

Health care in Slovenia: an interview with the Minister

EDITOR'S NOTE

The original intention was to ask the same questions of the Australian and Slovenian Ministers for Health, so that readers might compare the answers.

The Slovenian Minister was happy to answer questions without notice, and to accept the interviewer's interpretations (as they appear below). The Australian Minister asked that questions be submitted in advance, and then prevaricated for two months. We are still waiting for a positive response: the invitation remains open.

We decided to go ahead and publish the Slovenian Minister's responses. We hope that readers find them of interest on their own.

In passing, it seems to me that one might reasonably conclude the Australian Minister has little interest in talking seriously to the many thousands of health care professionals who regularly read the AHR. If so, this is a sad state of affairs.

Interview with Dr Dusan Keber, 2 February 2002.



Dusan Keber is a medical doctor with a distinguished clinical and medical research record. He was Director of the Department of Angiology at the Ljubljana Medical Centre (a 2000-bed teaching hospital) from 1983-1996, and Medical Director of the Centre from 1996-2000. He has been Minister for Health since 2000. Questions are italic.

Most of Slovenia's health care is financed from an integrated, government-owned, compulsory and universal health insurance scheme. Would you like to see more privately owned and operated insurance schemes?

No. Government ownership is the best guarantee of equity of health insurance coverage, cost-effectiveness of covered services, and efficiency.

On the matter of efficiency, private insurers competing in the marketplace are bound to have higher administrative costs. Private health insurers around the world typically spend at least 10% of revenues on administration. We cannot afford to waste scarce health sector resources in such a way. In Slovenia, we spend only about 3% on administration, about the same as most similar government schemes in other countries.

Should there be more voluntary and less compulsory insurance?

I need to clear up a definitional matter before continuing. In some countries, people may make a choice of the level and type of insurance, within limits, but they cannot choose to have no insurance. I define this not to be voluntary in my response.

In general, I favour compulsory insurance, especially for services of high value for money. Any degree of choice sounds good in principle, but this is only true if people have a real choice and they have enough information to make a sound choice. In reality, people are likely to make poor choices – and consequently risk the health and wellbeing of themselves, their families, and the community as a whole.

Health insurance contributions in Slovenia are almost wholly income-based. In other words, contributions are in proportion to ability to pay. Would you like to see a higher proportion of risk-based insurance: for example, to have elderly people pay higher contributions because they are more likely to need services?

No, mainly on grounds of equity. Risk-based premiums would penalise those most in need of community support.

Most services covered by the government insurance scheme are free, or have a small copayment. Would you like to see copayments increased? Many people believe this is a good way to control demand.

No. Not only on grounds of equity but also for reasons of efficiency. Copayments obviously penalise the sick and the poor. Less obvious, copayments are inefficient because the responsibility for deciding what services represent good value for money is transferred from clinicians to the patients themselves.

In general, ordinary people cannot easily judge whether, say, screening programs are a good investment, or whether their own need for scarce resources of cardiologists is greater or less than the needs of other patients. Rationing of health care is essential and fundamentally difficult. No responsible government can transfer the task to individuals.

Please note, however, that I am not saying that all insurance should be compulsory and that there should never be copayments or risk-based insurance. I am simply saying that, once a country has decided how much it wants to spend on health care, the largest part of that money must be managed by government agencies that have carefully judged which services are sufficiently cost-effective to be covered by insurance. Where a service is covered, it should generally be free of charge.

However, there will be unmet needs in any country, no matter how rich it is. Most social democracies therefore allow individuals to choose to pay more in order to get more services. I do not object to this, as long as the services they obtain are the residuals that are not of sufficient value for money to be included in the universal scheme – and as long as there is no subsidisation of these optional services from government sources.

We do not have a perfect rationing system by any means. There are some services covered by our compulsory scheme that are of relatively low value for money, and conversely there are high value for money services that are not available to everyone because of a shortage of supply. At least, there are services for which there are inappropriately long waiting times. However, I think we have the vision and the commitment to do better.

The overwhelming majority of health care facilities are government-owned, and some of them would benefit from additional capital investments. Do you see the possibility of going to private investors to obtain the capital? Do you see changes like the private financing initiatives in the UK occurring in Slovenia in the foreseeable future?

No. The English phrase that is relevant here is that there are no free lunches. Why would anyone in their right minds choose to invest in hospitals and health centres if there were no good possibility of a return on investment? And any return on investment represents a loss of scarce resources for patient care.

I would be pleased if some philanthropist were to offer to rebuild some of our facilities. I would take the money and be happy to name the new buildings after the donor.

But the PFI is not of this kind. It is presumably the act of a government that would like to reduce its own budget pressures before the next election. It is an act of selfishness against our children since we would be replacing a community asset with one that they will never own – but one they will have to support financially in order to gratify the investors.

However, I do think there are circumstances in which private ownership might be seriously considered. Assume, for example, that health care infrastructure is being badly managed – the wrong types of facilities are being built in the wrong places, they are not being adequately maintained, and so on.

If poor management by government were a 'chronic illness' for which no treatment exists, then there would be reason to find out whether the private sector can do better. This, however, is an unlikely scenario. My view is that, if government officials do not know how to design buildings or maintain them, the most effective treatment in the long run is to show them how – and give them the right incentives to use their new knowledge.

It is often argued that salaried government employees are poorly motivated and lacking initiative. This would be an important weakness in Slovenia, if true, because the majority of clinicians are in salaried positions.

We certainly have problems of this kind, but I'm not sure we would improve overall by changing to private practitioners. Again, there are ways of creating change without requiring the government to back away from health care altogether.

Indeed, I would argue that productivity and motivation compare well with most other similar countries, including those with a much larger proportion of privately employed clinicians.

However, we have been debating ways of getting better. One possibility is that we could create more financial incentives for clinical practice improvements, as well as larger rewards to those who are already working the hardest and contributing the most. Measurement would be difficult, but we should try.

I also think we need to try to involve the community in assessing clinical performance as a basis for financially rewarding the most effective. However, there are obvious difficulties. One is that the community's views on excellence are strongly influenced by the level of politeness of staff, the aesthetic quality of the facilities, and so on. I do not doubt these are important factors, but they are not the only ones that matter. We need to embark on a much more determined effort to inform consumers how to judge other aspects of health care including those that are associated with clinical risk and health outcomes.

Another factor that has to be taken into account is the type of clinician. It seems quite obvious to me that the basis for payment of GPs can and should be somewhat different from that of a doctor or nurse working in a team setting in an acute care hospital. In this regard, we have a very clear view about the best way to pay GPs. Capitation will always be better than fee-for-service, and any mixed model (whereby payment is related in some way to volume of visits or treatments) is bound to take us backward.

I do not mean that there should be no performance standards for GPs, other than the number of patients who choose to visit them and become part of the capitated workload. In fact, quite the reverse: we need more and better standards of work. An example of this is the change we made recently, whereby GPs are expected to become more active in seeking out consumers for the purpose of screening and other illness prevention and health promotion activities.

To what extent do you think Slovene clinicians are informed about best practice, and actually put evidence to use in their daily work? How much are you worried about clinical practice variation, which of itself is a reasonable indicator of failure to use evidence?

All the information we have suggests that we are about average in this regard among countries in Western Europe. We have some factors that would favour the use of evidence-based practice. For example, we are a small and relatively homogeneous society, and we have only a small number of training institutions, and therefore knowledge is easily shared. We have also worked hard to promote good clinical practice through licensing and re-licensing programs, and have developed continual learning programs that have high participation rates.

In spite of this, our quality of care and health outcomes are only average, and in some areas our performance seems unsatisfactory. For example, a recent study among European countries found that we performed poorly in terms of continuity of care for chronic illness.

So I believe we must do more. The strategies that we are pursuing at present include the development and promotion of use of both clinical pathways and clinical practice guidelines, and of various kinds of diagnostic and treatment algorithms. We are also actively improving our performance measures, and our expectations of internal and external audits that are built in part on these kinds of management technologies.

In passing, it occurs to me that the homogeneity of our clinical workforce and its training also carries risks. One is that we tend to look in the same directions for ideas for change, and for performance benchmarks.

One other point occurs to me at this stage. For some reason, there are large differences in knowledge among clinicians in the same disciplines. The knowledge curve may be Gaussian, but the standard deviation is not what I would have expected.

There are some possible explanations. One is that our continuing education programs may be too much oriented towards knowledge acquisition than to use of knowledge in daily practice. Another is that we have too little workforce mobility. Too many clinicians remain for too long at the same facility.

Slovenia is a democracy that is proud of its social solidarity. To what extent are the aspirations realised in health care? Is access equitable, and are services fairly distributed? More important, are the variations in health status fair?

In some respects, we can be proud. One highly satisfactory circumstance is that there are no significant differences in health status among social, cultural, religious or other sub-populations. We have a small ethnic minority that has lower health status than the average, the Romanies, but we have made progress in closing the gaps in spite of the logistical difficulties of dealing with a mobile population – and with managing the cultural differences themselves.

We are thankfully free of any significant degree of corruption in Slovenia, but we do have too much of what may be called grey corruption. There is no doubt that the wealthier, informed, and articulate citizens manage to jump some of the queues. Unlike in some other countries, we do not actively encourage or condone this. We do not believe in privilege in any formal sense. However, it happens, and our sins are those of passivity.

So, we are trying to improve in this regard. One example is a new primary health care program that will result in the majority of Slovenes being approached for the purpose of screening for risk factors.

Let me emphasise the point about equity by noting that our weaknesses are largely in terms of unequal access to services. Once a patient, it matters not one iota who you are. The same standards of care apply whether you are rich or poor.

To what extent are you concerned about overservicing?

I know for sure that there was a significant degree of overservicing before 1992, when we were paying care providers including hospitals on a fee-for-service basis. At least, we were basing their cost-weighted production on the number of items of service at the level of specific diagnostic and treatment procedures. Apart from the waste of resources, this resulted in poor outcomes. For example, given that the supply of facilities (such as imaging equipment) was limited, unnecessary usage sometimes meant that patients who needed the service the most were kept waiting or even missed out completely.

Although we lack adequate measures of unnecessary use, there is no doubt the situation has improved greatly since we moved to bundled payment methods such as capitation and per case payment. This said, I still believe much needs to be done.

One concern is that we are over-using due to a lack of management systems. Our clinicians do not always know what diagnostic tests have been performed elsewhere. In some cases, there is a lack of trust in the diagnostic skills of other clinicians. There are some obvious technical weaknesses too – such as ordering a series of tests and then continuing with the series even when a small number of repetitions has provided enough data for diagnostic purposes.

Furthermore, there is still an element of fee-for-service in our health care system that applies to most private medical specialists (with a few exceptions like obstetrics and gynaecology where we have succeeded in changing to a capitation model). There is little doubt that we have the balance wrong, in that the specialists are able to earn more money by ordering tests than by giving other forms of care. This is not, however, their fault. Rather, it is the purchasers' mistake for failing to give more sensible financial incentives.

For the most part, there are two separate funding streams for hospital and non-hospital services in Slovenia. Doesn't this lead to perverse incentives as well, with regard to patient-centred and integrated care?

Yes. We have tried hard to build bridges, and have even changed funding methods in part to encourage coordinated care. But we are still not good enough at working across settings and clinical professions to ensure seamless care from the patient's point of view. I want to see much more use of single-source funding of care teams that take the responsibility for the health of subpopulations across all settings.

Pending a major re-structure of funding, we will continue to get things wrong in spite of the good intentions of our clinicians. For example, we can have an excellent GP making the right decision to refer a patient for a colonoscopy, and then we can have that patient being put in the wrong place in a waiting list, and (if the patient is less well-informed or articulate) we have that patient simply giving up.

What about drugs? Are you satisfied with drug prices and prescribing patterns?

We have a satisfactory degree of control over both, although I would like to have more. Last year, benefit payments from our national insurance scheme for drugs increased by 14%. The statistic is enough by itself to suggest that we should not be complacent.

We control drug prices by law. In short, branded drugs must be priced at no more than 85% of the average price applying in the big three nearby countries – Italy, France, and Germany. And for generic drugs, the price must be less than or equal to the lowest price in those countries. We have established drugs lists and improved our purchasing methods.

We have also made good progress with regard to the control of prescribing patterns, by various means including the establishment of clinical practice guidelines. But we have a long way to go in this regard. We need more protocols, more drug utilisation review, better education, and so on.

I'm not sure we have come even close to controlling the often negative impact of the drugs companies. We seem to have more conferences (or at least, more influential ones) that motivate doctors to prescribe than we have educational and promotional activities emphasising the doctor's responsibility to care for the whole community.

Do you think you're doing better or worse than other countries in managing these powerful commercial interests?

In many ways, we're performing in much the same way – sometimes well, and sometimes badly. In my thirty years as a practising clinician, I have seen many changes in prescribing patterns. Take the case of drugs used in the treatment of hypertension. We used diuretics, then betablockers, then inhibitors, and so it goes. But meta-analysis shows that the latest drugs are not significantly better than the old ones. We have become more effective in some respects, especially with regard to managing very high blood pressure. But in total, the epidemiological statistics show that hypertension is as much a problem as it ever was.

I think we're doing better than most countries in some respects, but that may be saying very little. I certainly believe we need more concerted international action. I say this, in part, because of my ongoing personal interest in what has been happening in the poor world. For example, I have been particularly active in encouraging a different approach to drug pricing, whereby we would select, say, 30 to 40 lifesaving drugs and establish a process whereby drugs pricing would be in direct proportion to each country's wealth. I am for globalisation if this means using global forces for the promotion of basic justice and human rights. I'm afraid globalisation does not yet mean much more than strengthening current arrangements whereby the flow of wealth is increasingly from poor to rich.

How optimistic are you about Slovenia's health care system?

I am optimistic that we will continue to move forward. We are right now entering a very promising period of reform that emphasises health promotion, co-ordinated care, evidence-based care, and clinical governance that puts multidisciplinary teams at the centre of it all. But if you are a committed health care professional, progress is never fast enough. Perhaps that is related to expectations. We are among the cleverest of industries, but we have not yet worked out how to take the large numbers of well educated and motivated individuals and cause them to be as good as they should be when working in teams.

Here may be particular reason to say this about Slovenia, given its strong tradition of education and science. People say we should be satisfied with what we have achieved, often in difficult circumstances, and I agree. But the quality of our workforce is also a reason for wanting to do better, and for believing that we can.