

ANALYSIS OF THE
HEALTH SYSTEM IN SLOVENIA

Making Sense of Complementary Health Insurance

Final Report

Making sense of complementary health insurance

Final report
15 October 2015



The European Observatory on Health Systems and Policies supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health systems in Europe. It brings together a wide range of policy-makers, academics and practitioners to analyse trends in health reform, drawing on experience from across Europe to illuminate policy issues.

The Observatory is a partnership hosted by the WHO Regional Office for Europe, which includes the governments of Austria, Belgium, Finland, Ireland, Norway, Slovenia, Sweden, Switzerland, the United Kingdom and the Veneto Region of Italy; the European Commission; the World Bank; UNCAM (French National Union of Health Insurance Funds); the London School of Economics and Political Science; and the London School of Hygiene & Tropical Medicine. The Observatory has a secretariat in Brussels and it has hubs in London (at LSE and LSHTM) and at the Technical University of Berlin.

Making sense of complementary health insurance

Written by:

Steve Thomas, *Centre for Health Policy and Management, Trinity College Dublin*

Sarah Thomson, *WHO Barcelona Office for Health Systems Strengthening, Division of Health Systems and Public Health, WHO Regional Office for Europe*

Tamás Evetovits, *WHO Barcelona Office for Health Systems Strengthening, Division of Health Systems and Public Health, WHO Regional Office for Europe*

Acknowledgements:

The extensive support and comments of the Slovenian local working group were highly appreciated in the development of this report. The working group members were Dušan Jošar, Eva Zver, Boris Kramberger, Stane Vencelj, Davor Dominkus, Franc Klužer and Elda Gregorič Rogelj. The authors wish to thank them for all their insight and facilitation of data gathering.

Please address requests about the publication to:

Publications, WHO Regional Office for Europe, UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark.

Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office web site (<http://www.euro.who.int/en/what-we-publish/publication-request-forms>).

© World Health Organization 2016 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

All rights reserved. The European Observatory on Health Systems and Policies welcomes requests for permission to reproduce or translate its publications, in part or in full.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the European Observatory on Health Systems and Policies concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the European Observatory on Health Systems and Policies in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the European Observatory on Health Systems and Policies to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the European Observatory on Health Systems and Policies be liable for damages arising from its use. The views expressed by authors, editors, or expert groups do not necessarily represent the decisions or the stated policy of the European Observatory on Health Systems and Policies or any of its partners.

Table of contents

List of tables	iii
List of figures	iii
List of abbreviations	iii
1 Introduction	1
2 The options	2
Option 1: Abolishing co-payments.	2
Option 2: Replacing CHI with public compulsory pre-payment.	3
Option 3: Better regulation and oversight of CHI	4
Population, service and cost coverage	4
Transaction costs	5
Market structure and conduct.	6
CHI premiums	8
3 Discussion	9
4 Other roles for CHI and private insurers	10
References	11

List of tables

Table 1: SWOT analysis – CHI in Slovenia	1
Table 2: Illustrative example of new HIIS rates associated with phasing out co-payments	3
Table 3: Variants of the proposed levy for health and long-term care, monthly premium in €	4
Table 4: CHI in five European countries, 2011 (€ million)	6
Table 5: Monthly premiums for CHI (€), April 2015	7

List of figures

Figure 1: CHI membership and average premiums, 2006–2014	4
Figure 2: CHI coverage of the relevant population, 2007–2014	5
Figure 3: Revenues and costs across the CHI industry (€), 2006–2014	5
Figure 4: Profits and non-claim costs in the CHI industry (€), 2006–2014	6
Figure 5: Membership across the three private health insurers, 2006–2014	6
Figure 6: The number of members aged over 75 across the private insurers	7
Figure 7: The proportion of those aged over 75 in the portfolio of each private insurer	7

List of abbreviations

CHI	Complementary health insurance
EU	European Union
HIIS	Health Insurance Institute of Slovenia
UHC	Universal health coverage
VHI	Voluntary health insurance

1 Introduction

Complementary health insurance (CHI) in the Slovenian health care system fully covers the cost of co-payments for a very large share of the population. In doing so it provides financial protection to households from co-payments and allows the public sector to shift costs on to households without apparently creating much unmet need. At the same time, CHI adds to the complexity of the system, incurs transaction costs (including those related to CHI profits, CHI administration costs and government regulation costs) and charges flat-rate premiums which are regressive. This balance of factors needs to be explored fully to identify possible options for ensuring that CHI helps contribute to national objectives for health care financing.

Key objectives for health care financing relate to raising sufficient revenues to provide or purchase appropriate levels of care, ensuring access to a comprehensive range of needed services without financial hardship and pooling risks across different subsections of the population (Normand & Thomas, 2008). 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).

To provide a foundation for considering the options, a SWOT analysis is presented which outlines the strengths, weaknesses, opportunities and threats involved with CHI (Table 1). The analysis is populated by key features of the Slovenian system, points of evidence and also relates to the financing objectives presented.

Table 1
SWOT analysis – CHI in Slovenia

Strengths 1. CHI protects people against the negative effects of co-payments which would otherwise be substantial. 2. CHI allows the public sector to shift costs on to the private sector in a way that does not create unmet need. 3. CHI premiums appear at present to be largely affordable by the vast majority of the population. 4. CHI administrative costs are low by international standards. 5. The current risk equalization scheme helps reduce risk selection.	Weaknesses 1. CHI premiums are flat rate and hence regressive. Poor households pay as much as rich households. Larger households pay more. 2. CHI incurs transaction costs associated with insurer profits and administrative costs and, indirectly, the costs of government regulation. 3. There is some evidence of oligopolistic pricing which is inefficient. 4. Current risk equalization mechanisms do not remove the incentive to risk select. 5. CHI makes the system more complex and there is currently little information and transparency on its performance. 6. CHI may remove an incentive for the HIIS to control costs/create efficiencies.
Opportunities 1. Could the CHI market be reformed to ensure CHI provides good financial protection for all households and is financed more equitably? 2. Could the resources consumed by CHI transaction costs be lowered? 3. Could the market be more transparent for regulatory authorities and consumers?	Threats 1. If the public system continues to shift costs on to the private sector: a. The financing of the system may become more regressive (as a larger portion of the overall funding comes from flat-rate premiums). b. The increasing flat-rate premiums may become less affordable to poorer households who then drop cover and face co-payments. 2. CHI transaction costs may continue to rise over time reducing the administrative efficiency and affordability of this option, particularly because of new solvency requirements. 3. Any attempt to remove CHI would threaten fiscal sustainability without a plan to mitigate the impact of co-payments, which would require significant additional public funding.

The SWOT analysis highlights that a nuanced approach will need to be taken to any reform of CHI and its role. Given the problems with public funding over the austerity period and the health system's over-reliance on payroll contributions, CHI has played a key role in raising and pooling funding from households to minimize the financial burden and other problems associated with co-payments. Consequently, any intervention needs to be considered carefully. The cure proposed needs to be better than the cause or the status quo will be the best default option. Intervention presents a potential threat in that it might undermine the private insurance industry to such an extent that large sections of the population would not have financial protection from co-payments (unless the government is willing to replace CHI with public funding), which would in all likelihood lead to a more inequitable and inefficient health financing system and prove hugely unpopular.

With this risk in mind, the following options are considered below:

- Option 1: Abolishing co-payments
- Option 2: Replacing CHI with public compulsory pre-payment
- Option 3: Better regulation and oversight of CHI

The remainder of this report presents and assesses each of these options. Finally, a concluding section highlights the key dimensions of choice for the government.

2 The options

Option 1: Abolishing co-payments

Perhaps the simplest solution to the problems caused by CHI is to abolish all co-payments, except where such charges support appropriate referral. Removing co-payments for care would immediately remove the need for households to purchase CHI to protect themselves from the burden of out-of-pocket payments. This would then remove any problems or potential problems associated with affordability of voluntary health insurance (VHI) premiums, high transaction costs and any enduring risk selection (see later analysis). It would help secure universal access to services. It would also increase the transparency and simplicity of the system, making it more efficient and perhaps more acceptable to households.

In several European Union (EU) member states, co-payments are minimal and primary care and inpatient care are free at the point of use. Shifting away from co-payments to publicly financed services has been a significant theme for other high-income countries pursuing and achieving universal health coverage (UHC) (Lu et al., 2007), such as South Korea. Nevertheless, such transitions are rarely achieved in one phase and require persistence and significant budgetary commitment.

Abolishing co-payments would, in all likelihood, lead to the disappearance of the CHI market for cover of co-payments (though not for supplementary VHI). It would also create a significant funding gap. Given the good financial protection that CHI currently provides, the impact of the economic crisis on household income and the identified need for additional health finances it would be imperative for the government to find sufficient resources to fund the equivalent of CHI claims of around €400 million. This may be challenging to achieve in one step and may work better as a longer-term strategy once the fiscal space allows.

Additional public revenue could be raised in a range of ways, as discussed briefly under Option 2 and more fully in an accompanying report (Evaluating health financing).

Option 2: Replacing CHI with public compulsory pre-payment

If the government is not satisfied with the performance of the CHI market and chooses not to abolish co-payments it could establish its own pre-payment scheme. CHI covering co-payments would be replaced by compulsory payments through a new pre-payment fund managed by the Health Insurance Institute of Slovenia (HIIS). Instead of paying for CHI, people or households would be required to contribute to the new pre-payment fund on a monthly or annual basis.

There are two important advantages to this option. First, there would be no need to generate profits and cover would be provided by a single entity, so transaction costs would be lower than under CHI. Second, coverage would be truly universal, across the whole of the population. However, it would also be likely to lead to considerable loss of employment in the private insurance industry¹ and cause substantial stakeholder opposition (including potential legal challenges) from private insurers. The currently very small market for other forms of VHI cover would not be affected.

CHI claims currently amount to €404 million per year. Any attempt to replace CHI must find an alternative way to raise this revenue, as well as trying to channel these funds into the health system in a more efficient, equitable and sustainable manner. To cover €404 million would require an average annual pre-payment of €262 per individual already covered by the HIIS (compared to an average CHI premium of around €330 in 2014).

¹ Insurance Europe (2013) estimate that the Slovenian insurance industry as a whole employs around 6000 people. Estimates of employment related to health insurance are around 600 people.

This revenue could be raised on a flat-rate basis, as in the CHI market. However, to abolish the CHI market – with all the risks and opposition this entails – and yet maintain its regressive approach to financing would be a missed opportunity. The political and implementation costs of replacing CHI would be extremely high in relation to the relatively marginal benefits gained. For this reason, we recommend that this option should involve financing based on ability to pay (i.e. linked to income).

The most straightforward income-based option, with the lowest transaction costs, would be to use the existing HIIS payment system and simply extend it to cover compulsory pre-payment for co-payments. Total HIIS revenues in 2014 were between €2.3 billion and €2.4 billion. Additional revenues from contributions to cover CHI claim costs would need to be around 17.5% higher than current HIIS funding levels (€2.3 billion). The financial implications of a uniform jump of 17.5% in HIIS contribution rates are modelled in Table 2.

If the potential unpopularity of simply increasing HIIS contribution rates (especially among richer households) is an issue, then the government could consider an alternative income-based approach – one that is less redistributive, such as the government's proposed 'levy' for additional financing of CHI and long-term care (Table 3).

Table 2
Illustrative example of new HIIS rates associated with phasing out co-payments

HIIS group	Numbers 2014	2014 average paid monthly contributions (€)	Monthly rates to cover compulsory pre-payment or abolition of co-payments (€)
Formal sector employed	719 510	203	238
- employers	719 510	104	123
- employees	719 510	98	115
Self-employed	70 315	129	152
Farmers	12 819	40	46
ZPIZ for pensioners	547 513	56	65
Unemployed	19 931	104	122
Insured by paragraph 20	70 821	20	24
Insured by paragraph 21	53 065	28	33
Other	47 421	44	52

Source: Modelling based on HIIS data, 2015.

Note: ZPIZ – government money paid to the HIIS for pensioners.

Table 3

Variants of the proposed levy for health and long-term care, monthly premium (€)

Level of income	Variant 1	Variant 2	Variant 3
Below 60% average income	14.0	15.0	15.0
From 60% to 140% average income	17.5	18.0	18.5
From 140% to 200% average income	24.5	26.5	28.0
Above 200% average income	30.0	30.5	31.0
Financial outcome (€ million per year)	310.4	307.4	308.8

Source: Ministry of Health, 2015.

Notes: A fourth variant – a flat-rate levy – was included in the original proposal. Further, the costs are slightly out of date in relation to the size of funding required (and therefore the pre-payment rates to be charged are also too low) but these can be updated on the same banded basis.

Variants 2 and 3 exclude segments of the population from contributions, thus resulting in lower financial outcomes than Variant 1.

Option 3: Better regulation and oversight of CHI

It may be thought that the above options are not achievable in the short run and that CHI is an indispensable part of the health care financing infrastructure. This is because of the dangers of households having to face out-of-pocket payments and the difficulties in raising sufficient revenue from the current system that is so dependent on payroll contributions. In such circumstances, it could be that the government's best policy is to improve its regulation of the CHI sector to guarantee optimal performance. Key objectives would be to guarantee affordability for the population, to mitigate the regressive element of financing and to evaluate and promote efficiency.

Key performance metrics would be set out for the insurance industry on the understanding that good performance will not lead to remedial government intervention or reform to correct for the lack of market competition. Points of focus for regulation would then be: monitoring population coverage to ensure financial protection from co-payments, monitoring price movements to ensure affordability, monitoring the efficiency of financing through CHI in relation to claims costs as a proportion of overall premiums and in relation to risk selection and equalization.

With recent health financing in Slovenia relying more on CHI it is important to evaluate how well the CHI sector is performing and to what extent it can be improved by effective regulation. The authors assess key metrics below.

Population, service and cost coverage

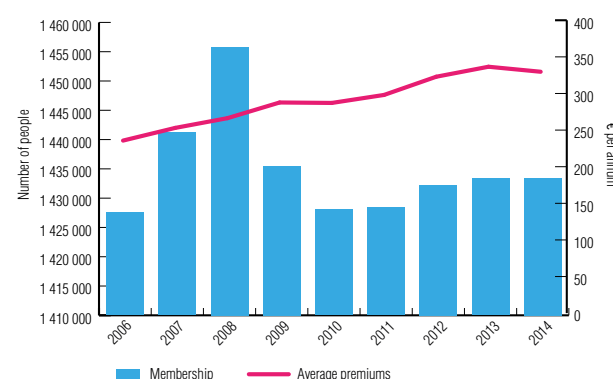
CHI covers around 83% of the total population and around 95% of those who are eligible to pay co-payments.

There was a drop in CHI membership with the onset of the economic crisis, as can be seen in Fig. 1. In 2014, 22 000 fewer people had cover than in 2008. Indeed, between 2008 and 2010 the number of individuals who had apparently lost CHI cover was even higher, at approximately 28 000. Where there is a drop in CHI cover

it may imply that more people are not covered for their out-of-pocket payments. A small proportion of this drop may be explained by net emigration in 2010 after several years of net immigration, but this would account for less than 1000 people (Cukut Krilić, Novak & Jurišić, 2013).

Figure 1

CHI membership and average premiums, 2006–2014

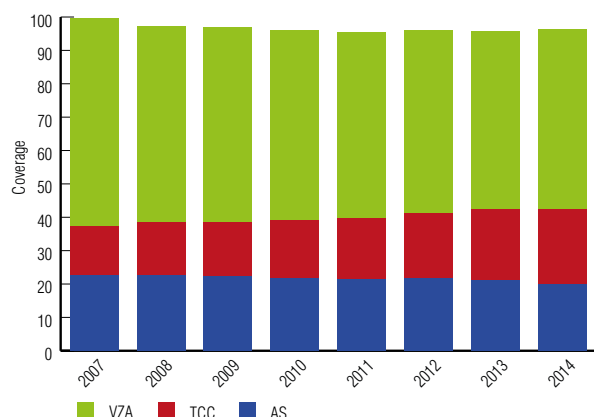


Source: Ministry of Health, 2015.

Fig. 2 shows the proportion of the relevant population covered by the three CHI companies. This fell from 98% of individuals who contribute to compulsory health insurance (or on whose behalf the government makes contributions) in 2007 to 96% in 2014 (children under 18 years and students under 26 years are exempt from paying contributions and co-payments). This is still very high and shows that there is almost universal coverage, but may indicate a trend that needs to be investigated and reversed.

Figure 2

CHI coverage of the relevant population, 2007–2014



Source: Adapted from Insurance Supervisory Agency data, 2015.

It has been reported by government sources that the government started to pay out-of-pocket payments directly for those who were no longer able to take out CHI. It is not clear to what extent this is true. What is also unclear is whether these two factors account for the entire drop in coverage. Those who have lost cover tend to be those who can least afford out-of-pocket payments (unless there has been migration). They then may be impacted by having to pay directly for care, where not covered by the state, in terms of delaying seeking care, potential impoverishment and unmet need.

CHI policies provide full reimbursement of the co-payments they cover. CHI's share of private spending on health (around 48% in 2013) is the second highest in Europe (after France, 59%) and the sixth highest in the world. This suggests it does very well in covering gaps in publicly financed coverage. However, Slovenia lags behind France in this respect and it may therefore 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 financial hardship in Slovenia, according to EU-SILC data on unmet need and analysis of financial protection carried out by WHO.

Identifying where and why gaps in coverage occur must be a priority for government action. This information could be obtained through surveys.

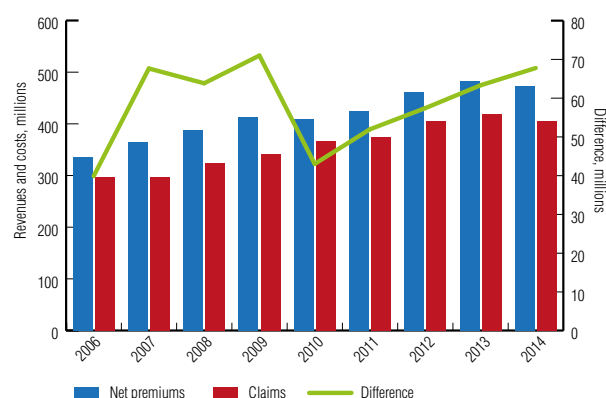
Transaction costs

The average insurance premium shows a persistent upward trend in recent years (Fig. 1). From 2006 to 2013 the average premium increased by €93 per policy (40%), although there was a slight drop in price from 2013 to 2014. It appears that austerity had little impact on price levels. However, similar patterns of price increases for CHI were found throughout Europe.

To understand the reason for the escalation in the cost of premiums, it is useful to explore the relationship between income from premiums and claim costs (see Fig. 3). This helps in analysing the efficiency of CHI in health care financing. The gap between revenue and claims costs indicates the transaction cost of using CHI for this key role in health care financing. Where it is growing it indicates inefficiency, given that the same numbers are covered but with higher administrative costs, and may in due course undermine the affordability of CHI, particularly for poorer households.

Figure 3

Revenues and costs across the CHI industry (€), 2006–2014

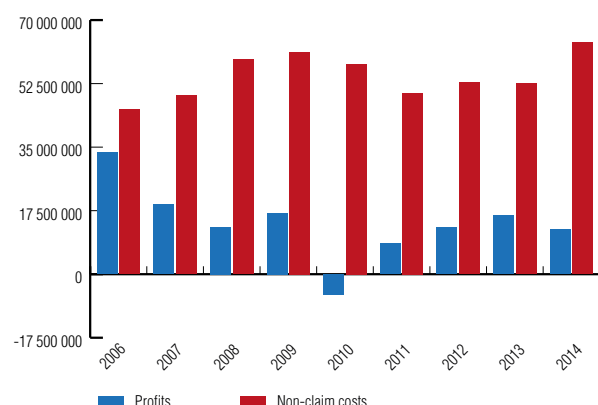


Source: Ministry of Health data, 2015.

Fig. 3 shows how claims costs rose between 2007 and 2013 and then fell slightly in 2014 (as a result of lower provision costs, which is partly dictated by government pricing policy and what is covered). Revenues from premiums rose before the crisis but fell slightly in 2010 and 2014. The gap between revenues and costs rose sharply before the crisis, reaching a peak of around €70 million in 2009. The crisis had the effect of initially reducing the gap between net premiums and claims costs. Nevertheless, this gap has started to open up again and profits and non-claims costs are trending upwards, accounting in 2014 for around €70 million, returning to 2009 levels. Fig. 4 shows a breakdown of the difference between premium income and claims expenditure, indicating that much of it is due to actual operating costs rather than profits. However, official profit levels may not fully represent the difference between revenues and costs.

Figure 4

Profits and non-claim costs in the CHI industry (€), 2006–2014



Source: Ministry of Health data, 2015.

Still, compared to other countries that devote similar resources to CHI, Slovenia's transaction costs are actually very low (Table 4). This may not be too surprising as Slovenian insurers do not purchase care and so should have smaller administrative costs. Interestingly, France – with a very similar role for CHI (i.e. cover of co-payments with limited purchasing) – has a slightly worse claims ratio of 83%, implying that Slovenian CHI is currently performing well in this respect. Nevertheless, there are indications that the claims ratio in Slovenia is falling to around 85% in 2014 from a peak of 90% in 2010. Furthermore, there are concerns that new requirements for solvency may actually push up transaction costs further, though the extent of this is not yet fully understood.

Rising transaction costs should be a focus for regulation, to ensure CHI continues to be affordable for everyone and the CHI market is administratively efficient. It should also be a focus for better monitoring, so that the market is more transparent for regulatory authorities and consumers. In a truly competitive market, insurers would automatically correct prices downwards when their cost base is reduced. A helpful piece of regulation would be to set a minimum claims ratio so that insurers must spend a minimum share of premium income on health care costs. This would

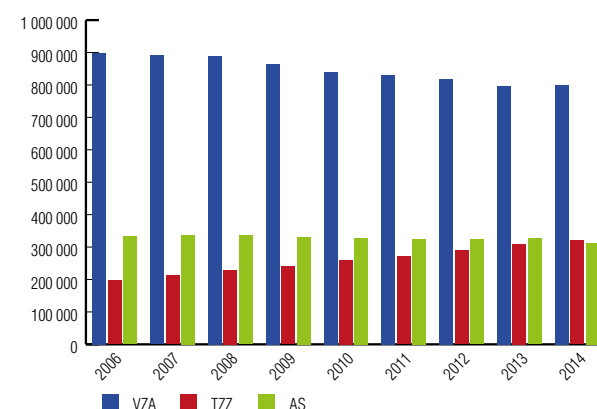
limit transaction costs and help secure affordability in the CHI market. The government should also tighten reporting requirements.

Market structure and conduct

The membership trends of private health insurers in Slovenia between 2006 and 2014 are shown in Fig. 5. There are only three private health insurers in the CHI market, making it an oligopolistic market. The key theoretical features of such an oligopolistic market are that there is little price competition, prices tend to move together and never downwards, and advertising, branding and add-ons tend to be the main mode of competition, alongside growing margins.

Figure 5

Membership across the three private health insurers, 2006–2014



Source: Ministry of Health data, 2015.

Notes: VZA – Vzajemna, Mutual Health Insurance Company
 TZZ – Triglav zdravstvena zavarovalnica (Triglav Health Insurance Company), Inc.
 AS – Adriatic Slovenica (AS Health Insurance Company), Inc.

As noted, overall CHI coverage has not changed hugely (see Fig. 1). Yet there has been some redistribution of membership across the private health insurers. Membership of VZA, the largest and oldest firm, has fallen steadily largely in favour of TZZ. International literature implies that it is the young and healthy who tend to switch, and the old and unwell who do not (Royalty & Solomon, 1999; Van Dijk et al., 2008; Strombom, Buchmueller &

Table 4

CHI in five European countries, 2011 (€ million)

	Premiums	Claims	Difference	Claims paid as a % of premium income
Belgium	1 308	904	404	69%
Finland	218	170	48	78%
France (2011)	9 501	7 239	2 262	76%
France (2013)	10 300	8 533	1 767	83%
Portugal	540	452	88	84%
Slovenia	429	375	54	87%

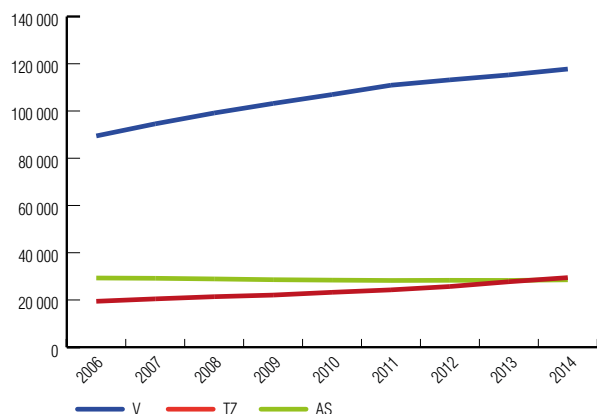
Source: Adapted from Insurance Europe, 2014.

Feldstein, 2002). Private health insurers may well compete to attract low-cost segments of the population to boost their own profitability.

In this light, it is interesting to note the coverage trends of those aged over 75 in Slovenia, who on average represent the highest costs and potentially (without robust risk adjustment) the least profitable group. TZZ expanded strongly into younger age groups between 2006 and 2010, with the average age of members decreasing from 40.3 to 39.5 years of age. TZZ has also managed to reduce the proportion of those aged over 75 in its portfolio between 2006 and 2013 (see Figs 6 and 7). In contrast, VZA's coverage of the over 75s has continued to expand until it has more than two-thirds of all those covered in this age group.

Figure 6

The number of members aged over 75 across the private insurers



Source: Ministry of Health, 2015.

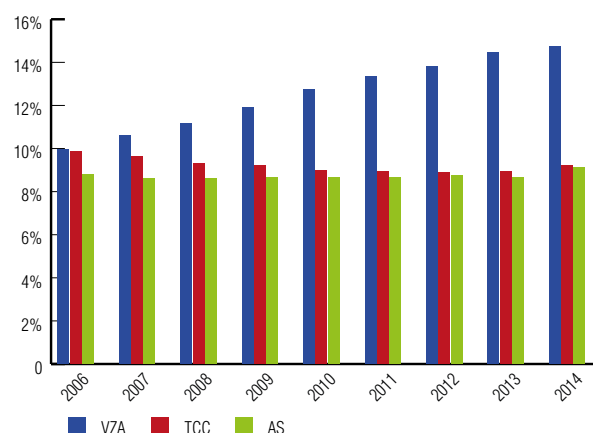
Notes: V – Vzajemna, Mutual Health Insurance Company

TZ – Triglav zdravstvena zavarovalnica (Triglav Health Insurance Company), Inc.

AS – Adriatic Slovenica (AS Health Insurance Company), Inc.

Figure 7

The proportion of those aged over 75 in the portfolio of each private insurer



Source: Ministry of Health, 2015.

Notes: VZA – Vzajemna, Mutual Health Insurance Company

TZZ – Triglav zdravstvena zavarovalnica (Triglav Health Insurance Company), Inc.

AS – Adriatic Slovenica (AS Health Insurance Company), Inc.

Evidence from Ireland shows that not only is there a market for the young and healthy but also that insurers use deliberate strategies to discourage the old from applying (Thomas & Darker, 2013). Insurers whose focus is on the young and healthy may well reach a maximum market size beyond which they are not interested in expanding for fear of taking on too many higher-risk customers. A typical pattern would then be that all insurers are careful not to give price incentives for older people to switch. Consequently, they tend to raise their prices around the same time. This is the case in the Slovenian context, with prices typically being very similar and tending to move together. Current prices for CHI (in April 2015) are shown in Table 5. The monthly premiums are within 75 cents of each other, a difference of 3%. AS and TZZ prices are slightly higher than VZA and this may be a form of risk selection.

Table 5

Monthly premiums for CHI (€), April 2015

	Vzajemna	Triglav	Adriatic
3% discount	26.79	27.51	27.49
Basic premium	27.62	28.36	28.34

Source: Ministry of Health, 2015.

In this scenario the insurers are playing a zero-sum game with very little benefit to society as a whole as they compete for more profitable members. It also allows them to generate profits through cream-skimming rather than by operating efficiently. To limit such activities it is necessary to have an effective risk equalization scheme. If this is working well, then the competition in the market will be less focused on attracting the younger healthier groups and more on trying to minimize operating costs.

The evidence from the Slovenian experience of risk equalization is that there are regular payments from TZZ and AS to VZA, as would be appropriate given their risk profiles. Nevertheless, such payments are quite small, being only €12 million in 2014. This is equal to around 3% of total revenue from premiums. As such, it is unlikely to remove the incentive for cream-skimming. There may well be need, then, to revisit the risk equalization formula so that dumping costly patients on VZA is disincentivised. The most basic risk adjusters used to risk equalize premiums are based on age and sex. They are easy to collect and monitor, but are poor measures of expected health care costs (Ellis, 2007). As a consequence, payments based on these factors are usually poor at reducing incentives for risk selection. More sophisticated models involve measures of health risk as predictors: utilization-based adjusters (such as hospital admissions, length of hospital stay) or clinical diagnoses or even pharmacy data.

Improving the risk equalization formula should be a focus for government action, to ensure the CHI market operates efficiently. Economists agree that robust risk equalization is vital to effective competition where premiums are community rated. Stronger risk equalization would help to bring down insurer transaction costs.

CHI premiums

It is clear that the flat-rate premiums offered by CHI are regressive. They take no account of income or ability to pay. The fact that CHI coverage is almost universal implies that poorer households are currently purchasing it, which may produce some hardship. Where there has been a slight drop in coverage, as noted earlier, then this may indicate that such payments are impacting on coverage decisions and there may then be exposure to co-payments and potential unmet need. From the analysis of financial protection included in the Health expenditure review (see separate report) it is apparent that financial protection in the system has been very good but is getting slightly worse, probably as a consequence of austerity and associated unemployment and falling wages. Yet levels of unmet need still appear to be low according to EU-SILC data (2013).

One possible way to counteract this regressive aspect, and avoid poorer households deciding to give up cover, would be to change the payment method for CHI. Ideally, payments would be made according to ability to pay. This may not be practical given that CHI would then need to know income data which, although held by government, may be confidential. Also, while it would be popular among poorer households and larger households, which would pay less or the same for CHI as at present, it would be unpopular among richer households, which would pay more for CHI than they do currently.

Alternatively, lessons could be drawn from other countries. For instance, in France, where CHI plays a very similar role covering co-payments, the authorities introduced two measures to help poorer people afford CHI (Chevreul et al., 2010). In 2000, the CMU Act (*couverture maladie universelle*) provided free CHI to individuals whose annual income was below €7521 (as of January 2010). This is mainly financed through a tax on CHI business (€1.8 billion in 2009). In 2008, this covered 7% of the population. Further, in order to help people at the margin of the CMU income ceiling to access CHI, a voucher scheme was created in 2004 by the Health Insurance Reform Act. Financial assistance in the form of a “health cheque” (*cheque santé*) is offered to people whose income is below a certain ceiling. The amount offered depends on the person’s age. In 2010, it ranged from €100 per year for people aged under 25 years to €400 for people aged over 60. In 2008, it was €220 on average.

Such an option in the Slovenian system could be well worth exploring, with funds generated by a tax on CHI business targeted at households according to their income.

Gaining a better understanding of the affordability of CHI should be a priority for government. This would enable the government to develop effective policies to ensure good financial protection for all households and improve equity in financing CHI.

The previous options entail political risks (especially Options 1 and 2, which would effectively abolish the market for CHI covering co-payments) or may be constrained by fiscal policy. Even the regulatory option requires additional resources to boost current performance evaluation and information systems, and potentially a new tariff to improve equity which may also be resisted. Consequently, government may wish to do nothing. While this strategy will not risk undermining the current strengths of population coverage from co-payments, it will also fail to address the existing weaknesses of CHI’s role in the system, many of which could be tackled through better regulation.

3 Discussion

CHI in Slovenia achieves very high coverage 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. Nevertheless, it is complex and regressively financed, and the number of subscribers has fallen in recent years, while transactions costs and insurer profits have risen. It is also lacking in transparency.

If the government feels that radical reform is needed to meet national health policy objectives, then it could consider removing the need for people to buy CHI covering co-payments. This could be done by **abolishing co-payments (Option 1) or replacing CHI with a public compulsory pre-payment option (Option 2).**

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 3, by provoking opposition from private insurers (and others). They also raise additional challenges for the government.

- Both options would have a major impact on the CHI market, probably resulting in large job losses. However, Option 1 could be phased in over a period of time, which would give the industry time to adapt and develop new products.
- Both options raise the question of how to bridge the funding gap – of around €400 million – created by the demise of CHI covering co-payments (Option 2) and the abolition of co-payments (Option 1). This is a fundamental issue for the government to consider, given short-term fiscal constraints and the longer-term importance of broadening the public revenue base.
- 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.

Alternatively, **better regulation and oversight of the CHI market (Option 3)** 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 equalization 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, and ensure that CHI continues to provide good financial protection for all households.

CHI's share of private spending on health (around 48% in 2013) is the second highest in Europe (after France, 59%) and the sixth highest in the world. This suggests it does very well in covering gaps in publicly financed coverage. However, Slovenia lags behind France in this respect and it may therefore 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 the cause of one of the few instances of unmet need and hardship in Slovenia.

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.

4 Other roles for CHI and private insurers

One strategy that has been put forward by some stakeholders is to change the role of private health insurers to become purchasers of all health care services and so to introduce competition for purchasing HIIS benefits. While at first sight it may seem 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 in Slovenia, for the following reasons:

1. **Economies of scale and small population:** Typically, purchasers of care tend to perform better when they are larger. They can then exploit economies of scale. Interestingly, after a period of consolidation and merger the Dutch system settled down into four main insurance groups covering a total population of 16 million (Ryan, Thomas & Normand, 2009). This implies that economies of scale were gravitating towards one scheme per 4 million people. Given the small size of the population in Slovenia, just over 2 million, it is unlikely that the country is large enough to sustain large enough competing insurers to capture available economies of scale. The current single health care purchaser, the HIIS, is more appropriate.
2. **Inefficient complexity:**
 - a. Additional regulatory costs. In 2006 the Netherlands moved from a system of compulsory and competitive multiple sickness funds for two-thirds of the population to a universal system operated by private insurers. The Dutch government had to employ an additional 600 civil servants to administer and regulate the new system because of its complexity (Okma, Marmor & Oberlander, 2011)
 - b. Increased transaction costs (duplication). Typically, systems that rely on multiple purchasers have higher transaction costs (WHA, 2011). Part of this is because there needs to be duplication of capacity to purchase care (across several insurers). This is also partly related to the complexity of parallel negotiations (and the need for profit-making if commercial insurers are involved).
3. **Cost escalation:** International evidence is unequivocal in highlighting that the most expensive health care systems globally are those that rely on private insurers as the main purchasers of health care (the Netherlands, Switzerland, the US) (McPake, Normand & Smith, 2013). The Dutch experience shows very rapid cost escalation once the new system had bedded down, running at more than 5% ahead of inflation (Thomas & Darker, 2013). Much of this relates to the failure to drive down producer prices and an increase in activity in the system.
4. **It is challenging to remove incentives for risk selection and associated inefficiency:** Even with a very sophisticated risk equalization scheme, the Netherlands system has not removed the incentive for insurers to cream-skim. Insurers still risk select, sometimes on the basis of consumer choice of additional VHI coverage (Thomas & Darker, 2013). While profits can be had from cream-skimming, there are few incentives for insurers to drive down the cost of care. Cream-skimming is in effect a zero-sum game with no aggregate benefit to the health care system. Such distractions are not present in a single purchasing system. The information requirements and transaction costs associated with developing a robust risk equalization mechanism are substantial.
5. **Equity:** A system in which health financing is based on ability to pay may result in two-tier access with associated high levels of unmet need. If contributions are not related to income, they will be regressive. While it may be possible for government to compensate for such inequities with a system of subsidies for the worse off, the system will be complex (see above, problems with regulation and transaction costs).
6. **Transparency:** One of the potential advantages of a system financed through payroll taxes earmarked for health is that the population appreciates seeing where their funds are going and so may find it acceptable to pay more funding (McPake, Normand & Smith, 2013). Where there is more complexity, this lack of transparency may undermine the acceptability of health care funding.
7. **Choice of provider:** An unexpected consequence of introducing selective contracting in the Netherlands is that there is now less choice of health care provider (Okma & Crivelli, 2010).

It is clear from the international evidence that introducing purchaser competition – especially if purchasers are private insurers with little or no experience of purchasing – will lead to a rise in transaction costs and may also lead to cost escalation, inequity, inefficiency and less transparency.

References

- Chevreul K et al. (2010). France: health system review. *Health Systems in Transition*, 12(6):1–291.
- Cukut Krilić S, Novak T, Jurišić B (2013). Dynamic historical analysis of longer-term migratory, labour market and human capital processes in Slovenia. Country report developed within the project ‘SEEMIG – Managing Migration and Its Effects – Transnational Actions Towards Evidence Based Strategies’ (<http://www.seemig.eu/downloads/outputs/SEEMIGHistoricalAnalysisSlovenia.pdf>, accessed 14 August 2015).
- Ellis RP (2007). Risk adjustment in health care markets: concepts and applications. In: Lu M and Jonsson E, eds. *Financing health care: new ideas for a changing society*. Weinheim, Wiley-VCH Verlag.
- Insurance Europe (2014). Statistics No. 50: European insurance in figures (dataset). Published 6 January 2015.
- Kutzin J (2008). *Health financing policy: a guide for decision-makers*. Copenhagen, WHO Regional Office for Europe.
- Lu J-F et al. (2007). Horizontal equity in healthcare utilisation – evidence from three high-income Asian economies. *Social Science & Medicine* 64(1):199–212.
- McPake B, Normand C, Smith S (2013). *Health economics: an international perspective*, 3rd edn. London, Routledge.
- Normand C, Thomas S (2008). Health care financing and the health system. In: Heggenhougen HK, Quah SR, eds. *International encyclopaedia of public health*. Oxford, Elsevier.
- Okma K, Crivelli L (2010). *Six countries, six reform models: the healthcare reform experience of Israel, The Netherlands, New Zealand, Singapore, Switzerland and Taiwan*. Singapore: World Scientific Publishers.
- Okma KGH, Marmor TR, Oberlander J (2011). Managed competition for Medicare? Sobering lessons from the Netherlands. *New England Journal of Medicine*, 365(4):287–289.
- Royalty AB, Solomon N (1999). Health plan choice: health plan choice price elasticities in a managed competition setting. *Journal of Human Resources*, 34(1):1–41.
- Ryan P, Thomas S, Normand C (2009). Translating Dutch: challenges and opportunities in reforming health financing in Ireland. *Irish Journal of Medical Sciences*, 178:245–248.
- Strombom BA, Buchmueller TC, Feldstein PJ (2002). Switching costs, price sensitivity and health plan choice. *Journal of Health Economics*, 21(1):89–116.
- Thomas S, Darker C. (2013). Which is the right model of universal health insurance for Ireland? In: O’Connor T, ed. *Integrated care for Ireland in an international context: challenges for policy, institutions and specific service user needs*. Cork, Oak Tree Press.
- Van Dijk M et al. (2008). Consumer price sensitivity in Dutch health insurance. *International Journal of Health Care Finance Economics*, 8(4):225–244.
- WHA (2011). Sustainable health financing structures and universal coverage: 64th World Health Assembly agenda item 13.4 (<http://apps.who.int/medicinedocs/documents/s21474en/s21474en.pdf>, accessed 14 August 2015).