COMPULSORY HEALTH INSURANCE IN SLOVENIA
TODAY FOR TOMORROW

HEALTH INSURANCE INSTITUTE OF SLOVENIA
www.zzzs.si

Compulsory health Insurance in Slovenia – Today for Tomorrow
Health Insurance Institute of Slovenia (HIIS)
24 Miklošičeva cesta, Ljubljana, Slovenia, European Union

Person in charge: Samo Fakin, Director General

This Publication was prepared by the Editorial Board comprising:
Klemen Ganziti, Eva Godina Jalen, Sladjana Jelisavčić, Damjan Kos (editor), Boris Kramberger, Vlasta Lavrih, Rosana Lemut Strle, Peter Pustatičnik, Janko Štok, Barbara Pišek.
Translation: Alenka Drame, PSD prevajalske storitve d.o.o., HIIS

Layout and design: Dejan Paska, Studio 3S d.o.o.

This edition was printed in 1000 copies

Print: Mond grafika d.o.o.

CIP - Kataložni zapis o publikaciji
Narodna in univerzitetna knjižnica, Ljubljana

364.32(497.4)

OBVEZNO zdravstveno zavarovanje v Sloveniji : danes za jutri / [publikacijo je pripravil uredniški odbor v sestavi Klemen Ganzitti ... et al.]. - Ljubljana : Zavod za zdravstveno varstvo Slovenije = Health Insurance Institute of Slovenia, 2007

Vsebuje tudi angl. prevod, tiskan v obratni smeri: Compulsory health insurance in Slovenia : today for tomorrow / [translation Alenka Drame]

ISBN 978-961-6327-15-2
1. Ganzitti, Klemen 2. Compulsory health insurance in Slovenia

236146432

Index

A word from the Director General of the HIIS 4
Basic information on Health Insurance Institute of Slovenia 7
1 Introduction 9
2 Financing of health care in Slovenia 11
2.1 Developmental landmarks 11
2.2 Finance resources for health care today 13
3 Health Insurance Institute of Slovenia 17
3.1 Our mission and development vision 17
3.2 Managing the HIIS – the mechanisms of democratic management 18
3.3 Organisation – a wide and accessible organisational network 19
4 Inclusion and coverage of the population with the compulsory health insurance 23
4.1 Population 23
4.2 Health situation 24
4.3 Insured persons 26
5 The Types and the Scope of Rights Derived from Compulsory Health Insurance 29
5.1 Rights to health care services 29
5.2 Rights to cash benefits 31
6 Overall financing and allocation procedure of compulsory health insurance funds 33
6.1 Financing of compulsory health insurance 33
6.2 Procedures for planning and allocation of the overall budget of compulsory health insurance 34
6.3 Partnership negotiations and contracting process 35
6.4 Payment mechanisms and cost containment 37
7 HIIS's Business results 41
7.1 Revenue trends 42
7.2 Expenditure trends 43
8 Exercising the Rights Deriving from Compulsory Health Insurance 45
8.1 Supply and Accessibility of Health Care Services 45
8.2 Drugs 48
8.3 Medical and Technical Aids 50
9 Implementation of International Health Insurances and Cooperation with Foreign Countries 53
9.1 Exercising the Right to Health Services in the Republic of Slovenia 53
9.2 Exercising the Right to Health Services Abroad 54
9.3 Referrals Abroad for Treatment 55
9.4 International Cooperation 57
10 Development Activities in Respect of Quality and Business Performance in Health Care 58
11 Communication technologies 60
12 Contacts 62
13 Sources 63

Following development needs of the modern times

Since its initial establishment in 1992, when Slovenia re-established its health insurance system, the Health Insurance Institute of Slovenia (hereinafter: HIIS), has been successfully pursuing its mission of providing efficient collection and distribution of resources, intended for the implementation of health and other programmes and, on basis of the mentioned and in accordance with the principles of solidarity, non-profitableness and social justice, of enabling the insured persons access to quality exercision of their rights arising from the compulsory health insurance as well as appropriate health and social security during their illness or injury.

Until now, HIIS has managed to implement its tasks without any major difficulties and to maintain a high level of quality. Simultaneously, we have been aware of the importance of investing in the development of professional knowledge and of new services the whole time. Among others, we concluded a number of important national projects in this period. We performed systematic consolidation of numerous novelties in the field of compulsory and voluntary health insurance; established the Vzajemna voluntary health insurance company with more than one million insured persons; we also established the national health insurance card system which introduced numerous advantages of the new information technologies into Slovene health care system. In the period 2003 – 2006, HIIS focused the majority of its activities into implementation of economic measures (pricing policy in the field of drugs and of medical and technical aids; management of health absenteeism; optimisation of exercision of reimbursement claims, etc.), on basis of which HIIS improved its financial operation after the period of borrowing and operating with a net loss in the years 2000 to 2004 due to certain decisions made on the national level (increase in salaries of health workers, introduction of the value-added tax, etc.). Financial improvement did not narrow the scope of rights, the latter were also broadened in particular areas mainly due

Samo Fakin, MD
Director General of
Health Insurance
Institute of Slovenia

to the fast progress of the areas of medicine and pharmacology. Due to the presence of current problematics of long waiting periods, from 1999, HIIS has been allocating increasing amounts (particularly because of the favourable growth of gross domestic product) of resources for additional health care programmes and for introduction of new modern methods of treatment, rehabilitation and prevention. In 2004, the HIIS introduced as one of the first in the European Union the European Health Insurance Card, which can be ordered by the insured persons on-line or via self-service terminals. The HIIS participates very actively in the European projects for introduction of the European electronic health insurance card. Since its introduction in 2000, the Slovene health insurance card system has facilitated numerous simplifications in Slovene health care system (automated validation of the duration of insurance on electronic terminals) and introduction of various other novelties for quality implementation of services (recording of the drugs and medical and technical aids issued; recording of the declaration for post-mortem donation of organs). In 2006, HIIS started introducing the so-called on-line system (direct access to insurance and health-related data) and upgrading the Slovene health insurance card system in the scope of which a smart chipcard is to become merely a key to the informatised databases and will not be a carrier of data anymore.

The Health Insurance Institute of Slovenia today is a supremely qualified and technologically equipped public health insurance institute for provision of mandatory health insurance and one of the foundations of social and health security in Slovenia. As such, HIIS is entirely comparable to analogous organisations and providers of health insurance which finance health care in the European states with similar social models of health insurance. Today, it can be deemed that, in terms of development, HIIS has justified the intentions of its initial establishment. Stable policy which enables undisturbed operation of the health care system helped maintain a rather high level of accessibility of health services as well as a comprehensive system of the insured persons' rights. In terms of level, scope and accessibility of health services, Slovenia at present is quite comparable to the western European countries despite the fact that its gross domestic product per capita was falling behind the EU-15 countries initially.

The results, achieved in the preceding years, are an incentive for tackling new challenges in the future. Maintaining stable financial operation of the HIIS will definitely remain the key task in the future. However, further steps will be needed in doing that. The HIIS will endeavour to provide the conditions which will enable the Slovene health care system to be able to follow numerous new development needs of modern times successfully. Among the basic development challenges, the first place belongs to modernising the health information system on the national level, which will provide higher quality, efficiency and effectiveness by preparing adequate policies and standards as well as an uniform system of management of health-related information. Investments in modernisation

of this area will also have long-term economic effects which will be important in the light of national economy. Our efforts will be focused on active solving of development problems with cost management in a way that is harmonised with the European Union guidelines and on further gradual development of financing models for the health services providers. Adequate systemic responses to the new needs of the population, arising from the phenomenon of the so-called ageing society, and which cause serious dilemmas in terms of long-term financial sustainability of the system, will remain a particular long-term challenge. In this regard, introduction of compulsory insurance for long-term care which would facilitate access to health, social and other in-home support services for particular patients represents a special challenge. Efforts for higher quality and cost-efficiency of the health care service providers represent another challenge which, in particular, comprises of the efforts for improved accessibility to health services (shortening of waiting lists for health services) and for optimum utilization of space, equipment and personnel.

In all its strategic development documents, HIIS has also noted down its policy to be an efficient, friendly and professional service for all insured persons. I believe that our commitment to common objectives and our professional work make us capable of embracing new development challenges and winning the recognition in the Slovene and international areas as an excellent institution in the field of public health insurance.

Samo Fakin, MD
Director General

Basic information on Health Insurance Institute of Slovenia

NAME:

Health Insurance Institute of Slovenia (HIIS)

HEAD OFFICE:

24 Miklošičeva cesta, Ljubljana, Slovenia, European Union

TELEPHONE:

01/30 77 200

INTERNATIONAL CALLS:

00 386 01 30 77 200

FAX:

01/23 12 182

WEBSITE ADDRESS:

http://www.zzzs.si

DIRECTOR GENERAL:

Samo Fakin, MD

LEGAL STATUS:

Independent legal entity with public institute status, operating uniformly in the territory of the Republic of Slovenia

ORGANISATION:

The HIIS operates in the Head office (the Directorate and the Information Centre Functional Unit) and in 10 Regional Units and 45 Branch Offices throughout Slovenia

FUNDAMENTAL LEGAL BASIS:

Health Care and Health Insurance Act

PRINCIPAL ACTIVITY:

Performance of the compulsory health insurance

MANAGEMENT BODIES:

Assembly, Board of directors, Director General, Regional Councils

MISSION:

On the grounds of public authorisation, the HIIS is the only institution and provider of compulsory health insurance in the Republic of Slovenia. It guarantees the rights to health services and cash benefits according to the rules of solidarity, social justice and non-profitableness. By doing so, the HIIS guarantees health and social security related to it to the insured persons in case of illness or injury.

1 Introduction

Slovenia has, in its long and dynamic development, managed to create a public health care system which guarantees a comprehensive and quality health care to all its population. Regardless of individual critical opinions, in the eyes of the majority of the citizens, health care still holds a very high and respectable position amongst all other public services, which is also indicated by certain domestic and international comparisons. Similarly, people tend to consider the public compulsory health insurance system, which in major part provides finances for the health care system exclusively provided by the Health Insurance Institute of Slovenia (hereinafter the HIIS), as a value. Like the citizens of other European Union countries, citizens of Slovenia are proud of our compulsory health insurance system which is based on principles of solidarity and which, on the basis of compulsory payments, offers equal opportunities for treatment to all people when they need it.

Similar to many developed health care systems in Europe and worldwide, Slovenia has recently been confronted with increasing problems in provision of sufficient funding which would enable not only undisturbed operation of the health care sector but also its development at a satisfactory pace. The largest challenge in this area is represented by typical demographic, social and economic, medicinal, pharmaceutical, technological and other trends which influence rapid growth of health care expenditure. In Slovenia, this type of pressure on expenditure growth was successfully 'covered' by novelties, introduced by the latest comprehensive health reform in 1992. In this case, it was mainly the system of additional payments, namely the introduction of voluntary health insurance which provided the system with quite substantial new, private sources of financing.

However, after 2000, certain new financial burdens (salaries for the health care personnel, introduction of the value-added tax, new legal obligations, etc.) brought increasing discrepancy between the income and the expenditure to the system in Slovenia, which HIIS managed to cover only through borrowing. At the end of 2004, cumulative debt of the HIIS amounted to EUR 119.5 million. The amount of this deficit could be much higher in case that HIIS failed to implement a special programme of measures, which, upon partial correction of contribution rate in 2002, enabled gradual stabilisation of the HIIS's operation. Thus, when Slovenia adopted the convergence programme for entry to the euro area, it was both anticipated and logical to expect from the state to take over the cumulative debt which, simultaneously, bound the HIIS to balanced and debt-free operation with the contribution rate unchanged in the next development period. HIIS achieved the said objective in 2005 as well as in years 2006 and 2007.

This publication is intended for presenting the mission, development vision and fundamental strategic objectives of HIIS as well as presenting the substance of its operation and basic information and trends in implementation of the health insurance system in the country in the recent years. These materials are intended for the general public and to all who would like to have a closer look into the operation of the compulsory health insurance system or are interested in the area of health care financing. It is also our wish to provide, during the period of Slovenia's presidency to the European Union, as much information as possible to the international public and to the experts from the European family of nations who would like to get acquainted with the Slovene health insurance system. This publication will certainly be warmly welcomed by numerous insured persons, or patients form the European Union states respectively, who will be seeking for information about the methods for providing health care during their potential stay in Slovenia.

2 Financing of health care in Slovenia

2.1 Developmental landmarks

Social health insurance has long tradition in Slovenia. Back in early 19th century, following contemporary examples based on solidarity and mutuality, workers set up several "fraternal funds". In 1889 the first regional sick-fund was established in Ljubljana, capital of Slovenia followed by other similar statutory health insurance providers. At the outset, this insurance was obligatory only to workers and not to other population groups. In time, insurance progressively extended to encompass other groups (apprentices, craftsmen etc., finally farmers in the 1973) and remained active for several years after the Second World War. At that time and later on, certain changes took place in the arrangement of health insurance and in the ideological views of this field. Despite these facts, Slovenia has preserved, at all times, the main characteristics of social health insurance such as financing through contributions, shared contributions by employers and employees, autonomy and selfgovernment of health insurance decision making and several others.

Differences among health insurance schemes and insured persons were abolished in 1972, when a referendum poll decision equalised the rights of all insured persons and united different separate insurance schemes into a single health insurance scheme. This act demonstrated the broadest solidarity among the entire population, regardless of the differences in financial capacities, activities or amount of contributions paid. At the end of 80-ies the management of the health care system passed entirely into the competence of the state. Its financing became part of integral national budget. This change was experienced as a period of severe financial instability which has posed "direct impulses" to accept new laws in 1992.

In 1992, legislation addressing the health care field was amended. The Health Care and Health Insurance Act (hereafter the Act) laid the basis for the present system of compulsory and voluntary health insurance, stipulated the process of privatisation in health care system, precisely defined roles of key players transferring particular functions to new organisations and structures.

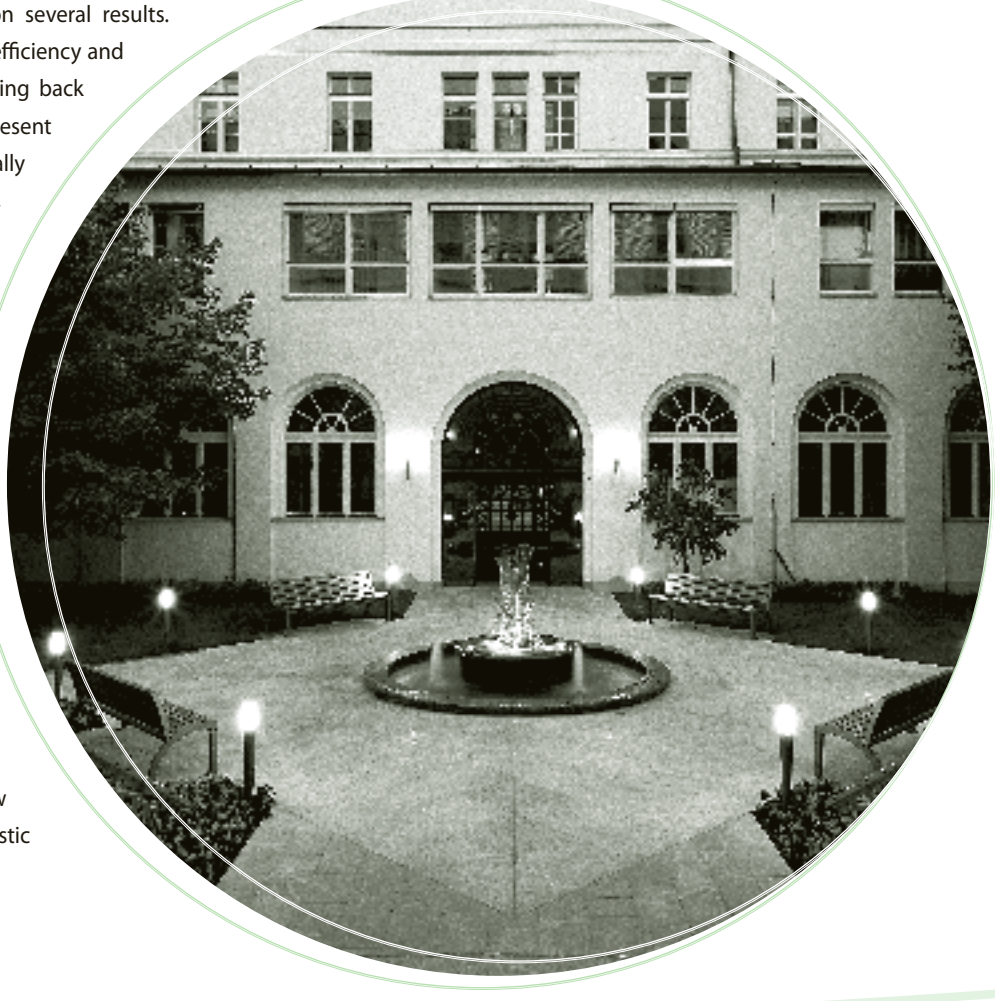
The key issue of the Act was the modernisation of the health care system. The following fields constituted the core of reform 1992:

- structural changes in the financing: reintroduction of compulsory health insurance and introduction of voluntary health insurance to engage public and (new) private resources in the financing of the health care ("public-private mix" in providing funds for health care);
- structural changes in the delivery of health care services: specific privatisation of health care providers work within public health care network ("public-private mix" in the health care delivery);
- free choice of doctors and "gatekeeping" at the primary level health care service;
- new roles and subjects (professional chambers, new partnerial model and contracting process).

The system's modernisation central topics were organisation and financing. In the field of financing reinstatement of compulsory health insurance was the first big strategic issue. The second was the introduction of voluntary health insurance which has been probably the bigest novelty of the reform and indeed a new concept. Compulsory health insurance in Slovenia is provided by the Health Insurance Institute of Slovenia (hereafter HIIS), which is the sole provider of compulsory health insurance in the country. Voluntary insurance is provided by competitive mutual or commercial insurers.

The concept of voluntary health insurance in Slovenia is based on cost-sharing and coinsurance strategies. Basically, the system of compulsory health insurance ensures that insured individuals receive health care services needed but within the scope or to the extent of coverage being defined by the Act. Certain (socially and/or health) vulnerable groups enjoy full coverage under the compulsory health insurance scheme, the same as curing of certain diseases, precisely defined by the Act, as well. For all other procedures and services insured persons (majority) must pay a certain share of the total value or costs of the services or take out their voluntary health insurance which cover such risks of copayments for health care services. Thus voluntary health insurance in Slovenia is closelly connected and complementary to basic compulsory health insurance scheme. As such it has become important source of health care financing in Slovenia since its introduction in 1993.

Such modernisation has given rise on several results. Huge efforts were performed to raise efficiency and financial stability of the system. Looking back onto the reform effects from the present perspective, the reform is generally assessed as a success. Most frequently, the attribute of the main reform achievement is assigned to the financial and general stability of the system. The most common effect was the improvement of the structure of sources, which, up to now, provides a foundation for stable financing of health care programmes in the country. Varied structure of public and private sources was a materialisation of strategic goals pursued by the legislators and reform promoters back in 1992, namely to contain the growth of the share of public sources at or below the rate of growth of the gross domestic product.



2.2 Finance resources for health care today

The health protection system in Slovenia is based on social health insurance respecting common values of solidarity, social justice and universal accessibillity. Compulsory health insurance is prevailing source of health care financing, yet interesting diversity in health care financing sources has been developed in Slovenia since the introduction of public-private mix into the health care system. The major part of financial resources, intended for health care in Slovenia, is – similar to the other European countries – drawn from the public funds. According to the estimates in 2006, public funds represent 79.7% of all funding, of which the funds for compulsory health insurance, i.e. HIIS funds represent 74.9%. The rest of the public funds are represented by funding from the municipal and state budgets (4.8%). An important part of expenditures for health care is represented by private funds (20.3% of all expenditures in 2006). The major part of private funding comes from the voluntary health insurance companies (Adriatic Slovenica, Triglav, zdravstvena zavarovalnica, Vzajemna zdravstvena zavarovalnica) which, for example, together covered a total of 12.3% of all expenditure by paying for the loss events in 2006. The majority of these funds are to be contributed to the complementary health insurance which covers the risks of additional payments up to the full price of those health services which are derived form the compulsory health insurance. Other private expenditures (8.0%) are assessed as the expenditures that are paid for different goods and health services in Slovenia directly by the citizens. Thus, public sources represent four fifth and private one fifth of all sources for health care services in Slovenia.

In the year 2006 Slovenia has been allocating arround 8.35 % of the gross domestic product (hereinafter GDP) (approx. 1,925 PPP$ per capita) where public funds described above represents 6.66 % of GDP and the rest (1.69% GDP) are private resources mostly gathered by voluntary health insurance (1.03% of GDP). In the course of recent 15 years Slovenia has been allocating to the health care sector a share in the range from 7.22 % (in 1992) to 8.35% (in 2006) of the total gross domestic product. The share of public funds has been kept in the range under 7% of GDP (7.22 % in 1992 and 6.66 % in 2006), the balance being contributed mainly from voluntary health insurance funds (Table 1).

The conversion into the current euro prices shows that in 2006 in Slovenia, EUR 1,228 were allocated per capita, of which EUR 979 were covered by public financing and EUR 249 were covered by private financing. The calculation of the HIIS expenditure per insured person however shows that in 2006, we were allocating EUR 928 per insured person for the compulsory health insurance.

The Table 1 shows data on public and private expenditures for health care in Slovenia in the last ten-year period for different individual health services or purposes which are defined by the Slovene health care legislation. Due to its historical evolution and the series of differences between the European (public) health care systems, precaution seems to be in order when comparing the countries of the European Union in regard of public and private expenditure allocated to health care, since different countries have certain "particularities" embedded in

their systems. In Slovenia, primarily the expenditures of the compulsory health insurance for financial compensations are such particularity. In the recent years, the uniform OECD method of "national health accounts" (Hereinafter, NHA) is in use to compare the countries, which should neutralise the influence of particularities in individual systems. The first calculations according to the NHA method were performed in Slovenia in 2006. In the Table 1, data according to the NHA methodology for years 2001 and 2006 are shown in the brackets. Based on the NHA methodology, cash benefits for these two years are excluded from the funds of compulsory health insurance, while assistance and attendance allowance of the Pension and Disability Insurance Institute of Slovenia was included in public health care expenditures, this allowance being included in the long-term care expenditures under the OECD methodology.

According to the OECD data for 2004, Slovenia is comparable with other European Union countries in regard of the share of all expenditures and of the share of public expenditures for health care. Slovenia's average of all funds is somewhat below the EU average and somewhat above the said average regarding the public funds for health care, where the OECD data exclude Lithuania, Latvia, Estonia and some other countries which became full members of the European Union in the recent years (Image 1).

Table 1: Public and private resources in the health care system of Slovenia, 1996 – 2006.

	1996		2001****		2006****	
	Millions of EUR	% GDP	Millions of EUR	% GDP	Millions of EUR	% GDP
Public expenditures	**731.72**	**6.88**	**1,359.08 (1,271.24)**	**7.13 (6.44)**	**1,960.86 (1,845.89)**	**6.66 (6.27)**
Compulsory health insurance	704.81	6.62	1,307.88 (1,176.68)	6.86 (6.18)	1,843.35 (1,663.66)	6.26 (5.65)
(Cash benefit for LTC)	no data	no data	(-43.36)	(-0.23)	(-64.72)	(-0.22)
National budget expenditure	19.86	0.19	37.22	0.2	92.1	0.31
Municipal budgets	7.05	0.07	13.98	0.07	25.41	0.09
Private expenditures	**89.09**	**0.84**	**369.3**	**1.94**	**498.92**	**1.69**
Voluntary health insurance *	89.09	0.84	216.87	1.14	302.2	1.03
Direct payments**	no data	no data	152.44	0.80	196.71	0.67
Total	**820.81**	**7.71**	**1,728.38 (1,640.54)**	**9.07 (8.61)**	**2,459.77 (2.344.81)**	**8.35 (7.96)**
GDP***	10,652.10		19,054.37		29,440.83	

Note: The data for the period before Slovenia joined the European Monetary Union in 1.1.2007 are converted from Slovene Tolar (SIT) using the irrevocably fixed conversion rate (1 EUR = 239.64 SIT) into euro (EUR). This demonstration enables the comparison in the country through time and guarantees maintenance of the development indicators (growth rate).

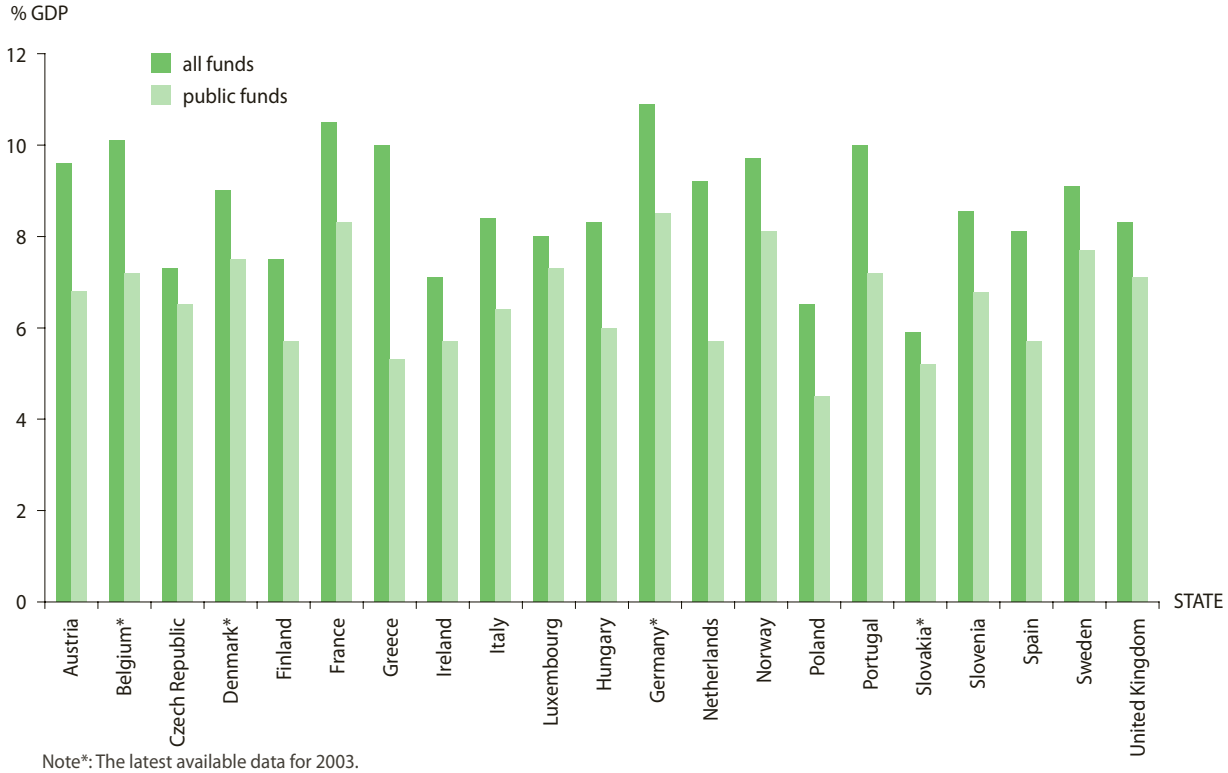
* Data from 2001 onwards include the appraisal of funds for voluntary health insurance of all Slovene insurance companies which perform such insurance: Adriatic, i.e. Adriatic Slovenica and Vzajemna zdravstvena zavarovalnica, and in 2006 also Triglav, zdravstvena zavarovalnica; the year 1996 includes only HIIS expenditures for voluntary health insurance without data for Adriatic.

** These data are an assessment performed on the basis of the poll on use of financial sources of the households in 2003.

*** The data on gross domestic product (GDP) for 2006 is an assessment of the Institute of macroeconomic analysis and Development of Slovenia, Economic Mirror, December 2006; thus, all calculated shares of GDP in 2006 are merely the assessments.

**** Data in brackets are shown according to the OECD methodology of national health accounts thus facilitating a more objective comparison with other states since this method neutralises the specifics of individual systems.

Image 1: Share of public and private funds for health care (% of GDP) in selected countries of the European Union, 2004.



Note*: The latest available data for 2003.
Source: OECD Health Data 2006

3 Health Insurance Institute of Slovenia

3.1 Our mission and development vision

The mission of the HIIS derives from public authorisation, competence and responsibility, defined by the state in accordance with the law. HIIS was established in March 1, 1992, and is the sole provider of the compulsory health insurance in the country. In the period between 1992 and 1999, the HIIS was also implementing the voluntary health insurance which, upon changes of the relevant legislation, was later transferred to the newly established independent mutual health insurance company.

The HIIS implements the compulsory health insurance in the country in the manner, deriving from the social insurances model which assumes certain authonomy in management of the collected compulsory health insurance financial funds. The management bodies and the professional staff of the HIIS are thus obliged for responsible implementation of the statutory and other strategic mechanisms for effective collection and allocation of financial funds which are intended for covering health and other risks of the insured persons. In this regard, verifying and implementation of the fundamental principles such as solidarity, social justice, accessibility and effectiveness in providing health security to the population, are of particular importance. Thus, in adition to management of financial funds, the areas of implementing the rights and managing the relations with the health service providers are also of strategic importance. Rights deriving from the compulsory health insurance are defined in the Act; the detailed scope of rights and procedures, standards and other aspects of implementation of the system of rights, however, is defined by the management bodies of the HIIS in agreement with the State authorities and in compliance with the statute. The HIIS also represents the interests of the insured persons, employers and other contributors of finance in the health insurance sector in the partnerial negotiations i.e. the processes of contracting with the health service providers.

Due to the described aspects of exercising the principle of autonomy in management of the compulsory health insurance system, the HIIS has been dedicating a considerable amount of attention to the processes of strategic planning and decision-making. The system of long-term and annual planning of the HIIS is based on the method of strategic management and balanced performance indicators. Momentarily, the fourth strategic development programme of the HIIS is in preparation, namely for the period 2008-2013. In this period, careful and efficient management of the compulsory health insurance funds is of key importance for the HIIS since, regarding all known development trends (ageing of the population, rapid development of health technologies, increased demandingness from the population, etc.), balanced operation without changes in contribution rate will be needed in the coming period. HIIS will realise its obligations towards the insured persons and other contributors for the compulsory health insurance mainly through the measures for better accessibility and quality of the health care programmes. Further development of the information system pursuing the way of the so-called electronic ON-LINE operation, which will enable following the expenses of the system and of chosen parameters of quality implementation of the health care programmes on both macro and micro levels of the system, will play an especially important role in achieving these goals, which will represent a new step towards

the improvement of the entire system. By further growth of the electronic health insurance services, HIIS will also simplify all its services and bring them closer to the insured persons and to other clients thus becoming even more identifiable excellent public service both nationally and internationally.

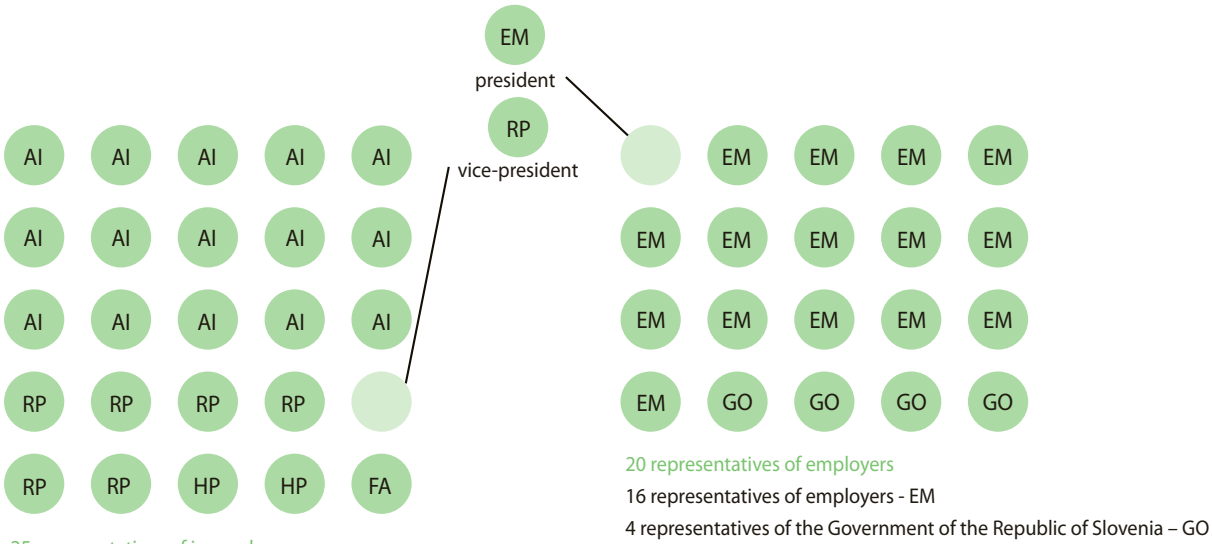
3.2 Managing the HIIS – the mechanisms of democratic management

The HIIS is being managed by the Assembly which comprises democratically elected representatives of the employers (among these, also the representatives of the Government of the Republic of Slovenia) and the representatives of the insured persons (Image 2). The most important tasks of the HIIS Assembly are:

- adopting the HIIS Statute and other general acts for implementation of the compulsory health insurance;
- defining the financial plan, adoption of the annual account of the HIIS and deciding on distribution of the surplus over the expenses;
- defining the narrower scope of rights to health services, standards and norms for the implementation of the compulsory health insurance;
- defining the guidelines for negotiations with partners in the health sector, namely for implementation of the programmes, setting the prices of services, and other foundations for contracting with the health care providers;
- other tasks of strategic importance.

The two executive bodies of the Assembly are the HIIS Board of directors and the Director General of the HIIS. The Regional Councils, which are established on all 10 Regional Units of the HIIS, play an important managerial role on the regional level. The Assembly, the Board of

Image 2: A schematic presentation of the HIIS Assembly.



25 representatives of insured persons
15 representatives of active insurees - AI
7 representatives of retired persons - RP
2 representatives of handicapped persons - HP
1 representatives of farmers - FA

20 representatives of employers
16 representatives of employers - EM
4 representatives of the Government of the Republic of Slovenia – GO

directors and the Director General adopt decisions autonomously and in accordance with the law, the Statute and other legal bases, while regarding other decisions, they have to obtain the consensus from the Parliament, the Government or the Ministry of Health. This way, the Assembly is not in a position to change the compulsory health insurance contribution rate on its own; it can only propose such a change to the Parliament. The Assembly is also obliged to obtain consent from the Government for the HIIS's Statute and the HIIS's financial plan; to change the Rules of the compulsory health insurance (the general legal act of the HIIS which is the basis for detailed determination of the scope, standard and the procedures for execution of the rights deriving from compulsory health insurance), the HIIS needs consent from the Minister of Health, as well as the approval of the Parliament for the election of the Director General of the HIIS for the 4-year term. Pursuant to the statutory provisions, financial operation of the HIIS is supervised by the Court of Audit, the Budget Inspection service and the Commission of the Parliament of the Republic of Slovenia for budgetary and other Finance Control. In addition to that, an Internal Revision Section also works within the HIIS.

3.3 Organisation – a wide and accessible organisational network

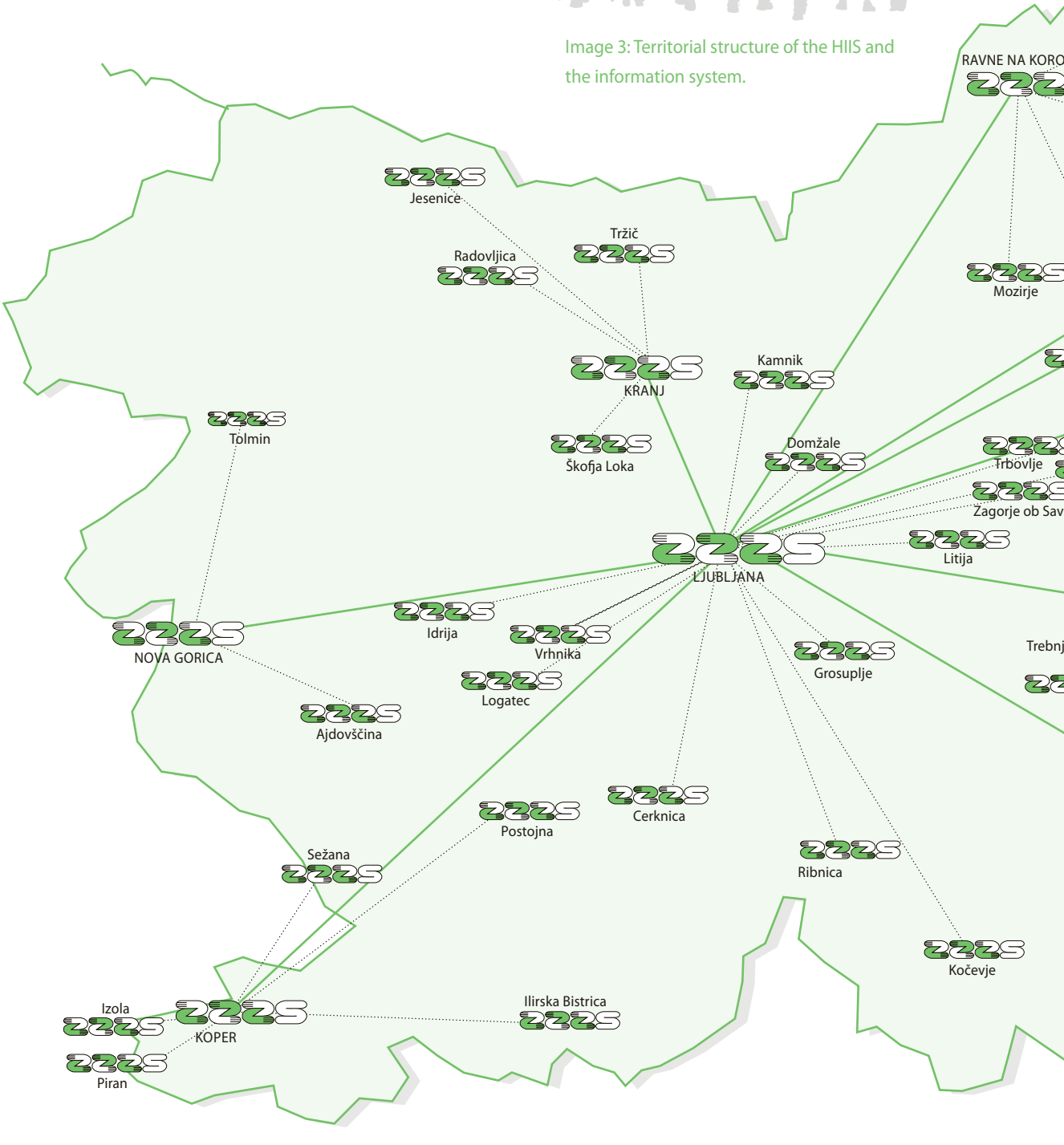
HIIS is organised in a decentralised fashion, in 10 regional units, with 45 branch offices (expositures) and directorate with independent sectoral unit for information system and technology. In 2006 the HIIS employed 929 persons, which implies that each HIIS employee covers about 2.135 insured persons. The average number of branch offices per regional unit is 4.5, with a maximum of 13 in Ljubljana and a minimum of 2, in Krško and Nova Gorica regional units.

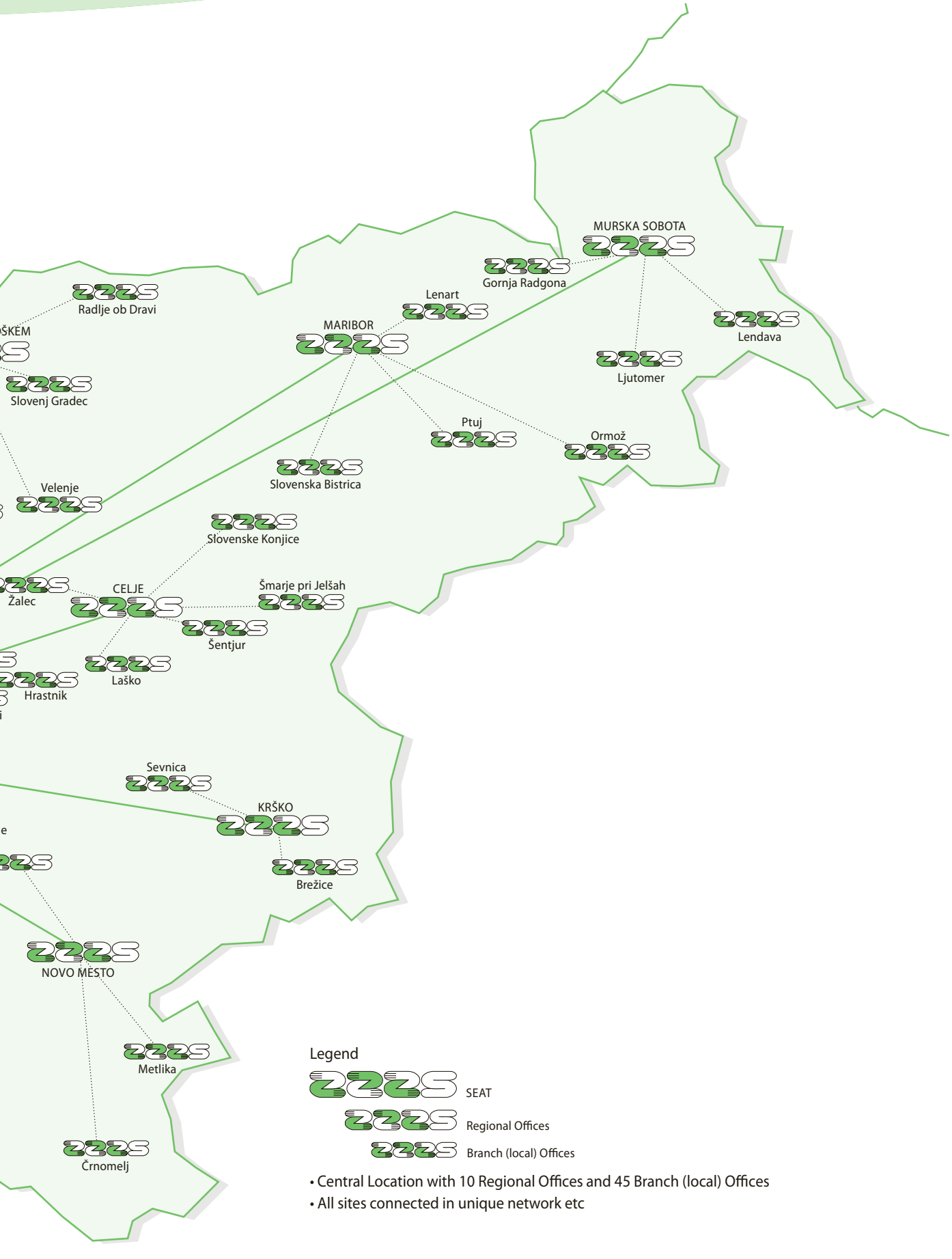
Due to a very demanding business subject, diversified own organisational structure, large funds managed, and a large number of business partners, the formulation of its own business strategy is certainly one of the HIIS central achievement. The HIIS's staff chose strategic project management approach to this task, by applying a special methodology of creation of priority functions and of information technology requirements arising in performing those functions and in decision making.

To perform the functions of compulsory health insurance, and to perform without interruptions its financial and monitoring tasks, HIIS needs tidy and continually updated databases, most of all on insured persons, health care service providers, insurers, consumed drugs, absences from work, performed health care services, etc. Since enormous amounts of data are involved in these databases, as the HIIS processes the insured persons in the country from birth to death, sophisticated information system model has been developed.

Compared with similar social health insurance sick-funds the resources devoted to administration of the health insurance system are quite low: app. 2.4 % of all expenditures in the year 2006 for example. The HIIS tries to increase internal and external efficiency by means of project management, monitoring professional services, the volume of work carried out, the realisation of agreed tasks in terms of their structure and of the workloads of the staff.

Image 3: Territorial structure of the HIIS and the information system.





- Central Location with 10 Regional Offices and 45 Branch (local) Offices
- All sites connected in unique network etc

4 Inclusion and coverage of the population with the compulsory health insurance

4.1 Population

According to data published in the Statistical Yearbook of Slovenia 2006, at the end of the year 2005, Slovenia had 2,003,385 residents. The population of Slovenia comprises the citizens of the Republic of Slovenia with registered permanent residence in Slovenia, foreigners holding a permanent or temporary residence permit or holding a valid work or business visa with a registered permanent residence in the Republic of Slovenia, and persons enjoying the right to asylum and to refugee status in the Republic of Slovenia pursuant to the Asylum Act. Compared to the previous year, the overall population of Slovenia has increased and has exceeded the total of two million, which is primarily the consequence of immigration. In 2005, 15,000 foreigners migrated to Slovenia, mostly from the states of the former Yugoslavia and from the European Union. This primarily concerns labour migration dominated by men.

The two most specific demographic phenomena in Slovenia are negative natural population growth and ageing of the population. Such trends pose a direct threat to long-term financial sustainability of the public health care system since the decrease in active population deteriorates income possibilities, while ageing of the population increases the pressure on health care and other expenditures growth within the public compulsory health insurance system. Momentarily, every active insured person in Slovenia sustains as much as 1,5 inactive insured persons, which poses an immense burden to the active population in maintaining the level of social and health security.

The demographic projections show that the trend of ageing of the Slovene population is going to continue in the future. According to the basal variant of these projections, the number of the population of Slovenia will grow from the present 1.99 million to almost 2.02 million in 2014, while gradually declining after that and reaching the total of 1.89 million by the year 2050. Such development will be the consequence of continuous increase of life expectancy at birth, low fertility rate and migrations of the population. In terms of life expectancy at birth and in terms of life expectancy without diseases in 2004, women in Slovenia were comparable with women in United Kingdom and in the Netherlands; they were also in a better position than women in Ireland, Denmark or Portugal. On the other hand, men in Slovenia had one of the lowest life expectancies (at birth and without diseases). Lower indicators were detected only in Hungary, Czech Republic, Slovakia and Poland. The share of women in the whole Slovene population has not changed (51%) and is comparable to some Northern European countries, e.g. United Kingdom, Germany and Finland, while the

Table 2: Selected demographic data in Slovenia in the period 1992 – 2004.

	1992	1996	2000	2004
Birth rate (no. of births per 1000 inhabitants)	10	9.5	9.1	9.0
General mortality (no. of deaths per 1000 inhabitants)	9.7	9.4	9.3	9.3
Natural population growth	0.3	0.1	-0.2	-0.3
Infant mortality (no. of deaths per 1000 inhabitants)	8.86	4.7	4.9	3.7
Life expectancy at birth - males	69.45	70.79	71.94	73.4
Life expectancy at birth - females	77.25	78.25	79.1	81.0

Sources: Public Health Institue of Slovenia. Health statistics annual. Ljubljana, IVZ: 1993, 1997, 2001, 2005.

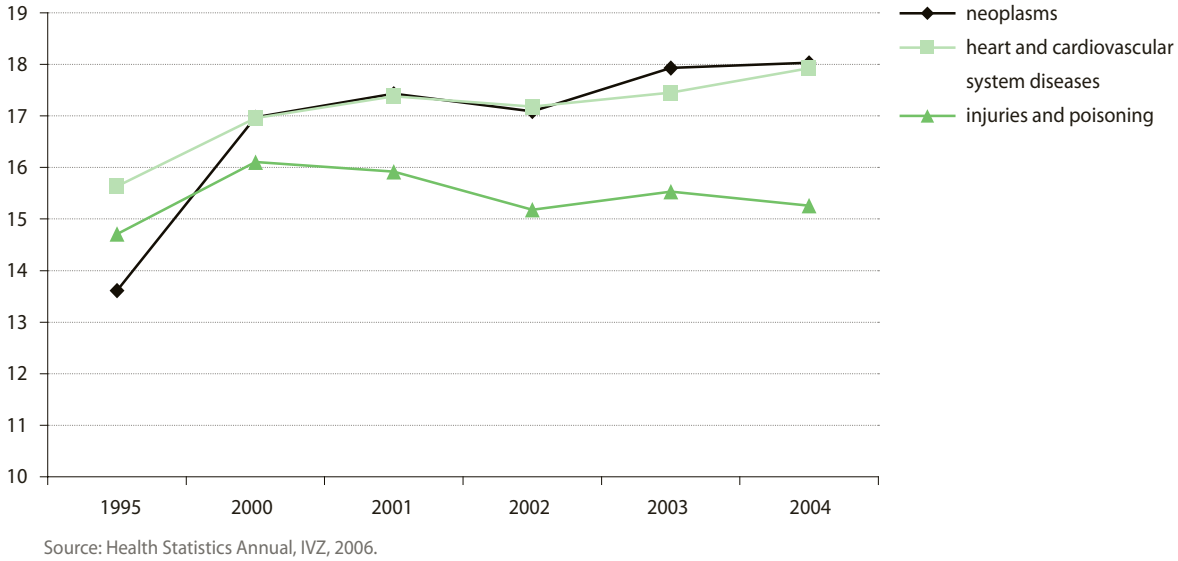
share of men totalled to 46.9%. Selected demographic data that are important for description of health situation of the population in Slovenia are shown in Table 2.

4.2 Health situation

The aforementioned trends are also shown in the general picture of health situation of the Slovene population. Some selected general indicators of health situation in Slovenia (Table 2) show quite a favourable situation, compared to the European Union member states. This is particularly true of infant mortality, gradual increasing of life expectancy and increasing of life expectancy without diseases. On the other hand, we are facing a relatively high rate of general mortality, since in 2004, the only state with a higher general mortality rate was Hungary. Ageing of the population is particularly associated with changes in health situation of the population. Among the diseases that are coming to the fore are malignant diseases, heart and vascular system diseases, bone and limb diseases, (self) injuries, mental and other chronical diseases. With ageing of the population, the needs and demands for health services are unremittedly increasing. Therefore, health service programmes will have to be adjusted to the target situation where chronical diseases and non-acute conditions will be treated equivalently to the acute patients. Such adaptation of the health care programmes to the actual needs poses a basis for a better quality operation of the health sector and subsequently leads to increased satisfaction of the entire population.

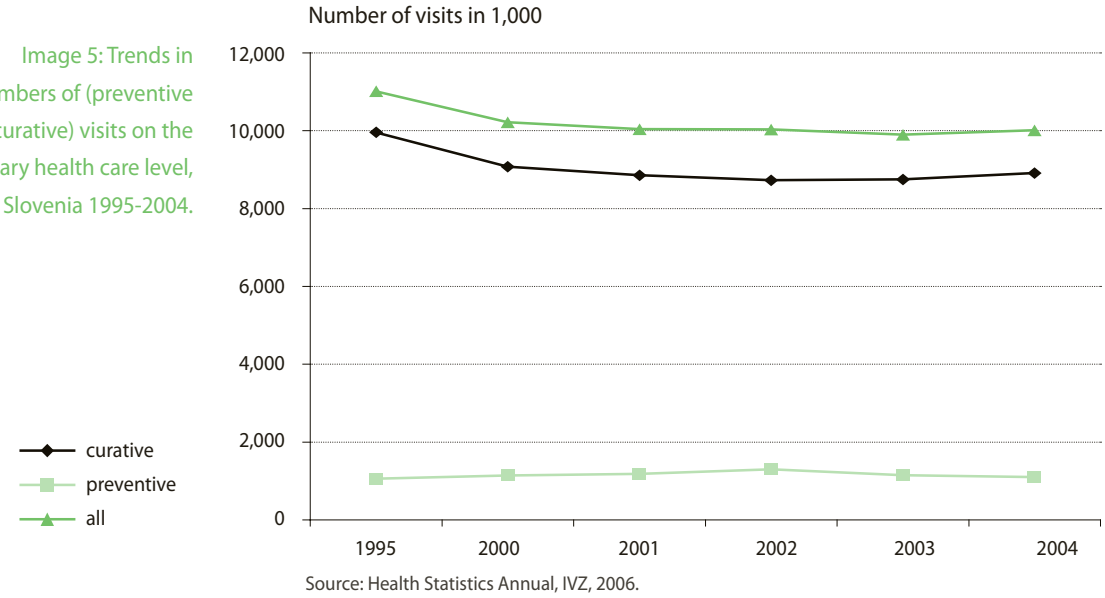
The most frequent causes of death among the Slovene population are cardiovascular diseases and malignant diseases. Such a state is typical for several years now and is comparable to the situation in most European countries. In 2004, malignant diseases, cardiovascular diseases, injuries and poisoning generated in total 33.3% of all hospitalisations in Slovenia (Image 4). These data point to the need for improvement of the programmes and projects for promotion of healthy life style and for preventing risk factors for emergence of chronical diseases.

Image 4: Trends of hospitalisation rate for neoplasms, heart and cardiovascular system diseases, injuries and poisoning; Slovenia, 1995-2004.

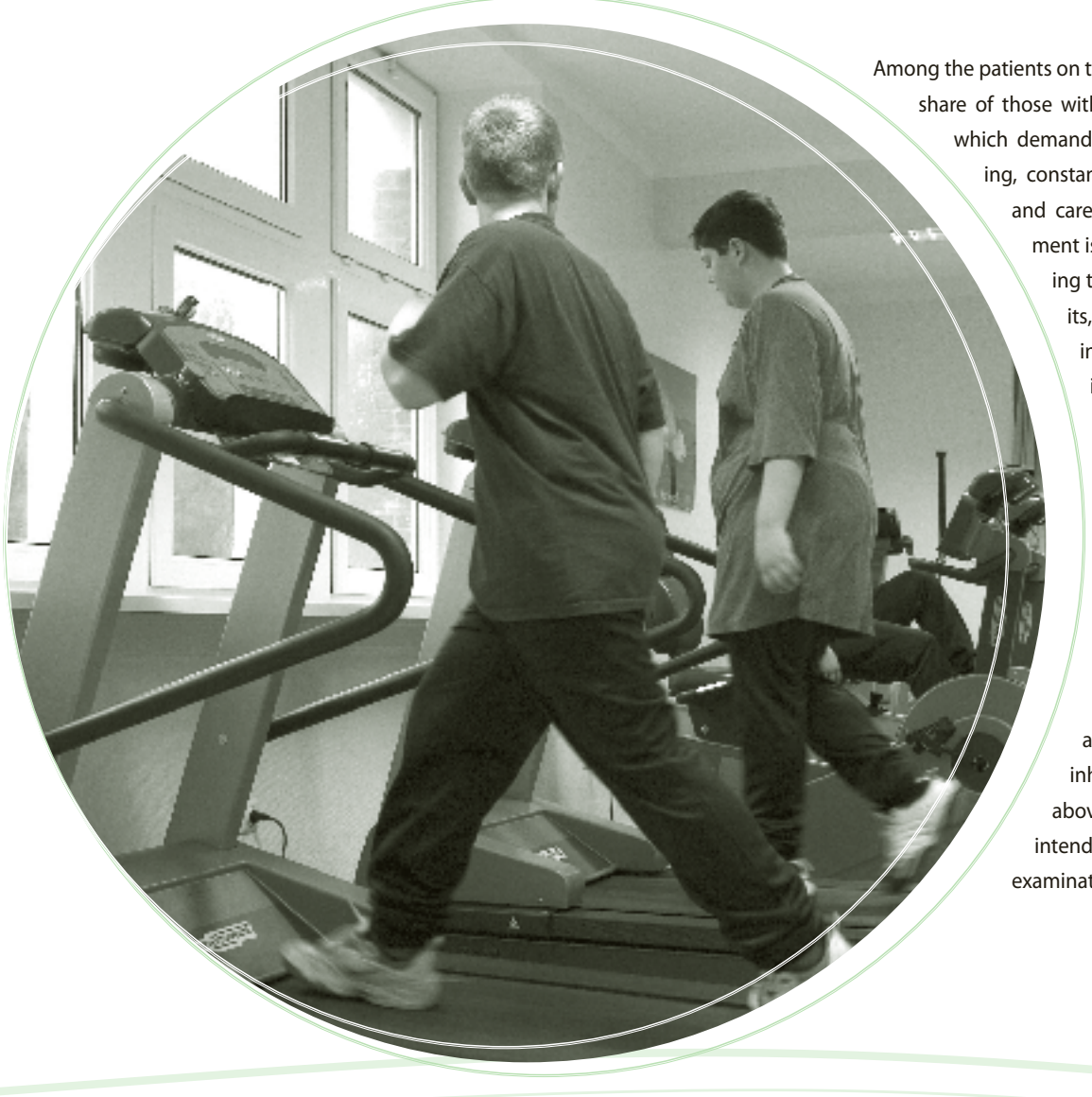


Source: Health Statistics Annual, IVZ, 2006.

Image 5: Trends in numbers of (preventive and curative) visits on the primary health care level, Slovenia 1995-2004.



Source: Health Statistics Annual, IVZ, 2006.



Among the patients on the primary level, the share of those with chronical diseases which demand thorough monitoring, constant instruction-giving and careful control of treatment is increasing. According to the number of visits, respiratory diseases, injuries and poisoning, cardio-vascular diseases, bone and limb diseases take the top positions. In 2004, somewhat more than 10 million visits were recorded on the primary level, which presents on average 4.9 visits per inhabitant; 11% of the abovementioned were intended for preventive examinations (Image 5).

4.3 Insured persons

The compulsory health insurance covers all population with permanent residence in Slovenia which is covered under the unique compulsory insurance scheme either as mandatory member or as their (family) dependants. Virtually the entire (100%) population is insured.

Coverage of the individual under compulsory health insurance is, in principle, related to his contribution, which entitles insured individuals and their family members to services. There are 21 categories of insured persons, which can be grouped into some main types. The largest category comprises all employed workers whose contributions are dependent on income or on other bases for payment of contributions (farmers pay a proportion of their cadastral income or of the basis for pension and disability insurance respectively; natural persons, independently performing business or professional activity as their only or prime occupation pay a proportion of the gross basis for pension and disability insurance, etc.). Pensioners also pay certain proportion of their gross pensions. The second group comprises categories whose contributions are fixed amounts. Socially disadvantaged groups are covered under different mechanisms from state or local selfgovernment budgets. The Employment service of Slovenia pays a fixed contribution for each unemployed person who receives financial benefits from the mentioned Service. Social groups with no income are registered in local communities which pay a fixed contribution.

At the end of 2006 in Slovenia there were 1,985,095 insured persons, of which 1,475,436 insured and 509,659 family members. Employed workers represented the largest part of all (58.1%), retired people represented 26.9%. Total number of employed is at the same rate as in 1997, number of their family members is decreasing. Further growth in number of retired people was registered. Numbers of persons who are owners of private companies and their family members, farmers, members of their household and other persons involved in agricultural activities as their main profession, unemployed persons and their family members and persons entitled to income from state budget are also decreasing.

Table 3: Insured by categories in %, 1996 - 2006.

Category	1996	2001	2006
Employed	58.27	57.60	58.10
Business-men, etc.	5.57	5.00	4.80
Farmers	2.09	1.60	1.30
Pensioners	26.47	27.20	26.90
National budget coverage	0.45	0.40	0.70
Unemployed	2.37	1.40	1.10
Municipality coverage	3.32	4.00	4.20
Else	1.46	2.80	2.90
Total*	**100.00**	**100.00**	**100.00**

Note: *Total in 2006: 1,985,095.

Family members are insured if they have permanent residence in the Republic of Slovenia (unless it is defined otherwise by international agreement). A child is health insured as a family member up to the age 15 years, or up to the age of 18 years if (s)he is not insured in other way, and after this age if he is attending school, i.e., to the end of regular education.

From legal point of view, no one can not be insured. But there is always a small group of people without settled insured status more than one year (approx. 0.12 percent of whole population) finding themselves in such position because of own careless or registration in insurance by employer is not being confirmed. To reach such a small portion of non-included several strategies were performed during last 10 years, among which the introduction of the health insurance card system in the 2000 was the most important tool.

5 The Types and the Scope of Rights Derived from Compulsory Health Insurance

The scope of rights within the compulsory health insurance scheme is defined by the Health Care and Health Insurance Act (hereinafter Act). Act which conferred certain powers to further regulate the rights and procedures to the HIIS. The HIIS regulates this area according to the Rules of Compulsory Health Insurance, initially adopeted by the Assembly on 24. November 1994, and the amendments to these Rules which take place or change usually once a year. Compulsory health insurance comprises insurance against diseases and injury outside employment and insurance against injuries at work and occupational diseases.

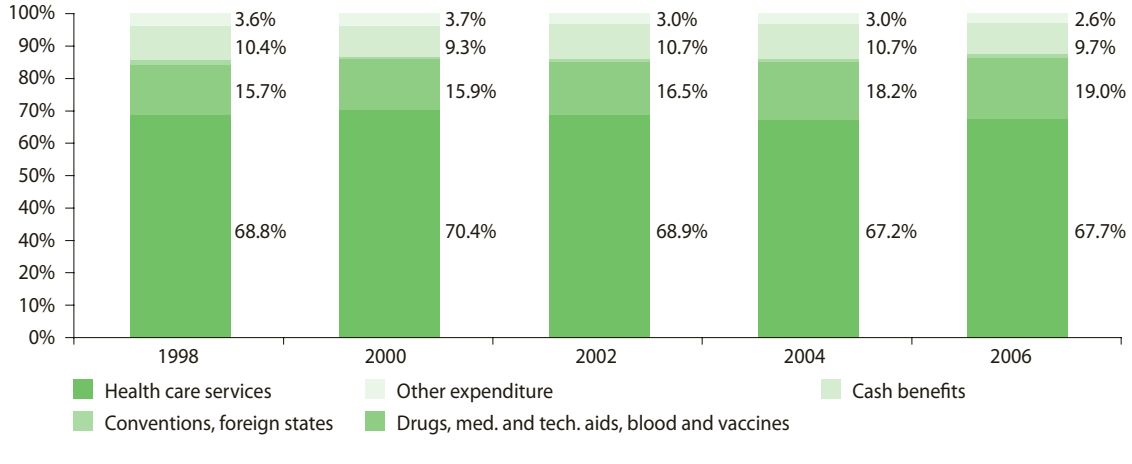
The rights deriving from the compulsory health insurance, for which the insured persons pay contributions, are classified into two groups. The first group comprises rights to health services, and the second comprises certain cash benefits. Among the latter, there are rights to compensation for the loss of salary in case of temporary absence from work due to medical reasons, refund of travel expenses, funeral allowances and death allowances.

5.1 Rights to health care services

The most comprehensive range of rights present the rights to health care services derived from the compulsory health insurance to which all insured persons are entitled to. These are preventive examinations and services (general health check-ups, measures for prevention of infectious diseases, measures for early detection of certain diseases, etc.), services for prevention, detection and treatment of illnesses on all levels of health sector, treatment and nursing care at home and in special social institutions and in nursing homes for senior citizens, emergency transportation by vehicles, drugs listed in the special list and medical and technical aids (orthopaedic, orthotic, eye, ear and other aids).

The implementation of certain rights (health resort treatment, temporary absence from work exceeding 30 days, certain most expensive medical devices) is subject to a prior opinion and approval by HIIS expert medical doctors and HIIS expert bodies. If an insured person considers his/her health insurance rights to have been violated, he/she may request the arbitration of the disputed matter in HIIS expert bodies which operate as senates of three members. As a last resort, the insured person may request judicial protection.

Image 6: Trends in expenditures for fundamental types of rights in the period 1998 - 2006.



As concerning the rights to health care services, medical drugs and aids, there exist no differentiation among insured persons. Everybody has unrestricted rights to seek help from his/her personal doctor, or, in cases of emergency, from any other medical doctors as well. But compulsory health insurance does not always cover all health care services and not in full prices. Namely health care legislators alleviated constant discrepancies between the economic potential of funds and real costs of health care programmes by introducing specific cost-sharing and co-payments mechanisms.

The Act has defined certain groups and diseases which are granted to be covered in full price (100%) by compulsory insurance (HIIS), e.g.:

- all health programs for children and youth: diagnosis, treatment and rehabilitation of diseases and injuries suffered by children, schoolchildren, minors with developmental impairments and students, as long as they attend school;
- counselling in family planning, contraception, pregnancy and childbirth care to female patients;
- services pertaining to programmes of preventive care, diagnosis and treatment of infectious diseases, including HIV infection;
- treatment and rehabilitation of occupational diseases or injuries, malignant diseases, muscular or muscular nerve diseases, mental diseases, epilepsy, haemophilia, paraplegia, quadriplegia and cerebral palsy, as well as advanced diabetes, sclerosis multiplex, and psoriasis;
- medical services related to the donation and transplantation of tissues and organs, emergency medical treatment, including emergency transportation, nursing care visits, and treatment and care in the home and in social institutions;
- long term nursing care as home visits, and provision of treatment and home nursing in social care institutions, etc.

While these services for specific groups and diseases described above are covered to 100% by compulsory health insurance other services are covered only in a certain share of the total value of the service. Percentages have been introduced by the Act allowing HIIS to decide upon exact level of co-payments but within the legal framework. For example the level of co-payments vary from a minimum of 15 % to a maximum of 95%, and thus determine the minimum or maximum level of co-payments to be paid by the patients.

Thus compulsory health insurance covers, in the case of health care services (including drugs, medical and technical aids), the full prices only for legally described groups and certain diseases. In the cases of all other services and population groups, the compulsory health insurance covers just certain percentages of their full prices. The difference to the full price shall either be covered by the insured person himself, or can be covered by the voluntary health insurance company, at which the person has taken a voluntary health insurance policy for copayments. Since 1993 such regulation of compulsory health insurance which presume co-payments and cost-sharing in the system has opened good opportunities to a wide affirmation of the voluntary i.e complementary health insurance.

5.2 Rights to cash benefits

Concerning cash benefits some of this rights does not apply to all employed insured persons. For example, persons entitled to receive compensation of lost salary during temporary absence from work are: employed persons, sole proprietors, private enterprise owners, farmers with pension and disability insurance policies, top-class athletes and chess players, as well as the unemployed persons who receive unemployment allowance or unemployment assistance from the Employment Service of Slovenia. In determining the amount of compensation, the average monthly salary of the insured person and the compensation are taken into consideration, i.e. the average basis for payment of the contributions for the calendar year before the year in which the concerned temporary absence from work appeared, and the percentage of the compensation depends on the nature of the cause for absence form work. In the cases of injury at work and occupational disease, 100% of the basis is compensated, in the cases of disease, 90%, and in the cases of absence due to nursing a family member or injury sustained outside work, 80%. One of the causes of absence from work entitling the insured person to cash benefit is the nursing of a family member. This term includes the spouse and children. Yet, this right is subject to a time limitation (7 and 15 working days) in each case and can be prolonged in exceptional cases when medical condition of a family member demands that.

Insured persons are entitled to a compensation for lost salary from the resources of the compulsory health insurance up to the 31st working day lost due to absence form work, caused by a disease or injury at work. Insured persons are entitled to receive the compensation for lost salary form the funds of the compulsory health insurance from the 1st day of absence from work in case when the reasons for absence from work are one of the following: nursing care of an immediate family member, transplantation of living tissue and organs for the benefit of another person, consequences of donating blood, quarantine or a follow up which is prescribed by a doctor, as well as in cases when the injury originated from organised public works of general interest, or from fire-fighting, mountaineering rescue or other rescue operations.

The right to reimbursement of travel costs applies to all insured persons when exercising their statutory rights when they need to travel to see a physician or a health institution in another place because in their place of employment or their permanent residence there is no physician or a corresponding health institution, or in cases when their personal doctor, health institution or the health committee of the HIIS refers or calls them to the place outside their regular place of residence or place of employment.

The amount of the reimbursement of travel costs paid in a calendar month is not limited, however, a fixed amount of deduction (contribution) is envisaged to be paid by the insured person in the amount of 3% of the minimum salary, valid in that particular month.

The right to reimbursement of funeral costs applies to the person who provided for the funeral of the insured person and amounts to certain percentage of the average necessary costs of funeral services in Slovenia. The right to death allowance in the form of one-off cash allowance upon death of an insured person applies to the family member of the insured person, whom they supported until their death; the amount equals to 100% of the guaranteed minimum wage in Slovenia.

6 Overall financing and allocation procedure of compulsory health insurance funds

As it is described in chapter 2.2. the funds raised through compulsory health insurance contributions are not the only source to finance health care programs, yet they represents approx. three quarter of all funds. In addition to the compulsory health insurance public funds, national and local budget sources are engaged (approx. 4.8% of all funds). Among private resources voluntary health insurance are of greatest importance (approx. 12.3 % of all funds), however, the scope of direct payments ("full payment") is not negligible, since it is estimated to amount to 8% of all health care expenditures.

Distribution of financial resources for health care programmes in Slovenia is implemented and monitored by elected democratic mechanisms for harmonization of interests of the major holders, in which the authorised state agencies and health care system and health insurance institutions authorised by law are included. The HIIS financial plan is adjusted with the Ministry of Finance and the Ministry of Health. Partnerial negotiations are the common ground where the representatives of the Ministry of Health, service providers (Medical Chamber and Chamber of Pharmacy, associations of health institutions, health resorts, social institutions, senior citizens' homes, etc.) and the HIIS negotiate on the scope and the value of the health care programme. Every year, the upward limits of available funds for activity programmes on a yearly basis are determined, which is also expressed with the calculated level of the contribution rate. They also agree on payment mechanisms, i.e. on appropriate manner of financial funds transfer to the public or private providers of health services. The next step represents the contracting with public institutions and with private health service providers.

The HIIS Assembly is the next important organ in the process of all mentioned steps, where the elected representatives of the contributors (insured persons and employers) autonomously consider and decide on proposals, deriving from the coordinatory activities described. Following are the descriptions of the mechanisms for collecting and allocating the compulsory health insurance funds which are being managed by the HIIS.

6.1 Financing of compulsory health insurance

The contributions for the compulsory health insurance are the main source of financing the compulsory health insurance. The contributions are collected from different categories of insured persons on a solidarity basis (Chapter 4.3.). Active insurees, who contribute the largest share of the income, pay the contribution as a certain percentage of their gross salaries, while their employers also pay a similar amount. In Slovenia, the aggregate contribution rate for active insured persons was corrected only once in the past 10 years, namely in 2002 when it rose from 13.25% to the present 13.45% of gross salary (Image 7). The above is broken down into the employee's contribution totalling to 6.36% while the employer's totals to 6.56%; employers, however contribute the further 0.53% for occupational diseases and injuries at work. The retired persons only pay the contribution, equal to the employee's share. The basis for determining the contribution in case of farmers is their cadastral income or the basis for pension and disability insurance. For other categories of contributors, a flat-rate contribution is determined ranging approximately around the contribution rate of an employee with a minimum salary (Table 4). In addition to that, the employers and those organising different public works are obliged to pay a special contribution for covering occupational diseases and injuries at work.

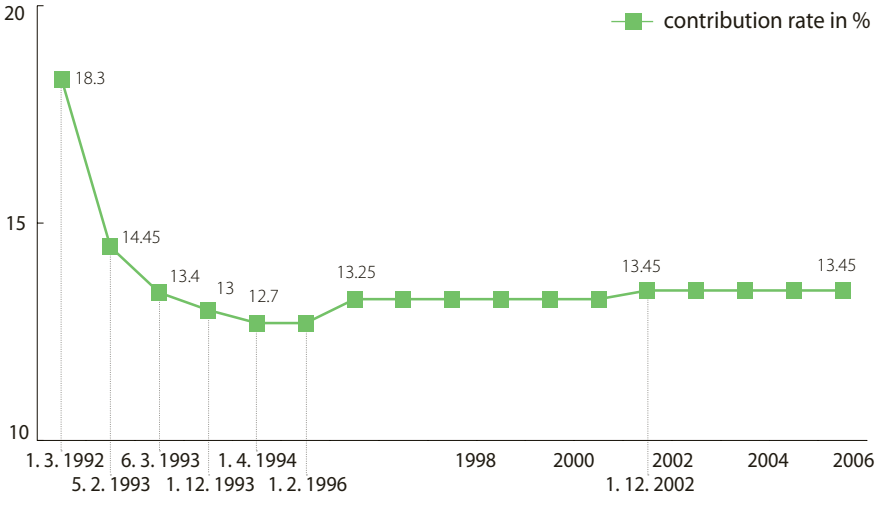


Image 7: Overview of the movements of the contribution rate (aggregate contribution rate) in the period 1992 – 2006.

Typically, the contributions are paid directly to the HIIS's account monthly. The contributions are collected by a special national agency for the account of the HIIS, with the agency which also concluded a special agreement. In case of unpaid contributions, the HIIS has the right and an obligation to recover the claims.

Table 4: Overview of all contribution rates, persons liable to pay contributions, and the types and the scope of rights.

Type and scope of rights	Employer	Employer	Farmer	Pension and Disability Insurance Institute	National Employment Office	The Republic of Slovenia
Diseases and injuries outside work						
For all rigths	6.56%	6.36%			12.92%	
For health services, reimbursement of travel costs, funeral allowances and death allowances				5.96%		5.96%
For health services and reimbursement of travel costs			5.12% or 18.78%			
Compensation of lost salary during temporary absence from work, funeral allowances and death allowances			1.15%			
Injury at work or occupational disease						
For all rigths	0.53%		0.53%			
For health services, reimbursement of travel costs, funeral allowances and death allowances						0.18%

6.2 Procedures for planning and allocation of the overall budget of compulsory health insurance

The HIIS plans and distributes the funds available on the basis of its financial plan which is adjusted with the annual macroeconomic basic premises of the state regarding determination of public finance contexts. The financial plan is adopted by the assembly of the HIIS as its

highest management body. In this document, the necessary financial funds for the four fundamental areas of implementation of compulsory health insurance are determined in terms of content, in particular for:

- health care services programmes (these programmes are defined and formally adopted on the grounds of partnerial negotiations and presented app. 69% of all HIIS's expenditure in 2006);
- drugs and medical and technical aids (expenditures in 2006 presented 17% of all HIIS's expenditures);
- cash benefits under the compulsory health insurance (expenditures for compensation for the lost salary in the case of temporary absence form work, travel costs, funeral allowances and death allowances in 2006 amounted to 10% of all HIIS expenditures);
- administrative costs of HIIS (expenditures for service cost of the HIIS in 2006 amounted to 2.4% of all HIIS expenditure).

The actual planning of the funds needed for individual tasks of the HIIS is founded on professional experience and the expected movements in terms of quantity, structure and prices of services and the estimated values of the programmes. Of fundamental importance in planning are the projections of the income and the expenditure of the compulsory health insurance which have to consider all essential macroeconomic premises in the country (salary, price, employment dynamics, etc.). Based on this, the financial plan should be balanced, and the contribution rate should assure the necessary revenues.

6.3 Partnership negotiations and contracting process

Every year, the representatives of the health care service providers, the Ministry of Health and the HIIS negotiate on the common scope of health care service programmes and funds necessary to pay the programme on the state level. Negotiations between partners are the most important mechanism for allocation of the overall budgets. It is implemented each year in two stages. The first stage comprises the adoption of a General Agreement, meaning the reconciliation of different proposals and interests within HIIS's available funds, collected through contributions and other revenues of compulsory health insurance. The proposal for the General Agreement is prepared by a joint negotiation group proposed by the partners, whose work is organised by special rules of procedure. Each year, this group submits an agreement proposal to the partners. The partners can present different standpoints. Often, matters at issue require arbitration. Such matters are communicated to all partners, who try to reconcile them before an arbitration procedure. If they do not manage to do so, the matters at issue are decided upon by an arbitration tribunal composed of the representatives of the three partners. If such arbitration is not successful, in line with the Act, the matters at issue are decided upon by the Government of the Republic of Slovenia. (Image 8)

In the second stage, on the basis of the General Agreement, the partners make field agreements for individual narrower areas, namely for health centres and private medical

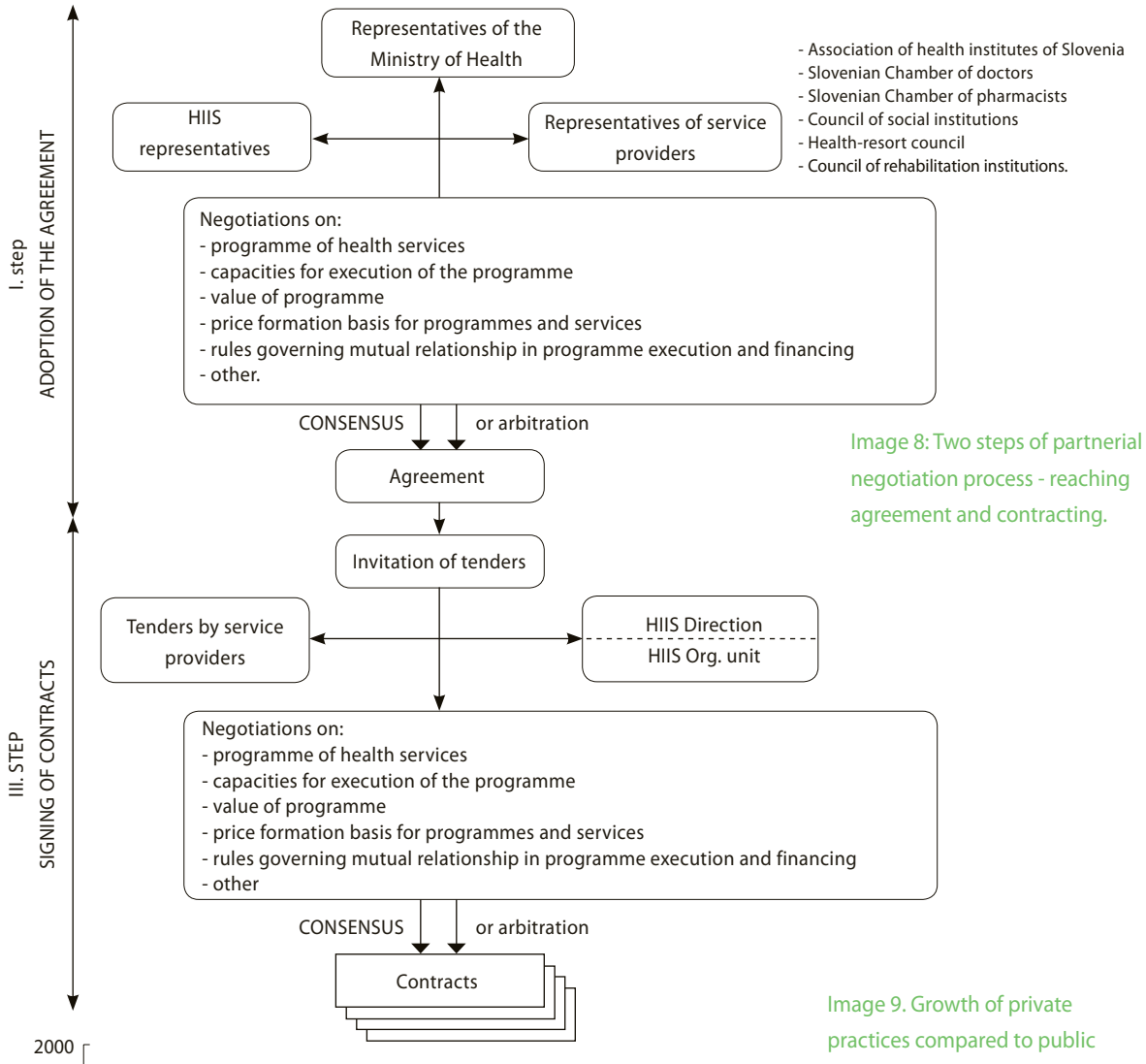


Image 8: Two steps of partnerial negotiation process - reaching agreement and contracting.

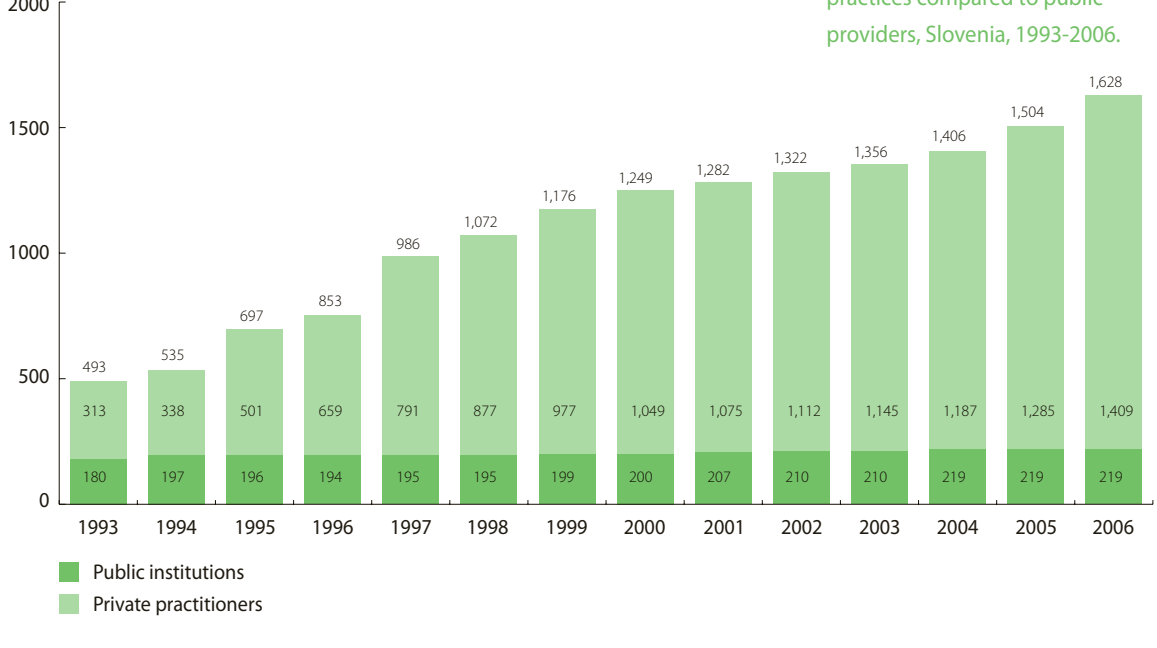


Image 9. Growth of private practices compared to public providers, Slovenia, 1993-2006.

activities in primary level, then hospitals, pharmacies, social care institutions and natural health resorts. The framework contents and deadlines for concluding area agreements are defined in the General Agreement, with the sectoral agreements arranging in detail the specifics of individual areas. These agreements arrange the programmes of individual activities by Slovenian regions in order to provide equal access to health services to all insured persons, which is based on personnel and material standards for financing individual programmes. These are formed by the partners on the bases of annual analysis of the situation and the agreement on the methodology and criteria for the fairest possible distribution of programmes, taking into account their own information and statistical movements in the prices of materials. In line with the priorities defined in the HIIS's Business Plan and harmonised with the Ministry of Health, the partners can also agree on increasing individual programmes.

The general and sectoral agreements represent the legal basis for the invitation of tenders for programmes of health services and are simultaneously a system of rules on how to mutually arrange the contracting relations between the HIIS and the providers with regard to performing and financing the programme of health services. The tender is open to all public institutes and private providers with the right (concession) to work in the public health care network. The providers are thus hospitals, health centres, private medical facilities, old people's homes, establishments for persons with special needs and educational establishments, pharmacies and health resorts. The number of contracts that the HIIS signs with the providers is steadily increasing due to constant growth of the number of private providers (Image 9). A contract made with an individual provider is the legal basis for financing the providers' work.

In the national level of HIIS which is organised in the whole territory of Slovenia the allocation of overall resources is technically managed in a centralised way despite the decentralised organisational structure. This financial organisation enables better short-term liquidity and investment policy. Thus the performance of payment transactions ensures more accurate financial operations and the establishment of additional internal control over fund outflows. HIIS pays its liabilities for the programmes of health services mainly within 20-30 days, while the liabilities for cash benefits activities are paid within 15-20 days.

6.4 Payment mechanisms and cost containment

In the scope of health insurance in Slovenia, the funding in most of the primary, secondary and tertiary level programmes applies prospective service provider accounting or. remuneration methods. These systems are of important consequence as regards the containment of health care costs, and they are relatively transparent and controllable.

PAYMENT MECHANISMS ON PRIMARY LEVEL

For the major part primary health care services provided by **chosen personal physicians** (general physicians, occupational, traffic and sports medicine doctors, and primary level

paediatricians) are paid in accordance with the capitation fee, implementation of the minimal scope of services and preventive programme, and according to the number of referrals to the secondary level. 92% of the programme value in these activities is paid in accordance with the number of declared patients ("capitation fee") on condition that the minimum number of services is performed by the providers. The providers are allocated the remaining 8% of the programme value in case that they perform the preventive programme and there is no deviation from the agreed standard on the referrals to the secondary level. For the purposes of accounting, a special list is applied. The number of declared patients per doctor or health care organisation is drawn from the HIIS computer databases, since the service providers are bound to currently report all data (copies of the doctor selection forms) concerning patients selection or change of a personal doctor. This database serves as the basis for the calculation of the capitation component payment sum for a doctor or health care organisation. The average and maximum allowable numbers of declared patients per doctor to be taken into account in calculating the capitation payment sum are also specified. Likewise, the volumes of services payable by the HIIS are also bounded and depend on the number of declared patients. The plans of these activities are financially valued based on calculation elements agreed by the statutorily competent partners, and they cover planned salaries, material expenses and equipment depreciation. The material expense calculation comprises the funds for laboratory examinations to be paid directly by the doctor rather than by the HIIS.

In **other primary level health care activities**, including dentistry, the services are planned, recorded and accounted according to the volume of services provided, based on a special catalogue of services ("Green Paper"). For each service, this document states its relative value, expressed as the number of points. The document was adopted 25 years ago, and later amended or modified in certain sections. Along with the list of services, which was designed following the special WHO manual on the classification of medical procedures, the document provides their relative values. The point score of a service is calculated on the structure of the team involved in the service, the team qualification structure, the time consumption. At the time of entering the contract, the service provider and the purchaser (HIIS) determine the plan (annual volume) of points and their value.

The planning of real volume of services for each service provider, which then serves as the basis for the contract, is based on norms and standards specified by the partners in the annual agreement. The financial valuation of services (points) takes into account calculation elements globally determined by statutorily competent partners, concerning the calculation salaries, proportions and amounts of material expenses, depreciation and overall consumption funds. According to this point value and within the scope of the agreed plan, a service provider can account the services and charge them to the HIIS. The payment is bounded to services provided within the volume agreed in the contract, while any exceeding of the plan is not paid for. In the ambulance service, in the non-emergency transport segment, the unit of accounting is ambulance kilometre travelled, while in the emergency transport segment, the accounting is in the form of fixed sums.

Slovenia has a particular arrangement regarding the pharmacies in terms of paying for the work done in relation to preparation and dispensing medicinal products. In most other

countries, predominantly the system of margins is in use in this field of activity. This means that upon dispensing the drug, in addtition to the wholesale pharmacy price the pharmacy charges also the margin amounting to a certain percentage of the drug price. But in Slovenia, the fee-for-service system for charging for pharmacist's activities is in use. The work done by the pharmacies is defined by the services and quantified by points thus being of similar financial structure as in other health-related activities. The most important among these services are processing the prescription and dispensing the drug. These are the two services charged by any pharmacy upon dispensing any prescription drug, while simultaneously charging the purchase (wholesale pharmacist's) value of the drug to the payer.

PAYMENT MECHANISMS ON SECONDARY AND TERTIARY LEVEL

In the **specialist dispensary service**, Slovenia operates a fee-for-service remuneration system, i.e. the recording and accounting are based on services provided. Like in the primary health care level segment not in the scope of the capitation fee, these services are specified in the "Green Paper", along with their point values, determined according to the same methodology. In the same way, the points are valued in financial terms. An exception in this respect are the dialysis services, where differentiated prices are determined depending on the complexity. In this sector, too, the service providers shall submit their plans to the HIIS, drawn up following uniform bases agreed between the partners. These operational plans are financially valued according to the financial calculation elements, and thereby, the contract point value for services are determined. In the specialist dispensary service, the laboratory services are not accounted and charged separately, but their costs are rather incorporated in the value of the point. In this segment, the rule is that the HIIS pays only those services provided and within the volume agreed in the contract.

Since the publishing of the "Green Paper", the progress in the medical science gave rise to emergence of a number of services, which have been provided in the practice yet are not properly specified in the catalogue. This situation leads to non-uniform recording in the cases of certain procedures. To overcome this problem, the HIIS undertake, in 1997, to update the service catalogue, i.e. the "Green Paper". Lists have been drawn up for some specialities, yet have not yet entered application, since the partners have not yet reached the required agreement.

In the **hospital acute care** a reimbursement payment per diagnostic related groups (Australian type) is used (hereinafter DRG model). Number of days are followed statistically. The same system is in effect for the "one day hospital" and the "daily hospital". DRG model in combination with the introduction of the "clinical path" concept, should optimise the incentives to service providers in the hospital, clinical and institute sector of the secondary and tertiary level health care service.

On the basis of the DRG model, the HIIS does not pay for transplantations, hospital treatment of psychiatric patients, for rehabilitation and for non-acute hospital treatment. Payments for the mentioned programmes are based on the average case price, i.e. on the hospital care days, when non-acute hospital treatment is in question. The price of transplantation in Slovenia includes costs of the surgery, donor and costs of treatment one year after the intervention.

7 HIIS's Business results

Expert studies, based on projections of social and demographic structure and on health status of the population, emphasize that, for maintaining the level of quality of health care sector, the share of public income, i.e. the income from compulsory health insurance, should be moving around 6.9% to 7.0% of gross domestic product (hereinafter GDP). Maintaining the share of compulsory health insurance income on the said level should be an imperative due to constant growth of expenditure in the health sector, caused by increased needs for health care services because of the ageing population, increased awareness and demandingness of the population, development of new treatment and rehabilitation methods along with improved qualification level of the health services, new medicaments and medical and technical aids, and last but not least, care for quality accessibility of health services for all insured persons.

However, the trends detected in Slovenia lately have shown reverse dynamics to a certain extent. There are numerous reasons for the said; among them, there is the ever increasing growth of gross domestic product in the recent past. In the recent past, as already mentioned, Slovenia has been encountering serious discrepancies between income and expenditure, which were shown as HIIS's deficits in the period 2001-2004. The reasons for deficits in the mentioned years were multy-faceted and were to a significant extent a consequence of factors which the HIIS had no influence on, namely on both, the income and the expenditure sides. After 2000, the impacts of certain negative trends kept intensifying after a decade of relatively stable operation. On one side, there were the already described impacts of long-term trends, among which ageing of the population is the most important one, the increasingly expensive drugs and the new medicinal procedures and equipment. In addition to these long-term trends, faster growth of salaries in health sector having a significant impact on expenditure in that period, introduction of the value added tax for material expenses, and in particular numerous new requirements for additional health programmes were the important contributing factors to the growing expenditure. Since the level of the aggregate contribution rate did not suffice for covering all the HIIS obligations, the latter was forced to borrow in the period 2001 – 2004 despite correction of the contribution rate in 2002.

Typical movements of income and expenditure of the HIIS in this period are shown in Image 10 and Table 5. In the period from 2000 through the end of 2004, the share of the HIIS expenditure for compulsory health insurance in GDP was continuously larger than the share of income. In 2002, this discrepancy lessened due to the raised aggregate contribution rate. The said difference lessened also because of numerous measures taken by the HIIS, which comprised selected activities for augmentation and optimisation of the income and different systemic measures to control the expenditure. Of special importance among the measures were the effects of the agreement made with the commercial insurance companies on lump sum payment of compensation for treatment after injuries in traffic accidents (new source, after 2004), the effects of the introduction of mutually interchangeable drugs and other measures in the field of managing the expenditures for drugs, medical and technical aid and cash benefits (expenditure management, after 2004), and the effects of the amended Taxation Procedure Act (one-off effect in 2005). For the purpose of maintainig the ability of balanced current operation, paying the cumulative debt of the HIIS, which totalled to EUR 119.5 million

in the beginning of 2005, was a reasonable and a necessary thing to do. By adopting the Act Governing the Assumption of the Debts as of July 1 2005, Republic of Slovenia took over the entire debt of the HIIS thus settling the deficit to its whole extent. On this basis, the movements of income and expenditure of the HIIS were balanced in 2005 and 2006.

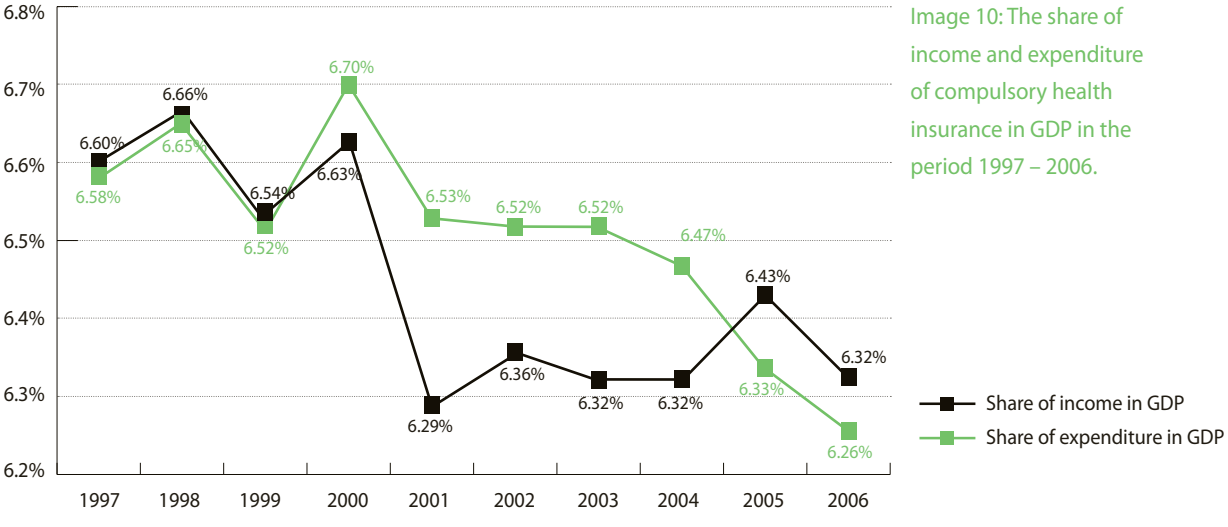


Image 10: The share of income and expenditure of compulsory health insurance in GDP in the period 1997 – 2006.

In 2005, the HIIS was financially stabilised owing to several years of implementation of numerous economic measures and on the basis of taking over the cumulative debt by the State budget. Financial reconstruction was recognised as an effective one, since the aggregate contribution rate after 2002 remained unchanged, while simultaneously keeping the same level of rights deriving from the compulsory health insurance which even broadened in certain areas, and the extent of health care service programmes significantly expanded with the aim of shortening the waiting periods.

Table 5: HIIS business results in the period 2002 – 2006 in EUR*.

	2002	2003	2004	2005	2006
INCOME	1,420,516,813	1,533,655,959	1,653,244,220	1,775,604,682	1,860,034,139
EXPENDITURE	1,457,111,108	1,580,995,764	1,693,929,069	1,749,206,126	1,845,443,428
SURPLUS/DEFICIT	**-36,594,296**	**-47,339,806**	**-40,684,848**	**26,398,556**	**14,590,711**
DEBT STATUS (BORROWING)	32,073,110	46,720,080	40,761,142	0	0
CUMULATIVE DEBT**	32,073,110	78,793,190	119,554,331	0	0
INCREASE/DECREASE OF FUNDS ON THE ACCOUNT	**-2,992,451**	**-538,925**	**278,075**	**26,419,846**	**14,616,562**

* The data for the period before Slovenia joined the European Monetary Union in 1.1.2007 are converted from Slovene Tolar (SIT) using the irrevocably fixed conversion rate (1 EUR = 239.64 SIT) into euro (EUR). This demonstration enables the comparison in the country through time and guarantees maintenance of the development indicators (growth rate).

** By adopting the Act Governing the Assumption of the Debts of the PDII and the HIIS, the Republic of Slovenia took over the debt for the account of the HIIS in the amount of EUR 119,554,000.

7.1 Revenue trends

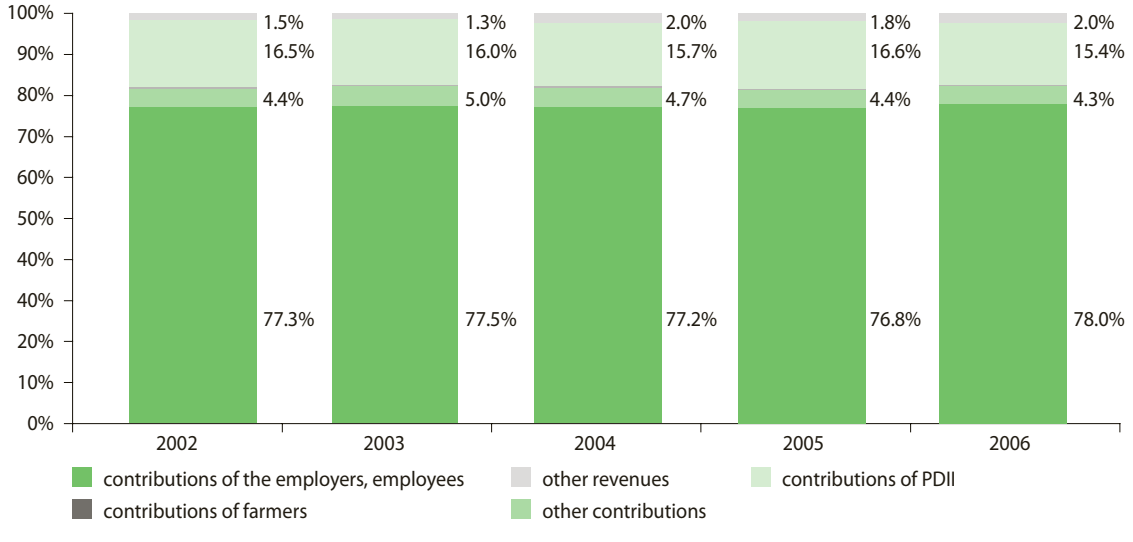
The total revenue of the compulsory health insurance comprises the revenues from contributions (totalling to app. 98%) and other revenues such as revenues from

reimbursement claims, conventions, investments, and other revenues. In the revenue structure, contributions by the employers and the employees represent the largest share, following are the contributions by the Pension and Disability Insurance Institute of Slovenia (hereinafter PDII), and contributions by the farmers along with other contributions. The level of contribution rate and the value of unpaid contributions have the greatest direct impact on the value of the revenue. In addition to that, certain general trends such as growth of the gross domestic product, the unemployment rate, the ratio between active and inactive population, migration, and others also have a significant impact. In the recent years, the HIIS has been striving to increase the effectiveness in controlling and recovering the contributions for the compulsory health insurance by the Tax Administration of the Republic of Slovenia and in exercising reimbursement claims in cases of injuries by the third person.

Table 6: The structure of the revenues of the HIIS for the period 2002 – 2006 in current prices (EUR) and by shares (diagram).

	contributions of the employers, employees	other contributions	contributions of farmers	contributions of PDII	other revenues	total
2002	1,098,487,131	62,588,299	3,313,862	234,741,521	21,386,000	**1,420,516,813**
2003	1,188,101,235	76,585,862	3,993,778	245,576,869	19,398,214	**1,533,655,959**
2004	1,277,120,648	78,150,221	4,643,544	260,228,643	33,101,164	**1,653,244,220**
2005	1,363,629,924	78,784,197	5,550,943	295,235,779	32,403,839	**1,775,604,682**
2006	1,450,300,388	80,478,451	5,342,468	286,597,112	37,315,719	**1,860,034,139**

* The data for the period before Slovenia joined the European Monetary Union in 1.1.2007 are converted from Slovene Tolar (SIT) using the irrevocably fixed conversion rate (1 EUR = 239.64 SIT) into euro (EUR). This demonstration enables the comparison in the country through time and guarantees maintenance of the development indicators (growth rate).



7.2 Expenditure trends

The basic expenditure categories in the compulsory health insurance comprise the expenditure for health care activities (87.7% of all HIIS expenditure in 2006), expenditure for cash benefits (9.9% of all HIIS expenditure in 2006), and the expenditure for the operation

of the HIIS service (2.4% of all HIIS expenditure in 2006). Health care activities expenditure shall comprise the expenditure for health services (primary health care, specialist outpatient and hospital activities, health resort treatment, social care services in social institutions, and expenditure for other programmes), expenditure for drugs and medical and technical aids, blood supply, social medicine, expenditure for treatment abroad (referrals) and expenditure for the implementation of international insurances and conventions. Cash benefits expenditure shall comprise expenditure for compensation for sick leave, expenditure for funeral allowances, death allowances, and expenditure for travel costs and transportation.

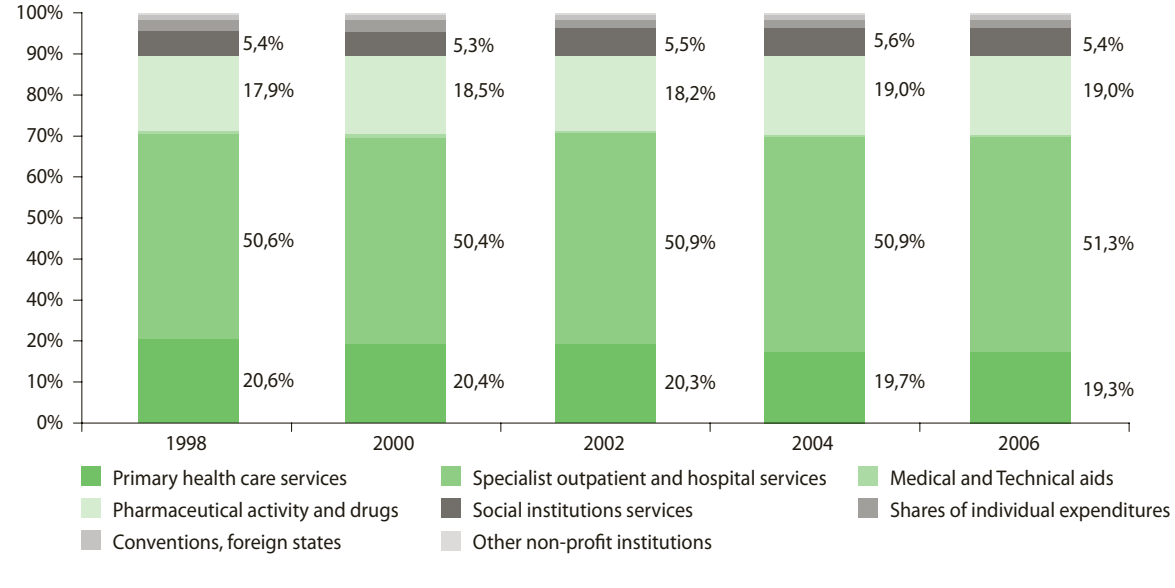
In the last 10 years, the HIIS has been continuously expanding the extent and, consequently, the value of the health service programmes due to the increased needs of the population, shortening of waiting periods and introduction of new treatment methods. Movements of expenditure trends according to the above described categories and types of expenditure are shown in the Table 7.

Table 7: The structure of the health service expenditure of the HIIS for the period 2002 – 2006 in current prices (EUR) and by shares (diagram).

	2002	2003	2004	2005	2006
primary health care	258,858,141	278,897,605	296,046,695	299,461,325	312,982,966
spec. outpatient and hospital activities	636,471,578	689,531,848	743,727,458	774,602,299	830,683,630
health resort act.	14,193,553	14,742,969	15,089,221	14,344,805	14,476,565
pharmacist act. and drugs	225,276,435	252,614,584	265,668,177	289,213,829	307,649,082
social inst. activity	67,605,938	72,490,615	79,662,761	84,954,369	87,148,919
medical aids	38,151,223	42,052,120	42,443,657	38,912,694	42,718,532
conventions, foreign countries	13,274,987	12,956,689	14,043,665	16,571,603	18,099,796
other non-profit inst.	3,892,322	4,055,129	4,214,664	4,606,631	4,736,538
total	**1,257,724,178**	**1,367,341,558**	**1,460,896,299**	**1,522,667,555**	**1,618,496,027**

* Data for the period before Slovenia joined the European Monetary Union in 1.1.2007 are converted from Slovene Tolar (SIT) using the irrevocably fixed conversion rate (1 EUR = 239.64 SIT) into euro (EUR). This demonstration enables the comparison in the country through time and guarantees maintenance of the development indicators (growth rate).

Shares of individual expenditures



8 Exercising the Rights Deriving from Compulsory Health Insurance

8.1 Supply and Accessibility of Health Care Services

Table 8: Value and structure of compulsory health insurance and complementary health insurance expenditures i.e. expenditures for co-payments for health care services, Slovenia, 2006.

As part of a long-term process of development, a comprehensive network of public and private health care service providers at the primary, secondary and tertiary levels, which is widespread and accessible to all insured across the whole country, has been established in Slovenia. From 1992 onwards health care services were financed in a stable manner through the public and private sources of compulsory and private voluntary insurance. Value and structure of compulsory health insurance (HIIS) expenditures and complementary insurance i.e. copayments for different health care services, including drugs and medical aids, are presented in the Table 8.

Types of Health Care Services	Expenditures of compulsory insurance *	%	Expenditure for co-payments**	%	Total health insurance expenditures	%
1. Services on primary level	317,719,504	19.7	63,028,643	22.3	380,748,147	20.0
2. Outpatient specialistic and hospital services	830,683,630	51.3	72,045,144	25.5	902,728,774	47.5
3. Spa rehab. services	14,476,565	0.9	9,719,088	3.4	24,195,653	1.3
4. Nursing in social homes	87,148,919	5.4	0	0.0	87,148,919	4.6
5. Drugs (including pharmacist services)	293,455,450	18.1	131,487,645	46.4	424,943,095	22.3
6. Medical aids and blood supply	56,912,164	3.5	6,259,778	2.2	63,171,942	3.3
7. Services abroad (international insurance according to the EU acquis and international agreements, referrals to treatment abroad)	18,099,796	1.1	500,100	0.2	18,599,896	1.0
TOTAL	**1,618,496,028**	**100.0**	**283,040,398**	**100.0**	**1,901,536,426**	**100.0**

Note: * Expenditures of HIIS for health care services in EUR and in %

**Estimated expenditure on co-payments which are covered by the voluntary health insurance companies or persons themselves when they are not insured on the voluntary basis, in EUR and by percentage shares.

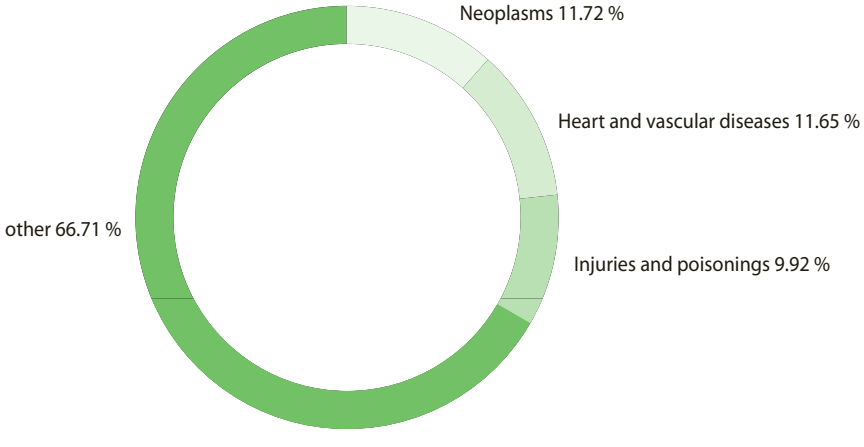
In order to provide quality services in accessible time and in terms of equitable arrangements to all insured persons, the most important regulation is included in partnership negotiations and contractual relationships. In these processes among partners the HIIS bears key responsibility. HIIS uses several mechanisms to manage equity of access. For example, to reach the goal of reducing the differences among different providers it admits the differences in supply with health capacities between regional units in the range from not less than 90 % and not more than 110 % of the Slovene average. There are several financial arrangements following this rule.

In the recent period, for example, an important step has been made in the process of partnerial negotiations with the service providers to achieve better accessibility of health care services and higher quality of consideration of the insured persons despite the strained financial situation and borrowing. On the primary level, the network of general physicians and community nurses has expanded, which improved the supply of the inhabitants with general medicine, child health care and school dispensaries programmes in such a way that the indicators of discrepancy from (financial) standards moved between 97 and 104 of the Slovene average. On this level, increasing needs for non-acute treatments remain the

greatest challenge (ageing of the population), which poses the demands for better supply of physiotherapeutic treatment and nursing care, including new capacities in social care institutions.

In the specialist outpatient and hospital activity on secondary and tertiary levels, chronic and other modern diseases are increasingly coming to the foreground as well. Neoplasms, heart and vascular diseases, injuries and poisonings represent a third of all hospitalisations (Image 11). Problems in comparable fields have occured in Slovenia as result of increasing medical needs which reflect the ageing of the population and the consequent increase of the share of chronic diseases. Suchlike situation keeps changing the structure of needs for hospitalisation, which causes certain delays in accessing different individual health services (waiting periods) and certain complications in organisation of non-acute treatment of the patients, prolonged treatment, nursing and social care and other forms of this type of treatment.

Image 11: The share of hospitalisation due to neoplasms, heart and vascular diseases, injuries and poisonings in 2004.

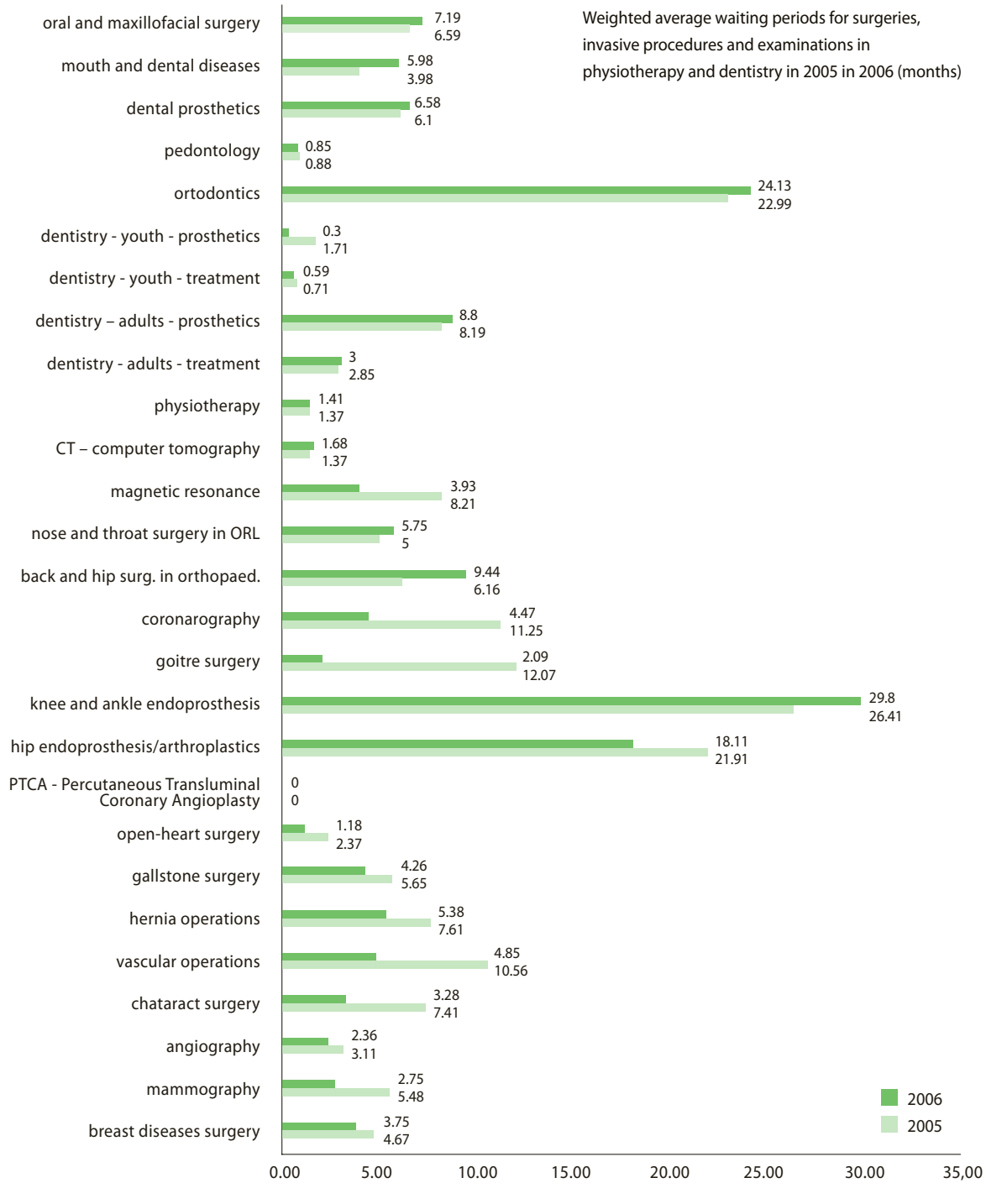


The above mentioned facts are the reasons for the HIIS recent efforts for improvement in accessibility and quality of the services in secondary and tertiary levels of health sector. By negotiations and contracting processes, HIIS has been regulating working hours and waiting lists and periods for certain procedures for years. Beside some information and promotion demands concerning waiting periods HIIS has tried to regulate this field also by prioritising special fields of activities in agreement with the partners. In this way additional contracts with several providers has been signed in recent years in order to increase the regular programme of health services and to reduce long waiting periods. Thus, in the period 1997-2006, HIIS allocated additional funds in order to shorter waiting periods or to increase such priority programmes of health service as for cataract operations, hernia operations, gall bladder operations, open heart and other cardiovascular surgery operations, orthopaedic hip, knee and backbone surgeries, gallstone surgeries, nose and throat surgeries, magnetic resonance examinations, CT, IVF procedures, transplants, extension of the programme of restorative rehabilitation etc.

In 2004, the HIIS in cooperation with its partners in the health care system for acute hospital treatments introduced a new method of payment according to the diagnostic related groups

(DRG), which renders planned activities and implementation of financial incentives for better accessibility and shortening of waiting periods possible. In this way, the additional financial funds in 2004 and 2005 were systematically and on the priority basis allocated to the programmes with long waiting lists, where majority of the selected medical procedures have shown positive changes. In some areas, such as orthopaedics or dentistry, the results still do

Image 12: Realised average waiting periods in 2005 and 2006 in Slovenia.



not correspond to the expectations (Image 12). Due to increasing needs for nursing care, several measures for improvement of this kind of treatment were adopted on the hospital level (introduction of the programme for non-acute treatment of the patients in hospitals, i.e. prolonged medical treatment and nursing care).

8.2 Drugs

In Slovenia comprehensive attention and regulation is devoted to provision of drugs and prescription. HIIS closely monitors the area of drugs prescription, the expenditures and many other parameters (average costs of medicines prescribed to insured persons, by doctors, by types of medicine and other indicators provided by the database on medicines). In line with the Act HIIS's responsibility is to classify the medicines into positive and intermediate lists. Listing has been performed regularly according to special rules and in co-operation of the most distinguished pharmacotherapeutic and pharmacoeconomic experts in the country (special independent committee). The two lists define the share of the value of prescriptions covered by public funds from the compulsory health insurance and the level of excess charge on individual prescriptions. Drugs for health curing certain population groups and certain disease and health condition (chapter 5.1.) are always on positive lists and are covered to 100%. The most important and effective drugs are on the positive lists and covered in the level of 75 % by compulsory health insurance. Other medicines (including paralels etc) are on intermediate lists covered 25 %.

The experience show, that a positive list does not automatically guarantee best cost-containment. This can be demonstrated by different measures and activities of HIIS in period 1992-2006 (Image 13). Furthermore, it should be mentioned, that the control of prices of drugs is the statutory domain of the Agency for Medicinal products and Medical Devices of the Republic of Slovenia.

Classifying drugs in positive and intermediate is not the only system mechanism to contain costs of drugs. The list of different such measures and activities in Slovenia in past decade is very long:

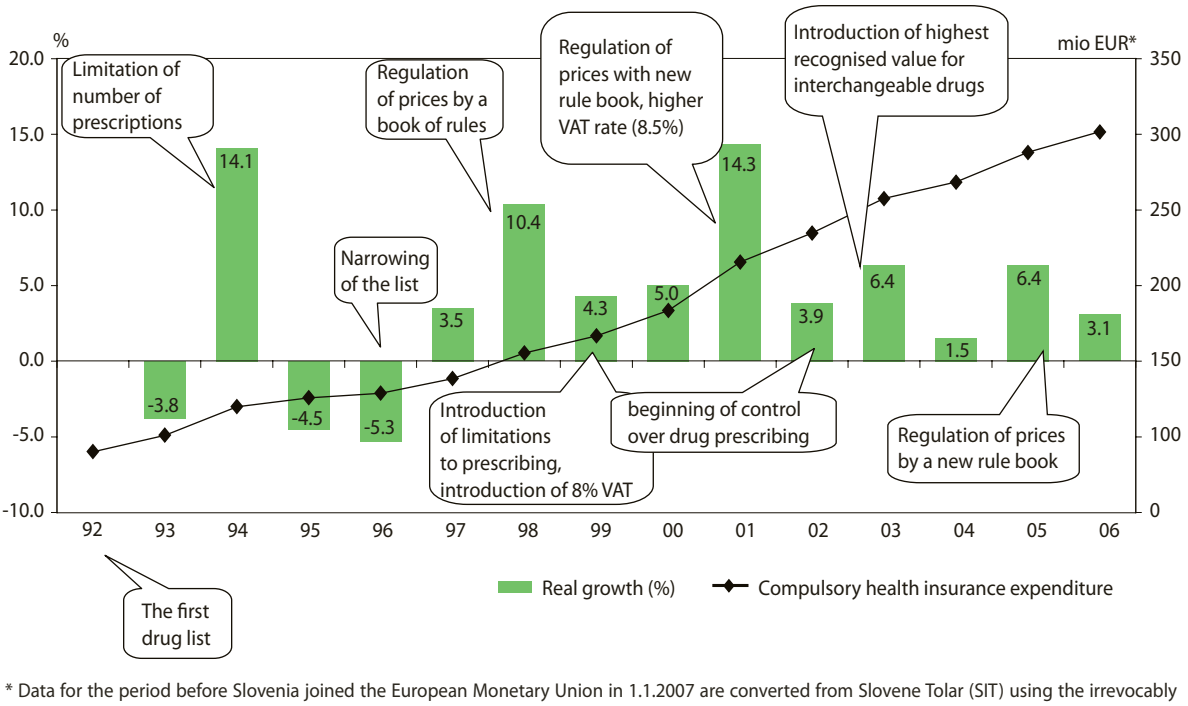
- 1991: introduction of drug product lists, co-payment;
- 1992: new Act, novelties in classification of drug products to lists;
- 1993: start of implementation of co-payments for drug products, i.e. the voluntary health insurance for co-payments;
- 1994: limitations to prescribing;
- 1995: narrowing of the positive list;
- 1996: the Medicinal Products Act;
- 1998: pricing;
- 1999: limitations to prescribing;
- 2001: informing and educating the physicians, the commission for new drug products, systematic control over prescribing;
- 2002: introduction of new biological medicinal products according to the criteria;

- 2003: the list of interchangeable drug products, determining the highest approved values (Slovene reference price system);
- 2004: negotiations on drug products prices, informing the physicians, control;
- 2005: project for promotion of safe and appropriate use of drug products, informing the physicians, control;
- 2006: new Rules on pricing for drug products, informing and educating the physicians.

Image 13 shows the growth of expenditure for drug products which are prescribed in Slovenia chargeable to the compulsory health insurance. The image clearly shows the impact of different individual measures and activities to restrain the real growth of expenditure and the level of successfulness in this area in Slovenia.

So in Slovenia more and more attention is given to evidence based approaches for rational prescribing of medicines and appropriate use of medicines by consumers. HIIS issues certain recommendations and special information for doctors and continually educate and inform doctors. The Slovene model of reference prices of drug products however deserves special attention regarding the measures for controlling expenditure for drug products due to its favourable effects on the expenditure. It was introduced in 2003 based on the implemented system of interchangeable drug products and determining of the highest approved values (prices) for those drug products. On the grounds of the said, the HIIS classifies the drug products which are recognised as being essentially similar and having the same effects (containing the same drug substance, having the same dosage

Image 13: Real growth and the HIIS measures for controlling expenditure for drug products in the period 1992 - 2006.



* Data for the period before Slovenia joined the European Monetary Union in 1.1.2007 are converted from Slovene Tolar (SIT) using the irrevocably fixed conversion rate (1 EUR = 239.64 SIT) into euro (EUR). This demonstration enables the comparison in the country through time and guarantees maintenance of the development indicators (growth rate).

and form, and which are of proven comparable quality, safety and efficiency) into the groups of interchangeable drug products, while determining the highest approved value still to be covered by the health insurance. In every group there is at least one drug product whose price does not exceed the highest approved value thus being covered to

Table 9: Prescription drug products in 2002 and 2006, and the index (2006/2002).

	2002	2006	Index 2006/2002
Gross domestic product per capita (eur)	12,084	15,167	126
No. of all prescription drugs	2,102	1,801	86
No. of drugs on the Positive list	1,036	1,220	118
No. of drugs on the Intermediate list	248	385	155
No. of reimbursed substances (INN)	474	557	118
No. of prescriptions per capita	6,54	7,30	112
Consumption (in Defined Daily Doses)	627,995,813	761,996,028	121
Total prescription drugs expenditures (eur)	321,645,048	424,058,076	132
Compulsory health insurance expenditures for drugs (eur)	215,534,105	293,455,450	136
Total prescription drugs expenditures per capita (eur)	161	211	135
Compulsory health insurance drugs expenditures per capita (eur)	108	138	117

the full amount by the compulsory and voluntary health insurance in accordance with the classification to drug product lists. In case that an insured person insists on issuing a drug product exceeding the highest approved value they have to pay the difference between the price of that drug product and the highest approved value themselves. The system also enables the HIIS to negotiate with the producers and suppliers on drug product prices every year before the actual implementation of every current new list.

8.3 Medical and Technical Aids

In case of certain diseases and conditions, the insured persons in Slovenia are entitled to medical and technical aids chargeable to the compulsory health insurance. The need for a medical aid is determined by a personal physician or, at their proposal, another authorised physician who prescribes the aid using a special order form. An insured person can obtain the prescribed aid or borrow it from the authorised supplier holding a contract with the HIIS and having their status visibly declared (with a special green sticker) as being a supplier and a borrower of medical and technical aids on behalf of the compulsory health insurance. Certain aids (separately defined in the Rules of Compulsory Health Insurance) do not become a possession of the insured person but are rather given to them to use and return them to the borrower afterwards.

By signing the contract with the HIIS, the suppliers undertook to provide quality and functionally adequate standard aids to the insured persons without charging for them unless otherwise provided in the Act or the Rules. Upon the supply of the aid, the suppliers shall provide the insured person with all necessary instructions, warranty certificate, and the list of

authorised service centres. All service costs arisen during the warranty period, which are not a result of inappropriate and unprofessional handling by the insured persons, are covered by the suppliers. As a rule, the supplier is obliged to provide a substitute product for the period needed to repair the aid. In addition to that, the suppliers also provide for regular maintenance and servicing of the issued aid for its entire life period. The suppliers may also supply the above standard aids, but only in case of an insured person's special request and upon their written assurance that they are willing to pay for the price difference. The suppliers are obliged to keep all types of standard aids of adequate quality in their stock at all times.

Table 10: Issued order forms for medical and technical aids and their value in 2006.

Group	No. of order forms issued	Share of order forms issued	Value of medical and technical aids issued (EUR)	Value share	Average value per order form (EUR)
Limb prostheses	896	0.14%	950,562	2.24%	1,060.89
Aesthetic prostheses	4,587	0.70%	473,760	1.11%	103.28
Orthoses	9,377	1.44%	871,644	2.05%	92.96
Orthopaedic footwear	5,569	0.86%	451,372	1.06%	81.05
Wheel chairs and other movement, standing and sitting aids	12,335	1.90%	2,031,896	4.78%	164.73
Electric stimulators and other appliances	4,234	0.65%	611,628	1.44%	144.46
Sanitary aids	4,386	0.67%	274,353	0.65%	62.55
Bedsore protection cushions	1,195	0.18%	120,018	0.28%	100.43
Hernia belts	3,627	0.56%	165,039	0.39%	45.50
Aids for artificial intestinal outlets	14,930	2.29%	3,450,431	8.11%	231.11
Aids for urinary incontinence problems	284,913	43.77%	12,221,504	28.74%	42.90
Diabetes treatment aids	101,180	15.55%	12,356,717	29.05%	122.13
Cannulas	7,286	1.12%	583,382	1.37%	80.07
Other technical aids	2,407	0.37%	72,461	0.17%	30.10
Aids for visually impaired and blind persons	119,117	18.30%	1,954,720	4.60%	16.41
Hearing aids	13,894	2.13%	2,698,126	6.34%	194.19
Dressings	50,092	7.70%	1,637,765	3.85%	32.70
Solutions	10,840	1.67%	48,124	0.11%	4.46
Servicing			898,444	2.11%	
Lending enterprise labour costs			334,333	0.79%	
Services			323,321	0.76%	
TOTAL	**650,865**	**100.00%**	**42,529,600**	**100.00%**	**65.34**

In 2006, the largest share of the issued order forms were those for aids for urinary problems (43.77%), aids for blind and visually impaired persons (18.30%) and aids for diabetes treatment (15.55%); the value of all three groups of aids amounts to more than half of all aid funding (62.39%). Aids for artificial intestinal outlets represent 8.11% of all aids funding, hearing aids represent 6.34%, wheelchairs and other movement, standing and sitting aids represent 4.78%, etc.

9 Implementation of International Health Insurances and Cooperation with Foreign Countries

9.1 Exercising the Right to Health Services in the Republic of Slovenia

The process of exercising and the extent of rights to health services of foreign insured persons in the Republic of Slovenia depend on the country of origin of the insured person, since the Republic of Slovenia implements international treaties on social security with certain states (Republic of Croatia and Republic of Macedonia) or, for the citizens of the European Union member states, the European Economic Area and Switzerland, exercising of health services is implemented according to the European acquis.

A) CITIZENS OF THE EUROPEAN UNION MEMBER STATES, THE EUROPEAN ECONOMIC AREA AND OF SWITZERLAND

Insured persons of the European Union Member States (hereinafter The EU), the European Economic Area (hereinafter the EEA) and Switzerland are entitled to health services necessary on medical grounds during a stay in the territory of Slovenia, taking into account the nature of the services and the expected length of the stay (Regulation (EEC) No. 1408/71).

Using the European Health Insurance Card, such insured persons can exercise their rights to emergency, i.e. necessary medical services directly at the physicians who have concluded a contract with the HIIS. These medical services can be exercised only on the primary health sector level, while the specialist or hospital treatment demand for an acquisition of the referral from a general practitioner on the primary level. Emergency medical help can, however, be obtained directly in the nearest hospital.

In case of emergency hospital care additional payments are not anticipated, since such services are covered by the compulsory health insurance to the full extent. All other services are available free of charge only to a certain percentage of the service value, since some of these health services require an additional payment ranging between 5% and 75% of their value.

B) CITIZENS OF THE REPUBLIC OF CROATIA AND THE REPUBLIC OF MACEDONIA, WITH WHOM THE REPUBLIC OF SLOVENIA HAS CONCLUDED INDIVIDUAL BILATERAL AGREEMENTS

The insured persons from these two countries can exercise their rights to emergency treatment and emergency medical services with the physicians and health institutions in the Republic of Slovenia which have concluded a contract with the HIIS. On the basis of the HR/SLO 3, or the RM/SLO 3 forms, which they submit at an HIIS Regional Unit or a branch office where they are issued an appropriate document. On the basis of that document, medical services can be exercised only on the primary level, while the specialist or hospital treatment demands for an acquisition of the referral from a general practitioner on the primary level. Emergency medical help can, however, be obtained directly in the nearest hospital.

In case of emergency hospital care additional payments are not anticipated, since such services are covered by the compulsory health insurance to the full extent.

C) CITIZENS OF OTHER STATES WHICH ARE NOT MEMBERS OF THE EUROPEAN UNION, THE EUROPEAN ECONOMIC AREA, OR SWITZERLAND, OR STATES WITH WHICH NO INTERNATIONAL AGREEMENTS ARE CONCLUDED

With other states, the Republic of Slovenia has not concluded any international agreements on social security managing the area of health care and health insurance, which means that citizens of those states have to pay for the health services provided in the Republic of Slovenia themselves.

Pursuant to the Health Care and Health Insurance Act, the Republic of Slovenia provides funding from the budgetary funds for emergency health care for persons of unknown residence, foreigners from states with whom it has no international treaties concluded, and for foreigners and citizens of the Republic of Slovenia with permanent residence abroad who temporarily stay in the Republic of Slovenia or are travelling through the Republic of Slovenia and for whom no payment for health care service could be provided otherwise.

9.2 Exercising the Right to Health Services Abroad

Insured persons temporarily staying abroad who have compulsory health insurance concluded in the Republic of Slovenia are entitled to enjoy the same level of rights to emergency and necessary health care services during their stay abroad.

A) EXERCISING THE RIGHT TO HEALTH CARE SERVICES IN THE EUROPEAN UNION MEMBER STATES, THE STATES OF THE EUROPEAN ECONOMIC AREA AND IN SWITZERLAND

With the European Health Insurance Card or a corresponding certificate Slovene insured persons can use health care services in these states, needed for medical reasons and considering the nature of the services and the anticipated duration of such stay in another Member State, directly with the physicians and health institutions that are a part of the public health care network. The mentioned services can be exercised in accordance with the legal provisions of the state where the service is being used, which means that in certain individual states, additional payment is needed for certain services, the same way as do the insured persons residing in that particular state.

B) EXERCISING THE RIGHT TO HEALTH CARE SERVICES IN THE STATES – SIGNATORIES OF BILATERAL AGREEMENTS

In the Republic of Croatia and the Republic of Macedonia with whom the Republic of Slovenia has concluded bilateral agreements, Slovene insured persons have the right to exercise basic or emergency health care services with the physicians and health care institutions that are a part of public health care network, on the basis of submission of the European Health Insurance Card or a corresponding certificate.

C) EXERCISING THE RIGHT TO HEALTH SERVICES IN OTHER STATES

Slovene insured persons who exercise their right to health services in the states where European legislation does not apply or with whom no bilateral agreements on social security

have been concluded, have to pay for these services themselves. In justified cases and upon submission of the relevant medical documentation and the original invoices, the HIIS makes the reimbursement of the costs in the amount equalling to the average price of the same services in the Republic of Slovenia.

9.3 Referrals Abroad for Treatment

Pursuant to the Health Care and Health Insurance Act, the insured persons have the right to examination and treatment abroad in case where in the Republic of Slovenia all possibilities of such treatment have been depleted, while complete recuperation or improvement of the affected patient's health condition or prevention of further deterioration of their health condition can be justifiably anticipated. The HIIS decides on the justification of the referral to treatment abroad in an administrative procedure, namely the appointed physician by the HIIS or the health committee of the HIIS performs the procedure.

In 2006, the HIIS received 493 requests for granting referrals for treatment, examination or physical examination abroad, for approval of acquisition of eye prostheses, which exceeds the numbers for the year 2005 by 18%. This way, 212 insured persons were referred for treatment or an examination abroad. Since some of the insured persons needed to take several trips abroad for treatment or examination, the total number of trips was 260.

In 2006, the insured persons were referred to treatments or examinations to Austria, Croatia, France, Germany, United Kingdom, Italy, the Netherlands, Spain, and Switzerland and to the USA. The largest number of insured persons was referred to Austria and Germany (Table 11).

Table 11: The overview of the number of Slovene insured persons by states where they were referred to treatment or medical examination, 2006.

State	No. of insured persons	No. of referrals
Austria	94	111
France	10	13
Croatia	13	13
Italy	9	11
Germany	42	58
The Netherlands	2	2
Spain	1	1
Switzerland	17	24
United Kingdom	23	24
USA	1	3
TOTAL	**212**	**260**

38 insured persons acquired their eye prostheses in Austria with the approval of the HIIS. 155 insured persons were approved the diagnostics of the tissue or blood samples sent abroad. The majority of samples (20% of all samples) were sent to Germany for analysis.

In 2006, the HIIS has, on the basis of compulsory health insurance and of the special decision of the Board of Directors of the HIIS on referrals abroad in cases of extensively long waiting periods, approved reimbursement of costs up to the amount of such services in Slovenia to 13 insured persons, who then undergone 14 procedures of In Vitro Fertilization abroad.

Table 12: The overview of the number of cases of foreign and Slovene insured persons, claims and obligations of the HIIS in accordance with the European legislation and according to the treaties on social security in 2006 (in EUR).

No.	State	No. of cases of foreign insured persons in Slovenia in 2006	No. of cases of Slovene insured persons abroad in 2006	New claims in 2006 (in EUR)	New obligations in 2006 (in EUR)
1	Austria	6,871	1,018	2,131,532.12	492,599.52
2	Belgium	87	118	20,952.46	19,937.38
3	Cyprus	0	0	0.00	0.00
4	Czech Republic	114	44	61,699.16	5,005.99
5	Denmark	18	0	28,353.92	0.00
6	Estonia	8	1	620.08	jul.86
7	Finland	18	7	1,712.94	4,848.75
8	France	176	89	46,749.11	41,914.00
9	Greece	34	0	13,961.42	0.00
10	Croatia	1,589	15,474	2,213,837.86	8,220,610.92
11	Ireland	50	0	7,693.25	0.00
12	Iceland	8	0	1,963.27	0.00
13	Italy	3,481	227	814,019.49	276,943.49
14	Latvia	5	0	183.52	0
15	Liechtenstein	1	0	41.52	0.00
16	Lithuania	5	0	1,300.98	0.00
17	Luxemburg	6	9	294.83	8,923.96
18	Malta	0	1	0.00	5,175.98
19	Hungary	72	120	20,841.59	523.81
20	FYROM*	99	1,286	77,333.12	6,958.51
21	Germany	3,888	964	1,804,216.22	746,610.70
22	The Netherlands	43	65	24,373.69	66,975.04
23	Norway	29	1	10,577.49	13,138.91
24	Poland	108	9	26,556.77	3,967.75
25	Portugal	39	4	8,379.35	233.31
26	Rumania	0	0	0.00	0.00
27	Slovakia	268	42	105,400.82	10,748.99
28	Spain	95	108	24,832.83	19,626.77
29	Sweden	179	20	61,285.69	19,521.82
30	Switzerland	14	0	2,457.09	0.00
31	Great Briatin and Northern Ireland	531	0	198,648.36	0.00
	TOTAL	**17,836**	**19,607**	**7,709,818.93**	**9,964,273.46**

* Former Yugoslav Republic of Macedonia

9.4 International Cooperation

The HIIS is actively involved in cooperation with the liaison bodies of individual states in implementing the European legislation and transnational treaties on social security and in concluding new treaties on social security.

Charging the costs of health care services between the Slovene and foreign providers of health insurance included Slovenia and 31 countries in 2006. The HIIS charged foreign states for the costs of health care services exercised in Slovenia by the insured persons from that states in the amount of EUR 7.5 million which included 17,836 individual cases. The majority of invoices issued by the HIIS were for Croatia (EUR 2.2 million), Austria (EUR 2.1 million), and Germany (EUR 1.8 million), as indicated in Table 12.

Health care services provided by foreign health care providers at the place of permanent or temporary residence to Slovene insured persons on behalf of the authorised institution in 2006 were charged by those foreign states to the HIIS in total amount of EUR 10 million for a total of 19,607 cases. The greatest amount of costs were charged by Croatia, namely in the amount of EUR 8.35 million. Following are Germany and Austria with EUR 742,780, and EUR 492,400, as indicated in Table 12.

Some foreign delegations visited the HIIS during this year, and the HIIS's experts were taking part in numerous international projects and attended several international conferences. In 2006, the HIIS experts, among other activities, cooperated in preparation of new international treaties on social security with Australia and Bosnia and Herzegovina.

10 Development Activities in Respect of Quality and Business Performance in Health Care

After the financial consolidation of the HIIS in the period 2004 – 2005, the efforts to provide higher quality and improved accessibility of health care for the insured persons are in the forefront of key development activities of the HIIS. This comprises a number of different activities, such as implementation of a standard according to which the insured persons should, on average, not be waiting more than 20 minutes in waiting rooms of the consulting rooms on primary level of health care sector. There are no waiting periods in Slovenia for examinations or medical procedures in general physician surgeries, children's and school surgeries and in cases where health condition of the affected insured person demands emergency or unavoidable services, in all other cases health care providers can keep waiting books in which the date and the exact time/hour of the examination or medical procedure are determined. In Slovenia, long waiting periods are the main source of dissatisfaction of the insured persons with the health care system. Waiting periods are mainly the result of increasing needs of the ageing population (in 2006, 16.2% of Slovene inhabitants were over 65 years old), reflecting in the form of increased needs for health care services, and in different individual cases they result from organisational, personnel and other difficulties that are reflecting in suboptimal utilization of the equipment, personnel and facilities. Due to the increased needs of the population, as from 1997 onwards, the HIIS has been allocating increasing amounts of funds for expansion of selected health care programmes with the view of shortening the waiting periods and introduction of new treatment methods. In 2006 alone, the HIIS provided additional funds for these types of purposes in the amount of EUR 61 million. Long-term investments of this type and increased performance of the health service providers have given concrete results in shortening of waiting periods, for example for open-heart surgeries (currently about 1.2 months), cataract surgery (currently about 3.3 months), computer tomography (currently about 1.7 months).

Being a key payer of health care services, the HIIS also takes great efforts to optimise the prices. For this purpose, the HIIS keeps establishing the platforms for more specified analytical monitoring of costs of health care services from the aspect of cost efficiency, effectiveness, accessibility and quality of the implementation of health care programmes. On this basis, the HIIS proposes changes in financing structure of the health care services to the service providers.

Thorough cooperation of the HIIS in the national project "Development of management of the health care system" which was conducted under the auspices of the Ministry of Health and other cooperating institutions and upon co-financing by the World Bank, a new accounting model was introduced in June 2004 in the area of acute hospital treatment, which represents a more rational platform for planning hospital health care activities. For this purpose, changes were implemented in the system of computer exchange of accounting documents between the health service providers and the HIIS and changes in software for recording and monitoring these documents at the HIIS. Numerous descriptions of clinical paths of the service providers for specialist outpatient and hospital activities have been drawn up. The objective of introduction of clinical paths lies in improvement of working processes in terms of optimisation of needs for personnel in certain fields of work, optimisation of used time, better care for patients, etc.

It has been 2 years now since the HIIS, as an initiator of the project for the long-term care insurance, prepared a detailed proposal for introduction of this type of insurance which was intended to govern the problematic area of long-term health care in a long-term and systematic fashion. Long-term care is one of the contact areas between the areas of social care and health care which is not governed in Slovenia in a manner comparable to the European arrangement. The proposal was forwarded to the Ministry of Health and the Ministry of Labour, Family and Social Affairs with the intention for preparation and adoption of corresponding legislation.

In the area of drug products and medical and technical aids, the HIIS managed to lower the prices of drugs and medical and technical aids through negotiations and on this basis, assure the insured persons the access to numerous new drug products and medical and technical aids in accordance with development of medicine and pharmacist sciences. Positive results are particularly detectable in the field of drugs, where the HIIS in addition to yearly negotiations on price decrease, in 2003 introduced the method of implementing the right to drug products on the basis of their interchangeability – the Slovene version of the reference drug price system. In 2005, a new drug products database was established, which became an indispensable register for the work of the pharmacies, the HIIS and the Institute of Public Health. Activities and efforts in the area of drug products were further supported with the implementation of the national project for promotion of safe and accurate use of drug products which, in 2006, was focused mainly on the implementation of an extensive media campaign and on mass publishing of printed materials for promotion of safe and accurate use of drug products on the side of the users of these products.

Image 14: The recognizable slogan and the logo of the project Use of drugs – Cautiously with drugs. Your health is at stake!

With the intention of thorough renovation of the information support to recording and control of performed health care services charged to the HIIS for the purposes of monitoring the costs according to individual providers, activities and insured persons, the HIIS will, presumably until spring 2009, continue implementing a special project in order to organise the specified data in a manner of a database and to establish pilot information solutions to support analysis of data on performed health care services in acute hospital treatment and on drugs on prescriptions.

In the last three years, the HIIS focused intense efforts in organisational reform and introduction of information support in the field of implementation of reimbursement claims in cases where the HIIS is able to implement the reimbursement of damage caused because of injuries inflicted to the insured persons in traffic accidents, workplace accidents, damages caused because of fighting, food poisoning, etc. Integral information support system was developed and introduced in order to help in implementation of operational process to obtain, collect and record of data on damage caused and to exercise the reimbursement of damages to which the HIIS is entitled. The imbedded control assures timely, accurate and harmonised data management on the caused damages thus providing a solid basis for efficient implementation of reimbursement claims within individual Regional Units and the HIIS as a whole.

11 Communication technologies

Information support represents a foundation for undisturbed operation of the HIIS. It is unimaginable for modern institutions such as the HIIS, to even think of the operation without the most efficient information support possible. The HIIS information system supports all business areas, the key areas as well as the support ones. Closed private computer network connects all HIIS locations, and its bandwidth supports undisturbed operation of computer client/server solutions, e-communication and office operation.

In 2000, the HIIS introduced a modern electronic health insurance card in Slovene health sector, which brought the insured persons faster and friendlier entry into the health system (identification of the patient and verifying validity of their compulsory and voluntary health insurance) while simultaneously it meant a new phase in development of modern and integral health information system in Slovenia. With the intention of modernisation and more transparent procedures of compulsory health insurance, in 2002 – 2006 period, several additional projects were implemented in this area which enabled new usages of the card: recording of the prescribed drugs, medical and technical aids and data about organ donorship to the card, as well as electronic ordering of documents for implementation of health services abroad through the network of nearly 300 electronic self-help terminals across Slovenia.

Special care is taken care of availability and safety of the network which is safe when operating with outside partners and also connected to the public network in only one point. Due to the mentioned reasons, the HIIS started to implement pilot project activities in this area with the intention to establish uninterrupted operation of the information system with the possibility of operating on a reserve location and a project of modernisation of the Health Insurance Card system, and introduction of an online system through which the card will become merely a key to access the data and will not be a carrier of the data on health insurance. The HIIS was lead to this decision by numerous operational and technical reasons, continuously striving for gradual transition towards direct access to data which are currently saved on the Card itself. Simple, quality and efficient transfer of data and communication within online health insurance system is one of the main development guidelines of the HIIS in the following two years, which the HIIS will try to realise by implementing two projects focused on the introduction of the online system and on development of the new Health Insurance Card, the Professional Card and the infrastructure of public keys. This will simplify the procedures of implementing rights arising from the health insurance for the insured persons, and the service providers will have more accurate and timely personal and medical data at their disposal, which will increase the quality of health care services, and enable rationalisation of operational costs for health insurance companies. In the last three years, the activities in the area of the Health Insurance Card have been marked by intense cooperation of the HIIS in international activities and projects of the European Union (the projects NETC@RDS and INCOHEALTH), in which it actively involves in preparation of platforms for the introduction of European Electronic Health Insurance Card.

Image 15: Graphic image of the new generation Health Insurance Card (above for the insured persons) and Professional Card (below for health workers) which will be introduced on a pilot basis by the HIIS in May 2008.

12 Contacts

Web Site: http.//www.zzzs.si

HIIS Directorate
Miklošičeva cesta 24, 1507 Ljubljana
Tel. + 386 01 30 77 200, Fax: + 386 01 23 12 182
E-mail: di@zzzs.si

HIIS, Functional Unit Information Centre
Miklošičeva cesta 24, 1507 Ljubljana
Tel. (01) 30 77 200, Fax: (01) 23 12 182
E-mail: peic@zzzs.si

HIIS, Celje Regional Unit
Gregorčičeva 5 a, 3000 Celje
Tel. (03) 42 02 000, Fax: (03) 54 82 301
E-mail: oece@zzzs.si

HIIS, Koper Regional Unit
Martinčev trg 2, 6000 Koper
Tel. (05) 66 87 200, Fax: (05) 66 87 372
E-mail: oekp@zzzs.si

HIIS, Kranj Regional Unit
Zlato polje 2, 4000 Kranj
Tel. (04) 23 70 100, Fax: (04) 23 70 180
E-mail: oekr@zzzs.si

HIIS, Krško Regional Unit
Bohoričeva 9, 8270 Krško
Tel. (07) 49 02 490, Fax: (07) 49 01 081
E-mail: oekk@zzzs.si

HIIS, Ljubljana Regional Unit
Miklošičeva cesta 24, 1507 Ljubljana
Tel. (01) 30 77 200, Fax: (01) 43 12 154
E-mail: oelj@zzzs.si

HIIS, Maribor Regional Unit
Sodna 15, 2000 Maribor
Tel. (02) 29 09 300, Fax: (02) 25 21 591
E-mail: oemb@zzzs.si

HIIS, Murska Sobota Regional Unit
Slovenska ul. 48, 9000 Murska Sobota
Tel. (09) 53 61 550, Fax: (09) 53 21 236
E-mail: oems@zzzs.si

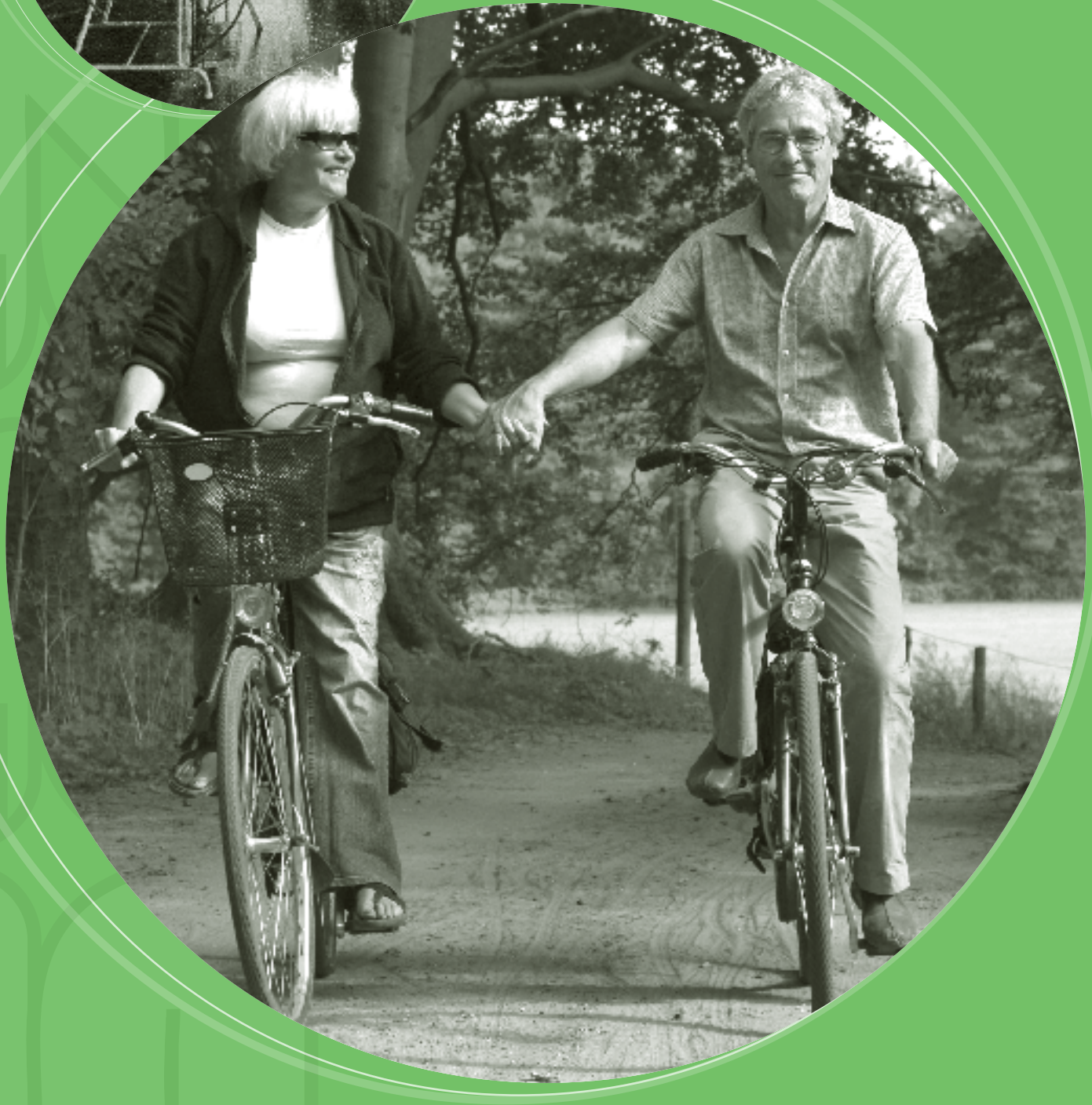
HIIS, Nova Gorica Regional Unit
Gradnikove brigade 1, 5000 Nova Gorica
Tel. (05) 33 81,000, Fax: (05) 30 28 379
E-mail: oeng@zzzs.si

HIIS, Novo mesto Regional Unit
Prešernov trg 7, 8000 Novo mesto
Tel. (07) 39 33 500, Fax: (07) 39 33 511
E-mail: oenm@zzzs.si

HIIS, Ravne na Koroškem Regional Unit
Ob Suhi 11 b, 2380 Ravne na Koroškem
Tel. (02) 82 10 100, Fax: (02) 82 10 260
E-mail: oerv@zzzs.si

13 Sources

1. Health Care and Health Insurance Act.
2. Rules of the compulsory health insurance.
3. Statute of the Health Insurance Institute of Slovenia.
4. Business Reports of the Health Insurance Institute of Slovenia, 1992-2006.
5. Health Statistics Annual. Institute for Public Health of Slovenia. Ljubljana, 1992 – 2004.
6. Statistical Office of the Republic of Slovenia.
7. Institute of macroeconomic analysis and Development of Slovenia.
8. Zupanič Slavec Zvonka, Healthy Seed - Abundant Crop: 110 Years of Health Insurance Among the Slovenian People. Ljubljana: Health Insurance Institute of Slovenia, 1999.



HEALTH INSURANCE INSTITUTE OF SLOVENIA
www.zzzs.si

OBVEZNO ZDRAVSTVENO ZAVAROVANJE V SLOVENIJI
DANES ZA JUTRI

ZAVOD ZA ZDRAVSTVENO ZAVAROVANJE SLOVENIJE
www.zzzs.si

Obvezno zdravstveno zavarovanje v Sloveniji – danes za jutri
Zavod za zdravstveno zavarovanje Slovenije (ZZZS)
24 Miklošičeva cesta, Ljubljana, Slovenija

Odgovorna oseba: generalni direktor Samo Fakin

Publikacijo je pripravil uredniški odbor v sestavi: Klemen Ganziti, Eva Godina Jalen, Sladjana Jelisavčić, Damjan Kos (urednik), Boris Kramberger, Vlasta Lavrih, Rosana Lemut Strle, Peter Pustatičnik, Janko Štok, Barbara Pišek.
Prevod: Alenka Drame, PSD prevajalske storitve d.o.o., ZZZS

Računalniško oblikovanje in prelom: Dejan Paska, Studio 3S d.o.o.

Publikacija je natisnjena v nakladi: 1000 izvodov

Tisk: Mond Grafika d.o.o.

CIP - Kataložni zapis o publikaciji
Narodna in univerzitetna knjižnica, Ljubljana

364.32(497.4)

OBVEZNO zdravstveno zavarovanje v Sloveniji : danes za jutri / [publikacijo je pripravil uredniški odbor v sestavi Klemen Ganzitti ... et al.]. - Ljubljana : Zavod za zdravstveno zavarovanje Slovenije = Health Insurance Institute of Slovenia, 2007

Vsebuje tudi angl. prevod, tiskan v obratni smeri: Compulsory health insurance in Slovenia : today for tomorrow / [translation Alenka Drame]

ISBN 978-961-6327-15-2
1. Ganzitti, Klemen 2. Compulsory health insurance in Slovenia

236146432

Kazalo

Beseda generalnega direktorja ZZZS 4
Osnovni podatki o Zavodu za zdravstveno zavarovanje Slovenije 7
1 Uvod 8
2 Financiranje zdravstvenega varstva v Sloveniji 11
2.1 Razvojni mejniki 11
2.2 Finančni viri za zdravstveno varstvo danes 13
3 Zavod za zdravstveno zavarovanje Slovenije 17
3.1 Poslanstvo in razvojna vizija 17
3.2 Upravljanje ZZZS - mehanizmi demokratičnega upravljanja 18
3.3 Organizacija - razvejana in dostopna organizacijska mreža 19
4 Vključevanje in pokritost prebivalstva z obveznim zdravstvenim zavarovanjem 23
4.1 Prebivalstvo 23
4.2 Zdravstveno stanje 24
4.3 Zavarovane osebe 26
5 Vrste in obseg pravic iz obveznega zdravstvenega zavarovanja 29
5.1 Pravice do zdravstvenih storitev 29
5.2 Pravice do denarnih dajatev 31
6 Postopek financiranja in razporejanja sredstev obveznega zdravstvenega zavarovanja 33
6.1 Financiranje obveznega zdravstvenega zavarovanja 33
6.2 Postopki načrtovanja in razporejanja sredstev obveznega zdravstvenega zavarovanja 34
6.3 Partnerska pogajanja in postopek sklepanja pogodb 35
6.4 Sistemi financiranja zdravstvenih storitev in obvladovanje stroškov 37
7 Poslovni rezultati ZZZS 41
7.1 Trendi v prihodkih 42
7.2 Trendi v odhodkih 43
8 Uresničevanje pravic iz obveznega zdravstvenega zavarovanja 45
8.1 Preskrbljenost z zdravstvenimi storitvami in dostopnost 45
8.2 Zdravila 48
8.3 Medicinsko–tehnični pripomočki 50
9 Izvajanje mednarodnih zdravstvenih zavarovanj in sodelovanje s tujino 53
9.1 Uveljavljanje zdravstvenih storitev v Republiki Sloveniji 53
9.2 Uveljavljanje zdravstvenih storitev v tujini 54
9.3 Napotitev na zdravljenje v tujino 55
9.4 Mednarodno sodelovanje 56
10 Razvojne aktivnosti na področju kakovosti in poslovne učinkovitosti zdravstvenega varstva 58
11 Komunikacijske tehnologije 60
12 Kontakti 62
13 Viri 63

Sledimo razvojnim potrebam sodobnega časa

Zavod za zdravstveno zavarovanje Slovenije (v nadaljevanju: ZZZS) že vse od svoje ustanovitve v letu 1992, ko smo v Sloveniji ponovno vzpostavili sistem zdravstvenega zavarovanja, uspešno sledi svojemu poslanstvu in skrbi za učinkovito zbiranje in razporejanje sredstev, namenjenih za izvedbo zdravstvenih in drugih programov, ter na tej podlagi v skladu z načeli solidarnosti, neprofitnosti in socialne pravičnosti omogoča zavarovanim osebam kakovostno uresničevanje pravic iz obveznega zdravstvenega zavarovanja ter ustrezno zdravstveno in socialno varnost v času bolezni ali poškodbe.

ZZZS je svoje obsežne naloge doslej izpolnjeval brez večjih težav in na kakovostni ravni. Obenem smo se ves čas zavedali pomena vlaganj v razvoj strokovnega znanja in novih storitev. Med drugimi smo v tem obdobju zaključili obsežne nacionalne projekte: sistemsko smo konsolidirali številne novosti na področju obveznega in prostovoljnega zdravstvenega zavarovanja, ustanovili smo Vzajemno zdravstveno zavarovalnico za prostovoljna zavarovanja z več kot milijon zavarovanci, vzpostavili pa smo tudi nacionalni sistem kartice zdravstvenega zavarovanja, ki je v slovensko zdravstvo vpeljal številne prednosti nove informacijske tehnologije. V obdobju 2003 – 2006 je ZZZS večino svojih aktivnosti usmeril v izvajanje gospodarnih ukrepov (cenovna politika na področju zdravil in medicinsko-tehničnih pripomočkov, obvladovanje zdravstvenega absentizma, optimiziranje uveljavljanja regresnih zahtevkov itd.) na podlagi katerih je saniral finančno poslovanje po tem, ko se je zaradi določenih odločitev na državni ravni (dvig plač zdravstvenih delavcev, uvedba davka na dodano vrednost itd.) v obdobju 2000 – 2004 zadolževal in posloval s primanjkljajem prihodkov nad odhodki. Finančna sanacija ni znižala obsega pravic temveč so bile le-te na določenih področjih tudi razširjene zlasti zaradi hitrega napredka medicine in farmacije. Zaradi aktualne problematike dolgih čakalnih dob na posamezne storitve pa je ZZZS od leta 1999 dalje vedno več dodatnih sredstev (zlasti zaradi ugodne

Samo Fakin, dr. med., generalni direktor Zavoda za zdravstveno zavarovanje Slovenije.

rasti bruto domačega proizvoda) namenjal za dodatne programe zdravstvenih storitev in za uvajanje novih sodobnih metod zdravljenja, rehabilitacije in preventive. ZZZS je v letu 2004 med prvimi v Evropski uniji uvedel evropsko kartico zdravstvenega zavarovanja, ki jo lahko zavarovane osebe naročajo tudi elektronsko preko interneta in samopostrežnih terminalov. Zelo aktivno sodeluje tudi v evropskih projektih za uvedbo elektronske evropske kartice zdravstvenega zavarovanja. Slovenski sistem kartice zdravstvenega zavarovanja je leta 2000, ko je bil uveden, omogočil slovenskemu zdravstvu številne administrativne poenostavitve (samodejno potrjevanje veljavnosti zavarovanja na elektronskih terminalih) in uvedbo številnih drugih novosti za kakovostno izvajanje storitev (zapis izdanih zdravil in medicinsko-tehničnih pripomočkov ter opredelitev za posmrtno darovanje organov na kartico). V letu 2006 je ZZZS pristopil k uvajanju t.i. on-line sistema (neposrednega dostopa do zavarovalniških in zdravstvenih podatkov) in nadgradnji slovenskega sistema kartice zdravstvenega zavarovanja, v katerem bo pametna kartica s čipom postala le še ključ do informatiziranih zbirk podatkov in ne več nosilec podatkov.

Zavod za zdravstveno zavarovanje Slovenije je danes vrhunsko usposobljen in tehnološko opremljen javni zavarovalni servis za izvajanje obveznega zdravstvenega zavarovanja in eden izmed temeljev socialne in zdravstvene varnosti v Sloveniji. Kot tak je povsem primerljiv s sorodnimi organizacijami in nosilci zdravstvenega zavarovanja, ki financirajo zdravstvo v evropskih državah s sorodnim socialnim modelom zdravstvenega zavarovanja. Danes lahko rečemo, da je ZZZS v razvojnem smislu upravičil namene, zaradi katerih je bil ustanovljen. S stabilno politiko, ki je omogočala nemoteno funkcioniranje zdravstvenega sistema, je bil ohranjen dokaj visok nivo dostopnosti do zdravstvenih storitev in celovit sistem pravic zavarovanih oseb. Slovenija je tako danes glede ravni, obsega in dostopnosti zdravstvenih storitev povsem primerljiva z zahodnoevropskimi državami, in to kljub temu, da po višini bruto domačega proizvoda na prebivalca v izhodišču še vedno zaostaja za državami EU-15.

Uspehi, ki smo jih dosegli v preteklih letih, pomenijo vzpodbudo za spoprijemanje z novimi izzivi v prihodnosti. Ključna naloga bo tudi v bodoče vsekakor zagotavljanje stabilnega finančnega poslovanja ZZZS. Pri tem pa bo potrebno storiti še korak naprej. ZZZS si bo prizadeval zagotoviti takšne pogoje, ki bodo omogočali tudi, da bo slovenski zdravstveni sistem lahko uspešno sledil številnim novim razvojnim potrebam sodobnega časa. Med osnovnimi razvojnimi izzivi je na prvem mestu posodobitev zdravstveno informacijskega sistema na nacionalni ravni, ki bo omogočala izboljšanje kakovosti, učinkovitosti in uspešnosti s pripravo ustreznih politik in standardov ter enotnega sistema upravljanja zdravstvenih informacij. Vlaganja v posodabljanje tega področja bodo imela tudi dolgoročne ekonomske učinke, ki bodo pomembni z vidika nacionalne ekonomije. Naši napori bodo usmerjeni tudi v aktivno reševanje razvojnih problemov obvladovanja izdatkov na način, ki je usklajen s smernicami Evropske unije ter v nadaljnji postopni razvoj

modelov financiranja izvajalcev zdravstvenih storitev. Posebni dolgoročni izziv ostajajo primerni sistemski odgovori na nove potrebe prebivalstva, ki izhajajo iz pojava t.i. staranja prebivalstva in ki sprožajo resne dileme z vidika dolgoročne finančne vzdržnosti sistema. V tem smislu predstavlja poseben izziv uvedba obveznega zavarovanja za dolgotrajno oskrbo, ki bi določenim bolnikom izboljšal dostop do zdravstvenih, socialnih in drugih storitev na domu. Dodaten izziv predstavljajo tudi prizadevanja za večjo kakovost zdravstvenih storitev in poslovno učinkovitost izvajalcev zdravstvenih storitev, ki vključuje zlasti prizadevanja za boljšo dostopnost do zdravstvenih storitev (skrajševanje čakalnih dob na zdravstvene storitve) ter optimalno izkoriščenost prostora, opreme in kadrov.

ZZZS je v vseh svojih strateških razvojnih dokumentih zapisal tudi usmeritev, da želi biti učinkovit, prijazen in strokoven servis vsem zavarovancem. Prepričan sem, da smo s predanostjo skupnim ciljem in s strokovnim delom sposobni sprejeti nove razvojne izzive in se uveljaviti v slovenskem in mednarodnem okolju kot odlična ustanova na področju javnega zdravstvenega zavarovanja.

Samo Fakin, dr. med.,
generalni direktor

Osnovni podatki o Zavodu za zdravstveno zavarovanje Slovenije

IME:

Zavod za zdravstveno zavarovanje Slovenije (ZZZS)

SEDEŽ:

Miklošičeva cesta 24, Ljubljana, Slovenija, Evropska unija

TELEFON:

01/30 77 200

MEDNARODNI KLICI:

00 386 01 30 77 200

TELEFAX:

01/23 12 182

INTERNET NASLOV:

http://www.zzzs.si

GENERALNI DIREKTOR:

Samo Fakin, dr. med.

PRAVNA OBLIKA:

Samostojna pravna oseba s statusom javnega zavoda, ki deluje enotno za območje Republike Slovenije

ORGANIZIRANOST:

ZZZS deluje na sedežu ZZZS (Direkcija in Področna enota Informacijski center) ter v 10 območnih enotah in 45 izpostavah po Sloveniji

TEMELJNA ZAKONSKA PODLAGA:

Zakon o zdravstvenem varstvu in zdravstvenem zavarovanju

OSNOVNA DEJAVNOST:

Izvajanje obveznega zdravstvenega zavarovanja

ORGANI UPRAVLJANJA:

Skupščina, Upravni odbor, generalni direktor, Območni sveti

POSLANSTVO:

Na osnovi javnih pooblastil je ZZZS edini nosilec in izvajalec obveznega zdravstvenega zavarovanja v Republiki Sloveniji. Zavarovanim osebam zagotavlja pravice do zdravstvenih storitev in denarnih dajatev po načelih solidarnosti, socialne pravičnosti in nepridobitnosti. S tem zagotavlja zavarovanim osebam zdravstveno in z njo povezano socialno varnost v primeru bolezni ali poškodbe.

1 Uvod

Slovenija je v dolgem in dinamičnem razvoju uspela oblikovati javni zdravstveni sistem, ki zagotavlja zelo celovito in kakovostno zdravstveno varstvo vsem prebivalcem. Ne glede na posamezna kritična mnenja je zdravstvo v očeh večine državljanov še vedno na visokem in uglednem mestu med vsemi javnimi službami, kar kažejo tudi določene domače in mednarodne primerjave. Podobno ljudje kot vrednoto doživljajo tudi javni sistem obveznega zdravstvenega zavarovanja, ki v največji meri financira sistem zdravstvenega varstva in ki ga kot edini nosilec izvaja Zavod za zdravstveno zavarovanje Slovenije (v nadaljevanju ZZZS) . V Sloveniji smo, podobno kot državljani drugih držav Evropske unije, ponosni na javni sistem obveznega zdravstvenega zavarovanja, ki temelji na načelih solidarnosti in ki na osnovi obveznih prispevkov nudi enake možnosti zdravljenja vsem ljudem takrat, ko ga potrebujejo.

Kakor v mnogih razvitih evropskih in svetovnih zdravstvenih sistemih se v zadnjem času tudi v Sloveniji soočamo z vse večjimi težavami pri zagotavljanju zadostnih finančnih virov, ki bi omogočali ne le nemoteno delovanje temveč tudi dovolj hiter razvoj zdravstvenega varstva. Največji izziv pri tem predstavljajo značilni demografski, socialno ekonomski, medicinski, farmacevtski, tehnološki in drugi trendi, ki vplivajo na skokovito rast izdatkov za zdravstvo. V Sloveniji smo tovrstne pritiske na rast izdatkov več let uspešno obvladovali z novostmi, ki jih je uveljavila zadnja obsežnejša zdravstvena reforma iz leta 1992. Predvsem gre za sistem doplačil oz. uvedbo prostovoljnega zdravstvenega zavarovanja, ki je v izdatnem deležu zagotovila v sistemu nova, zasebna sredstva.

Po letu 2000 pa smo se zaradi nekaterih novih finančnih bremen v sistemu (rast plač zdravstvenega osebja, uvedba davka na dodano vrednost, nove zakonske obveznosti idr.) v Sloveniji srečali z vse večjimi razkoraki med prihodki in odhodki, ki jih je ZZZS pokrival le na osnovi zadolževanja. Ob koncu leta 2004 je kumulativni dolg ZZZS znašal 119,5 milijonov evrov. Ta primanjkljaj bi lahko bil mnogo večji, če ne bi v tem času ZZZS uspešno izvedel posebnega programa ukrepov, ki je ob delni korekciji prispevne stopnje v letu 2002 omogočil postopno stabilizacijo poslovanja. Zato je bil ob sprejemu konvergenčnega programa države Slovenije za vstop v evro območje pričakovan in smiseln prevzem kumulativnega dolga s strani države, ki pa je hkrati zavezal ZZZS, da v naslednjem razvojnem obdobju ob nespremenjeni prispevni stopnji posluje uravnoteženo in brez zadolževanja. Ta cilj je ZZZS izpolnil tako v letu 2005 kot tudi v letu 2006 in 2007.

Pričujoča publikacija je posvečena predstavitvi poslanstva, razvojne vizije in temeljnih strateških ciljev ZZZS kakor tudi vsebine poslovanja ter osnovnih podatkov in gibanj v zadnjih letih pri izvajanju javnega sistema obveznega zdravstvenega zavarovanja v državi. Gradivo je namenjeno širši javnosti oz. vsem, ki se želijo podrobneje seznaniti z delovanjem sistema obveznega zdravstvenega zavarovanja oz. jih zanima področje financiranja zdravstvenega varstva. Prav tako želimo v času predsednikovanja Slovenije Evropski uniji z izdajo temeljito informirati mednarodno javnost in strokovnjake iz evropske družine narodov, ki si želijo bolje spoznati delovanje slovenskega sistema zdravstvenega zavarovanja. Publikacija pa bo zagotovo dobrodošla tudi številnim zavarovancem oz. bolnikom iz držav Evropske unije, ki bodo iskali informacije, kako v Sloveniji zagotavljamo zdravstvena varstvo v času njihovega morebitnega bivanja v naši državi.

2 Financiranje zdravstvenega varstva v Sloveniji

2.1 Razvojni mejniki

Zdravstveno zavarovanje ima v Sloveniji dolgo tradicijo. Že v začetku 19. stoletja so po zgledu takratnih blagajn, ki so temeljile na solidarnosti in vzajemnosti, delavci ustanovili več »bratovskih skladnic«. Leta 1889 je bila v Ljubljani, glavnem mestu Slovenije, ustanovljena prva bolniška blagajna, kateri so kmalu sledili še drugi podobni izvajalci obveznega zdravstvenega zavarovanja. Na začetku je bilo zdravstveno zavarovanje obvezno samo za delavce, ne pa tudi za druge skupine prebivalstva. Sčasoma se je zavarovanje postopno razširilo in je zajelo tudi druge skupine (vajenci, obrtniki itd. in leta 1973 končno tudi kmetje), ki je delovalo še dolgo po drugi svetovni vojni. V začetku, pa tudi kasneje, je prihajalo do različnih sprememb pri ureditvi zdravstvenega zavarovanja, spreminjali pa so se tudi ideološki pogledi na tem področju. Kljub omenjenim dejstvom je Slovenija ves čas ohranjala glavne značilnosti zdravstvenega zavarovanja, kot so financiranje iz prispevkov, hkratno prispevanje delodajalcev in delojemalcev, avtonomija in samouprava pri odločanju glede zdravstvenega zavarovanja ter mnoge druge.

Razlike med shemami zdravstvenega zavarovanja in zavarovanci so bile ukinjene leta 1972, ko so bile po referendumski odločitvi izenačene pravice vseh zavarovancev, različne zavarovalne sheme pa so bile poenotene v enotno shemo zdravstvenega zavarovanja. To je bil izraz najširše solidarnosti med prebivalstvom, ne glede na razlike v finančni zmožnosti, dejavnosti ali višini plačanega prispevka. Ob koncu 80. let prejšnjega stoletja je upravljanje sistema zdravstvenega varstva prešlo v izključno pristojnost države. Financiranje zdravstvenega varstva je postalo del integralnega državnega proračuna. Omenjena sprememba je ostala zapisana kot obdobje hude finančne nestabilnosti, kar je sprožilo »neposredne pobude« za sprejem novih zakonov leta 1992.

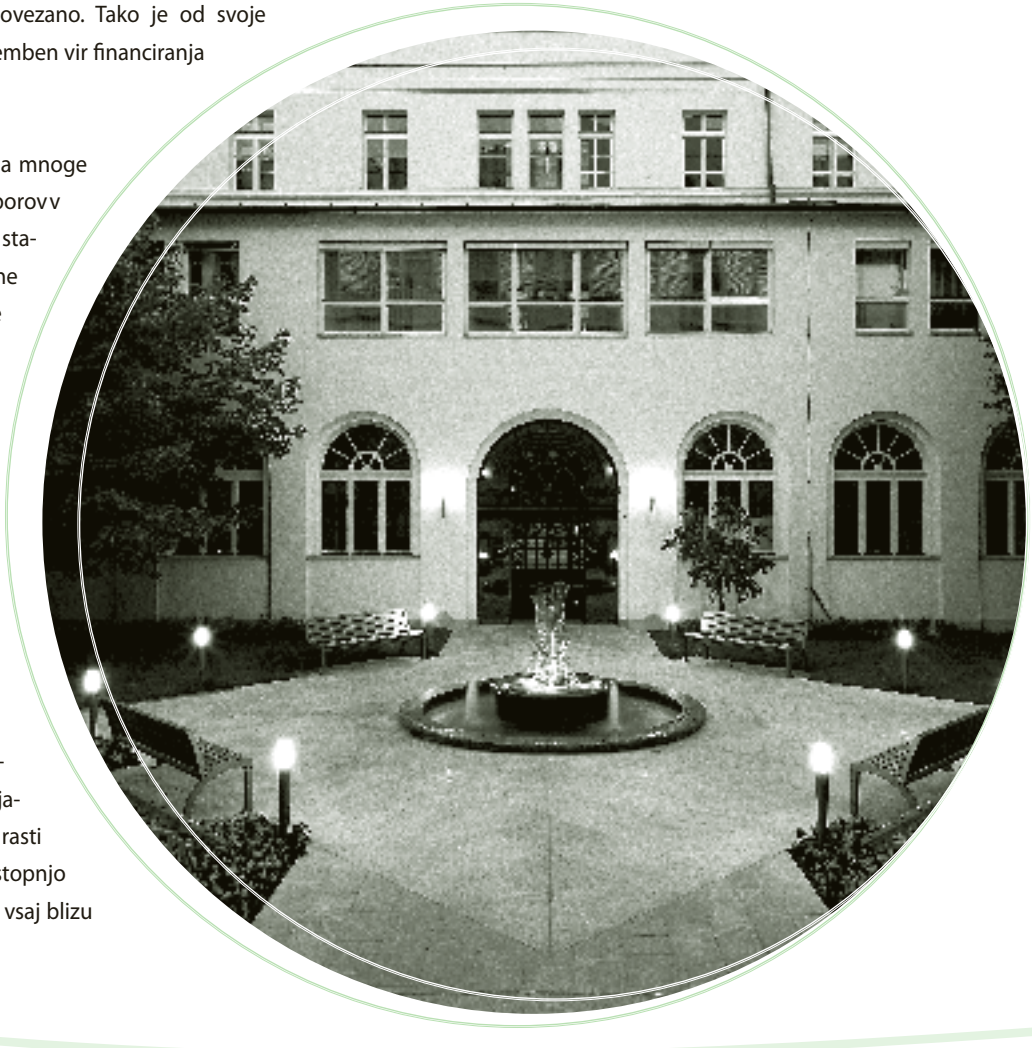
Zakonodaja, ki ureja področje zdravstvenega varstva, je bila dopolnjena leta 1992. Zakon o zdravstvenem varstvu in zdravstvenem zavarovanju (v nadaljevanju Zakon) je postavil podlago sedanjega sistema obveznega in prostovoljnega zdravstvenega zavarovanja, spodbudil proces privatizacije zdravstvenega sistema in natančno določil vloge ključnih partnerjev s tem, da je opravljanje nekaterih funkcij prenesel na nove organizacije.

Ključna značilnost Zakona je bila modernizacija sistema zdravstvenega varstva. Jedro reforme leta 1992 so predstavljala naslednja področja:

- strukturne spremembe pri financiranju: ponovna uvedba obveznega zdravstvenega zavarovanja in uvedba prostovoljnega zdravstvenega zavarovanja, s čimer naj bi v financiranju zdravstvenega varstva pridobili javna in (nova) zasebna sredstva (mešani javno-zasebni model financiranja zdravstvenega varstva);
- strukturne spremembe pri izvajanju zdravstvenih storitev: delna privatizacija izvajalcev zdravstvenih storitev znotraj mreže javne zdravstvene službe (mešani javno-zasebni model izvajanja zdravstvenih storitev);
- prosta izbira zdravnika in »sistem vratarja« na primarni ravni zdravstvenih storitev;
- nove vloge in partnerji (poklicne zbornice, nov model partnerstva in sklepanja pogodb).

Osrednji področji modernizacije sistema sta bili organizacija in financiranje. Prvi velik strateški premik na področju financiranja je bila ponovna vzpostavitev sistema zdravstvenega zavarovanja. Drugi je bila uvedba prostovoljnega zdravstvenega zavarovanja, kar je bila verjetno največja novost reforme in je predstavljala povsem nov koncept. Tako je obvezno zdravstveno zavarovanje v Sloveniji pričel izvajati Zavod za zdravstveno zavarovanje Slovenije (v nadaljevanju ZZZS), ki je edini izvajalec obveznega zdravstvenega zavarovanja v državi. Prostovoljno zdravstveno zavarovanje pa danes izvajajo konkurenčne vzajemne ali komercialne zavarovalnice.

Koncept prostovoljnega zdravstvenega zavarovanja v Sloveniji temelji na strategiji delitve stroškov in sozavarovanja. Sistem obveznega zdravstvenega zavarovanja načeloma omogoča, da so zavarovane osebe deležne potrebnih zdravstvenih storitev, vendar samo v določenem okviru oziroma v obsegu, katerega kritje je določeno z Zakonom. Nekatere (socialno in/ali zdravstveno) ogrožene skupine prebivalstva imajo z obveznim zdravstvenim zavarovanjem plačane vse zdravstvene storitve v celoti, enako velja tudi za zdravljenje nekaterih bolezni, ki jih natančneje določa Zakon. Za vse ostale storitve mora večina zavarovanih oseb plačati določen odstotni delež celotne vrednosti storitve ali pa skleniti prostovoljno zdravstveno zavarovanje, ki krije tveganja za tovrstna doplačila. Takšno prostovoljno zdravstveno zavarovanje v Sloveniji torej dopolnjuje sistem obveznega zdravstvenega zavarovanja in je z njim tesno povezano. Tako je od svoje uvedbe leta 1993 le-ta postal pomemben vir financiranja zdravstvenega varstva v Sloveniji.



Omenjena modernizacija je prinesla mnoge rezultate. Vloženih je bilo mnogo naporov v povečanje učinkovitosti in finančne stabilnosti sistema. Če na učinke reforme gledamo z današnjega stališča, je bila, splošno gledano, uspešna. Glavne dosežke reforme najpogosteje pripisujemo finančni in splošni vzdržnosti sistema. Najpomembnejši učinek je bilo izboljšanje strukture virov, kar je ves čas predstavljalo osnovo za stabilno financiranje programov zdravstvenega varstva v državi. Mešana struktura javnih in zasebnih virov financiranja je pomenila uresničenje strateških ciljev, h katerim je leta 1992 stremel zakonodajalec, namreč nadaljnje povečevanje rasti deleža javnih sredstev skladno s stopnjo rasti bruto domačega proizvoda ali vsaj blizu te stopnje.

2.2 Finančni viri za zdravstveno varstvo danes

Sistem zdravstvenega varstva v Sloveniji temelji na socialnem zdravstvenem zavarovanju, upoštevajoč načelo solidarnosti, neprofitnosti in socialne pravičnosti. Obvezno zdravstveno zavarovanje je glavni vir financiranja zdravstvenega varstva, vendar pa se je v Sloveniji po uvedbi mešanega javno-zasebnega modela financiranja razvila bolj pestra sestava virov za financiranje zdravstvenega varstva. Pretežni del sredstev, namenjenih zdravstvu, se v Sloveniji podobno kot v ostalih evropskih državah zagotavlja iz javnih virov – po ocenah predstavljajo javni viri v letu 2006 79,7% vseh sredstev, od tega predstavljajo sredstva obveznega zdravstvenega zavarovanja oz. ZZZS 74,9%. Preostali javni izdatki se zagotavljajo iz sredstev občinskih in državnih proračunov (4,8%). Pomemben delež izdatkov za zdravstveno varstvo pa predstavljajo tudi zasebna sredstva (20,3% vseh izdatkov v letu 2006). Večji del zasebnih sredstev prispevajo zavarovalnice s prostovoljnimi zdravstvenimi zavarovanji (Adriatic Slovenica d.d., Triglav, zdravstvena zavarovalnica, d.d., Vzajemna zdravstvena zavarovalnica d.v.z.), ki so s plačevanjem škodnih primerov v letu 2006 na primer pokrile skupno za okoli 12,3% vseh izdatkov. Večino teh sredstev gre na račun dopolnilnih zdravstvenih zavarovanj, s katerimi se pokrivajo tveganja doplačil do polne vrednosti zdravstvenih storitev, ki jih obvezno zdravstveno zavarovanje ne krije v celoti. Drugi zasebni odhodki (8,0%) pa so ocena izdatkov, ki jih za različno blago in zdravstvene storitve ljudje v Sloveniji plačajo neposredno iz lastnega žepa. Sredstva iz javnih virov tako predstavljajo štiri petine, zasebna sredstva pa eno petino vseh sredstev za zdravstveno varstvo v Sloveniji.

V letu 2006 je Slovenija namenila približno 8,35% bruto domačega proizvoda (približno 1.925 ameriških dolarjev na prebivalca preračunano po metodi PPP – poraba po kupni moči), pri čemer zgoraj opisana javna sredstva predstavljajo 6,66% BDP, ostalo (1,69% BDP) pa predstavljajo zasebna sredstva, zbrana večinoma iz prostovoljnih zdravstvenih zavarovanj (1,03% BDP). V preteklih petnajstih letih je Slovenija sistemu zdravstvenega varstva namenila delež skupnega BDP v razponu od 7,2% (v letu 1992) do 8,35% (v letu 2006). Delež javnih sredstev smo vzdrževali v obsegu pod 7% BDP (7,22% leta 1992 in 6,66% leta 2006), razliko pa so pokrivala sredstva iz prostovoljnega zdravstvenega zavarovanja in neposredna plačila (glej tabelo 1).

Preračun v tekoče cene v evre kaže, da smo leta 2006 v Sloveniji namenili za zdravstveno varstvo 1.228 evrov na prebivalca, od tega iz javnih financ okrog 979 evrov, iz zasebnih sredstev pa 249 evrov. Preračun odhodkov ZZZS na zavarovano osebo pa kaže, da smo v letu 2006 namenili za obvezno zdravstveno zavarovanje 928 evrov na zavarovano osebo.

Tabela 1 prikazuje podatke o javnih in zasebnih izdatkih za zdravstveno varstvo v Sloveniji v obdobju zadnjih desetih let za različne zdravstvene storitve in namene, ki so opredeljeni s slovensko zdravstveno zakonodajo. Zaradi zgodovinskega razvoja in vrste razlik med evropskimi (javnimi) zdravstvenimi sistemi pa je potrebno biti pri primerjanju z državami Evropske unije glede javnih in zasebnih izdatkov, ki se namenjajo zdravstvenemu varstvu

previden, saj imajo vse države določene posebnosti v sistemih. V Sloveniji so posebnost predvsem izdatki obveznega zdravstvenega zavarovanja za denarne dajatve. V zadnjih letih se za primerjanje držav uporablja enotna OECD metodologija »nacionalnih zdravstvenih računov (NZR)«, ki naj bi izničila vpliv posebnosti posameznih sistemov. V Sloveniji smo testno prvič izvedli izračune po metodologiji NZR v letu 2006. V tabeli 1 so podatki po metodologiji NZR za leti 2001 in 2006 prikazani v oklepajih. Na osnovi metodologije NZR so iz sredstev obveznega zdravstvenega zavarovanja za ti leti izvzete denarne dajatve, v javne izdatke za zdravstveno varstvo pa je vključen dodatek za pomoč in postrežbo Zavoda za pokojninsko in invalidsko zavarovanje Slovenije, ki ga po OECD metodologiji uvrščajo med izdatke za dolgotrajno oskrbo.

Po podatkih OECD za leto 2004 se Slovenija lahko po deležu vseh izdatkov in deležu javnih izdatkov za zdravstveno varstvo primerja z ostalimi državami Evropske unije in je rahlo pod izračunanim povprečjem za deleže vseh sredstev ter malce nad povprečjem za deleže iz javnih sredstev za zdravstvo, pri čemer OECD podatki ne zajemajo Litve, Latvije, Estonije in še nekaterih drugih držav, ki so postale polnopravne članice Evropske unije v zadnjih letih (slika 1).

Tabela 1: Javni in zasebni viri financiranja zdravstvenega varstva v Sloveniji, 1996–2006.

	1996		2001****		2006****	
	v milijonih EUR	% BDP	v milijonih EUR	% BDP	v milijonih EUR	% BDP
Javni izdatki	**731,72**	**6,88**	**1.359,08 (1.271,24)**	**7,13 (6,44)**	**1.960,86 (1.845,89)**	**6,66 (6,27)**
Obvezno zdravstveno zavarovanje	704,81	6,62	1.307,88 (1.176,68)	6,86 (6,18)	1.843,35 (1.663,66)	6,26 (5,65)
(Denarne dajatve za dolgotrajno oskrbo)	ni podatka	ni podatka	(43,36)	(0,23)	(64,72)	(0,22)
Državni proračun	19,86	0,19	37,22	0,2	92,1	0,31
Občinski proračuni	7,05	0,07	13,98	0,07	25,41	0,09
Zasebni izdatki	**89,09**	**0,84**	**369,3**	**1,94**	**498,92**	**1,69**
Prostovoljno zdravstveno zavarovanje*	89,09	0,84	216,87	1,14	302,2	1,03
Neposredna plačila**	ni podatka	ni podatka	152,44	0,80	196,71	0,67
Skupaj	**820,81**	**7,71**	**1.728,38 (1.640,54)**	**9,07 (8,61)**	**2.459,77 (2.344,81)**	**8,35 (7,96)**
BDP***	10.652,10		19.054,37		29.440,83	

Opomba: (1) Podatki pred vstopom Slovenije v evropsko monetarno unijo 1.1.2007 so preračunani iz slovenskega tolarja (SIT) z uporabo nepreklicnega menjalnega razmerja (1 EUR = 239,64 SIT) v evro (EUR). Ta prikaz omogoča primerjavo v državi skozi čas in zagotavlja ohranitev kazalcev razvoja (stopnje rasti).

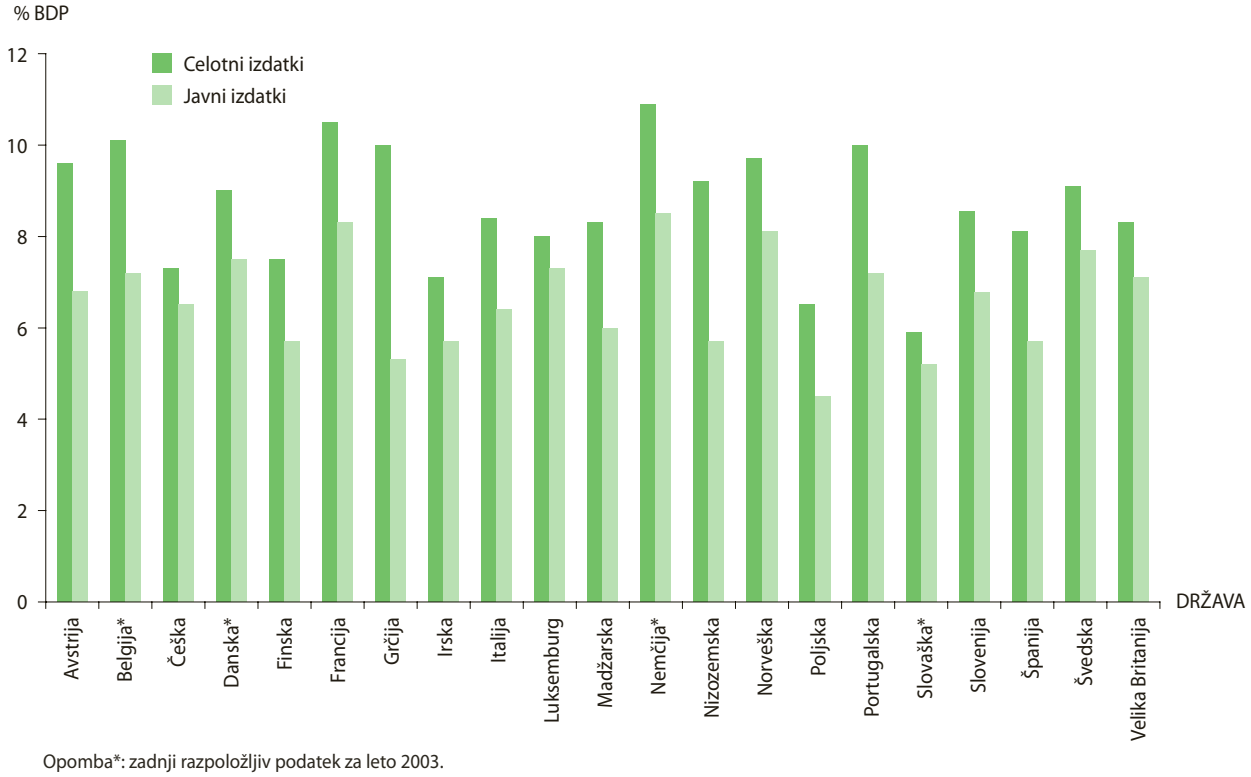
* Podatki od leta 2001 naprej vključujejo oceno sredstev za prostovoljno zdravstveno zavarovanje vseh slovenskih zavarovalnic, ki izvajajo tovrstno zavarovanje: Adriatic d.d. oz. Adriatic Slovenica d.d. in Vzajemna d.v.z., v letu 2006 še Triglav, zdravstvena zavarovalnica, d.d.; leto 1996 vsebuje le izdatke ZZZS za prostovoljno zdravstveno zavarovanje, brez podatkov za Adriatic d.d.

** Podatki so ocena, ki je bila opravljena na podlagi ankete o porabi denarnih sredstev gospodinjstev v letu 2003.

*** Podatek za BDP za leto 2006 je ocena Urada RS za makroekonomske analize in razvoj, Ekonomsko ogledalo, december 2006, zato so vsi izračunani deleži v BDP za leto 2006 ocene.

**** V oklepajih so prikazani podatki po OECD metodologiji nacionalnih zdravstvenih računov , ki omogočajo objektivnejšo primerjavo z drugimi državami, saj se s tem izničijo vplivi posebnosti posameznih sistemov.

Slika 1: Delež javnih in zasebnih sredstev za zdravstveno varstvo (v % BDP) v izbranih državah Evropske unije, 2004.



Opomba*: zadnji razpoložljiv podatek za leto 2003.
Vir: OECD Health Data 2006

3 Zavod za zdravstveno zavarovanje Slovenije

3.1 Poslanstvo in razvojna vizija

Poslanstvo ZZZS izhaja iz javnih pooblastil, pristojnosti in odgovornosti, ki mu jih je z zakonom opredelila država. ZZZS je bil ustanovljen 1. marca 1992 in je na podlagi zakona edini nosilec in izvajalec obveznega zdravstvenega zavarovanja v državi. V letih od 1992 do 1999 je na osnovi zakonske obveze izvajal tudi prostovoljno zdravstveno zavarovanje, ki pa ga je nato zaradi spremembe zakona prenesel na novo ustanovljeno samostojno vzajemno družbo oz. zavarovalnico.

ZZZS izvaja obvezno zdravstveno zavarovanje v državi na način, ki izhaja iz modela socialnih zavarovanj in ki predpostavlja določeno avtonomijo pri upravljanju z zbranimi sredstvi obveznega zdravstvenega zavarovanja. To narekuje organom upravljanja in strokovni službi ZZZS odgovorno uveljavljanje z zakonom predvidenih in drugih strateških mehanizmov za učinkovito zbiranje in razporejanje finančnih virov, ki se namenjajo pokrivanju zdravstvenih in drugih tveganj zavarovanih oseb. Posebej pomembno pri tem je preverjanje in uresničevanje temeljnih načel, kot so solidarnost, socialna pravičnost, dostopnost, kakovost in učinkovitost pri zagotavljanju zdravstvene varnosti prebivalstvu. Zato sta poleg upravljanja s finančnimi viri strateškega pomena tudi področji uresničevanja pravic in urejanja odnosov z izvajalci zdravstvenih storitev. Pravice iz obveznega zdravstvenega zavarovanja so opredeljene v zakonu, o podrobnejšem obsegu pravic in postopkih, standardih in drugih vidikih izvajanja sistema pravic pa v soglasju z državo oz. na osnovi zakonskih pooblastil odločajo tudi organi upravljanja ZZZS. ZZZS zastopa interese zavarovanih oseb, delodajalcev in drugih plačnikov prispevkov v obveznem zdravstvenem zavarovanju tudi pri t.i. partnerskih pogajanjih oz. procesih sklepanja pogodb z izvajalci zdravstvenih storitev.

Zaradi opisanih vidikov uresničevanja načela avtonomnosti pri upravljanja sistema obveznega zdravstvenega zavarovanja ZZZS že dlje časa posveča veliko pozornost procesom strateškega načrtovanja in odločanja. Sistem dolgoročnega in letnega načrtovanja na ZZZS temelji na metodi strateškega managementa in uravnoteženih kazalnikov uspešnosti poslovanja. Trenutno je v pripravi že četrti strateški razvojni program ZZZS, in sicer za razvojno obdobje 2008-2013. V tem obdobju je za razvojno vizijo ZZZS ključnega pomena skrbno in učinkovito upravljanje s sredstvi obveznega zdravstvenega zavarovanja, saj bo v naslednjem obdobju ob vseh znanih razvojnih trendih (staranje prebivalstva, hiter razvoj zdravstvenih tehnologij, večja zahtevnost prebivalstva, idr.) potrebno zagotoviti uravnoteženo poslovanje brez sprememb prispevne stopnje. Svojo odgovornost do zavarovancev in drugih plačnikov prispevkov za obvezno zdravstveno zavarovanje pa bo ZZZS uresničeval predvsem z ukrepi za boljšo dostopnost in kakovost zdravstvenih programov. Pri tem bo posebej pomemben nadaljnji razvoj informacijskega sistema v smeri t.i. ON-LINE elektronskega poslovanja, ki bo omogočalo spremljanje stroškov sistema in izbranih parametrov kakovosti izvajanja zdravstvenih programov na makro in mikro ravneh sistema, kar bo predstavljalo nov korak k izboljšanju delovanja celotnega sistema. Z nadaljnjim širjenjem elektronskih storitev zdravstvenega zavarovanja pa bo ZZZS približal in poenostavil tudi vse svoje storitve za zavarovane osebe in druge stranke ter tako postal še bolj prepoznavna odlična javna služba na nacionalni in mednarodni ravni.

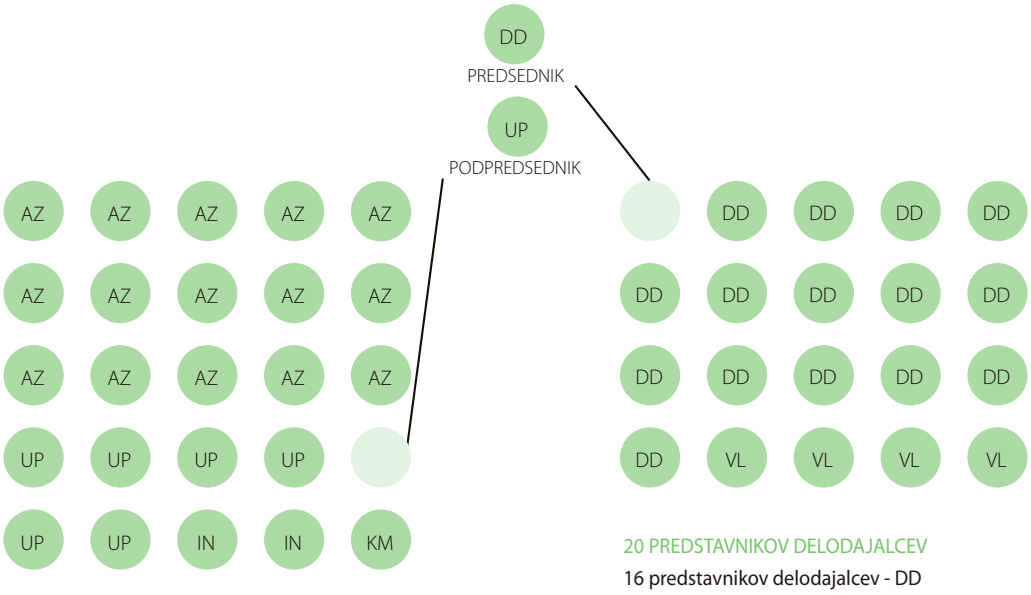
3.2 Upravljanje ZZZS - mehanizmi demokratičnega upravljanja

ZZZS upravlja Skupščina, ki jo sestavljajo demokratično izvoljeni predstavniki delodajalcev (med katerimi so tudi predstavniki Vlade Republike Slovenije) in zavarovancev (slika 2). Najpomembnejše naloge Skupščine ZZZS so:

- sprejemanje statuta ZZZS in drugih splošnih aktov za uresničevanje obveznega zdravstvenega zavarovanja;
- določanje finančnega načrta, sprejem zaključnega računa ZZZS in odločanje o razporeditvi presežkov prihodkov nad odhodki;
- določanje podrobnejšega obsega pravic do zdravstvenih storitev, standardov in normativov izvajanja obveznega zdravstvenega zavarovanja;
- določanje smernic in izhodišč za pogajanja s partnerji v zdravstvu, in sicer za izvajanje programov, oblikovanje cen storitev in drugih podlag za sklepanje pogodb z izvajalci zdravstvenih storitev;
- druge strateško pomembne naloge.

Izvršna organa Skupščine sta Upravni odbor ZZZS in generalni direktor ZZZS. Pomemben organ upravljanja na regionalni ravni pa so tudi območni sveti, ki so vzpostavljeni na vseh 10 območnih enotah ZZZS. Skupščina, Upravni odbor in generalni direktor v skladu z zakonom, statutom in drugimi pravnimi podlagami sprejemajo odločitve samostojno, pri drugih pa

Slika 2: Shematični prikaz sestave skupščine ZZZS.



25 PREDSTAVNIKOV ZAVAROVANCEV
15 predstavnikov aktivnih zavarovancev - AZ
7 predstavnikov upokojencev - UP
2 predstavnika invalidov - IN
1 predstavnik kmetov - KM

20 PREDSTAVNIKOV DELODAJALCEV
16 predstavnikov delodajalcev - DD
4 predstavniki vlade Republike Slovenije – VL

morajo pridobiti soglasje Državnega zbora, Vlade ali Ministrstva za zdravje. Tako na primer Skupščina ne more sama spreminjati višine prispevne stopnje za obvezno zdravstveno zavarovanje, temveč lahko to zgolj predlaga Državnemu zboru. Prav tako mora Skupščina pridobiti soglasje Vlade za statut ZZZS in za finančni načrt ZZZS, soglasje ministra za zdravje na spremembe Pravil obveznega zdravstvenega zavarovanja (splošni akt ZZZS, s katerim se na podlagi zakona podrobneje določa obseg, standard in postopki uresničevanja pravic iz obveznega zdravstvenega zavarovanja) kot tudi soglasje Državnega zbora k imenovanju generalnega direktorja ZZZS za mandat 4 let. Finančno poslovanje ZZZS po zakonu nadzorujejo Računsko sodišče, Proračunska inšpekcija in Komisija Državnega zbora RS za nadzor proračuna in drugih javnih financ. Poleg tega pa v okviru ZZZS deluje tudi sektor za notranje revidiranje.

3.3 Organizacija - razvejana in dostopna organizacijska mreža

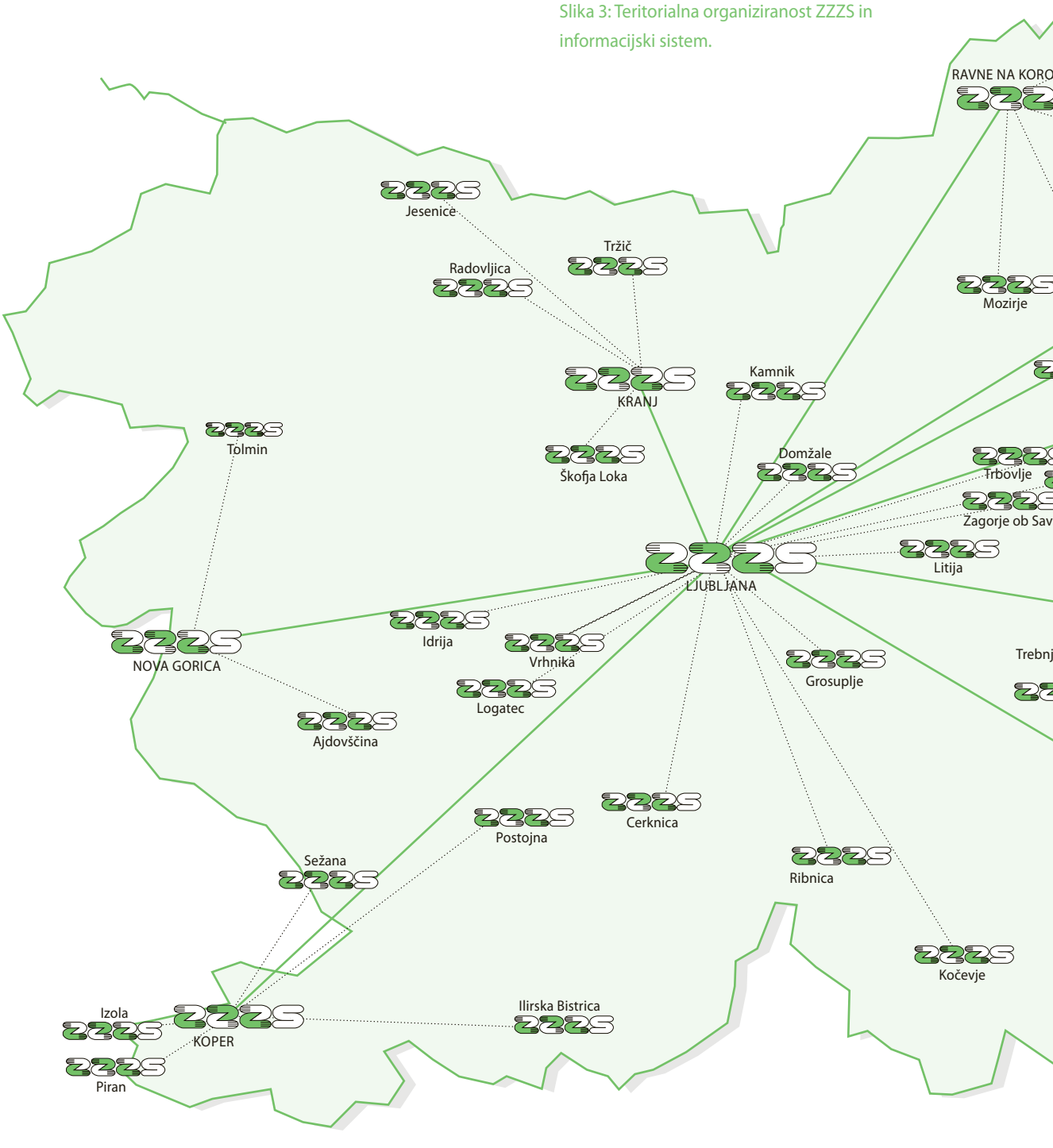
ZZZS je organiziran na decentraliziran način in posluje preko 10 območnih enot s 45 izpostavami (ekspoziturami), direkcije ter samostojne področne enote za informacijski sistem. V letu 2006 je ZZZS zaposloval 929 oseb, iz česar izhaja, da vsak zaposleni na ZZZS obravnava približno 2.135 zavarovancev. Povprečno število izpostav na posamezno območno enoto je 4,5 – z največjim številom (13) v ljubljanski in najmanjšim (2) v območnih enotah Krško in Nova Gorica.

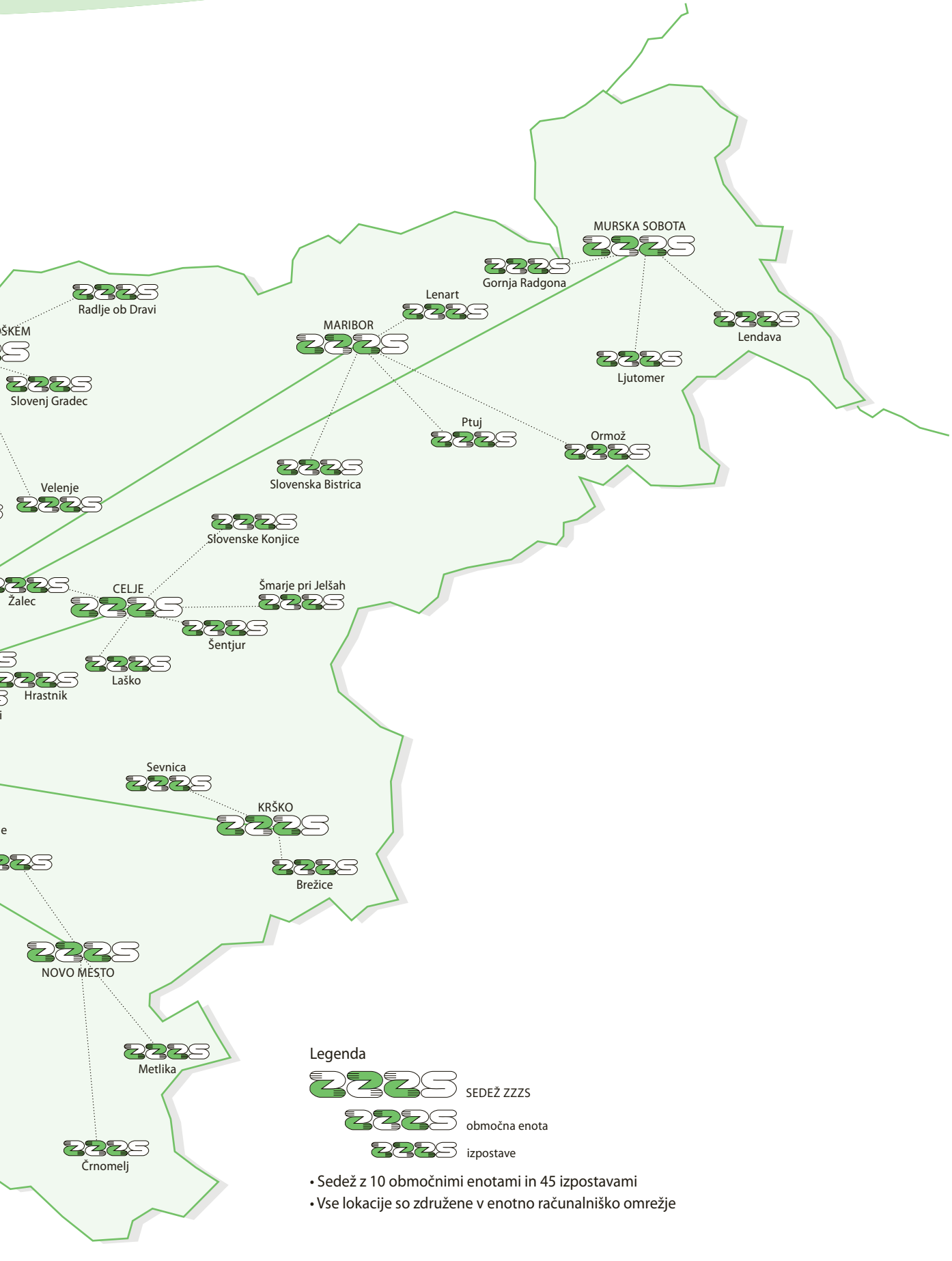
Zaradi izjemne zahtevnosti poslovanja, razvejane organizacijske strukture, velikega obsega sredstev, ki ga upravlja, in velikega števila poslovnih partnerjev je izoblikovanje lastne poslovne strategije vsekakor eden glavnih dosežkov ZZZS. Zaposleni na ZZZS smo za izvedbo te naloge izbrali pristop strateškega projektnega načrtovanja in uporabili posebno metodologijo postavljanja prednostnih poslovnih ciljev in zahtev informacijske tehnologije pri izvedbi omenjenih ciljev ter pri sprejemanju odločitev.

Za izvajanje obveznega zdravstvenega zavarovanja in za nemoteno izvajanje svojih finančnih in nadzornih nalog potrebuje ZZZS urejene in sprotno posodobljene zbirke podatkov, predvsem o zavarovanih osebah, izvajalcih zdravstvenih storitev, zavezancih za prispevek, porabljenih zdravilih, odsotnostih z dela, izvedenih zdravstvenih storitvah itd. Ker omenjene zbirke podatkov vsebujejo izjemne količine podatkov, je bil razvit kompleksen informacijski sistem.

V primerjavi s podobnimi izvajalci socialnega in zdravstvenega zavarovanja so v državah Evropske Unije sredstva, namenjena izvajanju obveznega zdravstvenega zavarovanja v Sloveniji, dokaj nizka: v letu 2006 so na primer znašala približno 2,4 % vseh odhodkov. ZZZS si prizadeva povečati notranjo in zunanjo učinkovitost tudi s pomočjo projektnega vodenja, z nadzorom nad izvajanjem zdravstvenih storitev in obsega izvedenega dela ter z izvajanjem dogovorjenih nalog glede na njihovo strukturo in obremenjenost zaposlenih.

Slika 3: Teritorialna organiziranost ZZZS in informacijski sistem.





Legenda

ZZZS SEDEŽ ZZZS

ZZZS območna enota

ZZZS izpostave

- Sedež z 10 območnimi enotami in 45 izpostavami
- Vse lokacije so združene v enotno računalniško omrežje

4 Vključevanje in pokritost prebivalstva z obveznim zdravstvenim zavarovanjem

4.1 Prebivalstvo

Po podatkih iz Statističnega letopisa Slovenije za leto 2006 je bilo konec leta 2005 v Sloveniji 2.003.358 prebivalcev. Prebivalstvo sestavljajo državljani Republike Slovenije s prijavljenim stalnim prebivališčem v Sloveniji, tujci z izdanim dovoljenjem za stalno ali začasno prebivanje oziroma z veljavnim delovnim ali poslovnim vizumom, ki imajo v Republiki Sloveniji prijavljeno prebivališče in osebe, ki jim je bila po zakonu o azilu priznana pravica do azila in status begunca v Republiki Sloveniji. Skupno število prebivalcev Slovenije se je v primerjavi s predhodnim letom nekoliko povečalo in je po dolgem času preseglo mejo dveh milijonov, kar je predvsem posledica priseljevanja tujcev. V letu 2005 se je v Slovenijo priselilo okrog 15.000 tujcev, večina od njih iz držav bivše Jugoslavije in Evropske unije. Gre predvsem za delovno migracijo, kjer prevladujejo moški.

Najznačilnejša demografska pojava v Sloveniji sta negativni naravni prirastek in staranje prebivalstva. Takšni gibanji predstavljata neposredno grožnjo za dolgoročno finančno vzdržnost javnega zdravstvenega sistema, saj manjšanje aktivne populacije poslabšuje prihodkovne možnosti, staranje prebivalstva pa krepi pritiske na rast zdravstvenih in drugih izdatkov javnega sistema obveznega zdravstvenega zavarovanja. Danes v Sloveniji vsak aktiven zavarovanec vzdržuje 1,5 neaktivnih zavarovanih oseb, kar pomeni veliko obremenitev aktivne populacije pri vzdrževanju ravni socialne oziroma zdravstvene varnosti.

Demografske projekcije kažejo, da se bo trend staranja slovenskega prebivalstva nadaljeval. Po osnovni varianti teh projekcij bo število prebivalstva Slovenije naraslo iz sedanjih 1,99 milijona na skoraj 2,02 milijona do leta 2014, nato pa počasi, a vztrajno upadalo in se znižalo na 1,89 milijona do leta 2050. Tak razvoj bo posledica stalnega povečevanja pričakovanega trajanja življenja ob rojstvu, nizke rodnosti in migracij prebivalstva. Po pričakovanem trajanju življenja ob rojstvu in po pričakovanem trajanju življenja brez bolezenskih obremenitev so bile npr. ženske v Sloveniji v letu 2004 primerljive z ženskami v Veliki Britaniji in na Nizozemskem ter na boljšem kot npr. ženske na Irskem, Danskem in Portugalskem. Na drugi strani pa so imeli moški v Sloveniji eno najnižjih pričakovanih trajanj življenja (ob rojstvu in brez bolezenskih obremenitev). Slabše kazalce so zabeležili samo Madžari, Čehi, Slovaki in Poljaki. Delež žensk v celotni slovenski populaciji se ni spremenil (51,1 %) in je primerljiv z nekaterimi severnimi evropskimi državami npr. Velika Britanija, Nemčija in Finska, moških pa je bilo 48,9 %. Izbrani demografski podatki, pomembni za opis zdravstvenega stanja prebivalstva v Sloveniji, so razvidni iz tabele 2.

Tabela 2: Izbrani demografski kazalci v Sloveniji med leti 1992 in 2004.

	1992	1996	2000	2004
Rodnost (št. rojstev na 1000 prebivalcev)	10	9,5	9,1	9,0
Splošna umrljivost (št. umrlih na 1000 prebivalcev)	9,7	9,4	9,3	9,3
Naravni prirastek	0,3	0,1	-0,2	-0,3
Umrljivost dojenčkov (št. umrlih na 1000 prebivalcev)	8,86	4,7	4,9	3,7
Pričakovano trajanje življenja ob rojstvu - moški	69,45	70,79	71,94	73,4
Pričakovano trajanje življenja ob rojstvu - ženske	77,25	78,25	79,1	81,0

Viri: Inštitut za varovanje zdravja Republike Slovenije. Zdravstveni statistični letopis. Ljubljana, IVZ: 1993, 1997, 2001, 2005.

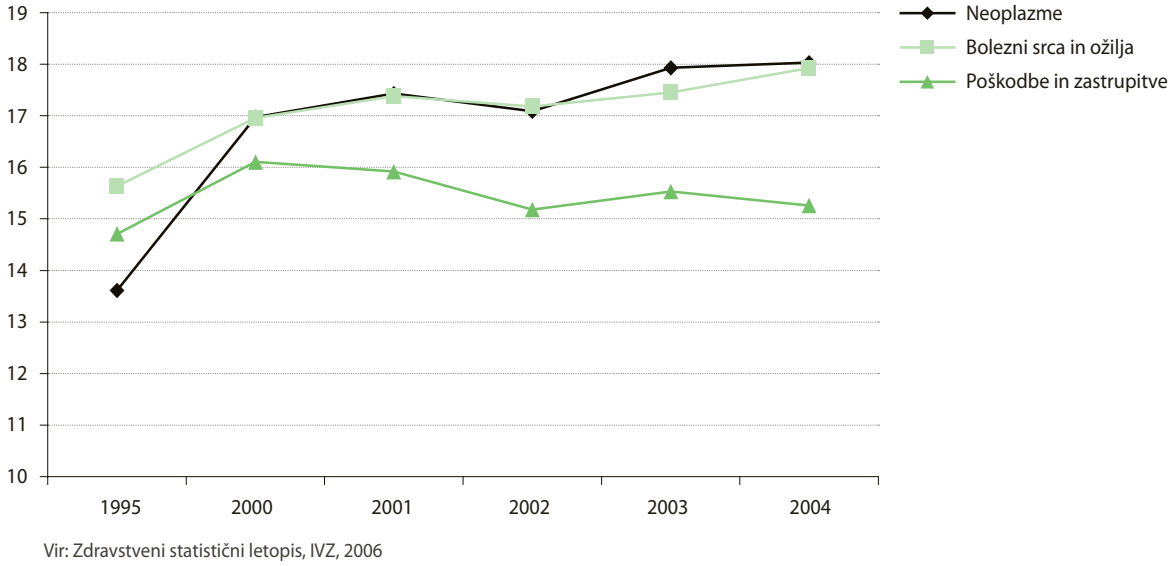
4.2 Zdravstveno stanje

Opisani trendi se odražajo tudi v splošni sliki zdravstvenega stanja prebivalstva v Sloveniji. Nekateri izbrani splošni kazalci zdravstvenega stanja v Sloveniji (tabela 2) sicer kažejo na dokaj dobro stanje, če ga primerjamo z državami Evropske unije. To velja predvsem za umrljivost dojenčkov, postopno podaljševanje trajanja življenja in pričakovanega trajanja življenja brez bolezenskih obremenitev. Na drugi strani pa se srečujemo z relativno visoko stopnjo splošne umrljivosti, saj je višjo stopnjo v letu 2004 beležila le Madžarska. Staranje prebivalstva je izrazito povezano s spremembami v zdravstvenem stanju prebivalstva. V ospredje stopajo rakave bolezni, obolenja srca in ožilja, kosti in gibal, (samo)poškodbe, duševne in druge kronične bolezni. S staranjem prebivalcev se vztrajno spreminjajo potrebe in zahteve po zdravstvenih storitvah. Zato bo v prihodnje potrebno programe zdravstvenih dejavnosti prilagoditi situaciji, ko bo obravnavi akutnih bolnikov bolj enakovredna tudi obravnava kroničnih bolezni in neakutnih stanj. Takšno prilagajanje zdravstvenih programov potrebam je temelj bolj kakovostnega delovanja zdravstva in tudi večjega zadovoljstva prebivalstva.

Slovensko prebivalstvo najpogosteje umira zaradi bolezni srca in ožilja ter rakavih bolezni. Tako stanje je značilno že vrsto let in je podobno razmeram v večini evropskih držav. Rakave bolezni, bolezni srca in ožilja ter poškodbe in zastrupitve so v letu 2004 predstavljale skupaj 33,3 % vseh hospitalizacij v Sloveniji (slika 4). Ti podatki kažejo na potrebo po izboljšanju programov in projektov za promocijo zdravega načina življenja in preprečevanja dejavnikov tveganja za nastanek kroničnih bolezni.

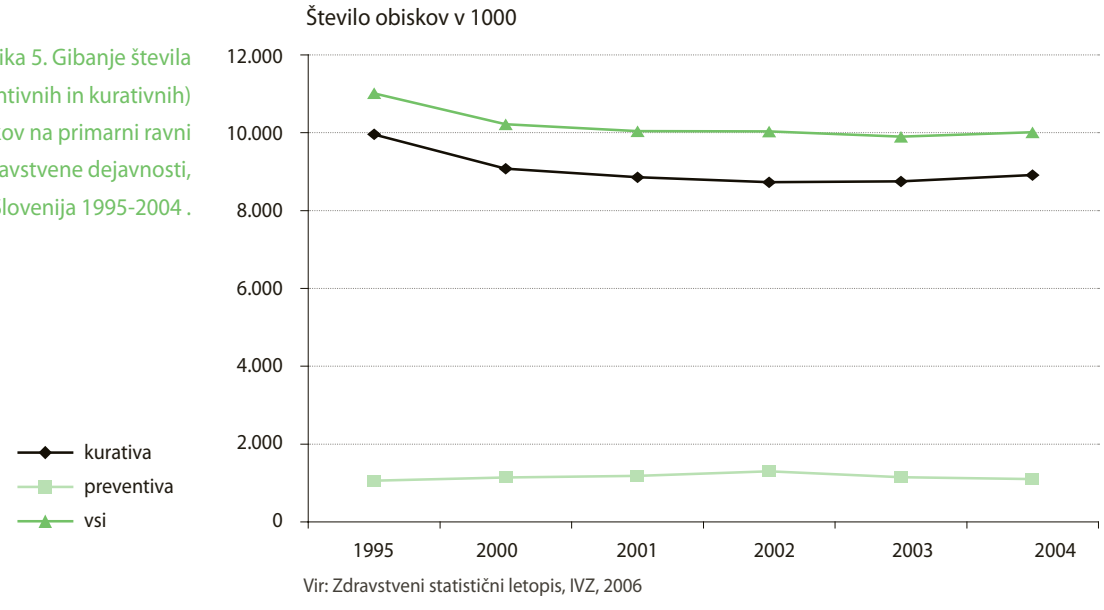
Slika 4: Gibanje stopnje hospitalizacije za neoplazme, bolezni srca in ožilja ter poškodbe in zastrupitve, Slovenija 1995-2004.

Stopnja hospitalizacije za neoplazme, bolezni srca ter za poškodbe in zastrupitve v letih 1995-2004

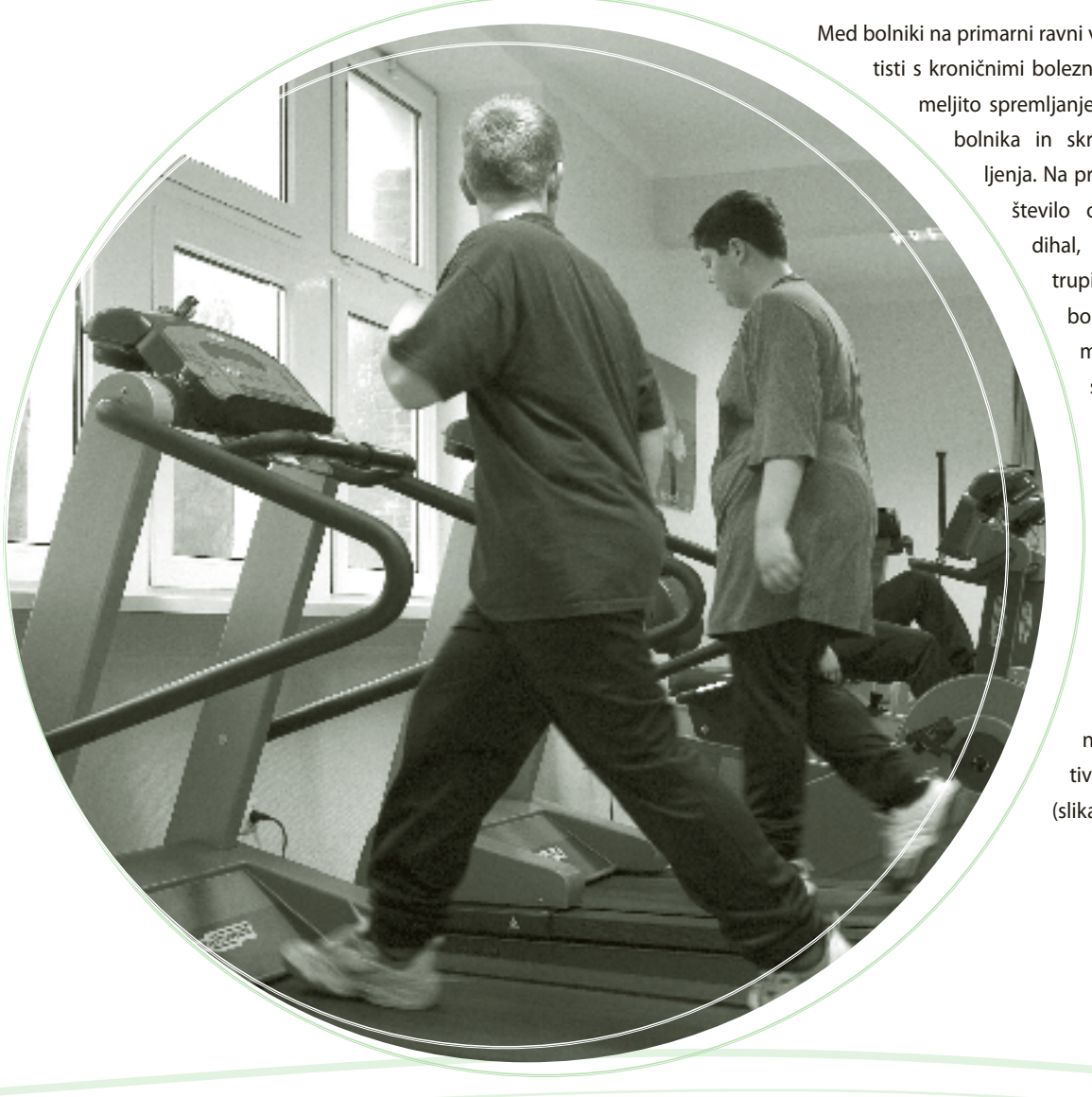


Vir: Zdravstveni statistični letopis, IVZ, 2006

Slika 5. Gibanje števila (preventivnih in kurativnih) obiskov na primarni ravni zdravstvene dejavnosti, Slovenija 1995-2004 .



Vir: Zdravstveni statistični letopis, IVZ, 2006



Med bolniki na primarni ravni vse bolj prevladujejo tisti s kroničnimi boleznimi, ki zahtevajo temeljito spremljanje, stalno poučevanje bolnika in skrben nadzor zdravljenja. Na prvih mestih glede na število obiskov so bolezni dihal, poškodbe in zastrupitve, srčno-žilne bolezni ter bolezni mišičnoskeletnega sistema in veziva idr. V letu 2004 je bilo na primarni ravni zabeleženih nekaj več kot 10 milijonov obiskov, kar pomeni 4,9 obiskov v povprečju na prebivalca, od tega jih je bilo 11% namenjenih preventivnim pregledom (slika 5).

4.3 Zavarovane osebe

Obvezno zdravstveno zavarovanje vključuje vse prebivalce s stalnim bivališčem v Sloveniji, ki se v zavarovanje obvezno vključijo bodisi kot zavarovanci ali kot njihovi družinski člani. Tako je dejansko zavarovano skoraj celotno (100%) prebivalstvo.

Pravice, ki jih zavarovanim osebam zagotavlja obvezno zdravstveno zavarovanje, so načeloma povezane s plačilom prispevka. Obstaja 21 kategorij zavarovancev, ki jih lahko razvrstimo v nekaj glavnih skupin. Največjo kategorijo predstavljajo vsi zaposleni, pri katerih je višina prispevka odvisna od njihovega dohodka ali od drugih osnov za plačilo prispevka (kmetje od katastrskega dohodka oz. osnove za pokojninsko in invalidsko zavarovanje, osebe, ki samostojno opravljajo gospodarsko ali poklicno dejavnost kot edini ali glavni poklic od bruto osnove za pokojninsko in invalidsko zavarovanje itd.). Prav tako plačajo določen delež od bruto pokojnin upokojenci. Druga skupina zajema kategorije, ki plačujejo ali za katere se plačujejo pavšalni prispevki (fiksni zneski). Socialno šibkejše skupine prebivalstva so vključene v druge skupine, za katere prispevek plača državni proračun ali občinski proračuni. Zavod za zaposlovanje Republike Slovenije plačuje prispevek za vse brezposelne osebe, ki prejemajo denarno dajatev pri temu zavodu. Osebe brez dohodkov pa v zavarovanje prijavijo občine, ki zanje plačujejo pavšalni prispevek.

Ob koncu leta 2006 je bilo v Sloveniji 1.985.095 zavarovanih oseb, od katerih jih je bilo 1.475.436 zavarovancev in 509.659 družinskih članov. Zaposleni so predstavljali največji delež vseh zavarovancev (58,1 %), upokojenci pa so predstavljali 26,9 % vseh zavarovancev. Skupno število zaposlenih je na enaki stopnji kot leta 1997, število njihovih družinskih članov pa upada. Število upokojencev nenehno narašča. Upada pa število lastnikov zasebnih podjetij in njihovih družinskih članov, število kmetov in članov njihovih gospodinjstev ter drugih oseb, ki se poklicno ukvarjajo pretežno s kmetijsko dejavnostjo ter število brezposelnih oseb in njihovih družinskih članov.

Družinski člani so zavarovani, če imajo v Republiki Sloveniji stalno prebivališče (ali če je z meddržavnim sporazumom določeno drugače). Otrok je kot družinski član zavarovan do dopolnjenega 15. leta oziroma do dopolnjenega 18. leta starosti, če ni sam zavarovanec, po tej starosti pa, če se šola, in sicer do konca rednega šolanja.

Tabela 3: Delež zavarovancev po kategorijah, 1996–2006.

Kategorija	1996	2001	2006
Zaposleni	58,27	57,60	58,10
Samostojni podjetniki itd.	5,57	5,00	4,80
Kmetje	2,09	1,60	1,30
Upokojenci	26,47	27,20	26,90
Upravičenci iz državnega proračuna	0,45	0,40	0,70
Brezposelni	2,37	1,40	1,10
Upravičenci iz občinskega proračuna	3,32	4,00	4,20
Ostali	1,46	2,80	2,90
Skupaj *	**100,00**	**100,00**	**100,00**

Gledano s pravnega vidika, nihče ne more biti brez zavarovanja. Vendar pa vedno obstaja manjša skupina oseb, ki so več kot eno leto brez urejenega statusa zavarovanja (približno 0,12% celotnega prebivalstva), ki se v takšnem položaju znajdejo zaradi lastne malomarnosti ali ker njihovi delodajalci niso uredili prijave v zavarovanje. V preteklih 10 letih je tako bilo izvedenih več različnih ukrepov, da bi vključili tudi omenjeni delež prebivalstva v zavarovanje, k čemur je še največ prispevala uvedba elektronske kartice zdravstvenega zavarovanja v letu 2000.

5 Vrste in obseg pravic iz obveznega zdravstvenega zavarovanja

Obseg pravic v obveznem zdravstvenem zavarovanju določa okvirno Zakon o zdravstvenem varstvu in zdravstvenem zavarovanju (v nadaljevanju Zakon), ki pa je prenesel določena pooblastila za podrobnejše ureditve pravic in postopke na ZZZS. Ta ureja to področje v Pravilih obveznega zdravstvenega zavarovanja, ki jih je prvič sprejela Skupščina ZZZS 24.11.1994, nato jih praviloma dopolnjuje oz. spreminja praviloma najmanj enkrat letno. Obvezno zdravstveno zavarovanje obsega zavarovanje za primer bolezni in poškodbe izven dela ter zavarovanje za primer poškodbe pri delu in poklicne bolezni.

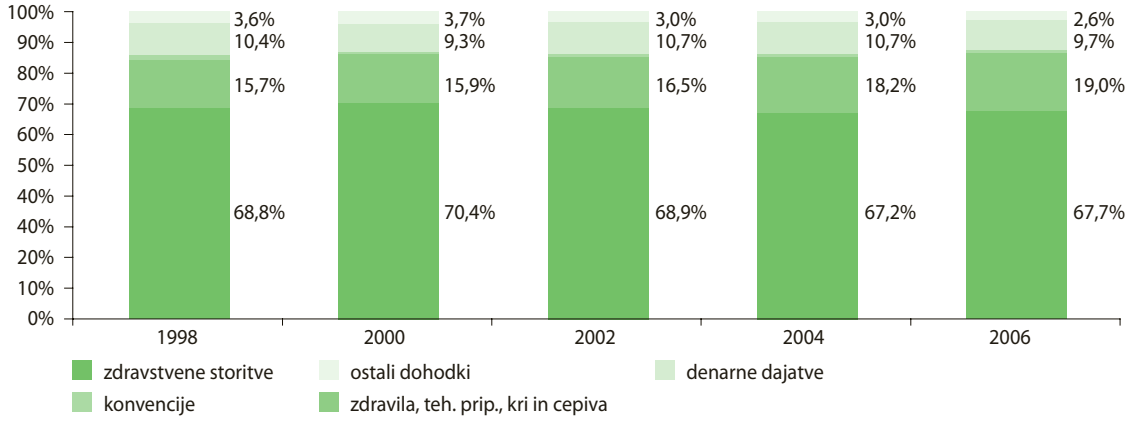
Pravice iz obveznega zdravstvenega zavarovanja, za katere zavezanci plačujejo prispevke, delimo v dve skupini. V prvo sodijo pravice do zdravstvenih storitev, v drugo pa določene denarne dajatve. Med slednje uvrščamo pravice do nadomestila plače med začasno zadržanostjo od dela iz bolezenskih razlogov, povračila potnih stroškov, pogrebnine in posmrtnine.

5.1 Pravice do zdravstvenih storitev

Najbolj obsežne so pravice do zdravstvenih storitev, do katerih so iz naslova obveznega zdravstvenega zavarovanja upravičene vse zavarovane osebe. Gre za storitve, kot so preventivni pregledi in storitve (sistematični pregledi, ukrepi za preprečevanje nalezljivih bolezni, ukrepi za zgodnje odkrivanje nekaterih bolezni itd.), storitve preprečevanja, odkrivanja in zdravljenja bolezni na vseh ravneh zdravstvene dejavnosti, zdravljenje in nega na domu ter v posebnih socialnih zavodih in domovih za starejše, prevozi z reševalnimi vozili, zdravila s posebne liste in medicinsko-tehnični pripomočki (ortopedski, ortotični, očesni, za sluh in drugi pripomočki).

Uresničevanje določenih pravic (zdraviliško zdravljenje, začasna zadržanost z dela, ki presega 30 dni, nekatere najdražje zdravstvene storitve) je odvisno od predhodnega mnenja in odobritve s strani imenovanih zdravnikov ZZZS in zdravstvene komisije ZZZS. Če zavarovana oseba pri uresničevanju teh pravic meni, da so ji bile kršene njene pravice, se lahko zoper odločitev imenovanega zdravnika ZZZS pritoži na 2. stopnji pri zdravstveni komisiji ZZZS, ki deluje kot tričlanski senat. Zoper odločitev zdravstvene komisije ZZZS lahko zavarovana oseba poda tudi tožbo na Delovno in socialno sodišče.

Slika 6: Trendi pri izdatkih za osnovne vrste pravic v letih od 1998 do 2006.



Pravice do zdravstvenih storitev, zdravil in medicinskih pripomočkov zavarovane osebe uresničujejo pod enakimi pogoji. Vsakdo ima pravico, da poišče pomoč svojega osebnega zdravnika, v nujnih primerih pa tudi katerega koli drugega zdravnika. Vendar pa obvezno zdravstveno zavarovanje ne krije vedno vseh zdravstvenih storitev in tudi ne krije vedno polne vrednosti teh storitev. Zakonodajalec je namreč z namenom ublažitve stalnih neskladij med narodno-gospodarskimi zmožnostmi financiranja in dejanskimi stroški programov zdravstvenega varstva na področju zdravstvenega zavarovanja uvedel specifične rešitve delitve stroškov in doplačil.

Z Zakonom so določene posamezne skupine prebivalcev in bolezni, katerih stroške zdravstvenih storitev v polnem obsegu (100 %) krije obvezno zdravstveno zavarovanje (ZZZS):

- sistematični in preventivni pregledi otrok, šolske mladine, študentov, ki se redno šolajo, žensk v zvezi z nosečnostjo in drugih odraslih oseb v skladu s posebnim programom, razen preventivnih pregledov, ki jih na podlagi zakona zagotavljajo delodajalci;
- zgodnje odkrivanje in preprečevanje bolezni, skladno s programom;
- zdravljenje in rehabilitacija otrok, učencev in študentov, ki se redno šolajo, ter otrok in mladostnikov z motnjami v telesnem in duševnem razvoju;
- zdravstveno varstvo žensk v zvezi s svetovanjem pri načrtovanju družine, kontracepcijo, nosečnostjo in porodom;
- preprečevanje, odkrivanje in zdravljenje infekcije HIV in nalezljivih bolezni, za katere je z zakonom določeno izvajanje ukrepov za preprečevanje njihovega širjenja;
- obvezna cepljenja, imunoprofilaksa in kemoprofilaksa skladno s programom;
- zdravljenje in rehabilitacija malignih bolezni, mišičnih in živčno-mišičnih bolezni, paraplegije, tetraplegije, cerebralne paralize, epilepsije, hemofilije, duševnih bolezni, razvitih oblik sladkorne bolezni, multiple skleroze in psoriaze;
- zdravljenje in rehabilitacija zaradi poklicnih bolezni in poškodb pri delu;
- zdravstveno varstvo v zvezi z dajanjem in izmenjavo tkiv in organov za presaditev drugim osebam;
- nujna medicinska pomoč, vključno z nujnimi reševalnimi prevozi;
- patronažni obiski, zdravljenje in nega na domu ter v socialnovarstvenih zavodih;
- zdravila na recept v skladu z razvrstitvijo zdravil, ortopedski in drugi pripomočki v zvezi z zdravljenjem pri osebah in stanjih iz predhodnih alinej;
- zdravila na recept iz pozitivne in vmesne liste za otroke, učence, dijake, vajence in študente ter otroke z motnjami v duševnem in telesnem razvoju.

Omenjene storitve se za zgoraj opisane določene skupine prebivalcev in bolezni financirajo v polnem obsegu (100 %) iz obveznega zdravstvenega zavarovanja, druge storitve pa le v določenem odstotku od polne vrednosti storitve. Odstotke vrednosti zdravstvenih storitev določa Zakon, ki dopušča ZZZS, da v okviru zakonskih določil sam natančneje določi odstotek in s tem višino doplačil. Višina doplačil se skladno z Zakonom giblje med najmanj 15 % in največ 95 %, s čimer je določena najnižja in najvišja stopnja doplačil za posamezne zdravstvene storitve, ki jih morajo plačati zavarovane osebe.

Obvezno zdravstveno zavarovanje tako v primeru zdravstvenih storitev (vključno z zdravili in medicinsko-tehničnimi pripomočki) krije njihovo polno vrednost samo za zakonsko predpisane skupine zavarovanih oseb in za določene bolezni. V primeru vseh drugih storitev in skupin zavarovanih oseb pa obvezno zdravstveno zavarovanje krije le določen odstotek od polne vrednosti zdravstvenih storitev. Razliko do polne vrednosti plačajo zavarovane osebe same

ali pa jo krije prostovoljna zdravstvena zavarovalnica, pri kateri je zavarovana oseba sklenila prostovoljno zdravstveno zavarovanje za tovrstna doplačila. Takšna ureditev obveznega zdravstvenega zavarovanja, ki predvideva doplačila in delitev stroškov v sistemu, je omogočila od leta 1993 dalje široko uveljavitev prostovoljnega zdravstvenega zavarovanja za doplačila k zdravstvenim storitvam, ki jih obvezno zdravstveno zavarovanje ne krije v celoti.

5.2 Pravice do denarnih dajatev

Nekatere pravice do denarnih dajatev se ne nanašajo na vse zaposlene zavarovance. Tako imajo na primer pravico do nadomestila plače med začasno zadržanostjo od dela osebe v delovnem razmerju, samostojni podjetniki, lastniki zasebnih podjetij, kmetje, ki so pokojninsko in invalidsko zavarovani, vrhunski športniki in vrhunski šahisti ter brezposelne osebe, ki prejemajo pri Zavodu RS za zaposlovanje denarno nadomestilo ali denarno pomoč. Pri določanju višine nadomestila plače se kot osnova upošteva povprečna mesečna plača zavarovane osebe in nadomestila oziroma povprečna osnova za plačilo prispevkov v koledarskem letu pred letom, v katerem je nastala začasna zadržanost od dela, odstotek nadomestila pa je odvisen od narave vzroka za odsotnost od dela. V primeru poškodb pri delu in poklicnih bolezni je višina nadomestila enaka 100 % osnove, v primeru bolezni znaša 90 % in v primeru odsotnosti z dela zaradi nege ožjega družinskega člana ali poškodbe, nastale izven delovnega mesta, znaša 80 % osnove. Nega ožjega družinskega člana je eden od vzrokov za odsotnost od dela, zaradi katere je zavarovana oseba upravičena do nadomestila plače. Med ožje družinske člane štejejo zakonec in otroci. Vendar pa je ta pravica časovno omejena (7 in 15 delovnih dni) za vsak primer bolezni, izjemoma pa tudi dlje, kadar to terja zdravstveno stanje ožjega družinskega člana.

Zavarovanci imajo pravico do nadomestila plače iz sredstev obveznega zdravstvenega zavarovanja od 31. delovnega dne zadržanosti od dela zaradi bolezni ali poškodbe pri delu. Od 1. dne zadržanosti od dela pa zavarovancem pripada nadomestilo plače iz sredstev obvezenega zdravstvenega zavarovanja, če je razlog zadržanosti od dela nega ožjega družinskega člana, presaditev živega tkiva in organov v korist druge osebe, posledic dajanja krvi, izolacije in spremstva, ki ju odredi zdravnik in tudi v primerih, ko je poškodba nastala pri organiziranih javnih delih splošnega pomena, gasilskih, gorskih in drugih reševalnih akcijah.

Pravico do povračila potnih stroškov imajo vse zavarovane osebe, kadar uveljavljajo z zakonom določene pravice, če morajo potovati k zdravniku ali v zdravstveni zavod v drug kraj, ker v kraju zaposlitve ali stalnega prebivališča ni zdravnika ali ustreznega zdravstvenega zavoda, ali če jih osebni zdravnik, zdravstveni zavod ali zdravstvena komisija ZZZS napoti ali pokliče v kraj zunaj stalnega prebivališča ali kraja zaposlitve.

Višina zneska povračila potnih stroškov v koledarskem mesecu ni omejena, je pa predviden fiksni odbitek (prispevek) zavarovane osebe v višini 3% minimalne plače, veljavne v istem mesecu.

Pravico do pogrebnine ima oseba, ki je poskrbela za pogreb zavarovane osebe in znaša določen odstotni delež povprečne cene nujnih stroškov pogreba v Sloveniji. Pravico do posmrtnine kot enkratne denarne pomoči ob smrti zavarovanca pa uveljavlja družinski član zavarovanca, ki ga je ta preživljal do svoje smrti, pri čemer znaša višina posmrtnine 100% zajamčene plače v Sloveniji.

6 Postopek financiranja in razporejanja sredstev obveznega zdravstvenega zavarovanja

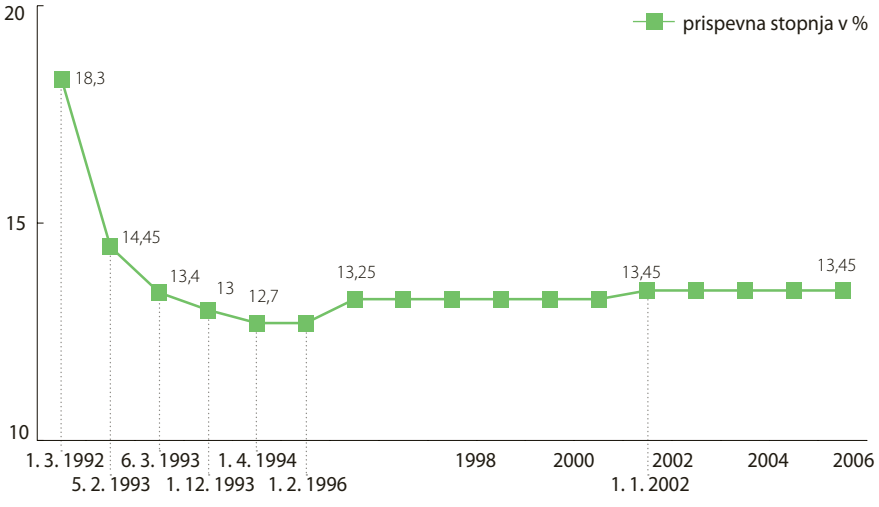
Kot je natančneje razvidno že v poglavju 2.2, sredstva obveznega zdravstvenega zavarovanja niso edini vir za financiranje programov zdravstvenega varstva, temveč predstavljajo le približno tri četrtine vseh sredstev. Poleg tega so kot javna sredstva vključena tudi sredstva iz državnega proračuna in občinskih proračunov (približno 4,8% vseh sredstev). Med zasebnimi sredstvi za financiranje programov zdravstvenega varstva pa je prostovoljno zdravstveno zavarovanje med najpomembnejšimi (približno 12,3 % vseh sredstev), vendar tudi obseg neposrednih plačil ("samoplačništvo") ni zanemarljiv, saj je ocenjen na 8 % vseh izdatkov za zdravstveno varstvo.

Razporejanje sredstev za zdravstvene programe se v Sloveniji izvaja in nadzira z izbranimi demokratičnimi mehanizmi usklajevanja interesov, v katere se vključujejo pooblaščene državne ustanove in z zakoni pooblaščene ustanove s področja zdravstvenega varstva oz. zdravstvenega zavarovanja (partnerji v zdravstvu). Finančni načrt ZZZS se usklajuje z ministrstvom za finance in ministrstvom za zdravje. V partnerska pogajanja se vključujejo predstavniki ministrstva za zdravje, izvajalcev (zdravniška in lekarniška zbornica, združenja zdravstvenih zavodov, zdravilišč, socialnih zavodov, domov za starejše idr.) in ZZZS, ki se dogovarjajo o obsegu in vrednosti zdravstvenega programa. Tako se vsako leto določajo zgornje meje razpoložljivih sredstev za programe dejavnosti na letni ravni, kar je izraženo tudi z izračunom višine prispevne stopnje. Dogovorijo se tudi za obračunske metode oziroma ustrezen prenos sredstev do javnih in zasebnih izvajalcev zdravstvenih storitev. Naslednji korak je podpisovanje pogodb z javnimi zavodi in zasebnimi izvajalci zdravstvenih storitev. Pomemben organ pa je pri vseh navedenih korakih tudi Skupščina ZZZS, kjer voljeni predstavniki plačnikov prispevkov (zavarovanci in delodajalci) avtonomno obravnavajo in odločajo o predlogih, ki izhajajo iz opisanih usklajevanj.

V nadaljevanju so opisani mehanizmi zbiranja in razporejanja sredstev obveznega zdravstvenega zavarovanja, s katerimi upravlja ZZZS.

6.1 Financiranje obveznega zdravstvenega zavarovanja

Prispevki za obvezno zdravstveno zavarovanje so osnovni vir financiranja obveznega zdravstvenega zavarovanja. Prispevki so zbrani s solidarnostnimi prispevki različnih kategorij zavarovancev (poglavje 4.3). Aktivni zavarovanci, ki prispevajo največji delež prihodkov, plačujejo prispevek v odstotnem deležu od bruto plače, podoben prispevek plača za njih tudi njihov delodajalec. V Sloveniji je bila zbirna prispevna stopnja za aktivne zavarovance v zadnjih 10 letih korigirana le enkrat, in sicer v letu 2002, ko je bila iz 13,25% dvignjena na današnjih 13,45% od bruto plače (slika 7) . Od tega prispeva 6,36% delojemalec in 6,56% delodajalec, ki pa prispeva še dodatnih 0,53% za poklicne bolezni in poškodbe pri delu. Upokojenci plačujejo le prispevek, ki ustreza prispevku delojemalca. Osnova za določitev prispevkov kmetov je njihov katastrski dohodek oz. osnova za pokojninsko in invalidsko zavarovanje. Za druge kategorije so določeni pavšalni prispevki, ki se gibljejo približno v višini prispevne stopnje delojemalca, če bi ta imel minimalno plačo (tabela 4). Poleg tega so dolžni delodajalci in organizatorji raznih javnih del plačevati poseben prispevek za poklicne bolezni in poškodbe na delu.



Slika 7: Pregled gibanja prispevne stopnje (zbirna prispevna stopnja) med letoma 1992 in 2006.

Prispevki se plačujejo neposredno na račun ZZZS praviloma mesečno. Za ZZZS pobira prispevke posebna državna agencija, s katero ima ZZZS tudi sklenjen poseben dogovor. V primeru neplačila prispevkov ima ZZZS pravico in dolžnost te sodno izterjati.

Tabela 4: Pregled vseh stopenj prispevkov, zavezancev za plačilo prispevkov ter vrste in obseg pravic.

Vrsta in obseg pravic	Delodajalec	Delojemalec	Kmet	Zavod za pokojninsko in invalidsko zavarovanje	Zavod za zaposlovanje	Republika Slovenija
Bolezen in poškodbe izven dela						
Za vse pravice	6,56%	6,36%			12,92%	
Za zdravstvene storitve, povračila potnih stroškov, pogrebnin in posmrtnin				5,96%		5,96%
Za zdravstvene storitve in povračila potnih stroškov			5,12% ali 18,78%			
Za nadomestila, pogrebnine in posmrtnine			1,15%			
Poškodba pri delu in poklicna bolezen						
Za vse pravice	0,53%		0,53%			
Za zdravstvene storitve, povračila potnih stroškov, pogrebnine in posmrtnine						0,18%

6.2 Postopki načrtovanja in razporejanja sredstev obveznega zdravstvenega zavarovanja

ZZZS načrtuje in razporeja razpoložljiva sredstva na podlagi finančnega načrta, ki se usklajuje z letnimi makroekonomskimi izhodišči države glede določanja okvirov javnih financ. Finančni načrt sprejema Skupščina ZZZS kot najvišji organ upravljanja. S tem dokumentom se v vsebinskem smislu opredelijo potrebna sredstva za štiri temeljna področja izvajanja obveznega zdravstvenega zavarovanja, in sicer za:

- programe zdravstvenih storitev (ti programi so opredeljeni in formalno sprejeti na osnovi partnerskih pogajanj in so v letu 2006 predstavljali cca. 69 % vseh odhodkov ZZZS);

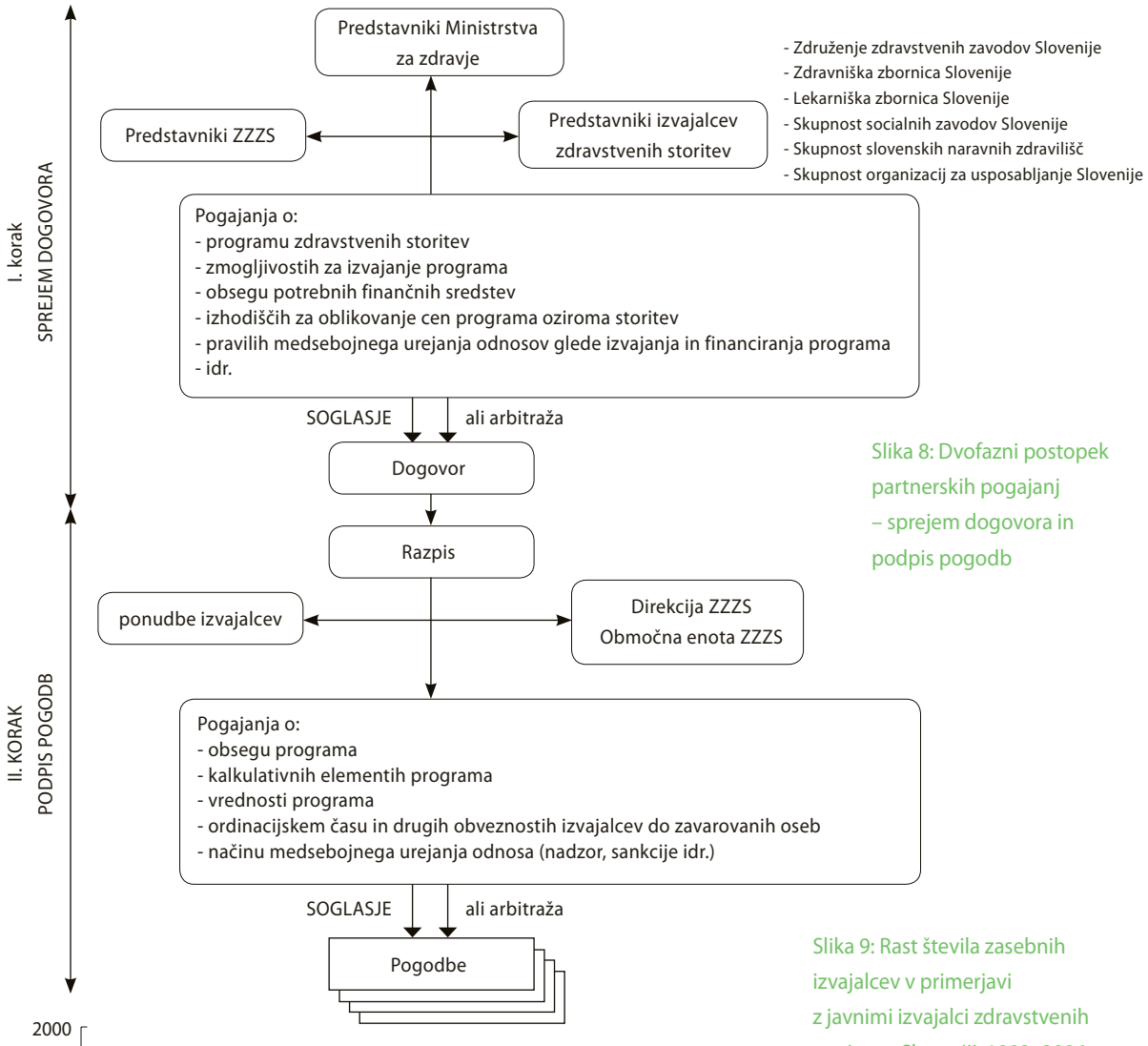
- zdravila in medicinsko-tehnične pripomočke (odhodki so v letu 2006 predstavljali 17% vseh odhodkov ZZZS);
- denarne dajatve, ki jih zagotavlja obvezno zdravstveno zavarovanje (odhodki za nadomestilo plače med začasno zadržanostjo od dela, potne stroške, pogrebnine in posmrtnine so v letu 2006 znašali 10% vseh odhodkov ZZZS);
- administrativne stroške ZZZS (odhodki za stroške službe ZZZS so v letu 2006 znašali 2,4% vseh odhodkov ZZZS).

Planiranje potrebnih sredstev za posamezne naloge ZZZS temelji na strokovnih izkušnjah in pričakovanih gibanjih glede količine, strukture in cen storitev oziroma ocenjenih vrednosti programov. Pri tem sta temeljni projekcija prihodkov in odhodkov obveznega zdravstvenega zavarovanja, ki morata upoštevati vsa bistvena makroekonomska izhodišča v državi (gibanja plač, cen, zaposlenosti idr.). Na tej osnovi mora biti finančni načrt uravnotežen, prispevna stopnja pa mora zagotoviti potrebne prihodke.

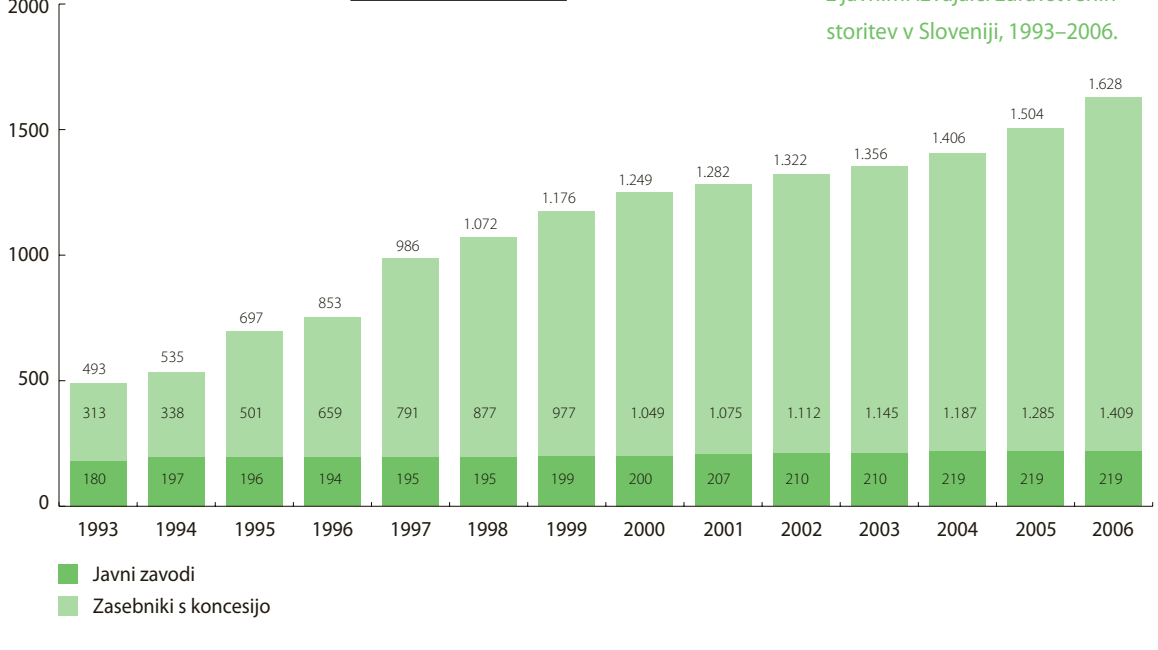
6.3 Partnerska pogajanja in postopek sklepanja pogodb

Vsako leto se predstavniki izvajalcev zdravstvenih storitev, ministrstva za zdravje in ZZZS pogajajo za skupen obseg programov zdravstvenih storitev in potrebnih sredstev za plačilo programa na državni ravni. Pogajanja med partnerji so najpomembnejši mehanizem za razporejanje sredstev. To se vsako leto odvija v dveh fazah. Prva faza obsega sprejetje Splošnega dogovora, ki pomeni uskladitev različnih predlogov in interesov v okviru sredstev, ki jih je ZZZS zbral iz prispevkov in drugih prihodkov obveznega zdravstvenega zavarovanja. Zdravstvene programe in njihove morebitne širitve sestavijo partnerji na osnovi letnih analiz stanja ter v skladu s prednostnimi nalogami, določenimi v Finančnem načrtu ZZZS in v dogovoru z Ministrstvom za zdravje. Predlog Splošnega dogovora pripravi skupna pogajalska skupina, ki jo predlagajo partnerji v zdravstvu, in katere delo je organizirano po posebnih pravilih. Ta skupina nato vsako leto poda predlog dogovora vsem partnerjem v sprejem. Partnerji lahko predstavijo drugačna stališča. Pri spornih zadevah je tako pogosto potrebna arbitraža. Takšna vprašanja so posredovana vsem partnerjem, ki skušajo pred postopkom arbitraže doseči o njih soglasje. V primeru, da do soglasja ne pride, o spornih vprašanjih odloča arbitraža, ki jo sestavljajo predstavniki vseh treh partnerjev. Če arbitraža ni uspešna, o spornem vprašanju skladno z Zakonom odloči Vlada Republike Slovenije (slika 8)

V drugi fazi pogajanj partnerji na osnovi Splošnega dogovora sklenejo področne dogovore za posamezna ožja področja zdravstvene dejavnosti: za zdravstvene domove in zasebno zdravniško dejavnost, za bolnišnice, lekarne, socialnovarstvene zavode, zavode za usposabljanje in za naravna zdravilišča. Vsebina in terminski roki za sklepanje področnih dogovorov so določeni v Splošnem dogovoru, področni dogovori pa natančneje določajo načrtovanje programov po posameznih zdravstvenih dejavnostih in območnih enotah Zavoda. Na ta način se omogoča enakopraven dostop do zdravstvenih storitev za vse zavarovane osebe.



Slika 8: Dvofazni postopek partnerskih pogajanj – sprejem dogovora in podpis pogodb



Slika 9: Rast števila zasebnih izvajalcev v primerjavi z javnimi izvajalci zdravstvenih storitev v Sloveniji, 1993–2006.

Splošni in področni dogovori predstavljajo pravno podlago za javni razpis za izvajanje programov zdravstvenih storitev in obenem tudi za urejanje pogodbenih odnosov med Ministrstvom za zdravje, ZZZS in izvajalci zdravstvenih storitev na področju izvajanja in financiranja programov zdravstvenih storitev.. Javni razpis se nanaša na vse javne zavode in zasebne izvajalce, ki imajo pravico (koncesijo) delati v mreži javne zdravstvene službe. Izvajalci so tako lahko bolnišnice, zdravstveni domovi, zasebne zdravniške ordinacije in drugi zasebni zdravstveni delavci, domovi za starejše občane, ustanove za osebe s posebnimi potrebami, lekarne in zdravilišča. Število pogodb, ki jih ZZZS sklepa z izvajalci, zadnje čase narašča predvsem zaradi povečanega števila novih zasebnih izvajalcev (slika 9). Pogodba, ki jo sklene ZZZS s posameznim izvajalcem, predstavlja pravno podlago za financiranje programa, ki ga opravi izvajalec.

ZZZS izvaja plačevanje programov zdravstvenih storitev centralizirano, kljub siceršnji decentralizirani organizacijski strukturi. Takšen način finančne organiziranosti omogoča večjo kratkoročno likvidnost in učinkovitejšo investicijsko politiko ZZZS. ZZZS plačuje svoje obveznosti za programe zdravstvenih storitev običajno v 20–30 dneh, obveznosti za denarne dajatve pa v 15–20 dneh.

6.4 Sistemi financiranja zdravstvenih storitev in obvladovanje stroškov

V okviru zdravstvenega zavarovanja se za financiranje izvajalcev zdravstvenih storitev na primarni, sekundarni in terciarni ravni uporablja večinoma prospektivni način. Tako se ohranja pomemben vpliv na obvladovanje stroškov zdravstvenega varstva, obenem pa zagotavlja ustrezno preglednost in obvladljivost sistema.

SISTEMI FINANCIRANJA NA PRIMARNI RAVNI

Večina zdravstvenih storitev na primarni ravni, ki jih izvajajo **izbrani osebni zdravniki** (zdravniki splošne oz. družinske medicine, zdravniki medicine dela, prometa in športa ter pediatri na primarni ravni) se plačuje na podlagi glavarine, izvedbe minimalnega števila storitev in preventivnega programa ter števila napotitev na sekundarno raven. 92 % vrednosti programa v teh dejavnostih se plačuje glede na število pacientov (t.i. »glavarina«) ob pogoju, da izvajalec opravi dogovorjeno minimalno število storitev. Preostalih 8% vrednosti programa izvajalec prejme, če opravi preventivni program in ne odstopa od dogovorjenega standarda napotitev na sekundarno raven. Za potrebe obračunavanja se uporablja poseben seznam storitev. Podatki o številu opredeljenih zavarovanih oseb na zdravnika ali posameznega izvajalca zdravstvenih storitev so na voljo pri ZZZS, saj morajo izvajalci redno posredovati vse podatke (kopije obrazcev za izbiro osebnega zdravnika), ki se nanašajo na izbiro ali zamenjavo osebnega zdravnika. Ta zbirka podatkov služi kot osnova za izračun plačila zneskov glavarine za posameznega zdravnika ali izvajalca. Prav tako je določeno povprečno in največje dovoljeno število opredeljenih pacientov na posameznega zdravnika, ki jih je treba upoštevati pri izračunu plačila glavarine. Obseg storitev, ki jih ZZZS plača, je prav tako omejen, in je odvisen od števila opredeljenih pacientov. Finančne vrednosti

programov teh dejavnosti so izračunane na podlagi posameznih kalkulativnih elementov, in zajemajo načrtovane plače, materialne stroške in amortizacijo opreme. Izračun vrednosti materialnih stroškov obsega tudi sredstva za laboratorijske preiskave, ki jih plačujejo zdravniki neposredno laboratorijem.

V ostalih zdravstvenih dejavnostih na primarni ravni, vključno z zobozdravstvom, so programi planirani in obračunani na podlagi obsega izvedenih storitev po posebnem katalogu storitev (»Zelena knjiga«). Ta knjiga za vsako storitev navaja njeno relativno vrednost, izraženo v točkah. Zelena knjiga je bila sprejeta pred 25 leti in je bila kasneje v določenih delih dopolnjena ali spremenjena. Poleg seznama storitev, ki je bil sestavljen na podlagi posebnega priročnika Svetovne zdravstvene organizacije za klasifikacijo medicinskih postopkov, knjiga predpisuje tudi relativne vrednosti teh storitev. Točkovna vrednost storitve se izračunava na podlagi sestave zdravstvenega tima, ki storitev izvede, njegove kvalifikacijske strukture in porabljenega časa. Ob podpisu pogodbe izvajalec storitev in naročnik (ZZZS) na podlagi dogovorjenih standardov dejavnosti določita plan (letni obseg) točk in njihovo vrednost.

Planiranje obsega storitev za posameznega izvajalca, ki služi kot osnova za pogodbo, je zasnovano na normativih in standardih, ki jih določijo partnerji v letnem dogovoru. Pri finančnem vrednotenju storitev (točk) se upoštevajo kalkulativni elementi, ki jih določijo partnerji, in ki se nanašajo na izračun plač, materialnih stroškov in amortizacije opreme.. Izvajalec lahko obračunava storitve ZZZS v skladu z vrednostjo točke in v okviru obsega dogovorjenega s pogodbo.. Plačilo je možno le za storitve, izvedene v pogodbeno dogovorjenem obsegu, medtem ko storitve, ki presegajo plan, niso plačane.

Za reševalne prevoze, ki niso nujni, je obračunska enota število prevoženih kilometrov reševalnega vozila, pri nujnih prevozih pa se stroški obračunavajo v fiksnih zneskih.

Pri financiranju lekarn in njihovega dela v zvezi s pripravo in izdajo zdravil imamo v Sloveniji nekoliko posebno ureditev. V večini drugih držav imajo namreč na tem področju uveljavljen maržni sistem. To pomeni, da lekarna ob izdaji zdravila obračuna plačniku (izvajalcu zavarovanja ali posamezniku) poleg veledrogerijske cene zdravila še maržo, ki je izražena z odstotkom cene zdravila. V Sloveniji pa je tudi na področju obračunavanja lekarniške dejavnosti v veljavi storitveni sistem. Delo lekarn je tako opredeljeno s storitvami , ki so točkovno in finančno ovrednotene podobno kot v drugih zdravstvenih dejavnostih. Med temi storitvami sta najpomembnejši obdelava recepta in izdaja zdravila. Ti dve storitvi obračuna lekarna ob vsaki izdaji zdravila, predpisanega na recept, hkrati pa zaračuna plačniku nabavno (veleprodajno) vrednost zdravila.

SISTEMI FINANCIRANJA ZDRAVSTVENIH STORITEV NA SEKUNDARNI IN TERCIARNI RAVNI

V **specialistično ambulantni dejavnosti** se storitve obračunavajo po storitvenem sistemu, kar pomeni, da se opravljeno delo evidentira in obračunava glede na dejansko izvedene storitve. Te storitve so navedene v »Zeleni knjigi« skupaj s številom točk za storitev, ki so določene po enaki metodologiji, kot to velja na primarni ravni. Izjema so dialize, kjer so cene določene za

posamezen tip dialize na podlagi težavnosti postopka. Tudi na tem področju morajo izvajalci zdravstvenih storitev izvajanje programov prilagoditi pogodbi z ZZZS, ki je bila pripravljena na skupnih podlagah, dogovorjenih med partnerji v zdravstvu. Ti programi so finančno ovrednoteni na podlagi kalkulativnih elementov, na podlagi česar se določi tudi pogodbena vrednost točke za storitve. V specialistični ambulantni dejavnosti se laboratorijske storitve ne obračunavajo in zaračunavajo posebej, temveč so njihovi stroški vračunani v vrednost točke posamezne storitve. Tudi v specialistično ambulantni dejavnosti velja pravilo, da ZZZS plačuje le storitve, ki so bile predvidene in izvedene v okviru pogodbeno dogovorjenega obsega (izjema so dialize, ki so plačane glede na njihovo celotno realizacijo).

Od izdaje »Zelene knjige« dalje je napredek medicinske znanosti pripomogel k pojavu številnih novih storitev, ki so bile sicer uvedene v prakso, a v katalogu storitev niso bile ustrezno klasificirane. To je v nekaterih primerih botrovalo k neenotnemu evidentiranju, zato se je ZZZS že leta 1997 lotil posodobitve kataloga storitev (»Zelene knjige«). Za nekatere specialistične dejavnosti so bili izdelani seznami, vendar še niso v uporabi, saj partnerji še niso dosegli potrebnega soglasja.

Na področju akutnih bolnišničnih obravnav se kot osnova za obračun opravljenega dela uporablja t.i. sistem skupin primerljivih primerov (avstralski model) (v nadaljevanju SPP).. Enak sistem je uveljavljen tudi v primeru dnevne in enodnevne bolnišnične obravnave. Sistem SPP naj bi v kombinaciji z uvedbo koncepta »klinične poti« optimiziral izvajanje storitev v sektorju bolnišnične, klinične in institucionalne obravnave na sekundarni in terciarni ravni zdravstvenih dejavnosti.

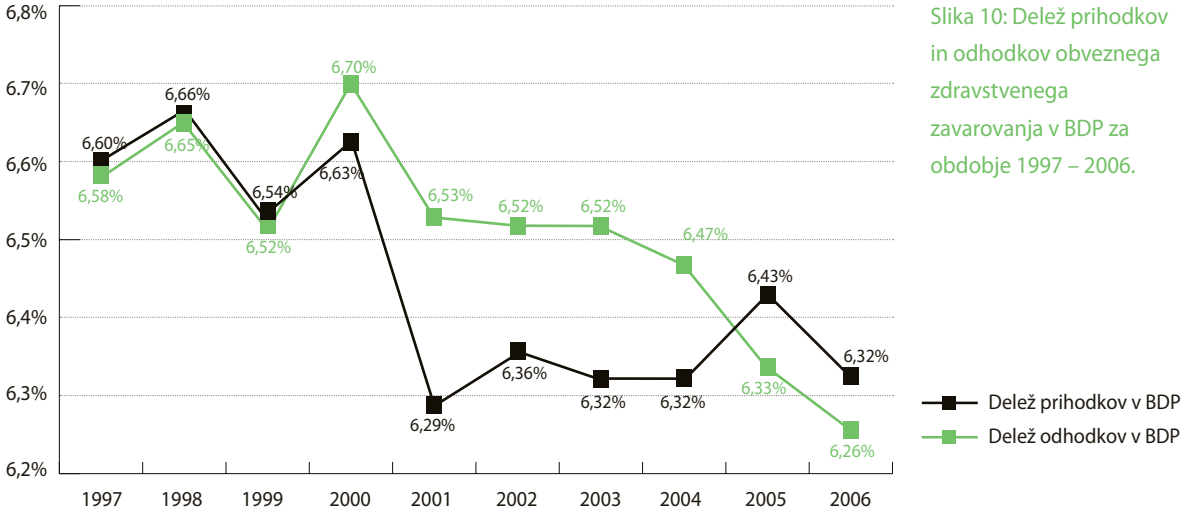
Sistem SPP ni uveljavljen pri financiranju transplantacij, bolnišnične obravnave bolnikov na področju psihiatrije in rehabilitacije ter na področju neakutne bolnišnične obravnave. Financiranje navedenih programov namreč temelji na povprečni ceni primera oziroma na bolnišnično-oskrbnem dnevu, če gre za neakutno bolnišnično obravnavo. Cena transplantacije v Sloveniji vključuje stroške, donorja, operacije in stroške zdravljenja eno leto po posegu.

7 Poslovni rezultati ZZZS

Strokovne raziskave, ki temeljijo na projekcijah demografske in socialne strukture ter zdravstvenega stanja prebivalstva, poudarjajo, da bi se moral za ohranjanje kakovostne ravni zdravstvenega varstva delež javnih prihodkov oz. prihodkov obveznega zdravstvenega zavarovanja gibati na ravni okoli 6,9 - 7,0 % bruto družbenega proizvoda (v nadaljevanju BDP). Ohranjanje deleža prihodkov obveznega zdravstvenega zavarovanja na takšni ravni bi namreč moralo biti nujno zaradi stalne rasti izdatkov za zdravstvo, ki jih povzročajo večje potrebe po zdravstvenih storitvah zaradi starajočega se prebivalstva, večja osveščenost in zahtevnost prebivalstva, razvoj novih metod zdravljenja in rehabilitacije in s tem večja usposobljenost zdravstvene službe, nova zdravila in medicinsko-tehnični pripomočki ter nenazadnje skrb za kakovostno dostopnost do zdravstvenih storitev vsem zavarovanim osebam.

Vendar v Sloveniji beležimo v zadnjem obdobju nekoliko nasprotna gibanja. Razlogov za to je več, med njimi je v zadnjem času tudi vse hitrejša rast BDP. Prav tako smo se v Sloveniji v neposredni preteklosti, kot je bilo že omenjeno, srečevali tudi z resnimi razkoraki med prihodki in odhodki, ki so se v letih od 2001-2004 izkazovali kot primanjkljaji ZZZS. Razlogi za primanjkljaje v teh letih so bili večplastni in so bili večinoma posledica dejavnikov, na katere ZZZS ni imel neposrednega vpliva, in sicer tako na prihodkovni kot odhodkovni strani. Po letu 2000 so se namreč po desetletju relativno stabilnega poslovanja stopnjevali učinki določenih neugodnih gibanj. Na eni strani je šlo za opisane vplive dolgoročnih trendov, med katerimi so najpomembnejši staranje prebivalstva, vse dražja zdravila in novi medicinski postopki in oprema. Poleg teh dolgoročnih gibanj pa so na izdatke znatno vplivale tudi hitrejša rast plač v zdravstvu v tem obdobju, uvedba davka na dodano vrednost na materialne stroške, še posebej pa tudi številne nove zahteve po dodatnih zdravstvenih programih. Ker višina zbirne prispevne stopnje ni zadoščala za pokrivanje vseh obveznosti ZZZS, se je moral ZZZS v času od leta 2001 do 2004, kljub korekciji prispevne stopnje v letu 2002, zadolževati.

Značilna gibanja prihodkov in odhodkov ZZZS v tem času so razvidna tudi iz slike 10 in tabele 5. Od leta 2000 do konca leta 2004 je bil delež odhodkov ZZZS za obvezno zdravstveno zavarovanje v BDP vselej večji od deleža prihodkov. V letu 2002 se je ta razkorak zmanjšal zaradi dviga zbirne prispevne stopnje. Razkorak se je manjšal tudi zaradi številnih ukrepov ZZZS, ki so zajeli izbrane aktivnosti za povečanje oz. optimiziranje prihodkov in različne sistemske ukrepe za obvladovanje odhodkov. Med ukrepi so bili zlasti pomembni učinki sklenjenega sporazuma s komercialnimi zavarovalnicami o pavšalnem plačilu regresnih odškodnin za zdravljenje po poškodbah v prometnih nesrečah (nov vir, po letu 2004), učinkov uvedbe sistema medsebojno zamenljivih zdravil in drugih ukrepov na področju obvladovanja izdatkov za zdravila, medicinsko-tehnične pripomočke in denarna nadomestila (obvladovanje izdatkov, po letu 2004) ter posledic spremembe zakona o davčnem postopku (enkraten učinek v letu 2005). Zaradi sposobnosti uravnoteženega tekočega poslovanja je bilo zato smiselno in nujno poplačati kumulativni dolg ZZZS, ki je v začetku leta 2005 znašal 119,5 milijonov evrov. Z zakonom o prevzemu dolga je Republika Slovenija s 1.7.2005 prevzela celotni dolg ZZZS in na ta način sanirala celotni primanjkljaj. Na tej osnovi so se gibanja prihodkov in odhodkov ZZZS v letu 2005 in 2006 uravnotežila.



Slika 10: Delež prihodkov in odhodkov obveznega zdravstvenega zavarovanja v BDP za obdobje 1997 – 2006.

V letu 2005 je bil tako ZZZS finančno saniran na podlagi večletnega izvajanja številnih gospodarnih ukrepov ter na podlagi prevzema kumulativnega dolga s strani države. Finančna sanacija je bila prepoznana kot uspešna, saj je ostala prispevna stopnja za zdravstvo enaka, na enaki ravni so ostale tudi pravice iz obveznega zdravstvenega zavarovanja, ki so se na nekaterih področjih celo razširile, obseg programov zdravstvenih storitev zlasti z namenom skrajševanja čakalnih dob in uvajanjem novih metod zdravljenja pa se je bistveno razširil.

Tabela 5: Poslovni rezultati ZZZS v letih od 2002 do 2006 v evrih*.

	2002	2003	2004	2005	2006
PRIHODKI	1.420.516.813	1.533.655.959	1.653.244.220	1.775.604.682	1.860.034.139
ODHODKI	1.457.111.108	1.580.995.764	1.693.929.069	1.749.206.126	1.845.443.428
PRESEŽEK/PRIMANJKLJAJ (1-2)	**-36.594.296**	**-47.339.806**	**-40.684.848**	**26.398.556**	**14.590.711**
STANJE DOLGA (ZADOLŽEVANJE)	32.073.110	46.720.080	40.761.142	0	0
KUMULATIVA DOLGA**	32.073.110	78.793.190	119.554.331	0	0
POVEČ./ZMANJŠ. SREDSTEV NA RAČUNIH	**-2.992.451**	**-538.925**	**278.075**	**26.419.846**	**14.616.562**

* Podatki pred vstopom Slovenije v evropsko monetarno unijo 1. 1. 2007 so preračunani iz slovenskega tolarja (SIT) z uporabo nepreklicnega menjalnega razmerja (1 EUR = 239,64 SIT) v evro (EUR). Ta prikaz omogoča primerjavo v državi skozi čas in zagotavlja ohranitev kazalcev razvoja (stopnje rasti).
** Z Zakonom o prevzemu dolga ZPIZ in ZZZS je Republika Slovenija s 1. 7. 2005 prevzela dolg ZZZS v višini 119.554.000 evrov.

7.1 Trendi v prihodkih

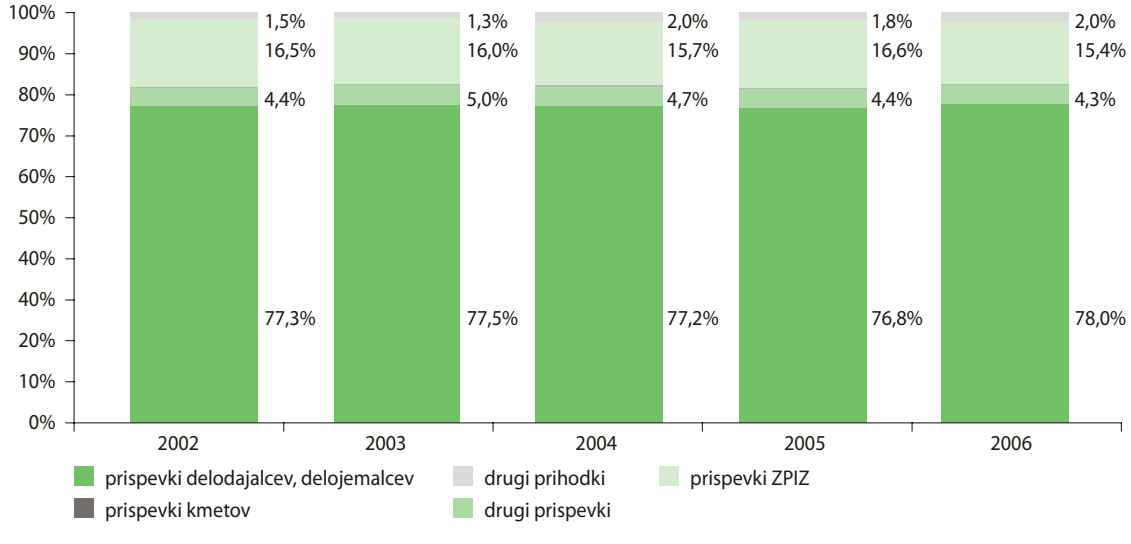
Celotne prihodke obveznega zdravstvenega zavarovanja tvorijo prihodki od prispevkov (v višini približno 98 %) in drugi prihodki, med katere sodijo prihodki od regresnih zahtevkov, konvencij, naložb in ostali prihodki. V strukturi prihodkov od prispevkov predstavljajo največji del prispevki delodajalcev in delojemalcev, sledijo prispevki Zavoda za pokojninsko in invalidsko zavarovanje Slovenije in prispevki kmetov skupaj z drugimi prispevki. Največji neposredni vpliv na vrednost prihodkov ima višina prispevne stopnje ter vrednost neplačanih

Tabela 6: Struktura prihodkov ZZZS v letih od 2002 do 2006 v tekočih cenah (v evrih)* in v deležih (graf).

prispevkov. Poleg tega imajo pomemben vpliv tudi nekateri splošni trendi, kot so rast bruto domačega proizvoda, stopnja brezposelnosti, razmerje med aktivnim in neaktivnim prebivalstvom, migracija in drugo. V zadnjih letih si ZZZS prizadeva za večjo učinkovitost pri nadzoru in izterjavi prispevkov za obvezno zdravstveno zavarovanje s strani Davčne uprave RS ter pri uveljavljanju regresnih zahtevkov v primeru poškodb po tretji osebi.

	prispevki delodajalcev, delojemalcev	drugi prispevki	prispevki kmetov	prispevki ZPIZ	drugi prihodki	skupaj
2002	1.098.487.131	62.588.299	3.313.862	234.741.521	21.386.000	**1.420.516.813**
2003	1.188.101.235	76.585.862	3.993.778	245.576.869	19.398.214	**1.533.655.959**
2004	1.277.120.648	78.150.221	4.643.544	260.228.643	33.101.164	**1.653.244.220**
2005	1.363.629.924	78.784.197	5.550.943	295.235.779	32.403.839	**1.775.604.682**
2006	1.450.300.388	80.478.451	5.342.468	286.597.112	37.315.719	**1.860.034.139**

* Podatki pred vstopom Slovenije v evropsko monetarno unijo 1.1.2007 so preračunani iz slovenskega tolarja (SIT) z uporabo nepreklicnega menjalnega razmerja (1 EUR = 239,64 SIT) v evro (EUR). Ta prikaz omogoča primerjavo v državi skozi čas in zagotavlja ohranitev kazalcev razvoja (stopnje rasti).



7.2 Trendi v odhodkih

Osnovne skupine odhodkov obveznega zdravstvenega zavarovanja tvorijo odhodki za zdravstvene dejavnosti (87,7% vseh odhodkov ZZZS v letu 2006), odhodki za denarne dajatve (9,9% vseh odhodkov ZZZS v letu 2006) in odhodki za delo službe ZZZS (2,4 % vseh odhodkov ZZZS v letu 2006). Med odhodke za zdravstvene dejavnosti sodijo odhodki za zdravstvene storitve, (osnovno zdravstveno varstvo, specialistično ambulantna in bolnišnična dejavnost, zdraviliško zdravljenje, dejavnost nege v socialnih zavodih, odhodki za ostale

programe), odhodki za zdravila in medicinsko-tehnične pripomočke, preskrbo s krvjo, socialno medicino, odhodki za zdravljenje v tujini (napotitve) in odhodki za uresničevanje mednarodnih zavarovanj oz. konvencij. Med odhodke za denarne dajatve sodijo odhodki za nadomestila bolniške odsotnosti, odhodki za pogrebnine, posmrtnine in odhodki za potne stroške, spremstvo in prevoze.

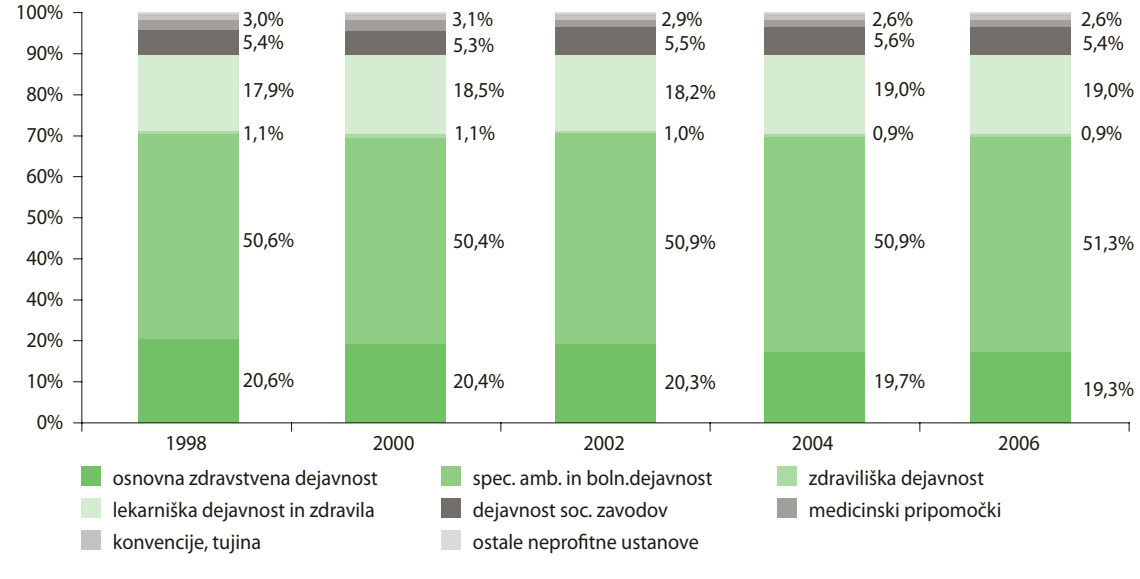
ZZZS v zadnjih 10 letih zaradi povečanih potreb prebivalstva po zdravstvenih storitvah, skrajševanja dolgih čakalnih dob in uvajanja novih metod zdravljenja nenehno širi obseg s tem pa tudi vrednost programov zdravstvenih storitev. Gibanja trendov v odhodkih po zgoraj opisanih skupinah in vrstah odhodkov so razvidna iz tabele 7.

Tabela 7: Struktura odhodkov ZZZS za zdravstvene dejavnosti v letih od 2002 do 2006 v tekočih cenah v EUR (tabela) in v deležih (graf).

	2002	2003	2004	2005	2006
osnovna zdravstvena dejavnost	258.858.141	278.897.605	296.046.695	299.461.325	312.982.966
spec. amb. in boln. dej.	636.471.578	689.531.848	743.727.458	774.602.299	830.683.630
zdraviliška dejavnost	14.193.553	14.742.969	15.089.221	14.344.805	14.476.565
lekarniška dej. in zdravila	225.276.435	252.614.584	265.668.177	289.213.829	307.649.082
dejavnost soc. zavodov	67.605.938	72.490.615	79.662.761	84.954.369	87.148.919
medicinski pripomočki	38.151.223	42.052.120	42.443.657	38.912.694	42.718.532
konvencije, tujina	13.274.987	12.956.689	14.043.665	16.571.603	18.099.796
ostale neprofitne ustanove	3.892.322	4.055.129	4.214.664	4.606.631	4.736.538
SKUPAJ	**1.257.724.178**	**1.367.341.558**	**1.460.896.299**	**1.522.667.555**	**1.618.496.027**

* Podatki pred vstopom Slovenije v evropsko monetarno unijo 1.1.2007 so preračunani iz slovenskega tolarja (SIT) z uporabo nepreklicnega menjalnega razmerja (1 EUR = 239,64 SIT) v evro (EUR). Ta prikaz omogoča primerjavo v državi skozi čas in zagotavlja ohranitev kazalcev razvoja (stopnje rasti).

delež posameznih odhodkov



8 Uresničevanje pravic iz obveznega zdravstvenega zavarovanja

8.1 Preskrbljenost z zdravstvenimi storitvami in dostopnost

V Sloveniji je bila v daljšem obdobju vzpostavljena obsežna mreža javnih in zasebnih izvajalcev zdravstvenih storitev na primarni, sekundarni in terciarni ravni, ki je zelo razvejana in dostopna vsem zavarovanim osebam v državi. Od leta 1992 dalje je bilo financiranje zdravstvenih storitev stabilno in se je financiralo iz javnih in zasebnih virov obveznega ter prostovoljnega zdravstvenega zavarovanja oz. neposrednimi plačili. Vrednost in struktura odhodkov obveznega zdravstvenega zavarovanja (ZZZS) in doplačil oz. dopolnilnega zdravstvenega zavarovanja za različne zdravstvene storitve vključno z zdravili in medicinsko-tehničnimi pripomočki v letu 2006 so prikazani v tabeli 8.

Tabela 8: Vrednost in struktura odhodkov obveznega in dopolnilnega zdravstvenega zavarovanja oz. doplačil za zdravstvene storitve v Sloveniji, 2006 (v EUR).

Vrste zdravstvenih storitev	Odhodki obveznega zavarovanja*	%	Odhodki za doplačila**	%	Skupni odhodki zdravstvenega zavarovanja	%
1. Storitve na primarni ravni	317.719.504	19,7	63.028.643	22,3	380.748.147	20,0
2. Specialistične ambulantne in bolnišnične storitve	830.683.630	51,3	72.045.144	25,5	902.728.774	47,5
3. Zdraviliške rehabilitacijske storitve	14.476.565	0,9	9.719.088	3,4	24.195.653	1,3
4. Nega v socialnovarstvenem zavodu	87.148.919	5,4	0	0,0	87.148.919	4,6
5. Zdravila (vključno z lekarniškimi storitvami)	293.455.450	18,1	131.487.645	46,4	424.943.095	22,3
6. Medicinsko-tehnični pripomočki in oskrba s krvjo	56.912.164	3,5	6.259.778	2,2	63.171.942	3,3
7. Storitve v tujini (mednarodno zavarovanje na podlagi pravnega reda EU in meddržavnih sporazumov, napotitve na zdravljenje v tujino)	18.099.796	1,1	500.100	0,2	18.599.896	1,0
SKUPAJ	**1.618.496.028**	**100,0**	**283.040.398**	**100,0**	**1.901.536.426**	**100,0**

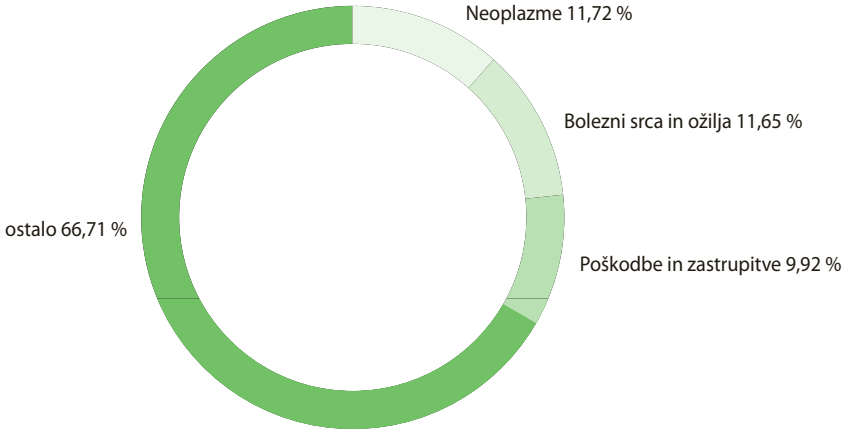
Opomba: * Odhodki ZZZS za zdravstvene storitve v evrih in odstotnem deležu.
** Ocena odhodkov za doplačila, ki jih krijejo prostovoljne zavarovalnice ali osebe same, če niso prostovoljno zavarovane v evrih in v odstotnem deležu.

Da bi zagotovili kakovostne storitve v razumnem času ter enakopravno dostopnost vsem zavarovanim osebam so v partnerska pogajanja in pogodbene odnose vključeni pomembni mehanizmi, pri izvajanju katerih ima ZZZS ključno vlogo. ZZZS tako pri zagotavljanju načela enakopravnosti dostopa do zdravstvenih storitev uporablja več mehanizmov. Tako na primer za zmanjšanje razlik med izvajalci priznava razlike v preskrbljenosti z zdravstvenimi zmogljivostmi po posameznih območnih enotah le v obsegu, ki znaša med 90 % in 110 % slovenskega povprečja.

Prav tako je bilo v zadnjem obdobju kljub zaostreni finančni situaciji in zadolževanju v okviru procesa partnerskega dogovarjanja dogovorjeno povečanje mreže splošnih zdravnikov in patronažnih sester na primarni ravni, kar je izboljšalo preskrbljenost prebivalstva s programi splošne medicine, otroškega in šolskega dispanzerja na način, da so se indeksi odstopanja od (finančnih) standardov gibali med 97 in 104 slovenskega poprečja. Na tej ravni tako ostajajo izziv vse večje potrebe po neakutnih obravnavah (staranje prebivalstva), kar terja boljšo oskrbo predvsem s storitvami fizioterapije in nege, vključno z novimi zmogljivostmi v socialnovarstvenih zavodih.

Tudi v ambulantno specialistični in bolnišnični dejavnosti na sekundarni in terciarni ravni so vse bolj v ospredju kronične in druge sodobne bolezni. Neoplazme, bolezni srca in ožilja ter poškodbe ter zastrupitve predstavljajo že kar tretjino vseh hospitalizacij (slika 11). Naraščajoče potrebe po zdravstvenih storitvah zaradi staranja prebivalstva in posledičnega naraščanja deleža kroničnih bolezni spreminjajo strukturo potreb po bolnišnični obravnavi, kar povzroča določene zastoje pri dostopu do nekaterih zdravstvenih storitev (čakalne dobe) in določene zaplete pri organizaciji neakutne obravnave bolnikov, podaljšanega zdravljenja, nege in drugih oblik tovrstne obravnave.

Slika 11: Delež hospitalizacij zaradi neoplazem, bolezni srca in ožilja ter zaradi poškodb in zastrupitev v letu 2004.

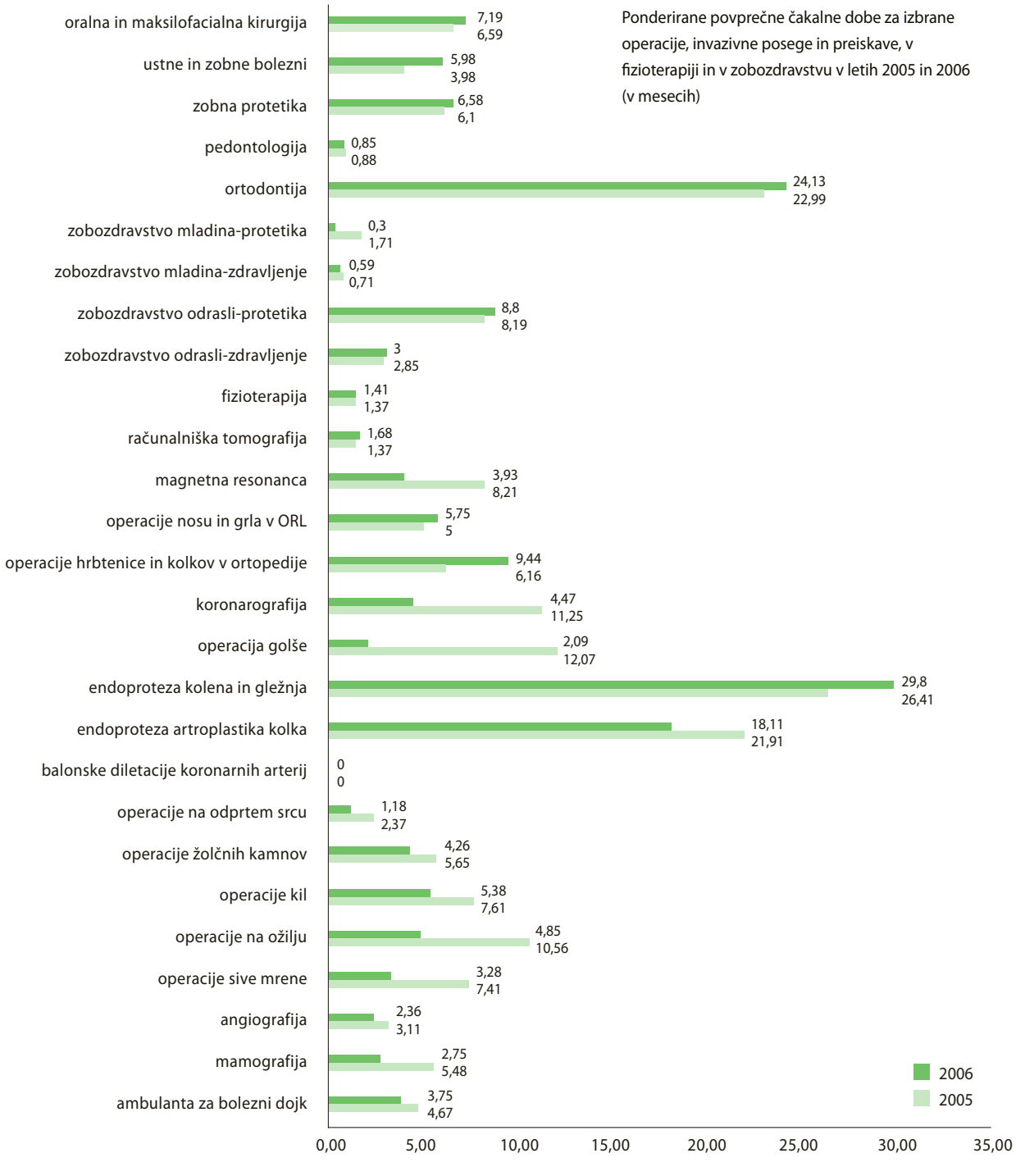


Zato delovanje ZZZS v zadnjem obdobju zaznamujejo napori za izboljšanje dostopnosti in kakovosti storitev na sekundarni in terciarni ravni zdravstvenih dejavnosti. ZZZS že več let s pogajanji in postopki podpisovanja pogodb opredeljuje ordinacijski čas ter čakalne dobe in čakalne knjige za posamezne zdravstvene storitve. Poleg spremljanja trendov posameznih čakalnih dob in zagotavljanja ustreznih informacij o čakalnih dobah zavarovancem tudi preko interneta itd. je ZZZS omenjenemu področju namenil posebno pozornost tudi v postopkih dogovarjanja s partnerji, s katerimi je opredelil prednostna področja ukrepanja. Tako so bile v zadnjih letih sklenjene pogodbe z več izvajalci, s katerimi je bil razširjen obseg rednih programov zdravstvenih storitev in skrajšane dolge čakalne dobe. Tako je ZZZS v obdobju 1997–2006 namenil dodatna sredstva za skrajšanje čakalnih dob in za širjenje prednostnih programov zdravstvenih storitev, kot so operacije katarakte, hernije, operacije žolčnika, operacije na odprtem srcu in druge srčno-žilne operacije, ortopedske operacije kolka, kolena in hrbtenice, operacije žolčnih kamnov, operacije nosu in grla, pregledi z magnetno resonanco, računalniška tomografija, postopki IVF, presaditve, širitev programa obnovitvene rehabilitacije itd.

V letu 2004 je ZZZS v sodelovanju s partnerji v zdravstvu za akutne bolnišnične obravnave uvedel novo metodo plačevanja po skupinah primerljivih primerov (SPP), ki omogoča ciljano načrtovanje storitev in uveljavljanje finančnih vzpodbud za boljšo dostopnost oz. krajšanje čakalnih dob. Tako so se na primer dodatna finančna sredstva v letih 2005 in 2006 sistematično in prednostno namenjala programom z dolgimi čakalnimi dobami, kjer je pri večini izbranih

posegov oziroma storitev bilo zaznati pozitivne premike. Na nekaterih področjih, kot so npr. ortopedija ali zobozdravstvo, pa rezultati še vedno ne ustrezajo pričakovanjem (slika 12). Zaradi rastočih potreb po negi pa je bilo na bolnišnični ravni sprejetih tudi nekaj ukrepov za izboljšanje tovrstne obravnave (uveden program neakutne obravnave bolnikov v bolnišnicah oz. podaljšano zdravljenje in nega).

Slika 12: Realizirane povprečne čakalne dobe v letih 2005 in 2006, Slovenija.



8.2 Zdravila

V Sloveniji je posebne pozornosti in pravne urejenosti deležno tudi zagotavljanje in predpisovanje zdravil. ZZZS tako natančno spremlja predpisovanje zdravil, odhodke za zdravila in številne druge kazalnike (povprečni odhodki za zdravila na zavarovano osebo, na zdravnika, po vrstah zdravil in glede na druge kazalnike iz zbirke podatkov o zdravilih). ZZZS je v skladu z Zakonom odgovoren za razvrščanje zdravil na pozitivno in vmesno listo zdravil. Razvrščanje na liste poteka redno skladno s posebnimi pravili in v sodelovanju z najuglednejšimi strokovnjaki s področja farmakoterapije in farmakoekonomije v državi (posebna neodvisna komisija). Obe listi določata odstotni delež vrednosti predpisanih zdravil, ki je plačan iz javnih sredstev obveznega zdravstvenega zavarovanja ter odstotni delež, ki ga plača zavarovana oseba sama ali njegovo dopolnilno zdravstveno zavarovanje. Zdravila za zdravljenje določenih skupin prebivalstva in določenih bolezni ter stanj (poglavje 5.1.) so vedno na pozitivni listi in jih obvezno zdravstveno zavarovanje krije v celoti (100%). Ostala najpomembnejša in najučinkovitejša zdravila so na pozitivni listi in jih obvezno zdravstveno zavarovanje krije v višini 75 % vrednosti. Druga zdravila (vključno z dražjimi generičnimi paralelami itd.) so na vmesni listi in jih obvezno zdravstveno zavarovanje krije v višini 25% vrednosti.

Izkušnje kažejo, da pozitivna lista sama po sebi ne zagotavlja tudi najbolj učinkovitega obvladovanja odhodkov za zdravila. To lahko prikažemo tudi z izvedenimi ukrepi ZZZS za obvladovanje izdatkov za zdravila v obdobju 1992-2006 (slika 13). Poleg tega je potrebno omeniti, da je nadzor nad cenami zdravil v Sloveniji v zakonski pristojnosti Javne agencije Republike Slovenije za zdravila in medicinske pripomočke, ne pa ZZZS.

Razvrščanje zdravil na pozitivno in vmesno listo pa ni edini sistemski mehanizem za obvladovanje naraščajočih odhodkov za zdravila. Seznam različnih ukrepov in aktivnosti v Sloveniji na tem področju v zadnjem desetletju je precej dolg:

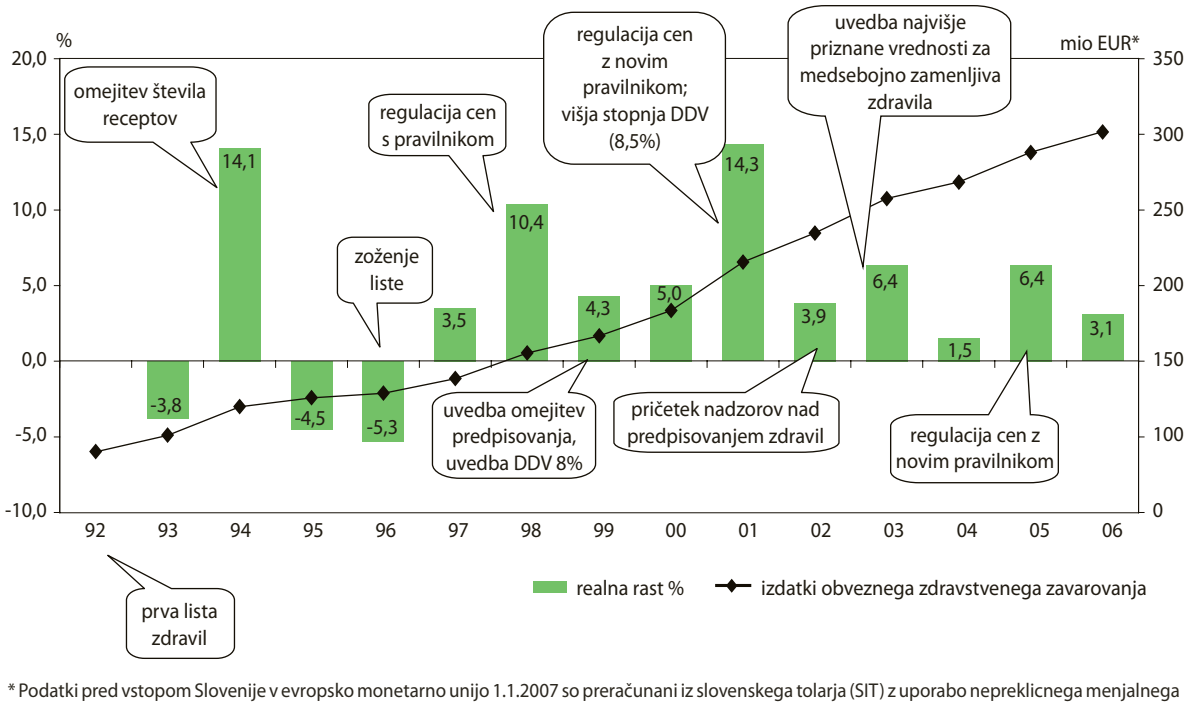
- 1991: uvedba list zdravil, participacija,
- 1992: nov zakon, novosti pri razvrščanju zdravil v liste,
- 1993: začetek izvajanja doplačil za zdravila oz. prostovoljnega zdravstvenega zavarovanja za doplačila,
- 1994: omejitve predpisovanja,
- 1995: ožanje pozitivne liste,
- 1996: zakon o zdravilih,
- 1998: določanje cen,
- 1999: omejitve pri predpisovanju,
- 2001: informiranje in edukacija zdravnikov (STIRA), komisija za nova zdravila, sistematičen nadzor nad predpisovanjem,
- 2002: uvajanje novih bioloških zdravil po kriterijih,
- 2003: seznam medsebojno zamenljivih zdravil, določanje najvišjih priznanih vrednosti (slovenski sistem referenčnih cen)

- 2004: pogajanja za cene zdravil, informiranje zdravnikov, nadzor,
- 2005: projekt promocije varne in pravilne rabe zdravil, informiranje zdravnikov, nadzor,
- 2006: nov pravilnik o oblikovanju cen zdravil, informiranje in edukacija zdravnikov.

Slika 13 prikazuje rast izdatkov za zdravila, ki se v Sloveniji predpisujejo v breme obveznega zdravstvenega zavarovanja. Iz slike je razvidno, kako so vplivali posamezni ukrepi in aktivnosti za zajezitev realne rasti izdatkov in koliko smo v Sloveniji bili pri tem uspešni.

V Slovenji tako vse večjo pozornost namenjamo pristopom, temelječih na dokazih, da bi izboljšali racionalno predpisovanje zdravil in da bi jih uporabniki varno in pravilno uporabljali. ZZZS v ta namen izdaja priporočila in posebne informacije za zdravnike ter nenehno izobražuje in informira zdravnike na primarni ravni o izbranih parametrih predpisovanja zdravil in novostih na področju zdravil. Posebno pozornost med ukrepi za obvladovanje izdatkov za zdravila pa zaradi svojih ugodnih učinkov zasluži slovenski model referenčnih cen zdravil. Uveden je bil leta 2003, in sicer na osnovi uveljavitve sistema medsebojno zamenljivih zdravil in določanja najvišjih priznanih vrednosti (cen) za ta zdravila. Na tej podlagi ZZZS zdravila, ki so prepoznana kot bistveno podobna in ki enako delujejo (imajo enako zdravilno učinkovino, enak odmerek in obliko ter dokazano primerljivo kakovost, varnost in učinkovitost), uvrsti v skupine medsebojno zamenljivih zdravil, za vsako od teh skupin pa določi najvišjo priznano vrednost, ki jo zdravstveno zavarovanje še krije. V vsaki skupini je najmanj eno zdravilo, katerega cena ne presega najvišje priznane vrednosti in jo zato obvezno in prostovoljno zdravstveno zavarovanje skladno z razvrstitvijo na listo zdravil v celoti krije. Če zavarovana oseba vztraja pri

Slika 13: Realna rast in ukrepi ZZZS za obvladovanje izdatkov za zdravila v obdobju 1992-2006.



* Podatki pred vstopom Slovenije v evropsko monetarno unijo 1.1.2007 so preračunani iz slovenskega tolarja (SIT) z uporabo nepreklicnega menjalnega razmerja (1 EUR = 239,64 SIT) v evro (EUR). Ta prikaz omogoča primerjavo v državi skozi čas in zagotavlja ohranitev kazalcev razvoja (stopnje rasti).

izdaji zdravila, ki presega najvišjo priznano vrednost, mora sama doplačati razliko med ceno zdravila in najvišjo priznano vrednostjo. Sistem pa omogoča tudi, da se ZZZS pred uveljavitvijo vsakokratnega novega seznama pogaja s proizvajalci oz. dobavitelji za cene zdravil.

Tabela 9: Zdravila, predpisana na recept v letih 2002 in 2006 ter indeks (2006/2002).

	2002	2006	Indeks 2006/2002
Bruto domači proizvod na prebivalca (v EUR)	12.084	15.167	126
Št. vseh zdravil na recept	2.102	1.801	86
Št. zdravil na pozitivni listi	1.036	1.220	118
Št. zdravil na vmesni listi	248	385	155
Št. zdravilnih učinkovin (INN) na pozitivni in vmesni listi	474	557	118
Št. predpisanih receptov na prebivalca	6,54	7,30	112
Poraba v definiranih dnevnih odmerkih	627.995.813	761.996.028	121
Vsi odhodki za zdravila na recept (v EUR)	321.645.048	424.058.076	132
Odhodki obveznega zdravstvenega zavarovanja za zdravila (v EUR)	215.534.105	293.455.450	136
Vsi odhodki za zdravila na recept na prebivalca (v EUR)	161	211	135
Odhodki obveznega zdravstvenega zavarovanja za zdravila na prebivalca (v EUR)	108	138	117

8.3 Medicinsko–tehnični pripomočki

Zavarovane osebe so v Sloveniji v primeru določenih bolezni in stanj upravičene tudi do medicinsko-tehničnih pripomočkov v breme obveznega zdravstvenega zavarovanja. Potrebo po pripomočku ugotovi osebni zdravnik ali na njegov predlog pooblaščeni zdravnik, ki ga predpiše na posebno naročilnico. Pripomoček lahko zavarovana oseba dobi oziroma si ga izposodi pri pooblaščenem dobavitelju, ki ima z ZZZS sklenjeno pogodbo in na vidnem mestu (s posebno zeleno nalepko) označeno, da izposoja oziroma dobavlja medicinsko-tehnične pripomočke iz obveznega zdravstvenega zavarovanja. Določeni pripomočki (posebej opredeljeni v Pravilih obveznega zdravstvenega zavarovanja) niso last zavarovane osebe, temveč jih zavarovane osebe dobijo v uporabo, nakar jih morajo vrniti izposojevalcu. Dobavitelji so se s sklenitvijo pogodbe z ZZZS zavezali, da bodo zavarovanim osebam zagotavljali kakovostne in funkcionalno ustrezne standardne pripomočke, za katere ob izdaji ne bodo zahtevali nikakršnih doplačil, razen če so predvidena z Zakonom ali Pravili obveznega zdravstvenega zavarovanja. Ob izročitvi pripomočka dobavitelji posredujejo zavarovani osebi vsa potrebna navodila za uporabo, garancijski list in seznam pooblaščenih servisov. Stroške vseh popravil pripomočka, ki nastanejo med garancijsko dobo in niso posledica neustreznega in nestrokovnega ravnanja zavarovane osebe, krijejo dobavitelji. Dobavitelj je za čas popravila pripomočka praviloma dolžan zavarovani osebi zagotoviti nadomestek. Poleg tega dobavitelji zagotavljajo tudi redno vzdrževanje in servisiranje izdanega pripomočka ves čas njegove trajnostne dobe. Dobavitelji sicer lahko dobavljajo tudi nadstandardne pripomočke, vendar le, če zavarovana oseba to izrecno želi in pisno izjavi, da je pripravljena doplačati razliko v ceni. Dobavitelj mora vedno imeti na zalogi tudi vse vrste standardnih pripomočkov ustrezne kakovosti.

Tabela 10: Izdane naročilnice za medicinsko-tehnične pripomočke in njihova vrednost v letu 2006.

V letu 2006 so največji delež izdanih naročilnic predstavljali pripomočki pri težavah z odvajanjem seča (43,77 %), pripomočki za slepe in slabovidne (18,30%) in pripomočki pri zdravljenju sladkorne bolezni (15,55 %) – vse tri skupine pripomočkov skupaj vrednostno predstavljajo več kot polovico vseh sredstev za pripomočke (62,39 %). Pripomočki pri umetno izpeljanem črevesju predstavljajo 8,11% vseh sredstev za pripomočke, slušni aparati 6,34%, vozički in ostali pripomočki za gibanje, stojo in sedenje 4,78 % itd.

Skupina	Št. izdanih naročilnic	Delež izdanih naročilnic	Vrednost izdanih med.-tehničnih pripomočkov (v EUR)	Delež vrednosti	Povprečna vrednost na naročilnico (v EUR)
Proteze udov	896	0,14%	950.562	2,24%	1.060,89
Estetske proteze	4.587	0,70%	473.760	1,11%	103,28
Ortoze	9.377	1,44%	871.644	2,05%	92,96
Ortopedska obutev	5.569	0,86%	451.372	1,06%	81,05
Vozički in ost.ali pripomočki za gibanje, stojo in sedenje	12.335	1,90%	2.031.896	4,78%	164,73
Električni stimulatorji in ostali aparati	4.234	0,65%	611.628	1,44%	144,46
Sanitarni pripomočki	4.386	0,67%	274.353	0,65%	62,55
Blazine proti preležaninam	1.195	0,18%	120.018	0,28%	100,43
Kilni pasovi	3.627	0,56%	165.039	0,39%	45,50
Pripomočki pri umetno izpeljanem črevesju	14.930	2,29%	3.450.431	8,11%	231,11
Pripomočki pri težavah z odvajanjem seča	284.913	43,77%	12.221.504	28,74%	42,90
Pripomočki pri zdravljenju sladkorne bolezni	101.180	15,55%	12.356.717	29,05%	122,13
Kanile	7.286	1,12%	583.382	1,37%	80,07
Ostali tehnični pripomočki	2.407	0,37%	72.461	0,17%	30,10
Pripomočki za slepe in slabovidne	119.117	18,30%	1.954.720	4,60%	16,41
Slušni aparati	13.894	2,13%	2.698.126	6,34%	194,19
Obvezilni material	50.092	7,70%	1.637.765	3,85%	32,70
Raztopine	10.840	1,67%	48.124	0,11%	4,46
Servisiranje			898.444	2,11%	
Strošek dela izposojevalnice			334.333	0,79%	
Storitve			323.321	0,76%	
SKUPAJ	**650.865**	**100,00%**	**42.529.600**	**100,00%**	**65,34**

9 Izvajanje mednarodnih zdravstvenih zavarovanj in sodelovanje s tujino

9.1 Uveljavljanje zdravstvenih storitev v Republiki Sloveniji

Postopek uveljavljanja in obsega pravice do zdravstvenih storitev tujih zavarovanih oseb v Republiki Sloveniji je odvisen od tega, iz katere države tuja zavarovana oseba prihaja, saj ima Republika Slovenija z nekaterimi državami sklenjene meddržavne sporazume o socialni varnosti (Republika Hrvaška in Republika Makedonija) oziroma velja za uveljavljanje zdravstvenih storitev državljanov držav članic Evropske unije, Evropskega gospodarskega prostora in Švice evropski pravni red.

A) DRŽAVLJANI DRŽAV ČLANIC EVROPSKE UNIJE, EVROPSKEGA GOSPODARSKEGA PROSTORA IN ŠVICE

Zavarovane osebe držav članic Evropske unije (v nadaljevanju EU), Evropskega gospodarskega prostora (v nadaljevanju: EGP) in Švice imajo v primeru začasnega bivanja v Republiki Sloveniji na podlagi evropske kartice zdravstvenega zavarovanja oz. certifikata, ki začasno nadomešča evropsko kartico zdravstvenega zavarovanja, pravico do »zdravstvenih storitev, ki so potrebne iz medicinskih razlogov, upoštevajoč naravo storitev in pričakovano dolžino bivanja v drugi državi članici« (Uredba (EGS) št. 1408/71).

Z evropsko kartico oz. certifikatom tako zavarovane osebe teh držav uveljavljajo nujne oz. potrebne zdravstvene storitve neposredno pri zdravnikih in zdravstvenih ustanovah, ki imajo sklenjeno pogodbo z ZZZS. Zdravstvene storitve lahko uveljavljajo le na primarni ravni zdravstvene dejavnosti, medtem ko morajo za specialistično ali bolnišnično zdravljenje pridobiti napotnico splošnega zdravnika na primarni ravni. Nujno medicinsko pomoč pa lahko uveljavljajo neposredno v najbližji bolnišnici.

V primeru nujne medicinske pomoči doplačila niso predvidena, saj je takšna storitev v celoti krita z obveznim zdravstvenim zavarovanjem. Ostale storitve pa so zagotovljene brezplačno le do določenega odstotka vrednosti storitve, saj je potrebno za posamezne vrste zdravstvenih storitev doplačilo od 5% do 75% vrednosti storitve.

B) DRŽAVLJANI REPUBLIKE HRVAŠKE IN REPUBLIKE MAKEDONIJE, S KATERIMI IMA REPUBLIKA SLOVENIJA SKLENJEN MEDDRŽAVNI SPORAZUM

Zavarovane osebe teh dveh držav lahko uveljavljajo v Republiki Sloveniji pravico do nujnega zdravljenja in nujne medicinske pomoči pri zdravnikih in zdravstvenih ustanovah, ki imajo sklenjeno pogodbo z ZZZS. Na podlagi obrazca HR/SLO 3 oz. RM/SI 3, ki ga predložijo na območni enoti oz. izpostavi ZZZS, jim le-ta izda ustrezno listino. Na podlagi slednjega lahko uveljavljajo nujne zdravstvene storitve le na primarni ravni, medtem ko morajo za specialistično ali bolnišnično zdravljenje pridobiti napotnico splošnega zdravnika na primarni ravni. Nujno medicinsko pomoč pa lahko uveljavljajo neposredno v najbližji bolnišnici.

V primeru nujne medicinske pomoči doplačila niso predvidena, saj je takšna storitev v celoti krita z obveznim zdravstvenim zavarovanjem.

C) DRŽAVLJANI OSTALIH DRŽAV, KI NISO ČLANICE EVROPSKE UNIJE, EVROPSKEGA GOSPODARSKEGA PROSTORA OZ. ŠVICA, ALI S KATERIMI NI SKLENJEN MEDDRŽAVNI SPORAZUM

Z ostalimi državami Republika Slovenija nima sklenjenega meddržavnega sporazuma o socialni varnosti, ki bi urejal področje zdravstvenega varstva in zdravstvenega zavarovanja, kar pomeni, da morajo državljani teh držav v primeru uveljavljanja zdravstvenih storitev v Republiki Sloveniji, le-te plačati sami.

Republika Slovenija v skladu z Zakonom o zdravstvenem varstvu in zdravstvenem zavarovanju iz proračuna zagotavlja sredstva za nujno zdravstveno varstvo oseb neznanega prebivališča, tujcev iz držav, s katerimi niso sklenjeni meddržavni sporazumi, ter tujcev in državljanov Republike Slovenije s stalnim prebivališčem v tujini, ki začasno prebivajo v Republiki Sloveniji ali so na poti skozi Republiko Slovenijo, in zanje ni bilo mogoče zagotoviti plačila zdravstvenih storitev.

9.2 Uveljavljanje zdravstvenih storitev v tujini

Zavarovane osebe, ki so obvezno zdravstveno zavarovane v Republiki Sloveniji, imajo med začasnim bivanjem v tujini zagotovljene pravice do nujnih oziroma potrebnih zdravstvenih storitev.

A) UVELJAVLJANJE ZDRAVSTVENIH STORITEV V DRŽAVAH ČLANICAH EVROPSKE UNIJE, EVROPSKEGA GOSPODARSKEGA PROSTORA IN ŠVICE

Z evropsko kartico zdravstvenega zavarovanja oz. certifikatom lahko slovenske zavarovane osebe v teh državah uveljavljajo zdravstvene storitve, ki so potrebne iz medicinskih razlogov, upoštevajoč naravo storitev in pričakovano dolžino bivanja v drugi državi članici, in sicer neposredno pri zdravnikih in zdravstvenih ustanovah, ki so del javne zdravstvene mreže. Navedene storitve se uveljavljajo skladno s predpisi države, kjer se storitev uveljavlja, kar pomeni, da je potrebno v nekaterih državah določene storitve tudi doplačati, enako kot to velja za zavarovane osebe te države.

B) UVELJAVLJANJE ZDRAVSTVENIH STORITEV V DRŽAVAH – PODPISNICAH MEDDRŽAVNIH SPORAZUMOV

Slovenske zavarovane osebe imajo v Republiki Hrvaški in Republiki Makedoniji, državah s katerimi ima Republika Slovenija sklenjen meddržavni sporazum o socialni varnosti, pravico do nujnih zdravstvenih storitev neposredno pri zdravnikih in zdravstvenih ustanovah, ki so del javne zdravstvene mreže, na podlagi evropske kartice zdravstvenega zavarovanja oz. certifikata.

C) UVELJAVLJANJE ZDRAVSTVENIH STORITEV V OSTALIH DRŽAVAH

Slovenske zavarovane osebe, ki uveljavljajo zdravstvene storitve v državah, kjer ne velja evropska zakonodaja oz. s katerimi ni sklenjen meddržavni sporazum o socialni varnosti, morajo te storitve plačati same. Na podlagi predložene medicinske dokumentacije in

originalnih računov nato ZZZS v upravičenih primerih opravi povračilo stroškov v višini povprečne cene teh storitev v Republiki Sloveniji.

9.3 Napotitev na zdravljenje v tujino

Zavarovane osebe imajo v skladu z Zakonom o zdravstvenem varstvu in zdravstvenem zavarovanju pravico do pregleda, preiskave ali zdravljenja v tujini, če so v Republiki Sloveniji izčrpane možnosti zdravljenja, hkrati pa je utemeljeno pričakovati ozdravitev ali izboljšanje zdravstvenega stanja oziroma preprečiti nadaljnje slabšanje. O upravičenosti do zdravljenja v tujini odloča ZZZS v upravnem postopku, in sicer imenovani zdravnik ZZZS oz. zdravstvena komisija ZZZS.

V letu 2006 je tako ZZZS prejel 493 vlog za odobritev napotitve na zdravljenje, preiskavo ali pregled v tujino ter odobritve očesnih protez, kar je za 18% več kot v letu 2005. Na zdravljenju ali pregledu v tujini je bilo na ta način napotenih 212 zavarovanih oseb. Ker so bile nekatere zavarovane osebe na zdravljenju ali pregledu v tujini večkrat, je bilo vseh napotitev skupaj 260.

Tabela 11: Pregled števila napotenih slovenskih zavarovanih oseb po državah, kamor so bile napotene na zdravljenje, preiskavo ali pregled, 2006.

Zavarovane osebe so bile v letu 2006 napotene na zdravljenje ali pregled v Avstrijo, Francijo, Hrvaško, Italijo, Nemčijo, Nizozemsko, Španijo, Švico, Veliko Britanijo in ZDA. Največ zavarovanih oseb je bilo napotenih na zdravljenje v Avstrijo in Nemčijo (Tabela 11).

Država	Št. zavarovanih oseb	Št. napotitev
Avstrija	94	111
Francija	10	13
Hrvaška	13	13
Italija	9	11
Nemčija	42	58
Nizozemska	2	2
Španija	1	1
Švica	17	24
Velika Britanija	23	24
ZDA	1	3
SKUPAJ	**212**	**260**

ZZZS je 38 zavarovanim osebam odobril nabavo očesne proteze, ki so jo prejeli v Avstriji. 155 zavarovanim osebam pa je bila odobrena diagnostika poslanih vzorcev tkiva ali krvi v tujino. Največ vzorcev (20% vseh) je bilo poslano na analizo v Nemčijo.

ZZZS je v letu 2006 na podlagi Pravil obveznega zdravstvenega zavarovanja in posebnega sklepa Upravnega odbora ZZZS o napotitvah v tujino v primeru predolgih čakalnih dob omogočil povračilo stroškov do višine cene te storitve v Republiki Sloveniji 13 zavarovanim osebam, ki so v tujini opravile 14 postopkov oploditve z biomedicinsko pomočjo.

9.4 Mednarodno sodelovanje

ZZZS aktivno sodeluje z organi za zvezo posameznih držav pri izvajanju evropske zakonodaje in meddržavnih sporazumov o socialni varnosti ter sklepanju novih sporazumov o socialni varnosti.

Obračunavanje stroškov zdravstvenih storitev med slovenskimi in tujimi nosilci zdravstvenega zavarovanja je v letu 2006 potekalo z 31 državami. ZZZS je tako obračunal tujim državam

Tabela 12: Pregled števila primerov tujih in slovenskih zavarovanih oseb ter terjatev in obveznosti ZZZS do tujine po evropski zakonodaji in sporazumih o socialni varnosti v letu 2006 (v evrih).

Št.	Država	Število primerov tujih zavarovancev v Sloveniji v letu 2006	Število primerov slovenskih zavarovancev v tujini v letu 2006	Novonastale terjatve v letu 2006 (v EUR)	Novonastale obveznosti v letu 2006 (v EUR)
1	Avstrija	6.871	1.018	2.131.532,12	492.599,52
2	Belgija	87	118	20.952,46	19.937,38
3	Ciper	0	0	0,00	0,00
4	Češka	114	44	61.699,16	5.005,99
5	Danska	18	0	28.353,92	0,00
6	Estonija	8	1	620,08	7,86
7	Finska	18	7	1.712,94	4.848,75
8	Francija	176	89	46.749,11	41.914,00
9	Grčija	34	0	13.961,42	0,00
10	Hrvaška	1.589	15.474	2.213.837,86	8.220.610,92
11	Irska	50	0	7.693,25	0,00
12	Islandija	8	0	1.963,27	0,00
13	Italija	3.481	227	814.019,49	276.943,49
14	Latvija	5	0	183,52	0,00
15	Liechtenstein	1	0	41,52	0,00
16	Litva	5	0	1.300,98	0,00
17	Luksemburg	6	9	294,83	8.923,96
18	Malta	0	1	0,00	5.175,98
19	Madžarska	72	120	20.841,59	523,81
20	Makedonija	99	1.286	77.333,12	6.958,51
21	Nemčija	3.888	964	1.804.216,22	746.610,70
22	Nizozemska	43	65	24.373,69	66.975,04
23	Norveška	29	1	10.577,49	13.138,91
24	Poljska	108	9	26.556,77	3.967,75
25	Portugalska	39	4	8.379,35	233,31
26	Romunija	0	0	0,00	0,00
27	Slovaška	268	42	105.400,82	10.748,99
28	Španija	95	108	24.832,83	19.626,77
29	Švedska	179	20	61.285,69	19.521,82
30	Švica	14	0	2.457,09	0,00
31	Velika Britanija in S.Irska	531	0	198.648,36	0,00
	SKUPAJ	**17.836**	**19.607**	**7.709.818,93**	**9.964.273,46**

stroške za zdravstvene storitve, ki so jih v Sloveniji uveljavljale njihove zavarovane osebe, v znesku 7,5 milijonov evrov, in sicer za 17.836 primerov. Največ obračunov je ZZZS posredoval Hrvaški (2,2 milijona evrov), Avstriji (2,1 milijona evrov) in Nemčiji (1,8 milijona evrov), kot je razvidno iz Tabele 10.

Zdravstvene storitve, ki so jih slovenskim zavarovanim osebam v imenu pristojne ustanove zagotavljali tuji nosilci zavarovanja v kraju stalnega ali začasnega bivanja v letu 2006, so tuje države zaračunale ZZZS v skupnem znesku 10 milijonov evrov za skupaj 19.607 primerov. Največ stroškov je obračunala Hrvaška, in sicer v višini 8,35 milijonov evrov. Sledita pa ji Nemčija in Avstrija z 742.780 oz. 492.400 evrov, kar je razvidno iz Tabele 10.

ZZZS so tudi v tem letu obiskale nekatere tuje delegacije, strokovnjaki ZZZS pa so se vključevali v številne mednarodne projekte ter sodelovali na mednarodnih konferencah. V letu 2006 so strokovnjaki ZZZS med drugim sodelovali tudi pri pripravi novih meddržavnih sporazumov o socialni varnosti z Avstralijo ter Bosno in Hercegovino.

10 Razvojne aktivnosti na področju kakovosti in poslovne učinkovitosti zdravstvenega varstva

Po finančni sanaciji ZZZS v obdobju 2004-2005 so v ospredju ključnih razvojnih aktivnosti ZZZS trenutno prizadevanja za zagotavljanje bolj kakovostnega in dostopnega zdravstvenega varstva zavarovanim osebam. Gre za sklop različnih aktivnosti, kot je na primer uveljavitev standarda, po katerem zavarovane osebe v čakalnicah pred zdravniškimi ordinacijami na primarni ravni zdravstvene dejavnosti povprečno ne bi čakale dlje kot 20 minut. Sicer pa v Sloveniji ni čakalnih dob za pregled ali poseg v splošnih ambulantah, otroških in šolskih dispanzerjih ter v primerih kadar zdravstveno stanje zavarovane osebe terja nujne in neodložljive storitve, za vse druge storitve oz. v vseh drugih primerih pa lahko izvajalci zdravstvenih storitev vodijo čakalno knjigo, v katerih določijo datum in uro pregleda, preiskave ali posega. Dolge čakalne dobe so v Sloveniji glavni vir nezadovoljstva zavarovanih oseb z zdravstvenim varstvom. Le-te so večinoma posledica naraščajočih potreb starajočega se prebivalstva (v letu 2006 je bilo 16,2% prebivalcev Slovenije starejših od 65 let), ki se odražajo v povečanih potrebah po zdravstvenih storitvah, v posameznih primerih pa so čakalne dobe tudi posledica organizacijskih, kadrovskih in drugih težav, ki se odražajo v neoptimalni izkoriščenosti opreme, kadra in prostorov. Zaradi povečanih potreb prebivalstva je ZZZS že od leta 1997 dalje vedno več dodatnih sredstev namenjal za širitve izbranih programov zdravstvenih storitev z namenom skrajševanja čakalnih dob in uvajanja novih metod zdravljenja. Tako je ZZZS za tovrstne namene samo v letu 2006 zagotovil dodatna sredstva v višini 61 milijonov evrov. Tovrstna dolgoročna vlaganja in povečevanje storilnosti izvajalcev zdravstvenih storitev je obrodilo konkretne uspehe pri skrajševanju čakalnih dob na primer za operacijo na odprtem srcu (trenutno povprečno 1,2 meseca), operacijo sive mrene (trenutno povprečno 3,3 mesece), računalniška tomografija (trenutno povprečno 1,7 meseca).

ZZZS si kot ključni plačnik zdravstvenih storitev prizadeva tudi za optimiziranje cen. V ta namen vzpostavlja podlage za podrobnejše analitično spremljanje stroškov zdravstvenih storitev z vidika stroškovne učinkovitosti, uspešnosti, dostopnosti in kakovosti izvajanja programov zdravstvenih storitev. Na tej podlagi predstavnikom izvajalcem predlaga spremembe v financiranju zdravstvenih storitev.

S sodelovanjem ZZZS v nacionalnem projektu »Razvoj upravljanja sistema zdravstvenega varstva«, ki je potekal pod okriljem Ministrstva za zdravje in sodelujočih ustanov ob sofinanciranju Svetovne banke, je bil junija 2004 uveden nov obračunski model na področju akutne bolnišnične obravnave, ki predstavlja racionalnejšo podlago za načrtovanje bolnišnične zdravstvene dejavnosti. V ta namen so bile izvedene tudi spremembe v sistemu računalniškega izmenjevanja obračunskih dokumentov med izvajalci zdravstvenih storitev in ZZZS ter spremembe v programski opremi za evidentiranje in kontrolo teh dokumentov na ZZZS. Izdelani so bili številni opisi kliničnih poti izvajalcev specialistično ambulantne in bolnišnične dejavnosti. Cilj vpeljave teh kliničnih poti je izboljšanje delovnih procesov v smislu optimizacije potreb po kadru za določeno področje dela, optimizacije porabljenega časa, boljšo oskrbo bolnikov ipd.

Kot pobudnik projekta za uvedbo zavarovanja za dolgotrajno oskrbo je ZZZS pred 2 letoma izdelal podroben predlog za uvedbo tega zavarovanja, ki bi sistemsko in dolgoročno uredil

problematiko dolgotrajne oskrbe v Sloveniji. Dolgotrajna oskrba je namreč eno od stičnih področij socialnega in zdravstvenega varstva, ki v Sloveniji še ni evropsko primerljivo urejeno. Predlog je bil posredovan ministrstvu za zdravje in ministrstvu za delo, družino in socialne zadeve z namenom, da se pripravi in sprejme ustrezna zakonodaja.

Na področju zdravil in medicinsko-tehničnih pripomočkov je ZZZS s pogovori in pogajanji uspel znižati cene vrsti zdravil in medicinsko-tehničnih pripomočkov ter uspel na tej podlagi zagotoviti zavarovanim osebam dostop do številnih novih zdravil in medicinsko tehničnih pripomočkov skladno z razvojem medicine in farmacije. Pozitivni rezultati so še posebej vidni na področju zdravil, kjer je ZZZS poleg vsakoletnih pogajanj o znižanju cen, v letu 2003 uvedel še način zagotavljanja pravic do zdravil na podlagi njihove zamenljivosti – slovenska različica sistema referenčnih cen zdravil. V letu 2005 je bila vzpostavljena nova baza zdravil, ki je postala nepogrešljiva evidenca za delo lekarn, ZZZS in Inštituta za varovanje zdravja. Aktivnosti in prizadevanja na področju zdravil je ZZZS podkrepil še z izvedbo nacionalnega projekta za promocijo varne in pravilne rabe zdravil, ki je bil leta 2006 usmerjen predvsem v izvedbo obsežne medijske kampanje ter množično izdajo tiskanih gradiv za promocijo varne in pravilne rabe zdravil na strani uporabnikov zdravil.

Slika 14: Prepoznavni slogan in logotip projekta Raba zdravil – Premišljeno z zdravili. Za vaše zdravje gre!

Z namenom temeljite prenove informacijske podpore beleženju in kontroli opravljenih in ZZZS zaračunanih zdravstvenih storitev za potrebe spremljanja stroškov po izvajalcih, dejavnostih in zavarovanih osebah, bo ZZZS predvidoma do spomladi l. 2009 izvajal poseben projekt, v okviru katerega bodo podatki s specifikacij organizirani na način zbirk podatkov ter vzpostavljene pilotne informacijske rešitve za podporo analizam podatkov o opravljenih zdravstvenih storitvah v akutni bolnišnični obravnavi in za zdravila, izdana na recept.

Intenzivna prizadevanja ZZZS so bila v zadnjih treh letih usmerjena tudi v organizacijsko prenovo in uvedbo informacijske podpore področju uveljavljanja regresnih zahtevkov v primerih ko lahko ZZZS uveljavlja povračilo škode, nastale zaradi poškodb zavarovancev v prometnih nesrečah, nesrečah pri delu, škode, nastale v pretepih, zastrupitvah s hrano itd. Razvita in uvedena je bila celovita informacijska podpora izvajanju poslovnega procesa za pridobivanje, zbiranje in evidentiranje podatkov o nastali škodi in uveljavljanje povračil škode, do katerih ima ZZZS pravico povračila. Vgrajene kontrole zagotavljajo ažurno, točno in enotno vodenje podatkov o nastalih škodah in s tem dobro osnovo za učinkovito uveljavljanje regresnih zahtevkov v okviru območnih enot in ZZZS kot celote.

11 Komunikacijske tehnologije

Informacijska podpora predstavlja temelj za nemoteno poslovanje ZZZS, saj si sodobnega poslovanja ustanov, kot je ZZZS, ne moremo predstavljati brez kar najbolj učinkovite informacijske podpore. Informacijski sistem ZZZS podpira vsa poslovna področja, tako ključna kot podporna. Zaprto zasebno računalniško omrežje povezuje vse lokacije ZZZS, s svojo propustnostjo pa podpira nemoteno delovanje računalniških rešitev odjemalec/strežnik, e-komuniciranja in pisarniškega poslovanja.

V letu 2000 je ZZZS uvedel sodobno elektronsko kartico zdravstvenega zavarovanja v slovensko zdravstvo, ki je za zavarovane osebe pomenila hitrejši in prijaznejši vstop v zdravstveni sistem (identifikacija pacienta in preverjanje veljavnosti njegovega obveznega in prostovoljnega zdravstvenega zavarovanja) in hkrati novo fazo v razvoju sodobnega in enovitega zdravstveno informacijskega sistema v Sloveniji. Z namenom poenostavitve in preglednejših postopkov obveznega zdravstvenega zavarovanja so bili v obdobju 2002-2006 na tem področju izvedeni še nekateri projekti, ki so omogočili nove uporabnosti kartice – zapis izdanih zdravil, medicinsko-tehničnih pripomočkov ter podatkov o darovalcu organov na kartico, pa tudi elektronsko naročanje listin za uveljavljanje zdravstvenih storitev v tujini preko omrežja skoraj 300 elektronskih samopostrežnih terminalov po vsej Sloveniji.

Posebna skrb je posvečena razpoložljivosti in varnosti omrežja, ki je za potrebe poslovanja z zunanjimi partnerji varno in v eni sami točki povezano tudi v javno omrežje. Zaradi navedenih razlogov je ZZZS na tem področju v letu 2006 pričel izvajati projektne aktivnosti za vzpostavitev neprekinjenega delovanja informacijskega sistema z možnostjo delovanja na rezervni lokaciji ter projekt prenove sistema kartice zdravstvenega zavarovanja in projekt uvedbe on-line sistema, po katerem bo kartica skladno s sodobnimi evropskimi trendi postala le še ključ za dostop do podatkov in ne več nosilec podatkov zdravstvenega zavarovanja. Za to se je ZZZS odločil zaradi številnih poslovnih in tehničnih razlogov, pri čemer si prizadeva za postopen prehod v smeri uvedbe neposrednih dostopov do podatkov, ki se sedaj nahajajo na kartici. Enostavno, kakovostno in učinkovito prenašanje podatkov ter komuniciranje v okviru on-line zdravstvenega zavarovanja je namreč ena temeljnih razvojnih usmeritev ZZZS v prihodnjih dveh letih, ki jo bo ZZZS skušal uresničiti z izvedbo dveh projektov, ki bosta usmerjena v uvedbo on-line sistema ter razvoj nove kartice zdravstvenega zavarovanja, profesionalne kartice in infrastrukture javnih ključev. S tem se bodo za zavarovane osebe poenostavili postopki uresničevanja pravic iz zdravstvenega zavarovanja, izvajalcem zdravstvenih storitev bodo na voljo bolj točni in ažurni osebni in medicinski podatki, kar bo povečalo kakovost zdravstvenih storitev, zdravstvenim zavarovalnicam pa omogočilo racionalizacijo stroškov poslovanja. Aktivnosti na področju kartice zdravstvenega zavarovanja pa v zadnjih letih zaznamuje tudi intenzivno sodelovanje ZZZS v mednarodnih dejavnostih in projektih Evropske unije (projekta NETC@RDS in INCOHEALTH), v katerih zlasti intenzivno sodeluje pri pripravi podlag za uvedbo elektronske evropske kartice zdravstvenega zavarovanja.

Slika 15: Grafična podoba kartice zdravstvenega zavarovanja (za zavarovane osebe zgoraj) in profesionalne kartice (za zdravstvene delavce spodaj) nove generacije, ki jo bo ZZZS pilotno uvedel maja 2008.

12 Kontakti

Spletna stran: http.//www.zzzs.si

ZZZS, Direkcija
Miklošičeva cesta 24, 1507 Ljubljana
Tel.: + 386 01 30 77 200, Fax: + 386 01 23 12 182
e-pošta: di@zzzs.si

ZZZS, Področna enota Informacijski center
Miklošičeva cesta 24, 1507 Ljubljana
Tel.: (01) 30 77 200, Fax: (01) 23 12 182
e-pošta: peic@zzzs.si

ZZZS, Območna enota Celje
Gregorčičeva 5 a, 3000 Celje
Tel. (03) 42 02 000, Fax: (03) 54 82 301
e-pošta: oece@zzzs.si

ZZZS, Območna enota Koper
Martinčev trg 2, 6000 Koper
Tel. (05) 66 87 200, Fax: (05) 66 87 372
e-pošta: oekp@zzzs.si

ZZZS, Območna enota Kranj
Zlato polje 2, 4000 Kranj
Tel. (04) 23 70 100, Fax: (04) 23 70 180
e-pošta: oekr@zzzs.si

ZZZS, Območna enota Krško
Bohoričeva 9, 8270 Krško
Tel. (07) 49 02 490, Fax: (07) 49 01 081
e-pošta: oekk@zzzs.si

ZZZS, Območna enota Ljubljana
Miklošičeva cesta 24, 1507 Ljubljana
Tel. (01) 30 77 200, Fax: (01) 43 12 154
e-pošta: oelj@zzzs.si

ZZZS, Območna enota Maribor
Sodna 15, 2000 Maribor
Tel. (02) 29 09 300, Fax: (02) 25 21 591
e-pošta: oemb@zzzs.si

ZZZS, Območna enota Murska Sobota
Slovenska ul. 48, 9000 Murska Sobota
Tel. (09) 53 61 550, Fax: (09) 53 21 236
e-pošta: oems@zzzs.si

ZZZS, Območna enota Nova Gorica
Gradnikove brigade 1, 5000 Nova Gorica
Tel. (05) 33 81 000, Fax: (05) 30 28 379
e-pošta: oeng@zzzs.si

ZZZS, Območna enota Novo mesto
Prešernov trg 7, 8000 Novo mesto
Tel. (07) 39 33 500, Fax: (07) 39 33 511
e-pošta: oenm@zzzs.si

ZZZS, Območna enota Ravne na Koroškem
Ob Suhi 11 b, 2380 Ravne na Koroškem
Tel. (02) 82 10 100, Fax: (02) 82 10 260
e-pošta: oerv@zzzs.si

13 Viri

1. Zakon o zdravstvenem varstvu in zdravstvenem zavarovanju.
2. Pravila obveznega zdravstvenega zavarovanja.
3. Statut Zavoda za zdravstveno zavarovanje Slovenije.
4. Poslovna poročila Zavoda za zdravstveno zavarovanje Slovenije, 1992–2006.
5. Zdravstveni statistični letopis. Inštitut za varovanje zdravja Republike Slovenije. Ljubljana, 1992–2004.
6. Statistični urad Republike Slovenije.
7. Urad Republike Slovenije za makroekonomske analize in razvoj.
8. Zupanič Slavec Zvonka, Zdrava setev - plodna žetev: ob 110-letnici zdravstvenega zavarovanja pri Slovencih. Ljubljana: Zavod za zdravstveno zavarovanje Slovenije, 1999.

ZAVOD ZA ZDRAVSTVENO ZAVAROVANJE SLOVENIJE
www.zzzs.si