

ANALYSIS OF THE
HEALTH SYSTEM IN SLOVENIA

Evaluating Health Financing

Final Report

Evaluating health financing

Final report

15 October 2015



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Evaluating health financing

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List of abbreviations

CHI	Complementary health insurance
EU	European Union
GDP	Gross domestic product
HIIS	Health Insurance Institute of Slovenia
IMAD	Institute of Economic Research
OECD	Organisation for Economic Co-operation and Development
SHI	Social health insurance
UHC	Universal health coverage

1 Introduction

Key performance metrics for any health financing system tend to relate to three different components: raising sufficient revenues to provide or purchase appropriate levels of care, ensuring access to a comprehensive range of needed services, especially for those who are less able to afford them and pooling risks across different subsections of the population (Normand & Thomas, 2008; Thomas & Darker, 2013). A key constraint, then, for any health care financing system will be financial sustainability (Thomson et al., 2009), which relates both to raising sufficient revenues for care from internal sources but also to having reliable and predictable sources of revenue to adequately cover needs (La Fond, 1995; McPake & Kutzin, 1997). A key objective, sometimes in competition with financial sustainability, is equity. Equity in health care can take many forms but may most usefully relate to health care financing according to ability to pay and access to health care services according to need (WHO, 2010). Often a key aim for equity of financing is that it is progressive, that is, that not only do the rich pay more than the poor but also that the rich pay a higher proportion of their income than the poor. Equity of access is most easily secured when services are free at the point of contact for the entire population. However, equity of access will also depend on the package of care being offered and the capacity of the health care system to deliver care in a timely way across an entire country. Other considerations also typically relate to the efficiency of revenue generation and administration, the quality of care financed and the transparency and simplicity of financing mechanisms (Kutzin, 2008).

As a foundation for this report on options for financing it is important to review how health care financing in Slovenia performs against such metrics. Drawing on the Health Expenditure Review of Slovenia (Cylus, 2015) there are several key features of the health financing system:

1. Public spending on health is heavily reliant on payroll taxes – the share of government budget funding is very low in contrast to other countries that use the labour market to finance health care – and contribution rates are currently among the highest in Europe. In spite of recent increases in contribution rates for some categories, Health Insurance Institute of Slovenia (HIIS) funding is not sufficient to meet current liabilities. This will become an even greater challenge in future, as the population ages and dependency ratios change (i.e. a smaller pool of workers is called on to pay for a growing pool of non-workers).
2. 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 (see Fig. 2). Financial contributions into the HIIS, the single purchaser of the publicly funded health care system, have fallen over the economic crisis due to rising unemployment, slower wage growth and increases in the share of inactive enrollees who make comparatively low monthly contributions. Furthermore, with the HIIS not being able to run a deficit year by year, then there is no automatic public subsidy into the system. A more stable system of funding sources is needed to secure quality care and full access to a comprehensive package for all.
3. Despite these funding challenges, the system has performed well in relation to both equity of financing and access. While there has been some cost-shifting on to private sources, the complementary health insurance (CHI) system (with almost universal CHI 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. Public financing through the HIIS is mainly progressive with higher contribution rates broadly by those on higher incomes. The funding of CHI is, however, regressive, being based on a flat payment, but the amount of funds paid into the system through this channel is not a large proportion of the total financing picture, and it is still a more equitable alternative than out-of-pocket expenditure.
4. The funding of long-term care is a growing problem which needs additional funding. The European Commission (2015) estimates that the costs associated with health care will rise by between 1.2% and 1.9% of gross domestic product (GDP) by 2060 (from 5.7%¹ of GDP in 2013 to between 6.8% and 7.5% of GDP in 2060). Furthermore, expenditure on long-term care will rise from 1.4%² of GDP in 2013 to between 3.0% and 4.1% of GDP in 2060. While this trajectory covers a long period, if it is not planned for appropriately then acute care systems may well reach straining point, which creates problems of capacity and leads to inefficiency and resource wastage through bed blocking. Furthermore, current financing of long-term care is extremely piecemeal. Given the recent economic difficulties it is not immediately obvious where extra funds will come from. There have been some suggestions that the CHI system, while effectively preserving access to care for the population and allowing the government to offload costs to pooled private funding, is nevertheless a source of high and inefficient transaction costs which could be put to better use, such as (partially) funding long-term care. Still, CHI plays an important role, as outlined above, and any attempt to displace it will incur risks with only

1 Public expenditure for health care according to SHA ** methodology, but excluding long-term health care expenditure.

2 Public expenditure for long-term health care according to SHA methodology, but including additional expenditure for disability from ESPROSS **.

limited financial gains. Therefore, a comprehensive and more strategic approach to devising a long-term care financing system is required.

There are key challenges to improving the sufficiency and the reliability of funding for the health care system, and making it more counter-cyclical while not sacrificing its good performance in terms of equity. This report will explore the context for health care financing, current trends and different financing reform options. An accompanying report will review the options for CHI (see report *Making Sense of Complementary Health Insurance*).

2 The macroeconomic context and its impact on health care financing

The Slovenian economy experienced a deep double-dip recession which has had huge implications for health care financing. In 2009, Slovenia suffered a severe economic decline and real GDP shrank by 7.8%, one of the largest declines in all of Europe in that year and deeper than the average contraction across the EU28 of 4.4%. While 2010 brought recovery with real GDP growth of 1.2% this rebound was small, below the EU average of 2.1%. However, from the last quarter of 2011 the economy again contracted, with real GDP declining by 2.6% and 1.0% in 2012 and 2013. Based on Eurostat data, the unemployment rate steadily increased from a low of 4.4% in 2008 to 10.1% in 2013. However, national data on the registered unemployed indicates an even higher unemployment rate, peaking at 13.1% in 2013. In addition, those still employed faced significantly lower wages through the crisis. While real growth in wages remained constant at the beginning of the crisis at over 2% per year, gross wage growth per employee slowed considerably in 2011 and declined in 2012 and 2013 by 2.4% and 2.0%.

Since at least 2006, the share of total government expenditure spent on health in Slovenia has been slightly below the EU28 average in all years; for example, in 2012 health comprised 14.4% of government spending, compared to the EU28 average of 14.6%. The health share of total government expenditure decreased to 11.6% in 2013 due to increased public expenditure to bail out the banks, placing Slovenia well below the EU28 average of 14.8%. Nevertheless, the recent return to growth of the Slovenian economy (3% GDP growth in 2014) may in time, and if sustained, provide some help with public financing through increased revenues for the HIIS when employment and wages increase. It will be important, therefore, to estimate future revenue projections of HIIS with a return to growth, notwithstanding the lower proportion of the population in the higher contribution categories for HIIS, and to refresh the projections for future health system financial sustainability, comparing costs and revenues. Nevertheless, a recent surplus for the HIIS was caused primarily by stark cost reductions and cost-shifting rather than recovering revenues.

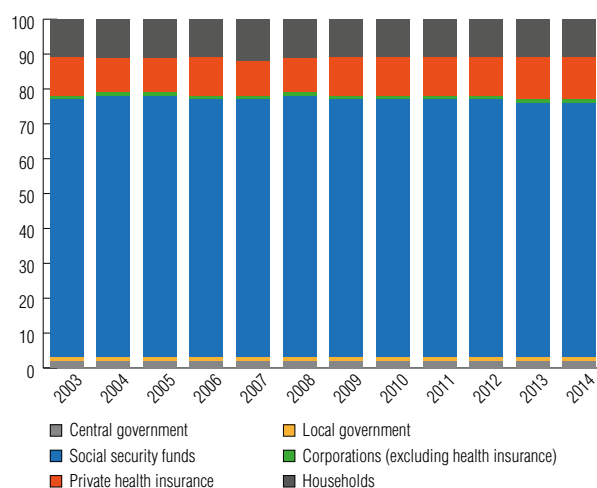
What has become apparent, though, is that revenue generation in the Slovenian health sector may be less reliable in times of crisis, because the health sector depends primarily on social insurance contributions – which are dependent largely on those in formal employment work and their earnings – and counter-cyclical mechanisms are inadequate.

3 The structure of health care financing

The Slovenian health care system is primarily financed by a single health insurance scheme (the HIIS). This is a Bismarckian social insurance model which was first introduced for workers as an extension to the compulsory accident insurance system in 1888 (Albrecht et al., 2009). More recently, the Health Care and Health Insurance Act of 1992 formed the legal basis of the current system. This is complemented by co-payments/out-of-pocket spending and voluntary health insurance, that is, CHI. CHI acts as a private pre-payment system allowing all those covered to avoid many out-of-pocket payments. CHI was introduced in 1993 and gained popularity because of its coverage of co-payments. Initially, there were two providers of CHI: the HIIS, the statutory body that is also responsible for the main social insurance fund, and Adriatic, a profit-making commercial provider (Albrecht et al., 2009). In 1998 the HIIS was obliged to separate its compulsory and voluntary components and a new mutual non-profit-making insurance company was formed, Vzajemna. Of the three current CHI providers Vzajemna is by far the largest with the worst risk profile (see later analysis). The remaining co-payments, outside of CHI cover, are primarily for accessing health care goods and services not included in the standard benefits package (see p. 11).

The division of health financing in 2014 was approximately 71% from public sources, including 68% from social security (i.e. the HIIS), with 15% for CHI and 13% from out-of-pocket payments (OECD Health Statistics, 2015), as shown in Fig. 1. There is a clear dependency on payroll contributions into the HIIS, which leaves overall health care financing hostage to the economic context.

Fig. 1
Structure of current health expenditure by source of financing, 2003–2014

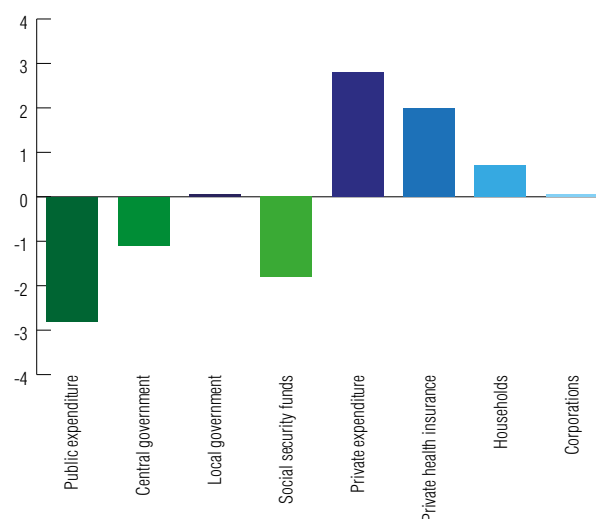


Source: SURS, 2000–2013; OECD, 2014, 2015a; calculations by IMAD.

Note: Current expenditure excludes capital formation; the 2014 column is based on preliminary data; GDP by ESA 2010 revision.

Fig. 2 shows the swing away from public financing of health care during the austerity period. It shows how vulnerable the public contributions are to economic cycles and the weakness of current counter-cyclical mechanisms (government budget transfers actually declined). All forms of private financing of health care increased their share of total health care financing over this period, although CHI absorbed a large part of the reduction in public spending.

Fig. 2
Change in total health financing of different forms of financing, 2008–2014 (%)



Source: WHO, 2015a.

It is interesting to note the cost-shifting from the public to the private sector. As wages and employment have fallen, the funds paid into the HIIS have contracted, leading to cost-shifting onto private sources. As a consequence, CHI has expanded. The cumulative effect of this is that, in terms of aggregate levels of health care financing, Slovenia may be about right by international standards after the expansion of CHI. Fig. 3a displays the relationship between total spending on health per capita and GDP per capita across 27 EU countries in 2013. The red point shows how Slovenia is slightly above the trend line, given its level of GDP per capita. Public spending on health is very slightly above the trend line in both Fig. 3b and Fig. 3c. Slovenia's position is slightly further from the trend line in Fig. 3c than in Fig. 3b, which may reflect changes in GDP rather than changes in public spending on health. These figures suggest that public spending on health has in part been controlled by shifting costs onto CHI. Any attempt to reduce the scope of CHI, or abolish it, would require a significant increase of public funding to maintain good performance in terms of keeping out-of-pocket payments low.

Fig. 3a

Total spending on health per capita and GDP per capita \$PPP, EU28,^a 2013

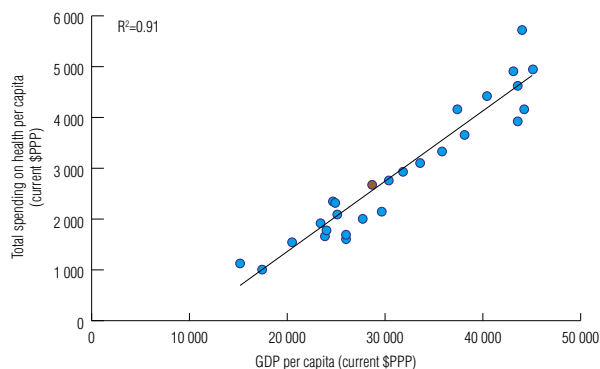


Fig. 3b

Public spending on health per capita and GDP per capita \$PPP, EU28^a

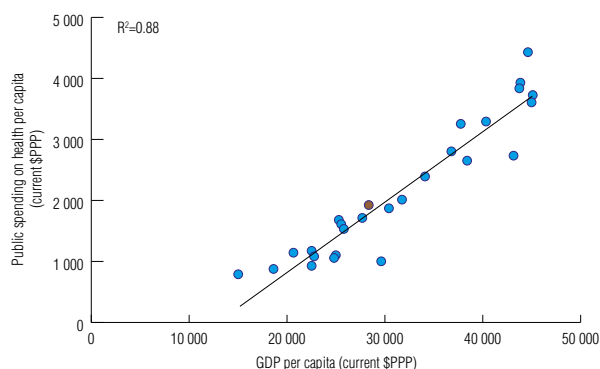
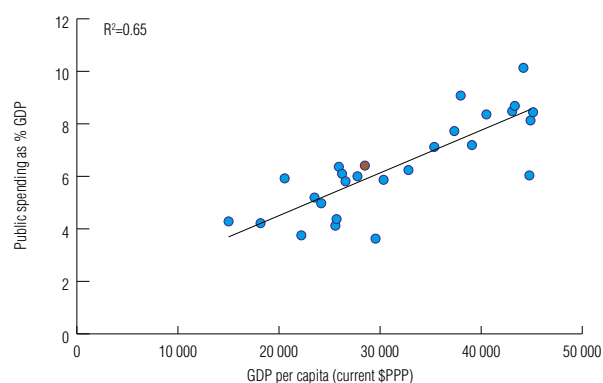


Fig. 3c

Public spending on health as a % of GDP and GDP per capita \$PPP, EU28,^a 2013



Source: WHO, 2015a.

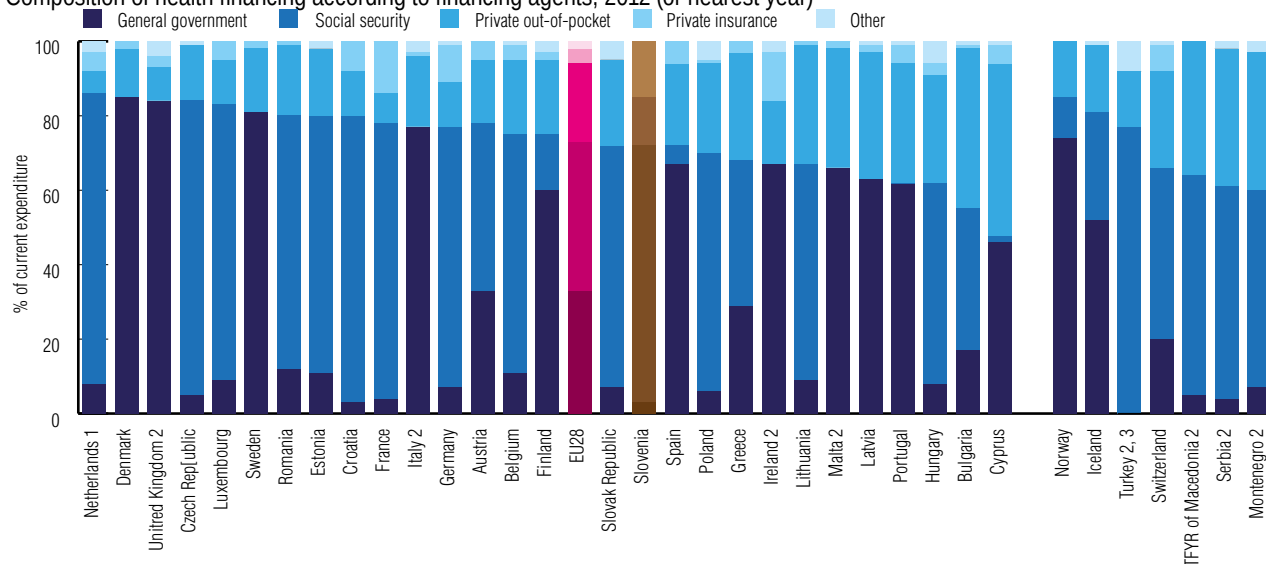
Note: ^a EU28 minus Luxembourg, as Luxembourg is a major outlier in terms of GDP per capita

Fig. 4 compares the composition of health care funding across European countries by financing agents. While this comparison does not fully take account of funding by source it does confirm two important features:

- Slovenia has high social security contributions and a very low contribution from general taxation. It therefore has a very high dependence on payroll contributions by international standards, and this threatens the stability of health financing.
- Slovenia has a very high proportion of funding flowing through CHI, the highest in Europe, higher even than France, which has displaced out-of-pocket payments but is less equitable than public funding sources.

Fig. 4

Composition of health financing according to financing agents, 2012 (or nearest year)



Source: OECD, 2014; Eurostat, 2015a; WHO, 2015b.

Note: The data refer to agents and not sources and therefore this may misrepresent some public sector funding and may limit the use of international comparisons.

TFYR Macedonia: The Former Yugoslav Republic of Macedonia.

Given the problems of a lack of stability in funding and an absence of counter-cyclical mechanisms we review the options for generating sufficient, stable resources for health care in an equitable manner. Three strategies are explored in detail:

1. diversification of public revenues for health and potential new resources to ensure adequacy and stability of health care financing
2. more stable funding of the HIIS through changed contributions
3. revisiting the current benefit package and user fee policy.

Specific options around CHI reform and regulation are presented in a separate accompanying report (see report on *Making Sense of Complementary Health Insurance*).

1) Diversification of public revenues for health and potential new resources to ensure adequacy and stability of health care financing

A notable feature of development in many social health insurance (SHI) systems in Europe is that they are not pure in terms of being entirely funded by payroll earmarked deductions. Indeed, it is becoming increasingly difficult to differentiate where SHI systems start and tax-based systems finish. Notable examples include France, Germany and Lithuania and some investigation of these is warranted.

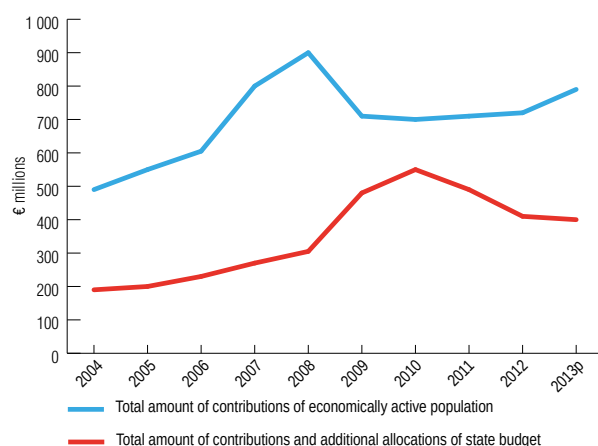
France is a very relevant case study in that it is a SHI system in which the levy base is income rather than wages and which also benefits from significant government budget support. In addition it has a significant market for CHI covering co-payments. It therefore provides an interesting point of comparison for Slovenia. In France, a diverse range of taxes are utilized to boost social insurance funding (Normand & Thomas, 2008). The French authorities levy social insurance contributions on income as opposed to wages, using a progressive structure, with higher income tax rates for incomes from capital and gaming (e.g. casinos) and lower rates for people on benefits. As Chevreul et al. (2010: 67) note: "The revenue base of SHI has, therefore, been widened and partially disconnected from earnings, making it less vulnerable to wage and employment fluctuations."

Sources of government budget support for SHI include a 1% tax on the turnover of pharmaceutical companies as well as taxes on their advertising and drug retailing. In 2007, this raised €662 billion for SHI (Chevreul et al., 2010). In addition, large companies, with a turnover of over €760,000 are taxed at a rate of 0.03% 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, which nets €2 billion, is earmarked for long-term care and support services for the elderly and those with disabilities. Hence, France presents an interesting and imaginative example for broadening the financing base of the health care system beyond payroll taxation.

Lithuania also has interesting lessons to offer. It has an elegant counter-cyclical contribution mechanism which it uses to stabilize SHI funding (Kacevičius and Karanikolos, 2015). First, the health insurance fund accumulates reserves. Second, the government makes transfers from its budget on behalf of the unemployed and those who are economically less active. Third, since 2007, these transfers have been based on average gross wages in the year two years prior to the transfer. Linking government budget transfers to average wages and the use of a two-year lag helps to prevent sudden drops in health insurance revenue and restrains expansion during periods

of growth. As a result of this system government budget transfers to mandatory health insurance increased during the crisis, as can be seen in Fig. 5. Hence, despite a huge increase in unemployment in Lithuania between 2008 and 2012, these policies helped to smooth and stabilize health insurance revenue (Kacevičius & Karanikolos, 2015). Lithuania offers valuable insights into developing a resilient and counter-cyclical funding system for health care.

Fig. 5
Impact of Lithuania's counter-cyclical mechanisms on health insurance revenue, 2004–2013



Source: Kacevičius and Karanikolos, 2015.
Note: 2013p – provisional data for 2013.

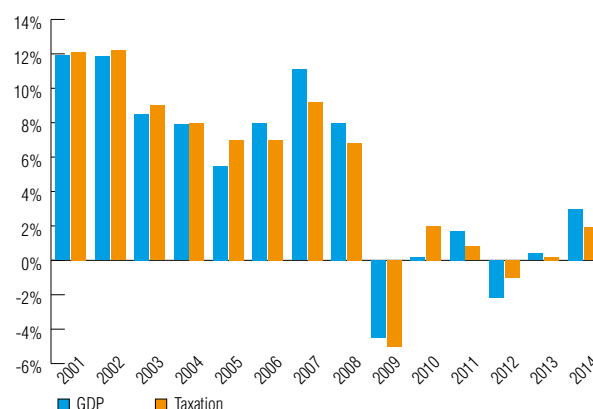
Thus, it may well be useful to consider whether there could be a more general taxation subsidy of the social insurance system for the health sector to stabilize revenues and help ensure, or at least improve, counter-cyclical. Currently, social insurance contributions account for a very high proportion of government spending in Slovenia (WHO, 2015a) and there may, therefore, be potential for change to reflect trends in other countries. Furthermore, social insurance contributions in general in Slovenia are some of the highest across the EU28, particularly for employees (Eurostat, 2014) implying there may be limited scope for significant further increases.

Nevertheless, it is important to identify whether there could there be extra support from taxation to plug any current or foreseeable deficits. The scope for expanding the taxation contribution to health care depends on the current macroeconomic situation, the existing taxation portfolio and what the current taxation burden is in aggregate and on different sections of the population.

Fig. 6 displays recent macroeconomic trends. It shows the sharp economic contraction in 2009 and, to a lesser extent, in 2012 and the tentative recovery in 2014. Taxation growth largely follows GDP growth but the recovery of taxation has not matched recent economic expansion. Furthermore, according to Eurostat (2015a) the overall tax to GDP ratio for Slovenia was lower than

the EU average (39.4% in 2012) and that of many of its neighbours, with the exception of Croatia. There may therefore be some scope for taxation increases which in turn help fund health care. Indeed, Ministry of Finance data state that the taxation burden in 2014 was only 36.7%.

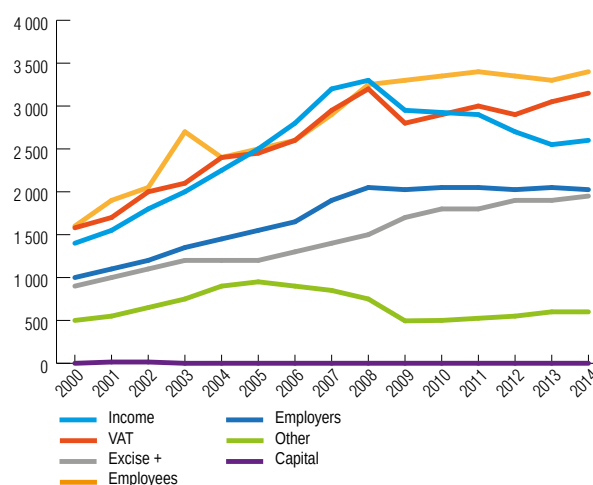
Fig. 6
Macroeconomic data relating to annual taxation and GDP growth and the overall taxation burden, 2001–2014



Source: Ministry of Finance, internal data, 2015.

To investigate this further, recent trends in the current taxation portfolio are shown in aggregate in Fig. 7. Of particular note is the decline in income tax since 2008 and the marked increase in excise duties and, to a lesser extent, since 2009, VAT. This suggests there has been a shift in taxation financing away from direct to indirect sources.

Fig. 7
The evolution of the taxation portfolio, 2000–2014



Source: Ministry of Finance, internal data, 2015.

To try and contain the ballooning debt as a consequence of austerity, the government has pursued fiscal consolidation since 2010 (OECD, 2015b). This has involved increased VAT and excise duties on alcohol, tobacco and fuel which have gone up sharply as a proportion of GDP. Indeed, the share of indirect taxes is

higher than the EU average. In particular, excise duties and consumption taxes were the third highest in the EU 28, as a proportion of GDP, accounting for €1.6 billion in 2012 (OECD, 2015b). Also, social contributions from employees were the highest in the EU at 7.7% of GDP in 2012, raising €2.7 billion. Indeed, taxes on labour are quite high in Slovenia thanks both to substantial social security payments and progressive income taxation (OECD, 2015b). Furthermore, energy taxes are also very high, accounting for 3.1% of GDP in 2012, the highest share in the EU28.

As a consequence of recent VAT increases, the HIIS now pays more in VAT. One option to free up scarce resources may be to reduce VAT for health services or make health service providers exempt. An important strategy might be to consider broadening the contribution base into the HIIS. The range of additional revenue sources could cover income taxation, VAT, and taxes on wealth, savings and trade. One option may be to substitute, at least partially, payment from payroll sources to payment from all income sources, alongside revenue from a diverse range of taxation sources as in France. In France taxation contributions for health care are based on all income and not just payroll, as noted earlier. Income taxation, as distinct from social contributions from employers and employees, has been falling recently and this may need revisiting. Wealth taxes are also a possibility for a diversified revenue stream and have been traditionally low in Slovenia, with taxation associated with property accounting for only 0.6% of GDP (OECD, 2015b) and raising only €188 million in 2014 according to the Ministry of Finance (internal data, 2015). Indeed, proceeds from capital taxation are lower than EU28 recommendations. According to the OECD (2015b), a newly adopted real estate tax was repealed by the Constitutional Court in 2014. It is understood that government will try again as the Constitutional Court ruled only against the particular form and implementation of the property tax and not the idea of a property tax in itself. Indeed, there may be significant potential here as revenue from taxes on property were only one-third of the OECD average in 2013. Furthermore, this form of taxation has been found to have relatively limited negative effects on economic growth (Arnold et al., 2011). Certainly a revised property tax would raise significant resources, with initial estimates of over €300 million (OECD, 2015b).

Another potential additional source is to review the scope for additional or higher sin taxes (on tobacco, alcohol, luxury products, fat, carbonated drinks) and earmark such funds for the HIIS. Such initiatives may prove reasonably acceptable to the population as such products can be seen to contribute directly to health care problems. Hence, taxing them has an easily accepted rationale. Revenues from such sources would be more modest but may still make a contribution to stabilizing health care funding. Other potential options could even

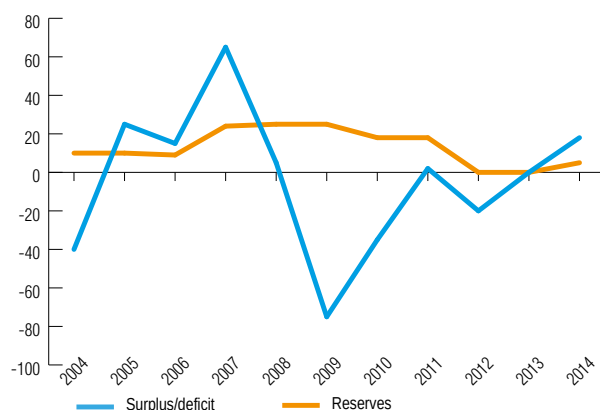
relate to small taxes on large corporations (as corporation tax yields are currently quite low) and additional new taxes on tourists (airport taxes, accommodation).

There is not the space here to explore and evaluate thoroughly the current general taxation arrangements in Slovenia. Nor is it the primary focus of this report on health care financing. Nevertheless, the point of this brief analysis is to show that there is a need for real consideration of raising more revenues from taxation for health care to improve stability of health care funding. Furthermore, this analysis indicates several possible approaches which may warrant further exploration. They are not exhaustive but may prove useful.

2) More stable funding of the HIIS through changed contributions

The HIIS is the main purchaser of health services in the Slovenian health care system. It ran sizeable deficits over the economic crisis. As noted the financial sustainability of the HIIS has been undermined by the economic crisis and the absence of robust counter-cyclical mechanisms. From 2008 the scheme incurred several annual deficits and depleted its reserves significantly (see Fig. 8). The return of economic growth, with better employment and insurance payments may alleviate – at least in part – the funding problems for the HIIS. However, it will not resolve the problem of the current pro-cyclical public funding of the health system based as it is almost exclusively on payroll contributions.

Fig. 8
HIIS – annual surplus/deficit and reserve balance, 2004–2014



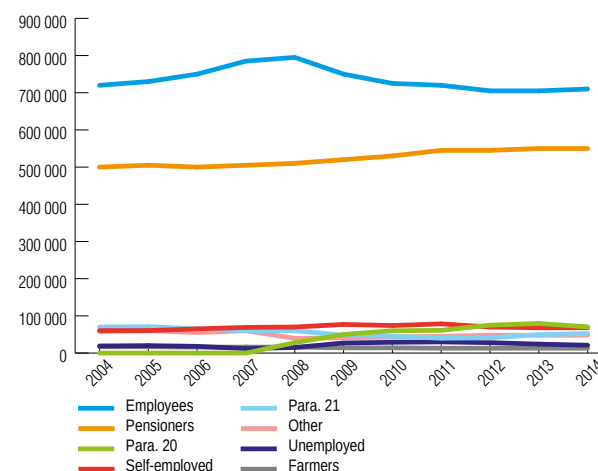
Source: HIIS, internal data, 2015.

There have been recent attempts to boost the sustainability of HIIS financing through cutting the prices paid to providers and shifting costs onto households by increasing user fee rates. Yet there is more that can be done, particularly on the financing side. The contribution rates of different groups may need to be reviewed where the proportion of the population in each group is shifting. Also, the contribution rates for poorer households and pensioners, which fall on the government, may need to be increased. This would be an excellent counter-cyclical mechanism.

Fig. 9 highlights the trends over the past decade in the number of insured in each HIIS category. Those in formal employment accounted for 52% of all those enrolled in 2004. From 2008 to 2013 the number in this category dropped significantly – by 80 000 – partly due to the severe economic austerity. While there was a recovery of around 10 000 in the contribution of the formally employed in 2014, due to the improved economy, the proportion of overall members in this group was still significantly lower than in 2008, dropping to 47%. The

significance of this was to reduce the revenue base of the HIIS. Employees and employers together pay much higher rates than any other group (see Table 1).

Fig. 9
Number of insured in each HIIS category, 2004–2014



Source: Derived from HIIS, internal data, 2015.

Note: Para. 20 – self-payers (those without income but with other means to pay); para. 21 – socially disadvantaged individuals without income paid for by the local community.

Nevertheless, the reduced revenues are only partly due to poorer economic circumstances. Between, 2007 and 2014 there was a significant increase in those covered as pensioners, up by 40 000 (see Fig. 9). Pensioners, despite being higher users of care, currently pay comparatively low rates, with little change in premiums between 2010 and 2014 (see Table 1). The monthly pensioner premium of €56 is just over half the rate for the unemployed, €104, and just over a quarter of what is contributed for those in formal employment, €203. From an equity perspective, such contribution rates are broadly progressive, with the exception of well-off pensioners, and are therefore to be welcomed. They demonstrate a cross-subsidy from the healthy, employed and better off to the poorer, sicker and older sections of society, highlighting an appropriate pooling of risk which is to be commended. Yet, there are valid concerns about maintaining such arrangements when relying significantly on payroll contributions.

The other group which has expanded strongly in recent years is the ‘self-payers’ group (insured by paragraph 20; see Fig. 10 and Fig. 11), which covers those without income but with other means to pay, as well as those with irregular income. This group also pays a very low rate (Table 1).

Table 1

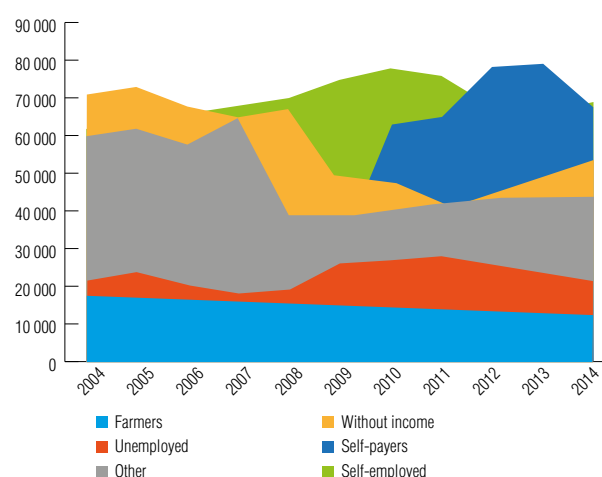
HIIS average monthly contribution (€) for different categories of insured, 2004–2014

Categories	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Formally employed ^a	143	151	156	164	179	191	198	200	202	198	203
Self-employed	78	83	86	89	94	95	95	100	118	117	129
Unemployed	52	53	68	74	64	65	76	96	102	125	104
Pensioners	43	49	48	50	53	54	55	56	55	55	56
Other	—	—	—	—	36	40	44	44	43	43	44
Farmers	23	29	29	30	34	34	40	36	37	38	40
Insured by para. 21 ^b	20	21	24	24	23	31	29	31	27	32	28
Insured by para. 20 ^b	—	—	—	—	13	10	11	12	11	13	20

Source: HIIS, internal data, 2015.

Notes: ^a This includes the contribution made by employers and employees.^b Para. 20 – self-payers (those without income but with other means to pay); para. 21 – socially disadvantaged individuals without income paid for by the local community.**Fig. 10**

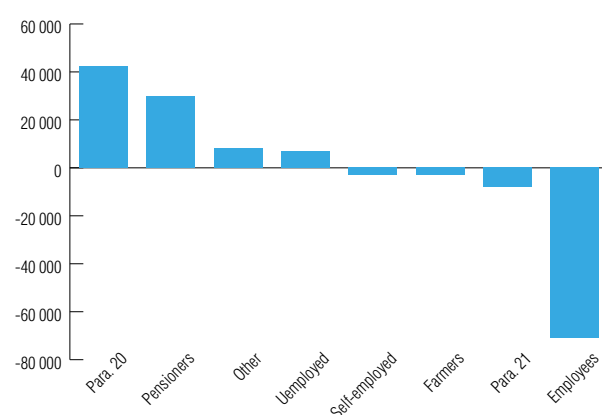
Membership of smaller HIIS contribution groups, 2004–2014



Source: Derived from HIIS, internal data, 2015.

Fig. 11

Changes in HIIS category memberships, 2008–2014



Source: HIIS, internal data, 2015.

Note: Para. 20 – self-payers (those without income but with other means to pay); para. 21 – socially disadvantaged individuals without income paid for by the local community.

In summary, there has been a strong movement out of higher contribution insurance categories and this seems to be partly a consequence of economic contraction, which is unpredictable, and partly because of an ageing population, which is entirely predictable.

Nevertheless 2014 saw a 3.4% growth in insurance revenues as the economy returned to growth. It is useful to analyse the factors behind this growth in revenue to discern whether further economic growth might resolve the funding constraints.

The contribution of different factors to revenue growth is outlined in Table 2. There was a small increase in revenues from population dynamics and expanded numbers being covered by the HIIS. There was also some movement from members from lower to higher paying categories, thanks to a return to economic growth and higher employment. Nevertheless, relying on economic growth to pull people back into higher paying contribution groups and on natural expansion of membership is unlikely to increase revenues significantly (by only 1% in this case). Instead, the key factor in bringing about the revenue increase was the higher rates set out for key groups. Even if economic growth provided a stronger boost to HIIS funding through improved payroll contributions, it is unpredictable and hence diversification of funding sources through additional government subsidy is likely to bring more stability to funding.

Table 2

HIIS revenue growth between 2013 and 2014 and contributing factors

Reasons for increase	Resulting growth in revenue (%)
Increased HIIS membership	0.2
Higher contribution rates	2.4
Move into higher rate groups	0.8
Overall	3.4

Source: Derived from HIIS contribution and membership data, 2015.

Based on the above discussions under Strategies 1 and 2, **five illustrative scenarios** are presented in Table 3, which investigate possible revenue stabilization and diversification strategies for the HIIS. For Scenario 1 the focus is on revising the rates for pensioners, as this group has experienced expanding membership and currently the

state pension fund, on their behalf, pays comparatively low rates, which are certainly below the costs for this group. Requiring the state to pay more for care through the government budget to top up the contribution from the pension fund will enhance financial sustainability. Nevertheless, there will need to be discussions about the fiscal envelope and feasibility in terms of the taxation portfolio and burden. The additional payments are only set at 20% to allow for affordability, but these could easily be expanded to reflect increasing health care costs in the future.

Scenario 2 looks at government budget transfers on behalf of children. This is a policy drawn from Germany where, in effect, the state covers the public health insurance premiums for children. The premium payments in this scenario are set at a low level, €20 per month.

Table 3

Illustrative scenarios for HIIS revenue stabilization

Options	Rationale	Description	Impact	Impact on financing objectives
Scenario 1	Higher effective rates for pensioners (with the additional amount paid by the state and not the pension fund)	20% increase for pensioners	Extra €73 million per annum (3.2% revenue growth)	If covered by budget transfers, this option improves diversification of funding sources and in turn sustainability of health financing. Generates significant additional revenue with the potential of adjusting further upwards if needed in the future.
Scenario 2	Government budget transfers on behalf of children	€20 per month per child paid by the state	Extra €89 million per annum (3.8% revenue growth)	This option improves diversification of funding sources and in turn sustainability of health financing. Generates significant additional revenue.
Scenario 3	General across-the-board increase	3% increase in premiums for all groups	Extra €69 million per annum (3.0% revenue growth)	Does not address the fundamental challenge of over-reliance on payroll contributions, but generates significant additional revenue.
Scenario 4	Extend levy base for health insurance contributions to all income	Additional 2% non-payroll income taxation earmarked for health	Extra €15.8 million per annum (0.7% revenue growth)	Improves equity in financing and sustainability of the health financing systems. Generates a little more revenue for health, but could be expanded.
Scenario 5	Equalization of rates between employed and unemployed	Contribution for unemployed to double from €104 to €203 per month	Extra €4 million per annum (0.2% revenue growth)	Very modest effect on generating additional revenue, but improves counter-cyclicality.

Note: The above scenarios are not exclusive and could be combined.

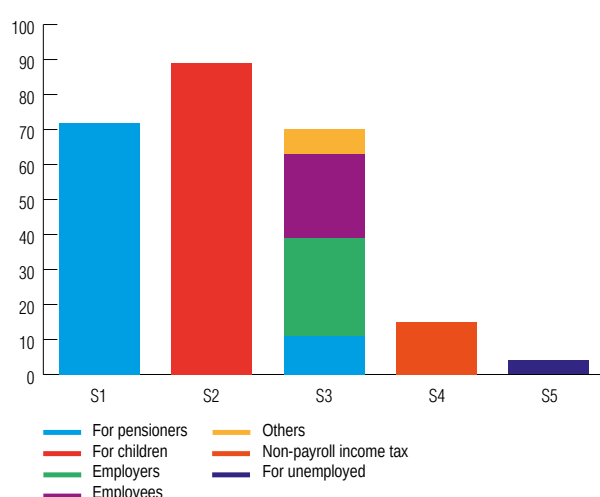
For Scenario 3 an across-the-board rate rise is modelled. This represents an increase in all premiums into the HIIS as a means of generating additional funds. The scenario here is based on a 3% increase for all groups. Some of these liabilities will fall on households and some on the state or state agencies (e.g. pensioners).

Scenario 4 explores extending the contribution base for health insurance contributions to all income. As noted with reference to the French system, there are a variety of ways in which this could be done. Here, the scenario models a 2% increase in yield from taxation on non-payroll income which is earmarked for health. A more specific charge on income from capital might also be a valuable additional source of income.

Equalization of rates across the employed and unemployed would be entirely counter-cyclical, similar to current arrangements in Lithuania, and would increase the proportion of general tax-based funding into the system. This is modelled in Scenario 5. Hence, in this case whether someone was employed or not would make no difference to the amount of funds that the health care system had. Interestingly, the cost of this to the exchequer is quite small, even given current fiscal constraints.

The impact on revenues shown in Table 3 is in addition to any caused by an increase in membership of higher paying contribution groups or by increased formal employment. The extra income produced by the three scenarios is also displayed by each contribution group in Fig. 12.

Fig. 12
Extra HIIS income (€ millions) from scenarios 1–5



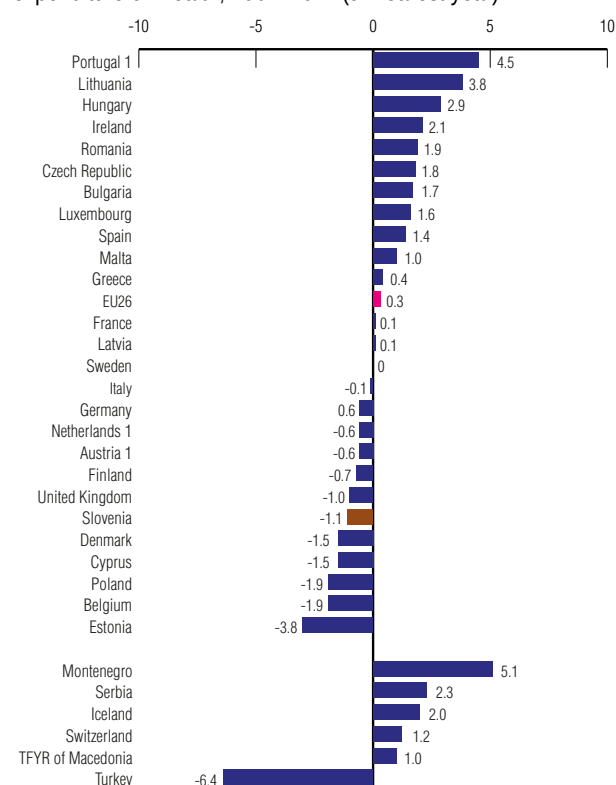
Source: Derived from HIIS data (2015) on membership and contribution rates and Ministry of Finance data (2015) on taxation revenues.

Note: S1, S2, S3, S4 and S5 refer to scenarios 1–5 outlined in Table 3 above.

3) Revisiting the current benefit package and user fee policy

The strengths and weakness of co-payments are clear in the international literature (James et al., 2006). Co-payments are rarely a large generator of income and they impede access, causing inequity and unmet need. They can be helpful to supporting policy in relation to gatekeeping and appropriate pathways to care. It is therefore not generally recommended to use or increase out-of-pocket payments, and certainly not in a European or high-income setting. However, where CHI covers co-payments the highly inequitable effects of co-payments are removed. Nevertheless, CHI payments are still currently regressive and certainly less equitable than public financing. Indeed, it appears that there was less reliance on out-of-pocket payments as a proportion of health funding in 2012 than in 2007.

Fig. 13
Change in out-of-pocket expenditure as share of total expenditure on health, 2007–2012 (or nearest year)



Source: OECD, 2014; Eurostat, 2014; WHO, 2015b.

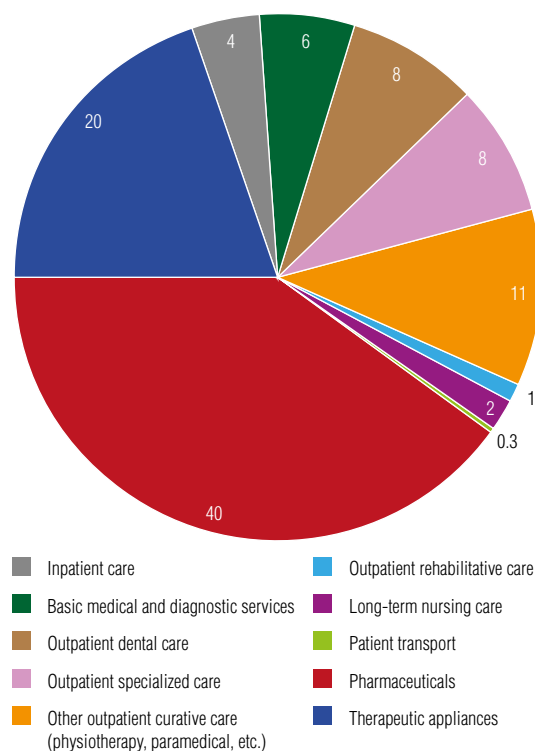
Note: TFYR Macedonia: The Former Yugoslav Republic of Macedonia.

It is important to review how out-of-pocket payments are utilized in a Slovenian setting. They are used both in relation to activities and goods which fall within and outside a public benefits package. The compulsory health insurance regulations of the Health Care and Health Insurance Act of 1992 define a benefits package of health services to the insured population. The benefits package comprises the coverage of primary, secondary and tertiary services, pharmaceuticals, medical devices,

sick leave exceeding 30 days and costs of travel to health facilities. Compulsory health insurance provides full coverage for many services with a range of co-payments. Co-payments for most care offered in the public health care system in Slovenia are set as a proportion of the cost of treatment (with co-insurance rates ranging from 5% to 25% for acute inpatient care, outpatient specialist centres and laboratory tests, and set at 15% for GPs, dental care and physiotherapists within the public sector; OECD, 2012). The remainder of the cost is covered through the compulsory health insurance system (Albreht et al., 2009).

Universal health coverage (UHC) requires a broad health care package (WHO, 2010) and historically Slovenia has done well in this regard, particularly because cost-shifting on to CHI has protected the population against co-payments. 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. Nevertheless, UHC and standard goals of health care financing also focus on the quality of health care (World Bank, 2013), which partly relates to the appropriate pathway through the health care system and the right care being provided in the most appropriate setting. It is important to identify, legitimize and fund this quality care provision. Evaluating such 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.

Fig. 14
Out-of-pocket spending (%)



Source: OECD, 2015a.

A substantial amount of out-of-pocket payments are made by households outside the basic public health care package and not covered by CHI. In 2014 this was equivalent to 13% of current health expenditure or €405 million (OECD, 2015a); however, in comparison to the EU average (21% in 2013) this share of out-of-pocket payments is relatively low and without CHI it would be substantially higher. The breakdown of out-of-pocket spending is shown in Fig. 14. Pharmaceuticals make up 40% of this, with therapeutic appliances (eyeglasses) also a significant factor at 20%. Though Slovenia typically has a low level of unmet need according to EU-SILC data (Eurostat, 2015b), there is some evidence of an increase during austerity and specifically in relation to dentistry. It may be that additional CHI cover for dental care might help avoid this problem.

One phenomenon that needs to be understood better is the practice of paying out-of-pocket to skip waiting lists. There is some anecdotal evidence that private fees are charged to skip formal public waiting lists for ambulatory care only for patients to then re-enter the public acute system. If this were the case it would clearly be inequitable and of no value to the system. However, more evidence is needed in this area on the scale of this activity before considering appropriate strategies.

4 Conclusions

In terms of aggregate health care financing, Slovenia has a heavy reliance on payroll contributions income which may not be financially sustainable. This issue has come into sharp relief with the economic crisis and has been compounded by austerity cost-shifting from public to private sources. There is also a long-term problem through a shift of the population into lower contribution categories for social insurance and a rapidly ageing population promising a future problem in funding long-term care. Further, there are dangers in promoting further cost-shifting onto the private sector because of regressive financing and the potential for growing transaction costs. Renewed economic growth will help but not by itself alleviate the problems of an over-reliance on payroll funding. It is in this context that additional general taxation support to the 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 to help stabilize funding. This is probably the most powerful option to improve the health financing system in Slovenia, though state funding of children's premiums may also be helpful. Contribution rates for the employed and unemployed could also be equalized to provide counter-cyclical funding. Of course there are fiscal challenges with the above strategies, but the French and Lithuanian experiences show what can be done. There may be some scope for proceeds from non-payroll income and property taxes to be earmarked for health care.

Further use of co-payments 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. It might also be worth investigating more what the extent and impact of private payments to skip waiting lists are in the system.

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