ABSTRACT

This article starts with background information on the Slovenian healthcare system and the description of the evolutionary process and privatisation reforms that bring a mix of public and private healthcare services. The authors’ aim is to conceptualise existing modes of public and private healthcare provision and discuss possible implications for user choice and accessibility of services. A descriptive and exploratory case study approach was employed. Literature and document analysis was complemented by secondary data and semi-structured interviews. The results demonstrate four modes of healthcare services in relation to public-private delivery. The ‘public non-profit’ type refers to publicly financed and delivered services. The ‘private within public’ type addresses services provided within and by the public sector for patients who pay out-of-pocket. The ‘private for public’ type deals with services provided by private entities with concessions. The ‘private for-profit’ type refers to completely private provision (without concession) of self-pay services. The strengths and weaknesses of each mode with respect to choice, space-time accessibility, financial accessibility and quality of services are critically discussed. The results of the study show that private healthcare services significantly complement and compete with public sector. In addition, there is a risk that uncontrolled mixing of public and private modes of practice may bring about unethical behaviour and corruption.

Keywords: Accessibility, Choice, Healthcare, Private, Privatisation, Public, Slovenia

INTRODUCTION

Throughout Europe, privatisation in healthcare is a hot topic of discussion. The situation is similar in Slovenia, where contemporary developments in the light of the financial crisis have uncovered serious weaknesses and the potential financial collapse of what has been traditionally a successful healthcare system.¹ Rethinking the sustainability of the healthcare system of Slovenia has brought once again to the forefront the debate on the (re)arrangement of public and private services in the new legislation.²
It is interesting to note that the premise common to these debates is the postulate that the healthcare system cannot function on public funds alone and therefore needs to be complemented with private funding. At the same time, access should remain universal, and the whole system should be based on the principles of equity, solidarity and fairness. These general principles directly reflect consistent public opinion (Toš, 2014).

Since the current state is highly path dependent, we follow the evolutionary process back to its origins and describe the major shifts. Our goal is to present the historical background and characteristics of healthcare privatisation in Slovenia. Our aim is to attempt to conceptualise existing modes of public and private healthcare provision. We address the following research questions: What modes of public and private healthcare provision exist in Slovenia? What are the advantages and disadvantages of each mode? What are the implications for user choice and accessibility of services? What sorts of trends can we expect for the future?

METHODS AND DATA

A descriptive and exploratory case study approach (Yin, 2009) was employed in order to illustrate the current situation of public and private healthcare in Slovenia in relation to choice and accessibility of services. Our literature review and document analysis provided background information on the Slovenian healthcare system, which was supported with secondary statistical data from Health Insurance Institute of Slovenia (HIIS) and Organisation for Economic Co-operation and Development (OECD) Health Statistics. The scarce evidence in the research reports was complemented with semi-structured interviews with key informants from the field (N=5) in order to gain an inside look into and understanding of the current situation. Audio recorded interviews lasting from 35 minutes up to 2 hours were carried out with leading representatives of a) a professional organisation (N=1), b) a primary healthcare organisation (N=1), c) tertiary healthcare organisation (N=1), and d) a non-governmental organisation [NGO] (N=2).

BACKGROUND: SLOVENIAN HEALTHCARE SYSTEM AND THE PROCESS OF PRIVATISATION

In Slovenia, we can historically trace the beginnings of social insurance back to the end of the 19th century, when it was a part of the Austro-Hungarian Empire. The first health insurance to cover the illnesses of workers was established in 1858, and compulsory insurance to cover injury was added in 1887. Regarding more recent times, in the 1970s, legal developments brought about equal insurance for the entire population (Albreht et al., 2009). On the other hand, Slovenia had a long history with private practice as well. According to Albreht and Klazinga (2009), it existed from the beginning of the organised medical profession in the 19th century and remained a key provider until the development of primary healthcare centres that were established between the world wars. Not long after World War 2, private practice was abolished. However, some services remained on the ‘grey market’ (Albreht & Klazinga, 2009).

The Slovenian healthcare system is characterised by a specific modification of the welfare system within which it evolved. The specific development of a former socialist society brought a state-socialist welfare system. The central role of the state meant that “the state was the owner, financer and controller of all institutions and organisations that provided services or paid for provision of social protection and welfare of its citizens” (Kolarič et al., 2011, p. 288). Later, in the 1990s, in the transition to a post-socialist society, the Slovenian welfare system was transformed into a dual model, with elements from both the conservative-corporate and social-democratic welfare systems. Compulsory social insurance systems provided social protection for the employed and their family members. At the same time, the strong public
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