the Health Systems Characteristics Survey response tool.

Q1Com

In Slovenia according to the Health Care and Health Insurance Act (the Act) the entire population (in the year 2015 in Slovenia there were 2,063,077 residents) is covered by the unique compulsory health insurance either as mandatory member or as (family) dependant. This means that, from legal point of view, the coverage is granted in 100% and no one could be uninsured. There were altogether 2,080,733 insured persons included in the compulsory health insurance in the year 2015. However in practice there is always a certain number of persons without properly regulated status of compulsory health insurance or with problems with the settlement of compulsory insurance liabilities for certain reason and for certain period of time. For example at the end of the year 2015 3,979 persons (0,19 % of all insured) were not registered properly more than two months. Larger is a group of persons who have “retained benefits” (except the right to emergency medical treatment) because they did not pay their contributions properly. At the end of 2015 there were a total of 24,254 such persons (1,16 % of all insured), 10,344 (0,50 % of all insured) of them with such status of “retained benefits” more than one year. The majority of this group represent self-employed entrepreneurs with financial problems or whose business has collapsed. Nevertheless, for these groups different strategies are carried out to regulate their status properly and to enable basic health protection to all.

Q2Com:

In Slovenia health care system is based on a social model of compulsory health insurance. There is a common compulsory health insurance scheme for all residents provided by sole provider – Health Insurance Institute of Slovenia (HIIS). This single-payer model still preserves basic characteristics of compulsory health insurance: relatively autonomous position within the health care system in financing function, specific flow of public finances (contributions), (self) management of HIIS by representatives of obligors for contributions payments, partnership and contracting process with providers for allocation of financial sources for health care, etc. On certain strategic issues (financial planning, settling contribution rates, pricing, coverage, etc.) the system is regulated by the state mainly through different system of formal approvals (Minister and/or Ministry of Health, Government, Parliament).

The concept of voluntary health insurance in Slovenia is based on cost-sharing and co-insurance. Basically, the system of compulsory health insurance guarantees that insured individuals receive
health care services needed but within the scope or to the extent of coverage being defined by the Act. Certain groups enjoy full coverage (children and youth till the end of regular schooling and studying, pregnant women) under the compulsory health insurance scheme, the same as certain patient groups cured of specific diseases, precisely defined by the Act (diabetes, cancer, para/tetraplegia, etc.). For all other procedures and services insured persons (the majority) should pay a certain share (from 5 to 25% for most frequent and needed services, and from 50% to even 95% for less needed/aesthetic services) of the total value or costs of the services. For all risks of copayments insured persons can take out voluntary (complementary) health insurance. Voluntary health insurance (VHI) in Slovenia is provided by competitive mutual or commercial insurers. Currently there are three competitive VHI providers, covering app. 73% of the entire population in Slovenia or app. 95% of all those at risk for co-payments.

Thus voluntary health insurance in Slovenia is closely linked to the basic compulsory health insurance scheme. As such it is also regulated by state on certain points of the system (flat premiums, limited discounts and premium loadings, measures to prevent cream-skimming, risk equalisation mechanism etc.).

Q4Com:

Answer to question 4 refers to the compulsory health insurance in Slovenia:

Contribution rates are determined by the Parliament based on a proposal of HIIS Assembly (main managing body). Contributions are proportional to the individual's income. Contributions of the employed population are the main source of compulsory health insurance. Altogether employers and employees pay a total of 13.45% of their gross income. This corresponds to 6.36% paid by employees and 6.56% paid by employers. Additional 0.53% is paid by employers to cover risks of work injuries and occupational diseases (so employers pay altogether 7.09%, employees 6.36%). Other active categories of insured (for example self-employed, farmers, entrepreneurs etc.) pay contributions (in relation to their income basis) or fixed amounts, both representing a minimum financial liability to cover health risks. Pensioners pay 5.96% of their pensions. For unemployed and socially weaker groups contributions are paid by state or local budgets. The system is regulated and coordinated with other parts of the social system.

According to the Act HIIS would have the possibility to collect funds independently, but based on pragmatic reasons, the collection of contributions is organised on the state level with national Tax office.

Q6Com

In compulsory health insurance there are no contracts between HIIS and insured persons. Obligations and benefits of compulsory health insurance are defined by the Act. However the obligation of insured person (or his/her employer as his/her obligor) is to settle his/her compulsory health insurance status properly and to be regularly registered in HIIS. Insured persons hold special e-health insurance card as identification document and as (certificated) electronic key for direct electronic data exchange between different stakeholders. For example data about insurance status of insured are constantly under process of changes in case of changes of employment, residence etc.

Insurance companies with complementary health insurance are required to enrol any applicant, the same holds for contract renewal.
There is no choice of the compulsory health insurance providers. As already mentioned the Act obliges HIIS to cover the entire population with the residence in the Republic of Slovenia as well as other insured persons in Slovenia under the unique compulsory insurance scheme either as mandatory member or as their (family) dependants.

There are no contracts between HIIS and insured persons. According to the Act HIIS assembly can propose (the level of) the contribution rate - but to put it on value the Parliament should give the approval to the HIIS proposal. In practise contribution rate policy is not part of HIIS autonomy but coordinated through the governmental macroeconomic and fiscal policy. Present contribution rate for active population has been at the level of 13.45 % of brut income already 15 years (since 2001).

In complementary health insurance is limit to premium increase (premium loadings) at maximum 3 %. The exception is for late entrants. Every person, liable for copayment, is by the law bound to take out complementary health insurance within one year. Every calendar year without complementary health insurance adds 3 % loading to the premium, but in total this loading cannot exceed 80 %

Q9Com

In the field of the compulsory health insurance for certain low-income groups contributions are paid directly by the state or by the local communities’ budgets as follows:

- state beneficiaries (38.429 persons or 1.8 % of the entire population in the year 2015 – paid by the state budget);

- registered unemployed (26.698 persons or 1.3 % of the entire population in the year 2011 – paid by the state budget through Employment Service of Slovenia);

- Persons without any income (66.195 persons or 3.2 % of the entire population – paid by local Communities’ budgets).

In the field of voluntary health insurance there is another public arrangement: for the persons with low income, the Ministry of Health covers voluntary health insurance for co-payment for health services obtained.

Q10Com

As already mentioned compulsory health insurance ensures benefits to the extent of coverage being defined by the Act. The Act defines certain high risk groups and diseases which are granted to be covered in full value (100%) by the compulsory health insurance (HIIS).

For example:

- all health programs for children and youth: diagnosis, treatment and rehabilitation of diseases and injuries suffered by children, schoolchildren, minors with developmental impairments and students, as long as they attend school;

- counselling in family planning, contraception, pregnancy and childbirth care to female patients;
— 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, sclerosis multiplex, and psoriasis;

— medical services related to the donation and transplantation of tissues and organs, emergency medical treatment, including emergency transportation, nursing care visits, and treatment and care in the home and in social institutions;

— long term nursing care as home visits, and provision of treatment and home nursing in social care institutions;

— holistic treatment and rehabilitation of blindness and visual impairment in accordance with the current classification of the World Health Organization, complete or very severe hearing impairment, according to the International Classification of Impairments, Disability and Handicaps World Health Organization (1980), cystic fibrosis and autism and people with head and brain injuries;

— medicines and foods for special medical purposes defined in positive and intermediate lists for children, pupils, apprentices and students, and persons with physical and mental development;

— foods for special medical purposes with nutrient-adapted formulation for the treatment of insured persons with inborn metabolic disorders.

While these services for specific groups and diseases described above are covered to 100% by the compulsory health insurance, other services are covered only to a certain share of the total value of the service.

Q24Com

The volume of services payable by the HIIS is outlined in prospectively determined annual contracts. One half of the programme value in these activities is paid per capita for the patients on the physician’s list, the other half is paid by fee-for-service payments in accordance with the volume of services provided. In 2003, financial incentives were introduced to reduce the number of referrals to specialists. Increased payments to providers are possible if the number of referrals to specialists they issue is below the national average. In the event that the provider’s level of referrals to specialists is above the national average, the HIIS is authorized to reduce payment by 2–4% of the total value of the agreed programme. In 2005, an additional incentive was introduced to strengthen the provision of preventive services: in order to be in line with eligibility criteria for HIIS payments, providers are required to implement programmes of prospectively determined volumes of preventive services; they may obtain the full budget if they perform the required preventive work, regardless of the number of provided curative services. (HIT Slovenia, 2016).

Q31Com

Data not available. It is not possible to distinguish between specialists supplying out-patient services and specialists providing inpatient services within hospital setting.
Simultaneous performance of health services, both within the public health network as well as privately is possible in the following cases:

- private practitioner, who obtained a concession just for a certain part of the health services he/she might provide, can the rest of health services he/she is providing (and are not covered by the concession) provide on the private basis;

- medical professional, an employee with the public health care institution, could perform health care services with another legal entity or natural person, which performs health activities, only on the basis of the written consent of his/her employer and prior consent of the founder of the said public health care establishment or structure;

- medical professional, an employee with the legal entity or natural person, which does not perform health activities within the public health service, could perform health services with the public health care establishment or structure in accordance with the Employment Relationships Act (competition assessment).

Q43Com

Comments to above two points: A new Faculty of Medicine (the second one) was established in Maribor. Due to the lack of doctors Universities have been under pressure to increase the number of available medical faculties posts for entrance. Recently an inverse trend of diminishing the number of available places for new students has been observed. The limit is set by the universities themselves, according to the Higher Education Act the higher-education institution may restrict admission to study programmes offered as a public service, if the number of applications substantially exceeds the number of places available or its capacities (personnel, facilities, equipment, etc.). A higher-education institution is obliged to obtain consent for the restricted admission from the Government of the Republic of Slovenia.

Q47Com

In 2010 the Act on Recognition of Professional Qualifications of medical doctor, specialist doctor, doctor of dental medicine and dental medicine specialist was adopted.

In 2011, a system of family medicine - ‘model practices’ - was introduced. These practices include, in addition to the regular nurse (i.e. associate professional nurse), a further part-time (0.5 full-time equivalent) registered nurse , who has received additional training and whose tasks include screening for chronic disease risk factors and preventive counselling of patients aged 30 and over, as well as the care coordination of all registered patients with stable chronic diseases, such as arterial hypertension, diabetes type 2, asthma, COPD, osteoporosis and depression (HIT Slovenia, 2016).

The location of physicians' practices is determined in the certificate granting the permission to offer healthcare services in the public healthcare network in the case of private practices.
Q48Com

Regulation in this matter relates predominantly to private practices which want to acquire concession (for publicly financed provision of services) in certain area. For primary care, it is municipality which grants concession. This decision depends on number of already existing practices and unmet needs (regarding accessibility) of the population in municipality. For secondary care, Ministry of Health grants concession, applying roughly the same criteria as there are for primary care. Private practice outside public provision of health care is not regulated in choosing location.

Q62Com

Despite the absence of the formally established HTA agency in Slovenia, there's in place a mechanism for introduction of new methods, programmes and technologies at the national level with the objective of securing clinically and financially efficient health care. Thus HTA elements exist. Namely, parts of HTA which correspond to a Rapid Relative Effectiveness Assessments for pricing and reimbursement of medicinal products are implemented in the Agency of Medicinal Products and Medical Devices and in the Health Insurance Institute of Slovenia.

In addition, the Health Council as a special advisory body to the Minister of Health evaluates the newest health technologies (medical and surgical interventions, and screening and diagnostic technologies), which follows the aim of HTA assessment methods.

The Ministry of Health actively participates in the third EU joint action on Health Technology Assessment (HTA) and thus use the cooperation at EU level in support to its activities to complete the implementation of the system (also in accordance with the Resolution on the National Health-care Plan).

Q65Com

There are several acts as well as regulatory provisions dealing with the domain of health care quality:

- Resolution on the National Health Care Plan 2016-2025
  [http://www.uradni-list.si/1/content?id=125979#!/Resolucija-o-nacionalnem-planu-zdravstvenega-varstva-2016-2025-Skupaj-za-druzbo-zdravja-(ReNPZV16-25)];

- National Strategy of Quality and Safety in Health Care 2010-2015

- Patient Rights Act
  [http://www.uradni-list.si/1/objava.jsp?urlid=200815&stevilka=455];

- Health Services Act
  [http://pisrs.si/Pis.web/pregledPredpisa?id=ZAKO4430];

- Guidelines on the Control and Prevention of Infections

- Manual on Quality Indicators.
There are no national standards set for health care quality yet, however the hospitals as well as some other healthcare providers are accredited according to the international standards (ISO, DNV, JCI).

There are standards related to medical devices, in line with EU regulation. The organization responsible is Agency of the Republic of Slovenia for Medicinal Products and Medical Devices (https://www.jazmp.si/en/). There is a national recommendation issued by MoH for healthcare providers to get accredited by one of the recognized international accreditation organizations.

In 2011 the Ministry of Health has initiated the introduction of "Family Medicine Model Practices", aimed at ensuring the work on the primary level with appropriate staffing, content and financial structure and consequently better quality and cost-effectiveness of the health care. To this end 32 quality indicators have been monitored and the special healthcare providers database has been set up.

In hospital sector Slovenia established the system of compulsory recording and gathering of quality indicators. In accordance with the Manual on quality indicators, the health care providers currently collect data on 74 quality indicators that are analysed and 6-10 of them are published on hospitals’ websites. Quality indicators, quality systems, the results of accreditation and newly introduced clinical pathways are reported in annual reports.

At the end of 2015, the Council for quality and safety in healthcare has been established at the Ministry of Health and in 2016 four priority areas will be discussed in project subgroups: revision of the existing set of quality indicators and methodology, regulation and institutionalisation of quality and safety, training in the field of quality and safety at undergraduate and postgraduate level and setting up an information contact point for patients/citizens. (Source: SPC draft report for Slovenia-2016)