

A comparison of health insurance in Slovenia and Croatia

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Abstract

Before Croatia and Slovenia became independent in 1991, they had similar health systems. They have generally taken the same reform path since then, but have also travelled in opposite directions on occasions. Of particular relevance here, both countries established quasi-government agencies to administer a new national scheme of compulsory health insurance in 1993. However, Slovenia's compulsory scheme involved much larger copayments, and a parallel voluntary insurance scheme was created mainly to cover them. In 2002, Croatia increased copayments and introduced a voluntary insurance scheme almost identical to that of Slovenia's. To complete the circle, Slovenia has announced it intends to abandon the use of voluntary insurance for copayments, and reduce the level of copayments for its compulsory scheme.

This paper describes and compares the two insurance systems, and I argue that there has been considerable success in difficult circumstances. However, the experiences reinforce aspects of design that seem to be generally relevant: the need to make use of consumers' informed opinions, to recognise and then redress a lack of experience of optional approaches among many of those making decisions about health insurance, to define and apply a rigorous evaluation framework that includes estimating people's total costs for health care, to emphasise the long term, to identify and ensure there is transparency of vested interests, and to use the financial power of the dominant government insurer to encourage and reward improvements in clinical practice.

From Yugoslavia to independence

When the Soviet Bloc collapsed in 1990, Croatia and Slovenia were ready to press their long-held aspirations for independence. Slovenia was the more fortunate: it was wealthier, more homogeneous in ethnic and social respects, and was first out of the blocks. In ten days, it had established itself with hardly a casualty. In contrast, Croatia had a traumatic five years of war that was mainly a consequence of having significant Serbian minority that preferred a future as part of a 'greater Serbia'.

Both countries began their independence with a complicated system of health insurance that had grown in scope and organisational complexity over time. In the case of Slovenia, 'sickness funds' had emerged during the late nineteenth century, along the lines of those in Germany. Thus there were multiple funds variously based on industries, employment categories, or regions. They gradually became more comprehensive, financial support from government general revenue progressively increased, and health insurance became equitable and universal in 1972. A mix of government, charitable, and private for-profit care provider agencies had emerged, but there was a process of nationalisation after 1945 that virtually eliminated private care facilities and private medical practice.

A similar model emerged in Croatia. A mix of insurance schemes was established after 1922 that initially targeted employees. Their membership was progressively expanded, and a compulsory national scheme was established in 1945 that covered most of the population. The Yugoslav government's move to devolution after 1974 caused a breakdown of many national systems including those for financing and delivery of health care. There had been a long history of private provision of personal health services but, as in Slovenia, most health care professionals became salaried government employees after 1945. In total, the health care systems of both countries emerged

over time and had both strengths and weaknesses. Problems were more evident in Croatia: as Vulic and Healy (1999) put it, the system in 1990 was "... extremely liberal, verging on anarchy, (and) satisfied nobody".

The challenges of reform were much the same as those in the other transitional economies in the early years. On the one hand, there was recognition that the old model provided a significant degree of equity – and 'social solidarity' was an important aspect of the new independence. On the other, the market promised opportunities for increased sensitivity to consumers' views, and for efficiency improvements as a consequence of providing greater rewards for innovation and competence. Reforms were complicated by many of the factors applying to other countries including an ageing and more demanding population and an uncertain economic situation.

An overview of the health systems of Croatia and Slovenia

Before 1990, an important basis for determination of health system attributes was international comparison – and particularly comparison with other eastern and central European countries. General economic indicators were taken into account when setting spending targets. However, a more significant consideration was the level of service provision, usually measured in terms of the ratios of health care facilities (and particularly hospitals and clinics) and healthcare professionals (and particularly doctors) to the population.

Increasing emphasis has been given to economic indicators since 1990. This has been associated in part with an increase in the influence of private sector forces, including drugs companies and private care providers.

Public opinion has clearly become more influential. Indeed, it has been argued that, in the case of Slovenia, there was "... a dramatic shift in consumer orientations and expectations" immediately following independence (Albrecht, Cesen, Hindle et al 2002). Governments have had to pay more attention to the balance between the community's views about the adequacy of services on the one hand, and the financial burden of health insurance contributions on the other. However, public opinion is not currently as well informed or as active as in the more wealthy democracies with their longer experience of consumerism.

As in most other transitional countries, there was an immediate sense of financial risk that was widely believed to be a consequence of the way that insurance was being managed by the many existing agencies. Both countries chose to address this in part by implementing what is, in effect, a predicated health tax built around compulsory employment-based insurance.

Public health services and hospital care have remained largely in government hands. However, there has been an increase in non-government participation in community-based services. Both countries made a major change with regard to primary medical care. GPs are now predominantly private practitioners, paid mainly on a capitation basis from government sources.

Croatia has gone further. For example, it has encouraged the privatisation of home nursing, and a significant part of medical specialist services. As might have been expected, this has been associated with increased cost. For example, the number of specialist encounters per insured person more than doubled between 1994 and 2001, and the cost per encounter increased over the same period by about 23% in constant prices.

In total, Croatia and Slovenia were sensitive to worldwide trends that emerged in the mid-1980s: economic rationalism, reduction of government involvement in (and hence responsibility for) health care, emphasis on organisation rather than clinical practice changes, and attempts to increase competition in financing, purchasing, and care provision. However, their history of socialism and their strong sense of national identity were mitigating factors.

Levels of health care spending

The per capita GDP of Croatia (population 4.6 million) was US\$4300 in 1999. This is marginally higher than the average for transition economies, but considerably lower than in all member countries of the European Union (EU). An indication of the effects of the war was that per capita GDP was US\$5106 in 1990 and fell to a low of US\$2079 in 1992. In contrast, the per capita GDP of Slovenia (population 2 million) only fell marginally between 1990 and 1992, and increased steadily since then to reach US\$9800 in 2000.

Croatia spends a high proportion of its GDP on health care relative to its per capita GDP. In 1999, its rate was about 9%, which was considerably higher than in other transition economies, and above average for EU countries. Slovenia's rate was about 8%.

Health sector performance

The health status of the Croatian population is relatively high for several reasons, including the sound investments that have been made in primary health care and environmental health. Croatia has had a long history of successful public health services and research (Borovecki, Belicza & Oreskovic, 2002), and has also established a relatively well-trained clinical workforce.

The level of efficiency of the health sector is not well understood. Many efforts have been made to contain health care costs, especially since 1990, but success appears to have been moderate. Some indicators of efficiency appear to be favourable, such as the high rates of visits to GPs. Other indicators are more worrying. For example, a recent study of ophthalmology services at a major teaching hospital in Croatia showed that the average length of stay for cataract procedures was 6.5 days – whereas in most developed countries it is about one day (Nasic & Oreskovic, 2002). Contributing factors include an oversupply of beds (which has been partially addressed since about 1994) and the use of itemised payments (a trial of per case payment began in 2000).

The Ministry of Health recently noted that there is considerable potential to reduce the provision of "... services with no proven effect on health improvement" (Croatian Ministry of Health 2000). Langenbrunner (2002) argues that there has long been a need to introduce financial incentives "... that encourage the efficient use of resources". Vulic & Healy (1999) argue that "... expenditure on pharmaceuticals remains high with no measures in place to control this cost." Improvements have, however, been made in the last two or three years including controls on drug prices and prescribing volumes.

There are few reliable data on quality of care and health outcomes. The small number of valid studies suggest Croatia performs well in some respects and poorly in others.

The health status of the Slovenian population is marginally higher than that in Croatia, and has increased more rapidly since 1990. The underlying factors are much the same – wise investments in public health, a well-trained clinical workforce, government control, and so on. Slovenia has benefited from higher incomes, and avoidance of social and political disruptions.

The Slovenian health sector seems to be marginally more efficient in some respects. For example, it introduced per case payment in 1999 and has long had a more effective approach to the capping of total expenditures. However, like Croatia, it suffers from remnants of the systems and cultures established in socialist days that failed to encourage and reward initiative.

Quality of care appears to be marginally higher than in Croatia, and may approach European Union levels in some respects (Keber 2002). However, like Croatia, there is a shortage of reliable data that is partly a consequence of weaknesses in clinical work process control. A major reform project is under way that is directed at resource allocation and care provision on the basis of clinical pathways. This should lead to the routine production and analysis of health outcomes data as a component of continuous quality improvement at the level of the multidisciplinary clinical team (Slovenian Ministry of Health 2002).

Health insurance in Croatia: the 1993 arrangements

Deppe and Oreskovic (1996) argue that Croatia, like most other transition economies in Europe, believed there was a need to "go back to Europe, and back to Bismarck". The main aims of reform were to put a degree of separation between the government and the health care sector, and to separate funding and service provision from each other. The so-called Bismarck model, as exemplified by Germany, seemed a desirable goal. In fact, only a subset of its elements has been implemented.

The Health Insurance Act (1993) established a compulsory and universal health insurance scheme termed the Health Insurance Fund (or simply the HIF-Croatia in this paper). A new quasi-government agency, the Croatian Institute for Health Insurance (HZZO) was created to administer the scheme. Since then, the

responsibility for financing most personal care services has rested with HZZO. The Ministry of Health retained its responsibilities with respect to public health and a few other functions.

HZZO was empowered to enrol all citizens, and to collect revenues through regular member contributions. For employees, the premiums were to be captured directly from the employers' payroll systems, as a percentage of gross salaries and wages. The contribution rates have been changed on several occasions. For example, only an employer contribution was defined initially, at the level of 18%. In 2000, the overall contribution rate was 16%, but both employee (9%) and employer (7%) shares were defined.

Contributions to HIF-Croatia by the self-employed were initially set at 18% of their declared income. This was considered unsatisfactory, mainly because there was widespread under-reporting of incomes. Therefore the basis was revised to 18% of an imputed income that is set at best estimates of the average income of nine categories of occupation. A base amount is defined each year, and multipliers have been set that range from 1.0 for non-skilled workers to 2.8 for holders of doctoral degrees. This change is believed to have increased revenues overall, but there may have been a loss of equity (since the premiums are now averaged across people with similar employment potential without regard to their actual incomes).

The central government pays the premiums of various disadvantaged groups. They include pensioners, unemployed people, and low-income families.

Copayments were introduced for several services including specialist consultations, inpatient accommodation, GP consultations, home nursing, and ambulance services. They were generally low, and many disadvantaged groups were exempted.

One obvious benefit of the new scheme was that it integrated health care financing and resource allocation processes. Previous arrangements had serious weaknesses including confusion of incentives and a general lack of control.

Voluntary health insurance in 1993:

The 1993 legislation made provision for the operation of voluntary health insurance schemes, which could be publicly or privately owned. Some schemes offered substitutive insurance – that is, a limited number of people were allowed to withdraw their contributions to the HIF and apply them to purchase of a private policy. However, only a small minority of the more wealthy did so.

More people chose to purchase supplementary insurance – that is, additional insurance for types of care already covered by the HIF-Croatia but with increased service (such as faster access to care and better accommodation). A significant proportion of this type of insurance has been purchased by employers on behalf of their employees, but membership never exceeded 40% of the population.

Between 1997 and 2001, voluntary insurance accounted for an average of 10.5% of the total revenues of health care providers. In contrast, payments under the compulsory scheme contributed an average of 82.6%. The importance of voluntary insurance varied considerably across the different types of care providers. In 2001, less than 4% of hospital revenues were derived from voluntary schemes compared with 55% of the incomes of private specialists.

Incidentally, there are relatively good data on costs of insurance premiums and copayments. In contrast, little is known about self-pay for uncovered services, or about informal payments (that is, unofficial charges levied by care providers predominantly for services that should be covered by insurance) although they are believed to be high.

The Health Insurance Act 2002:

The government made a significant change in 2002, when it introduced large copayments for many of the services covered by the HIF-Croatia. At the same time, it introduced a 'supplementary' health insurance scheme (called SHI below) that is intended mainly to cover the new copayments. SHI also covers receipt of brand-name drugs in addition to generics, aspects of long-term care, and better facilities (such as private rooms and private hospital accommodation). Complementary health insurance may continue to be provided, but substitutive health insurance is no longer permitted.

Until January 2004, SHI will only be available from HZZO. This appears to reflect a concern that provision by non-government insurers might add to the risks and complexities. More important may be the desire to generate additional revenues specifically for HZZO, which has significant budget problems.

The premiums of SHI are tax-deductible. There was a change in the income tax legislation in mid-2001 to allow premiums for voluntary health, life, and old-age insurance to be tax-deductible. The Health Insurance Act 2002 merely confirmed that this applied to health insurance premiums.

Disadvantaged sections of the population continue to be exempt from copayments, and therefore they are less likely to need to purchase SHI. However, the range of exempted people was reduced. For example, pensioners with low incomes were exempted under the old rules: the new rules only exempt them if they are living alone. The premiums of non-exempted pensioners are discounted by 40%.

In total, HZZO will gain revenue from SHI premiums and will have reduced expenses as a consequence of the copayments made by people who choose not to take out SHI. The Treasury will lose some tax revenues because the SHI premiums are tax-deductible. Ordinary citizens will lose because they will pay more – either in copayments or in SHI premiums. Disadvantaged people will mostly be unaffected, excepting those who are no longer considered to be disadvantaged.

There are many uncertainties about the effects of SHI. One is the net financial effect to the government (the difference between the new revenues from SHI and lost revenues through other taxes). The government clearly believed that there would be overall gains, given the fact that a majority of people had no voluntary insurance under the old arrangements. Anyway, there has been considerable pressure (some from international agencies) to reduce government expenditures and the shifting of costs to a 'voluntary tax' seemed a convenient approach.

Other uncertainties concern the additional administrative costs for HZZO, how out-of-pocket costs will change for the various sub-groups of the population (and particularly how the progressivity of personal health care costs will change), how many people will actually take up SHI by socio-economic classes, and how SHI will affect service utilisation and costs.

The last point is particularly important. Given that services like branded drugs and improved accommodation are covered by SHI, the overall effect will be to increase health expenditures. The additional consumption of health services by one group (those with SHI) might lead to reduced consumption by other groups of the population. In short, the re-distributional effects of SHI are of concern.

At the time of writing, some early statistics are emerging about the take-up of SHI, and associated revenues, service utilisation, and costs. Approximately 800,000 people were enrolled by the end of the first three months – a majority of those who are not exempted from copayments. There appears to be a degree of adverse selection. Initial use of the new insurance was lower than expected, but it is normal that utilisation is low until consumers become fully aware of their entitlements.

Health insurance in Slovenia since 1990

Many of Slovenia's experiences are similar to those of Croatia. In particular, Slovenia established its own national scheme of employment-based compulsory health insurance in 1992, which is termed the HIF-Slovenia below. It also created a quasi-government agency, the Slovenian Institute for Health Insurance (ZZZS), to administer the scheme.

As in Croatia, employed people contribute by way of deductions from salaries and wages, and the government pays contributions for disadvantaged groups. Unlike in Croatia, responsibility for premium collection has never rested with the insurance agency, but rather with the taxation office (for the most part).

The premiums of employed people are income-rated, as in Croatia. The rates have barely changed since the start of the scheme, and in 2002 they amounted to 13.45% of gross income (split almost equally between employer and employee).

There are more complicated arrangements for the financing the care of people outside the workforce. Contributions for the registered unemployed are paid by the central government, whereas contributions for other unemployed people are paid by local government authorities. Pensioners pay 5.65% of their gross pensions, and the self-employed pay a standard proportion of their after-tax incomes. There are particularly low rates for farmers.

From the start, there were much larger copayments than in the initial scheme in Croatia. The basic idea was that copayment rates would be set for various services in accordance with their estimated value for money. Thus there

were no copayments at all for services for children, childbirth and family planning, all preventive care, infectious diseases, malignancies, and so on. Services judged to be of an intermediate value (such as some types of orthopedics and orthodontics, dialysis, and organ transplantation) had copayments between 5% and 15%. Several services (including drugs from a positive list) have copayments of up to 25%. Copayments of 50% or more apply to most ophthalmological devices and orthodontic treatment of adults, and medications from an intermediate list.

Voluntary health insurance:

There were major differences from the outset. First, unlike the Croatian compulsory scheme, there was never any opportunity to opt out. Substitutive insurance was believed to represent a serious undermining of social solidarity. There have been various attempts to stimulate a public debate on this matter over the years, but they have been remarkably unsuccessful.

Second, voluntary insurance was immediately available: the HIF-Slovenia and voluntary insurance were a carefully integrated package. Voluntary insurance could be either complementary or supplementary, but the main target was copayments.

There were two major providers of voluntary insurance: ZZZS and a private for-profit company. In 1998, some distance was created between ZZZS and voluntary insurance by moving its scheme into a newly created mutual association. It had been estimated that voluntary insurance would be purchased by about 2% of the population in the first year. In fact, 60% purchased it. The level quickly rose to 95% and it has remained at that level to the present day.

Contributions are flat-rated for the most part. Everyone purchases cover for copayments, and a subset choose to purchase other elements relating to services not covered by the HIF-Slovenia, or concerning amenities or easier access. Insurers are not permitted to risk-rate, or to deny membership on any grounds.

The proposed health insurance reforms for 2003:

During 2002, a major evaluation of the health sector was initiated, and an early view of the consultative groups was that the voluntary insurance scheme needed to be reconsidered (Slovenian Ministry of Health 2002). If the system of copayments had been established in order to discourage demand, then it could hardly work if nearly all copayments were covered by voluntary insurance. If the intention were to give signals about value-for-money (through differential copayment rates), then this could not be realised. An obvious example concerns the differential copayments for drugs on the positive and intermediate drug lists: much of the impact is lost as a consequence of the way that voluntary insurance operates.

There were several other important concerns. One was that the use of flat rating reduced the overall degree of progressivity of health care costs. Another was that the operation of two distinct insurance models added to complexity for consumers, and excessive administrative costs in comparison to a single scheme.

This led to the development of an alternative model. In outline, this would involve elimination of insurance for copayments, and a compensating increase in contributions to the compulsory scheme – which would remain income-rated. There would be budget neutrality, and therefore a small decrease in contribution rates for low-income people would be counterbalanced by a small increase for the better-off.

There should still be voluntary insurance, on the grounds that no social democracy believes it should entirely deny people the right to pay more to get more. However, the basic principle would be to restrict it mainly to complementary services of lower value for money rather than those covered by the compulsory scheme.

Once the proposed new model had been outlined, the Ministry of Health mounted a public consultation process in late 2002. The results were surprising, even for the most convinced of the proponents: in short, there was overwhelming community support for change. The government has therefore decided to accelerate implementation. At the time of writing, it seems likely that the new arrangements will come into effect in mid-2003.

Discussion

Both countries have achieved progress since independence, in spite of the difficulties of economic, social, and political transition. They have avoided the mistakes of many other transitional economies such as Russia (Field 1999; Shishkin 1999), Romania (Bara, van_den_Heuvel, and Maarse 2002), Macedonia (Donev 1999), and China (Hindle 2000a).

It would be unwise to make a judgment about relative success. In total, Slovenia's insurance system is probably superior (and certainly so if the proposed changes to voluntary insurance are made) but it began from a more solid foundation in 1990 and has had fewer exogenous difficulties. As Vulic & Healy (1999) put it, the Croatian health sector "... did not break down and even managed to achieve fiscal stability" in spite of the large barriers including "... economic turmoil and armed conflict".

Neither country has seriously prejudiced its core policy of income-rated insurance that covers essential services largely free of charge in accordance with need. This is a significant achievement for any country, during a decade or so when many more advantaged countries (including Australia) have undermined social justice in health to a significant extent.

There have been serious attempts to inform and involve the community at large, especially in Slovenia. Neither country has mounted a misinformation campaign of the style that the Australian government used to persuade people to take out private insurance in the late 1990s – largely by force of arguments that stressed difference rather than solidarity, and fear rather than logic.

This said, both countries might have made mistakes at the margins, or at least presented unconvincing arguments to justify their insurance policies. For the most part, they are much the same as those that have dominated reform in virtually all the transition economies.

A good (if relatively unimportant) example is the distinction that has been drawn between employer and employee contributions to insurance. This is essentially a component of government policy regarding the balance between various taxes, rather than a matter of equity or cost-effectiveness in the health sector.

The same may be said of the overall contribution rate. The amount that is levied through social insurance is also a matter of judgement about the balance between alternative taxes. Yet both countries have claimed from time to time that health insurance is self-financing, that the insurance agency (HZZO or ZZZS) is somehow independent of government, and so on. An example of the interdependence comes from Croatia, where the insurance levy was reduced from 18% to 16% in 2000. In 2000 and 2001, the government made additional direct payments to HZZO of nearly AUS\$0.5 billion for the purpose of reducing its operating deficit.

The arguments used to justify establishment of separate health taxes administered by quasi-government agencies were not entirely convincing. The governments of both countries argued that 'a new source of revenue had been created'. In fact, the new revenue was largely the same as the 'old revenue' that was foregone. Another argument was that citizens would be given a clear message regarding the high cost of health care, if there were a specific levy. There are surely less expensive ways of giving the same message.

Another claim was that some of the difficulties of tax avoidance would be overcome. The reality is that tax avoidance is a general problem, regardless of the method of raising of the finances or the purpose to which they will be applied, and is usually better handled by a single agency. The Croatian government recognised this in 2002, when it introduced a single collection system under Treasury control that is responsible for all payroll taxes including health insurance premiums.

Other benefits have been claimed, such as a more open approach to the 'purchase' of services from care providers. However, the differences (if any) might have been achieved in another way – without the need to establish a predicated tax. It may be reasonable to claim that expenditures have been better controlled as a consequence of establishing a national health insurance agency. However, the existence of a separate agency (HZZO or ZZZS) means another boundary that has to be managed – between the agency and the Ministry of Health. There is no evidence that the gains from the split outweigh the penalties.

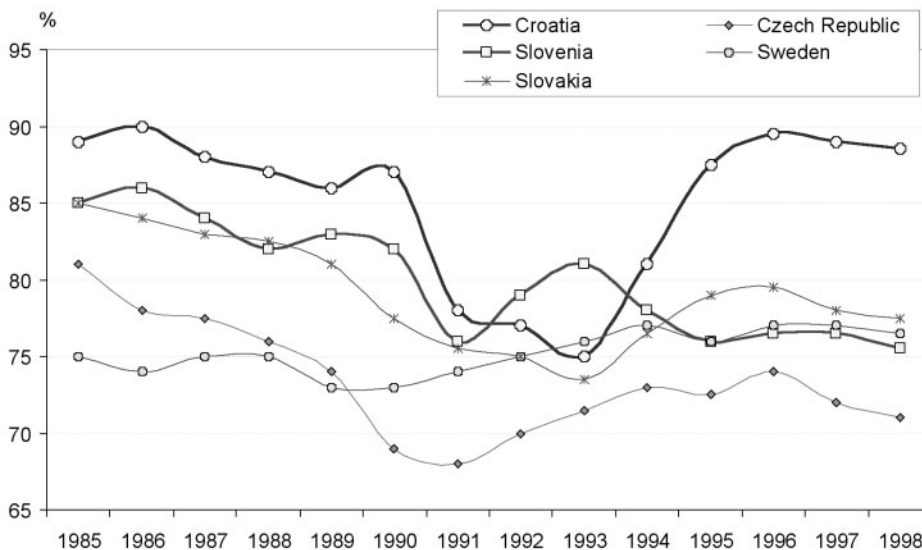
The voluntary insurance schemes cannot be claimed to be ideal. Slovenian health professionals and the community at large have acknowledged the weaknesses of voluntary insurance mainly for copayments, and yet Croatia has just implemented the same model.

Neither country has addressed the issues in a thorough way – although Slovenia now seems to be on a more thoughtful path. Langenbrunner (2002) calls the new voluntary insurance scheme in Croatia “... a public finance sleight-of-hand trick to generate new revenues for HZZO at the expense of the Treasury and local governments.” This might be an overstatement, but it is clear that voluntary insurance has mainly been viewed as an opportunity to tax by stealth, or a way to provide more consumer choice that the majority do not want or cannot use.

ZZZS has regularly claimed that one of the great successes of the Slovenian insurance arrangements is that of helping to ensure stability. There have been some obvious benefits, and many statistics show that Slovenia's health system has been more stable than that in Croatia. Figure 1 shows bed occupancy rates: there has been a gradual decline in Slovenia, whereas the rate has fluctuated much more in Croatia – where the main factors were immediate financing difficulties during the height of the war, and the government's policy of bed number reductions after 1994.

However, stability is not always beneficial if it means retaining features that are undesirable. That Slovenia's voluntary insurance changes should have been changed earlier is surely indicated by the overwhelmingly positive response to the changes proposed for 2003.

Figure 1: bed occupancy rates, selected countries, 1985-1998



The experiences of Croatia and Slovenia illustrate some points about health insurance that apply to most health systems. Six are noted below.

First, informed consumers are likely to have sensible opinions. The positive responses to Slovenia's proposed changes in voluntary insurance are a good example. In the case of Croatia, a recent unofficial survey by Mastilica & Babic-Bosanac (2002) showed there was a good understanding of problems – they were not asked about possible solutions. Most respondents believed the government's compulsory insurance scheme provided less access to care than under the old model. A majority recognised there was now greater consumer choice of services and service providers, but that this was associated with less equity. In 1997, 80% of Australians believed it would have been better to increase public hospital funding than to introduce the 30% rebate on private insurance. Governments often choose not to inform the community about options and then ask for their views, because they suspect the community might not give the answer that is wanted.

Second, it is important to ensure that people who are to make health care financing decisions have adequate knowledge or experience of optional approaches. Major changes in health insurance are relatively rare events, and therefore it is hard to find people who have been involved in more than one design. An obvious implication is that experiences from other countries need to be carefully evaluated. This is not necessarily easy, because

insurance officials from other countries will also tend to lack first-hand knowledge of multiple approaches. Moreover, it is rare that there is an adequate basis for evaluation – there are major difficulties in constructing effective experimental designs. These circumstances create good opportunities to repeat the mistakes of others.

In passing, it is clear that the insurance model adopted by many European transition countries during the 1990s was strongly influenced by the German model. Deppe and Oreskovic (1996) argue that most countries failed to separate features of the health care system from other aspects of the German economy, or assumed without good reason that Germany's economic successes were partly because of its health insurance system rather than in spite of it. The view is much less likely to be proposed at present, given the recent economic problems in Germany and the pressures to change the health care system (Hindle 2002).

Third, there should be an evaluation framework before options are rated, and it needs to be rigorously defined and applied. For example, one essential criterion is progressivity – the relationship between individuals' health care costs and their ability to pay. Many countries do not adequately address this matter. For example, the designers often look only at progressivity of insurance premiums. They may take account of copayments, and even of out-of-pocket payments for uncovered services. They are very likely to overlook unofficial payments, which are a major factor in many countries.

To put it simply, progressivity of premiums is only one component of a financing model, and it is of little use by itself. Of course, there are governments that prefer to manage only their own expenditures, and to ignore the expenditures of other parties. This has been a factor in many bad insurance decisions around the world: it was not so much that estimation of total costs was accidentally overlooked, but rather that there was no particular reason to bother.

Fourth, insurance decisions (like many other decisions about the health sector) need to take account of the long term, if only because health care systems respond poorly to frequent changes in response to crises. The reality is that decisions often reflect no more than the current government's concerns about the next election. This was arguably the case when the first Howard government introduced the 30% rebate for private insurance premiums in Australia in 1997. The senate discussions at the time show that the government had not made estimates for more than two years at best (Hindle 2000b). Recent events suggest there are regrets, given the large increase in the cost of rebates since then. Regardless of whether one agrees with those who argue that the rebate was inefficient and inequitable (Duckett & Jackson 2000; Hindle 2000b; Palmer 2000), there can be no doubt that the stated aims, including 'taking the pressure off public hospitals', have not been achieved and the long-term future of private health insurance remains unresolved (Butler 2002; Thwaites 2002).

There may be an element of 'short-termism' in Croatia's 2002 changes to voluntary insurance. There appear to be no long-term estimates of effects, although much has been said about the advantage of obtaining SHI premiums in order to address the current debts of ZZZO.

As a minimum, all processes of redesign of health insurance should involve four elements: a valid set of criteria, a list of options, a five- to ten-year scenario of the desired outcomes, and estimates of the extent to which each option is likely to achieve the desired outcomes. No such scenario had been defined in either Croatia or Slovenia in 1993, but there are encouraging signs that this gap will be filled in both countries in the near future. I doubt the same can be said of Australia.

Fifth, great care is needed to ensure vested interests are recognised and managed. It has been claimed recently in Croatia that a part of the SHI scheme was influenced by drugs companies – the change whereby copayments are covered for drugs not on the positive list (and including branded drugs even where there are substitutable generics). It was certainly the case that Australia's changes to voluntary insurance were strongly influenced by private medical specialists and private hospitals – who are the only parties actually to have benefited to a significant degree from the changes. Vested interests are not harmful by themselves. Rather, the dangers arise when misleading claims about motives go unquestioned: people want branded drugs, they want to be free of government interventions in the sacred relationship between doctor and patient, and so on.

Finally, an insurance scheme should not be viewed as an end in itself, but rather as a component of a management process directed at improving the health status of the population, and this requires more than prudent management of the scheme's balance sheet. In particular, the insurer – and especially the dominant government insurer that exists in Australia as well as Croatia and Slovenia – needs to make use of its financial

power to encourage and reward improvements in clinical practice. Health insurance changes that have encouraged unnecessary admissions (as in Slovenia), the prescribing of branded over generic drugs (as in Croatia), or the provision of more expensive private sector care (as in Australia) are not what any country would choose, if the majority of consumers were adequately informed and consulted about the choices.

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