Majda Černič Istenič*

THE IMPACT OF HEALTH INSURANCE PRIVATISATION ON RISK ABSORPTION

ABSTRACT

*The p*rivatisation *reform introducing new methods of collecting and distributing financial resources is a possible source of growing public distrust in the health care system. Patients' trust in their physicians could become less secure and health institutions could be viewed with diminishing confidence. The author analyses the level of trust among five groups of health service users by their inclusion in compulsory or voluntary insurance, awarness of their rights and other features of health system, their opinion regarding the accessibility of quality health services, possible consequences of the reduction of compulsory insurance rights, modes of payment for health services and their sense of security associated with the current system of health insurance. The findings confirm our hypothesis that the privatisation of health insurance system generates growing distrust into the health care system among the population. But for now the extent of a risk and uncertainty is still relatively low. Although differences between five groups of respondents are not marked, the following differention is very clear: the group of patients paying for health care services out of their pocket are in the most insecure situation; they participate in health care funds to the same extent as others, but are not in the position to assert their rights because their health difficulties are exluded from the insurance system. On the other hand, the users of the concession-holder services represent the most satisfied group in this sample having a fairly strong feeling of security.*

Key words: quality, health service, user evaluation, privatisation of social services, risk, trust

Introduction

At the end of the eighties the health care system in Slovenia was confronted with a highly critical financial situation. In spite of the increased financial resources being collected into the state budget each year, the covering of health care expenditures was becoming increasingly difficult. There were severe shortages of funds for medicines,

* Majda Černič Instenič is a Research Fellow at the Institute of Medical Sciences, Scientific Research Centre, Slovenian Academy of Sciences and Arts.

basic materials, medical equipment and for physicians' salaries. Their low working motivation, which has resulted from low salaries, had increasingly dissatisfied users of health services, especially because of the long waiting lists.[1] In view of these difficulties, it was generally recognised that the health care system needed an extensive reform. Widespread political and social changes at the beginning of the nineties stimulated the re-structuring of the health care system. One of the main tasks of the health care reform was to construct a stable system of health care financing that would allow for the permanent and lasting acquisition of resources. In this respect, among the remedial actions indicated by the Law on Health Care and Health Insurance (1992), a great deal was expected from the introduction of private practice, and from a compulsory and voluntary health care insurance system.[2]

With the introduction of a compulsory and voluntary insurance system (a variant of the Bismarck system), a different method of collecting and distributing financial resources for health was established. The overall state budget, which in the past had not enabled transparency of its incomes and expenditures (this was one of the main reasons for the financial crisis in the health care system and other social services as well), was replaced by a functionally specialised budget and additionally specialised budget resources, the so-called "Health Tolar". Under the new system, the Health Insurance Institute of Slovenia (hereinafter: HIIS) become one of the most important components for controlling expenditures, planning resources and enforcing standards of economic activity in the field of health. The HIIS is the only state institution, which is allowed to collect and distribute the compulsory health insurance resources, which are drawn from a percentage of the employee's gross salary and the employer's income.[3] Contributions for voluntary insurance, which include additional payment for services from compulsory insurance and complete payment of over-standard services respectively, are also collected by the HIIS and by other commercial insurance companies, though to a much lesser extent. At the present time, compulsory insurance covers approximately 90 percent of all the costs of health services, while voluntary insurance, together with patients' direct payments, covers 10 percent (Bevc, Hanžek 1999).

With the new system, methods for the remuneration of services also underwent changes. In the past physicians were treated as state clerks and paid with a lump-sum salary. The same practice is still currently in force for physicians who are employed in public health institutions. These institutions receive their resources from the HIIS according to the system of services shared with capitation and payment of material expenditures and amortisation (in hospitals additionally according to the system of nursing hospital days). But physicians are still paid according to the system of levelling of wages and are therefore not very strongly stimulated to provide services of better quality (Sotošek 1996). Rather different to this is the position of private physicians who hold a concession (license for a contract with the HIIS) and are included in the public health care network. Their remuneration is also a combination of service system and capitation. However, the HIIS does not reimburse their maintenance and property rental costs and it does not offer them investment resources. In addition, physicians who hold a concession have to assume the burden of all the financial risks of their activity

themselves and the HIIS pays them only for a fixed quota and not for additional over-standard services. And finally, if there are no patients or the number of services performed is too low, the HIIS cancels the contract for the following year (Sotošek 1996). With regard to all these facts, the position of private physicians who are concession-holders is much less secure than that of those employed in public health institutions. Nevertheless, their position is still much more secure than the position of pure private physicians who were also approved under the new legislation - the whole financial risk of their activity is in their own hands. They are paid directly by their patients (those who can afford it), merely according to the quality and competitive advantages of their services.

One question which arises here is whether these changes, the new methods of collecting health resources and the new system for remuneration of services, have any influence on the patient-physician relationship and, consequently, on the risk absorption within the health care system. The analysis presented in this article intend to establish whether the type of physician (in terms of the way they are reimbursed) has any impact on the differentiation of health-care users, i.e. if privatisation of health care financing in Slovenia has in any way stimulated the exposure of the population to risk or increased their distrust in the health system, e.g. the insurance system.

Theoretical guidelines

The concept of risk has become increasingly important in social scientific investigations because it provides a way of highlighting the concrete processes and dynamics of today's most burning social issues - e.g. the global capital crisis and the reconstruction of the welfare state (Neary, Taylor 1998). Risk is a feature of life characteristic of complex modern societies where the strength of the traditional bearers of social security and significance (e.g. the family, relatives, village community, the church, etc.) has significantly diminished. But modern societies have not managed to effectively replace the traditional modes of regulating social relations with new ones that can absorb risk. Hence, there is a widely held assumption that in recent years life has become increasingly less secure. Individuals are unavoidably forced to choose between unfamiliar alternatives in different spheres of life to assure their everyday existence and sense of being (Beck 1992).

Risk is closely connected with trust. In a complex social system it is precisely trust that reduces uncertainly and risk. It is a mechanism which, according to N. Luhmann (1984), enables the re-establishment of the ability to connect social actions with collectively constituted chains of action. In Luhmann's system theory (1984), a social system established by placing a boundary between its 'inside' and 'outside' requires a reduction of complexity in its 'inside' in order to operate successfully. In this respect each actor has to form specific expectations about the future behaviour of others by selecting from between a range of possibilities. The code which underlines these selection processes is trust. It is a mechanism by which actors reduce the internal complexity of their interaction system and which enables them to mutually establish specific

expectations about their future behaviour. Trust absorbs complexity insofar as someone who trusts acts, at least to some degree, predictably. However, the expectations about the future behaviour of the trustee may turn out to be erroneous. In this respect Luhmann states that there are mechanisms to contain the risk of misplaced trust. The most crucial of these is law, which is the most effective remedy against the inherent risk of trust. Legal regulations are seen as the background structure, which provides sanctions and thus prevents fraudulent practices. The predominant social function of law is to absorb risk and uncertainty and to foster co-operation rather than conflict. Besides the legal system there are also other environmental structures which are equally capable of providing for the reduction of risk: other social institutions (e.g. the education system, the economic system, professional associations, etc.), informal public opinion and, to an ever greater extent, the media. Luhmann (1984) emphasises the fact that the social function of institutions is to connect social actions with expectations. Social institutions are seen as mechanisms for the co-ordination of expectations and actions. They generally perform this process without a conscious reflection on the part of social actors.

In his further deliberations (1990) he distinguished between trust and confidence. Thus trust refers to interpersonal relationships, while participation in a functional system like the economy or politics, which is unavoidable, requires confidence. The relationship between trust and confidence is important because large functional systems depend not merely on confidence but also on trust. Luhmann states that if trust is lacking then the way people make decisions about important issues is changed (e.g. rejection of preventative medication, investment in socially owned property). However, trust also depends on confidence: the testing and control of trust requires a relatively concrete setting, a state of confidence. A lack of confidence will lead to feelings of alienation, new forms of ethnogenesis and fundamentalist attitudes. “Thus lack of confidence and the need for trust may form a vicious circle. However, the withdrawal of trust is not an immediate and necessary result of a lack of confidence. It may be possible to build up trust on the micro-level and protect the system against loss of confidence on the macro-level” (Luhmann 1990:104).

Luhmann’s elaboration of the term trust is very general and can be applied to different social sub-systems, for example the health care system. This can be seen from D. Mechanic’s (1998) discussion of trust in medicine. He states that trust, the expectation that institutions and professionals will act in one’s own interest markedly contributes to the effectiveness of health care. In spite of the lower level of trust into the current health policy considerations, which pay more regard to the cost issue, Mechanic believes that the main dimensions of trust-building between patient and physicians deserves special attention. The most important topics of Mechanic’s elaboration of the different dimensions of trust and the difficulties involved in building it up are continued below:

Trust in competence. Patients want their physicians to be highly competent but assessing medical competence is difficult even for experts. Trust in a physician generally reflects patients’ hopes rather than their actual experiences. The stake which seriously ill patients perceive in the patient-physician relationship significantly raises the risk of trust, but the information they have is always incomplete. Patients, unable to assess

competence directly, depend on trusted informal sources of information (relatives, friends, and acquaintances), and also on health professionals they know and, to an ever greater extent, the media. But, in any instance, the patient cannot know the product of caring before experiencing it.

Trust in the physician as agent. When they are seriously ill and highly dependent it is essential for patients to believe that their physicians are their agents and will represent their interests effectively. Although patients may understand that physicians have to consider their own interest in earning a decent living and having some control over their schedule, beyond these constraints medicine has been viewed traditionally as a selfless endeavour in which physicians are the dedicated agents of their patients. With changing organisational arrangements, managed care practice, and the growing gap between economic constraints and what medical knowledge and technology are potentially capable of, this key assumption has been eroded. Centralisation of management in medical care and the changing power and dependence relationship between insurance organisations and physicians have visibly placed physicians in a position where they face more evident conflicts between their motivation to serve the patient's needs and their own economic position. Reconciling expectations that the physician is an agent and not merely a neutral decision-maker, and understanding that physicians have to be economical when making decisions may appear difficult. Therefore, insurance companies which measure care more rigorously, have to convince the public that the quality-assurance process they put in place allows physicians to select appropriately what is viable and also that there are enough checks and balances in the system to protect the patient. Finally, no health care institution can sustain public trust without evidence that physicians' advocacy is strong and well protected.

Trust in control. In selecting a physician, patients take it for granted that the physician has access to the means needed to maintain their health. From the trust perspective, it is important that the patients believe that their physician has control over medical resources since they have less value if they cannot command the authority to mobilise the required resources. A rigorous medical administrative review has restricted the authority of physicians. As patients become aware of this, they may lose some of their trust in their physician's capacity to give them what they need in spite of their professional competence. In such circumstances health insurance should make an effort to convince subscribers that the system of review and quality assurance which they put into force increases the quality of care and provides additional protection for their welfare. Because there are significant difference between insurance companies' and physicians' judgement about what is necessary and desirable, physicians and insurance companies compete continually for patients' trust.

Trust in confidentiality. It has long been accepted that a patient can trust the confidentiality of his/her physician and that information will only be revealed with the patient's explicit permission. There are some exceptions, like reporting certain infectious diseases, the physical abuse of minors, treatment of patients in imminent danger, for example. The protection of confidentiality is a prerequisite for free and open communication in the patient-physician relationship without fear that the information

could be used against the patient. Organisational and administrative changes in medicine may contribute to the erosion of the patients' trust regarding the fact that what they tell their doctor is being treated confidentially.

Trust in disclosure. Patients have a right to be informed about all facts necessary for their good health. In practice and in law physicians are expected to ensure that patients are properly informed. But it is not uncommon for physicians to underestimate the patient's desire to receive information and physicians thus provide too little information. There are different forms of nondisclosure which erode trust. A potential conflict might result, for example, when a physician is involved in financial arrangements with the insurance company that tie the physician's reimbursement to utilisation quotas. The extent of the conflict of interest depends on the size of the stipulation and on the extent to which utilisation is measured: solely on the patients of a particular physician or on the larger pool of patients aggregated among physicians. And finally, full disclosure of treatment options, including decisions based on costs, is a significant requirement for the maintenance of trust.

From the above findings it can be summarised that the capacity to stimulate trust in the health system depends both on physicians' personal skills and abilities and on broader organisational arrangements and institutions and that both levels are interdependently connected. For the purpose of our analysis it is worth stressing that the financial risk imposed on physicians by insurance companies placing utilisation quotas on their reimbursement may have a negative effect on the elicitation of patients' trust in a particular physician and, furthermore, probably also on their insurance company.

With regards to this statement, it is also worth pointing out that there are some new trends that may influence further modes of state regulation regarding assurance of social rights and also of health care rights. M. Neary and G. Taylor (1998) warn that, due to the development of increasingly lottery-style state intervention, there is a growing risk of redundancy or of not being adequately cared for when one falls ill (their statements are based on the recent experiences of the UK). These authors ascertain that the collapse of the planner state (following the Keynesian model) creates a situation where both levels of social welfare and access to employment have increasingly become a game of chance - a lottery – which is strongly dependent on the crisis of state insurance (the Beverage model). The origin of this crisis lies in the prediction that the risk of future patterns of spatial and temporal development rests on the basis of the past. But an increasingly globalised economy has made insurance predictions more and more difficult. Additionally, they state that the crisis in insurance law is the crisis of the reproduction of labour as labour power in the circuit of capital accumulation. From this it could be supposed that the crisis of insurance principles arises from the decline of the previously strong power and will of social groups which in the past struggled for the accomplishment of social rights.

Empirical findings of our reserch

In our survey a considerable scope of the questionnaire was designed for the health insurance system. Through the selected set of questions we intended to establish:

- to what extent people are included in compulsory and voluntary health insurance and which forms of voluntary insurance they find most attractive;
- to what extent people are familiar with the rights resulting from their insurance agreements, with the price of a standard medical examination at the general physician and with the size of their monthly contribution to the health fund;
- people's opinion concerning the impact of the current insurance system on accessibility and quality of health services;
- people's opinion regarding the eventual further reduction of the rights ensured by compulsory insurance;
- to what extent people are prepared to pay for health services directly, with out-of-pocket money;
- the level of feeling secure in the current insurance system.

All these topics were observed through five quotas:

- respondents who visited a general physician working in a public institution,
- respondents who visited a general physician who holds a concession,
- respondents who visited a dentist working in a public institution,
- respondents who visited a dentist who hold a concession and
- respondents who visited a pure private dentist (all in the last twelve months).

Our main objective was to find out whether those who paid health services out of their pocket perceive their position in the existing system of health insurance to be less convenient than those who need services reimbursed by compulsory and voluntary insurance. And, additionally, we tried to find out whether those who use services in public institutions perceive their position in the health insurance system to be more favourable than those who use the services of physicians who hold concessions. The answer to these questions is important in terms of ascertaining whether the privatisation of health care insurance system creates any basis for stimulating risk in this system.

The first aim was to establish the level of inclusion in compulsory and voluntary insurance. Our results show that practically all respondents from all quotas without exception have compulsory insurance. This is not surprising as, according to the Law on Health Care and Health Insurance, all citizens in Slovenia are entitled to this type of insurance. Inclusion in voluntary insurance is also high. Over 80 percent of respondents applied for this type of insurance while the differences between quotas are very small. The highest share (88 percent) fell to respondents who visited a dentist with a concession, and the lowest one (82 percent) to those who visited a dentist in a public institutio. But in spite of the massive scope of compulsory and voluntary insurance applications, a substantial number of services can be abtained only throught out-of-pocket payment (particularly demanding, over-standard dental services). One question, which arises here, is whether this is really unavoidable. Some sort of answer is offered by the following result.

Table 1
Inclusion in compulsory and voluntary insurance

		general physician public	general physician concession holder	dentist public	dentist concession holder	dentist private
Do you have compulsory insurance?	Yes	100.0%	98.9%	98.5%	100.0%	98.8%
	No		1.1%	1.5%		1.2%
Do you have voluntary insurance?	Yes	84.5%	85.9%	82.2%	87.5%	83.5%
	No	15.5%	14.1%	18.8%	12.5%	16.5%
If you have voluntary insurance. which package does it cover?	Additional payment of services	70.5%	76.4%	74.5%	77.1%	69.0%
	Over-standard services	3.2%	5.5%	2.4%	2.9%	5.6%
	Other variants	1.6%		2.4%		2.8%
	Don't know	24.7%	18.1%	20.7%	20.0%	22.6%

Namely, forms of voluntary insurance, especially those earmarked for over-standard services, are very rare for all types of respondents. The only minor exception is a group of users of pure private dentists (about 8 percent). But this share is too small and certainly this type of insurance is insufficient for the remuneration of this type of services. Therefore, additional payment of services already partially covered by compulsory insurance is the most frequent form of voluntary insurance. According to some commentators (Česen 1999) this form is merely a continuation of practice from the former system and it does not bring many possibilities for new additional financial resources for health care. This type of insurance is less common among patients of general public physicians and among patients of pure private dentists (70 and 69 percent respectively) than among others (from 74 to 77 percent), but the differences are small. Thus, the insurance system still takes up more or less the same amount of resources from all citizens but it does not redistribute them on the same basis; some needs and health problems are excluded from the system.

Furthermore, data also show that a significant share of the respondents do not even know which package of voluntary insurance they are subscribed to. This was most commonly the case with respondents who visited a general physician in a public institution or a pure private dentist (25 and 23 percent respectively) but less often to patients of a general physician who holds a concession (18 percent).

Table 2
Acquaintance with rights and other financial characteristics of the health system

		general physician	general physician	dentist	dentist	dentist
		public	concession holder	public	concession holder	private
Are you acquainted with compulsory insurance rights?	Yes	58.0%	63.7%	58.7%	67.5%	67.9%
	No	42.0%	36.3%	41.3%	32.5%	32.1%
Are you acquainted with voluntary insurance rights?	Yes	56.1%	55.7%	54.7%	60.0%	64.6%
	No	43.9%	44.3%	45.3%	40.0%	35.4%
Do you know how much a routine medical check-up costs?	Yes	32.0%	27.2%	35.4%	32.5%	37.6%
	No	68.0%	72.8%	64.6%	67.5%	62.4%
Do you know what the amount of the contribution to the health fund is?	Yes	20.8%	23.9%	15.4%	20.0%	24.7%
	No	79.2%	76.1%	84.6%	80.0%	75.3%
(If positive answer) Is the level suitable regarding the rights you receive from compulsory insurance?	Completely suitable	47.7%	54.5%	50.0%	66.7%	57.1%
	Too low	2.8%	4.5%			
	Too high	17.2%	18.2%	10.0%	22.2%	19.0%
	Don't know if it is suitable	29.5%	22.7%	40.0%	11.1%	19.0%
	Other	2.8%				4.8%

Subsequently we inquired about the degree of patients' familiarity with their rights. The results are not optimistic. The data show that quite a substantial share (around 40 percent) of respondents have no knowledge of the rights deriving from their compulsory and voluntary insurance. They are ill informed in particular about the rights granted by voluntary insurance. Between the different types of respondents significant differences were not found. Nevertheless, respondents who visited dentists with concessions or pure private dentists indicated a slightly (10 percent) greater acquaintance with the rights accruing from their voluntary or compulsory insurance than did the other respondents.

A further set of questions were designed to gain an insight into respondents' awareness concerning the prices of services and the percentage they yield monthly from their salaries to the health fund. The results, once again, were not optimistic, since only a little less than one third of the respondents said that they were acquainted with the approximate price of usual routine medical examinations with their general physician.

A greater share of positive answers were gained from respondents who receive out-of-pocket consultations from their dentist, while the smallest share came from those who visit a general physician who holds a concession. As concerns the percentage contributed monthly to the health fund from one's own salary, the situation is even worse. In this respect only one fifth of the respondents gave a positive answer. Again, most common are respondents who pay directly for dental services and also respondents who visit general physicians who hold concessions. The amount of the monthly contribution is suitable for the majority of respondents. This aspect of the analysis revealed the greatest differences between the groups. The level of monthly contribution seems the most suitable for respondents who use the services of dentists who hold concessions and the least for users of the services of general physicians in public institutions. A considerable share of the respondents is not sure whether the level of this contribution is adequate; this share is considerably high with those, who visit a dentist in a public institution (40 percent). Very few of the respondents considered it appropriate and many of them regarded it as being too high, particularly those who use the services of dentists who hold concessions (22 percent). Therefore, these results created the impression that our population is rather ill informed about its rights and about the financial characteristics of the health insurance system.

Table 3
The impact of the insurance system on the accessibility of quality health services

To what extent do you agree or disagree with the following statements? (from 1 = strongly disagree, to 5 = strongly agree)		general physician public	general physician concession holder	dentist public	dentist concession holder	dentist private
Quality health services will not be available to poorer members of society who are not able to apply for voluntary insurance	Mean	3.6%	3.8%	3.6%	3.7%	3.8%
	Standard dev.	1.4%	1.3%	1.3%	1.4%	1.3%
It is correct that those who want more complete quality health services should pay for them out-of-pocket?	Mean	3.1%	3.1%	2.8%	3.1%	3.1%
	Standard dev.	1.4%	1.4%	1.4%	1.4%	1.4%
Those who take more health risks should contribute more to the	Mean	3.0%	3.3%	2.8%	3.0%	2.9%
fund (smokers. alcoholics)	Standard dev.	1.4%	1.3%	1.2%	1.4%	1.4%

We were also interested in patients' perceptions regarding the impact of the new insurance system on the health services' access to quality health services. Their opinions were measured on a five-level scale (from 19 = strongly disagree, to 5 = strongly agree). The obtained results reveal that the respondents were not very strongly inclined

towards any extreme grouping of opinion, their expressions mainly fall into the central groupings. Nevertheless, of all the subjects, they most strongly agreed with the statement that quality health services will not be available to poorer members of society who are not able to apply for voluntary insurance and to pay additional costs not covered by compulsory insurance. In general, all respondents, irrespective of group, have (according to their means) similar opinions about this first subject. Only a weak tendency could be observed among respondents who visit private physicians (concession-holders or pure private ones). They more strongly perceive a social differentiation in this sphere than other groups. But it can also be observed that the differences are much higher within each individual group (by means) than between groups (by standard deviation). Regarding the second statement, the respondents' answers express their complete neutrality. They neither agree with direct (out-of-pocket) payment for better and more complete services nor disagree. Respondents who use the dental services of public institutions differ slightly from the general line and disagree with this statement more than others. The same neutrality is also observed in the last statement. The respondents mainly neither agree nor disagree with the statement that those who take more health risks should have to contribute more to health costs. As in the first statement, in these two cases the differences within groups (by means) are greater than those between groups (by standard deviation). From such results the following generalisation can be made: opinions regarding the role of the insurance system on the accessibility of services are not very well elaborated by our population.

Table 4
Consequences of the reduction of compulsory insurance rights

What do you believe is the probability of the following consequences in the event that compulsory insurance rights are reduced? (from 1 = very probable to 5 = very unlikely)		general physician public	general physician concession holder	dentist public	dentist concession holder	dentist private
Quality of health services will increase.	Mean	2.8%	3.0%	3.0%	2.7%	3.1%
	Standard dev.	1.3%	1.3%	1.3%	1.4%	1.4%
Accessibility of health services will increase.	Mean	2.8%	2.9%	2.8%	2.6%	3.1%
	Standard dev.	1.2%	1.2%	1.3%	1.3%	1.2%
Care of people for their own health would increase.	Mean	3.3%	3.4%	3.4%	3.1%	3.5%
	Standard dev.	1.1%	1.1%	1.2%	1.2%	1.2%
The number of health care services would decrease.	Mean	3.3%	3.4%	3.3%	3.6%	3.2%
	Standard dev.	1.1%	1.1%	1.2%	1.1%	1.2%
Health condition of population would worsen.	Mean	3.6%	3.5%	3.4%	3.7%	3.2%
	Standard dev.	1.2%	1.2%	1.0%	1.3%	1.2%
There would be more money for health care.	Mean	2.9%	2.8%	2.9%	3.0%	2.9%
	Standard dev.	1.2%	1.1%	1.0%	1.0%	1.3%

Furthermore, we wanted to gain insight into patients' opinions regarding a possible further reduction of the rights resulting from compulsory insurance which could lead to increased direct payments. The answers were again measured on a five-level scale (from 1 = a very high probability, to 5 = a very low probability). Data show that differences (expressed in means) between selected groups are greater than in the previous case. The greatest differences are observed between the respondents who visited a dentist with a concession and those who needed the services of a pure private dentist. The first group is the most disinclined towards eventual reductions of all the groups. Namely, these respondents are the least convinced that the changes would contribute to an increase in the quality and accessibility of health services and peoples' care for their own health. They believe much more firmly that the changes would decrease the number of health services and worsen the health situation of the population while, at the same time, the health care funds would collect more money. The opposite attitude is expressed by those who pay for dental services directly. They are convinced that restrictions would stimulate people's care for their own health, in other words they would be left to their own devices to a greater extent. But it must be taken into account that the differences (expressed in standard deviations) within the groups are much higher than those between the two groups. The same holds true for the other groups as well.

Table 5
Modes of payment for health services

		general physician	general physician	dentist	dentist	dentist
		public	concession holder	public	concession holder	private
Which mode of payment for health services suits you most?	Regular payment of insurance premiums	14.3%	13.0%	21.5%	7.5%	9.8%
	Contribution of fixed share from salary	79.6%	82.6%	72.3%	87.5%	80.4%
	Direct payment after each service	6.1%	4.3%	6.2%	5.0%	9.8%

We were interested in the respondents' preferences regarding payments for health services as well. The monthly allocation of a considerable percentage of their income to the health fund is, for the vast majority of respondents, still the most suitable form of payment for health services. Thus the value of solidarity remains strong, albeit stronger in some groups than in others. This option was most frequently chosen by respondents who visit a private general physician and a dentist who holds a concession, and least frequently chosen by respondents who visit a general physician and a dentist in public institutions. These last two groups are more in favour of regular payment of premiums (which means better services for a higher premium). Direct payment for services is the

least preferable form of payment for health services but was most frequently chosen by respondents who already visit dentists with out-of-pocket consultation fees.

Table 6
Sense of security associated with the current system of health insurance

		general physician	general physician	dentist	dentist	dentist
		public	concession holder	public	concession holder	private
Does the way you are insured give you a sufficient feeling of security?	I feel completely secure	40.1%	40.2%	36.9%	37.5%	35.3%
	I feel partially secure	51.7%	55.4%	61.5%	55.0%	54.1%
	I feel rather insecure	8.2%	4.3%	1.5%	7.5%	10.6%

Finally, we intended to find out to what extent different types of respondent feel secure in the current insurance system. As regards our results in the current system, only a small share of people is burdened with a feeling of risk or uncertainty. Nevertheless, we cannot neglect the share of those, who felt partially secure. Especially evident among those who feel insecure are respondents who use the health services of a pure private dentist (11 percent). This is much less often the case with users of public dental services (1.5 percent). Among those who expressed only a partial feeling of security, respondents who visit a dentist in a public institution (61.5 percent) are especially prevalent. Among those who feel completely secure, the most common are those respondents who need the services of a general physician either in a public institution or a private physician who holds a concession (both 40 percent).

Conclusion

The results of our analysis show that the differences between groups were not marked. However, tendencies towards the presence of risk in our insurance system are clearly evident. Users of out-of-pocket consultation services were already undoubtedly confronted by market principles in relations with their physicians. Presumably, these users were treated with a high degree of professionalism and in a friendly manner, and their physicians were clearly ready to do everything they could for them. But this was dependent only on the users' readiness and ability to pay a price for the services which was by no means moderate. As our data show, this type of user is in an insecure position; they contribute to the health insurance fund as much as users with other health problems or even more but they cannot be sure of receiving the service they need via insurance application. Therefore, many of them have already developed an attitude that they can rely only on themselves and consequently experience a feeling of uncertainty. In this respect our expectations were confirmed.

The opposite was true regarding the position of users who chose the services of concession-holders. Our expectation that their place in the insurance system is worse than the position of those who chose services in public institutions (due to the supposedly more economical and even more market-oriented attitude of concession-holders) was not confirmed. Analysis reveals that those who use the services of concession-holders are the most satisfied group in our sample and that they have a fairly strong feeling of security. In the current system, where they receive the best quality health services from all aspects (as M. Macur's research shows), they have to pay for these services mainly on a solidarity basis. Because of this, the current insurance system suits them very well and they are more resistant to the eventual decline in the rights resulting from compulsory insurance. It could be said that this group is, of all the groups of users, the most strongly conformed to the old system of collecting resources for the health fund in spite of the fact that they are in favour of private physicians' practices. In this respect we could claim that the current insurance system is not righteous. One one hand it offers high-quality services to relatively advantageous terms to some groups of patients with particular health problems, but on the other hand it does not offer the possibility to insure some kinds of health problems, like dental, for instance. Here we have to remind that dentist's services, which now have to be paid out-of-pocket often used to be a part of the "grey market" in the former system.

The present analysis also revealed that our population is quite badly informed as regards the rights resulting from their insurance applications and other elements of the insurance system. This suggests a great deal of passivity and a lack of interest on the part of our population in relation to their physicians, insurance companies and other actors in the medical system. Further analysis should confirm this. But for now, it can be stated that this poor degree of information indicates a very low level of dialogue culture in Slovenia. It is supposed that this does not hold true only for the sphere of heath care but for other spheres as well. It can also be supposed that due to this passivity and lack of interest, user's position in the health care system could deteriorate in the future.

The analysis shows that the privatisation of health insurance system indubitably creates possibilities for growing risk. It is dependent, however, upon politicians, policy makers and people's awareness of their rights as to how extensive this will be.

NOTES

1. According to the survey Quality of Life in Slovenia (1987), a quarter of the respondents was unsatisfied with the health services and 72 percent of them were unsatisfied because of the long waiting lists.
2. Since their abolishment after the World War II., there were neither private funds financing health care services in Slovenia (until 1992), nor were there any private physician's practices.
3. From the employees' perspective, the way of collecting resources for obligatory health insurance is the same as in the former system.

REFERENCES

Beck, U. 1992. *Risky Society, Towards a New Modernity*. London: Sage.

Bevc, M., and M. Hanžek. 1999. *Human Development Report*. Ljubljana: Institute of Macroanalysis and Development.

Česen, M. 1999. "Moč in nemoč privatizacije v zdravstvu" (Power and Powerlessness of Health Care Privatisation). ISIS, 1: 52-56.

Luhmann, N. 1984. »Funktion und Kausalitet« in *Sociologische Aufklarung*. Ausatze zur Theorie socialer Systeme, Vol. 1. 5*th* Ed. Opladen: Westdeutscher Verlag.

Luhmann, N. 1990. "Familiarity, Confidence, Trust: Problems and Alternatives". Pp. 94-107 in *Trust: Making and Breaking Cooperative Relations* edited by D. I. Gambetta. Oxford: Basil Blackwell.

Mechanic, D. 1998. "The Function and Limitation of Trust in the Position of Medical Care". *Journal of Health Politics, Policy and Law*. 23, (4): 661-686.

Neary, M., and G. Taylor. 1998. "From the Law of Insurance to the Law of Lottery: An Exploration of the Changing Composition of the British State. *Capital & Class* 65: 55-72.

Quality of Life in Slovenia. 1987. Ljubljana: Institute of Social Sciences.

Sotošek, B. 1996. "Finančno-ekonomske relacije sistema zdravstvenega varstva" (Financial Aspects of Health Care System). Pp. 118-139 in *Privatizacija šolstva, zdravstva in kulture (Privatisation of Education, Health and Culture)*. Ljubljana: Teorija in praksa, FDV.