

Restructuring Public Health in Slovenia between 1985 and 2006

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Summary

Objective. This paper explores the developments in the public health infrastructure in Slovenia in the context of the socio-political and legislative changes in health care over the last 20 years. It assesses the responsiveness of the public health institutes in Slovenia to the various plans on public health developed by health policy makers over time

Methods. After an in-depth and externally validated search for key documents, we analysed the legislation, policy documents, research reports, theses, and other health policy papers related to the public health infrastructure in Slovenia. Findings were validated through consulting 3 external experts on public health in Slovenia.

Results. In the period discussed only few new services were added and health promotion was developed as an institutional field. Passivity in the past caused a lack of decisions on some traditional services in a changed economic environment. Moving from a passive supporter of the former infrastructure to an active promoter of the reform sets health policy as the main architect of the new public health building.

Conclusion. Slovenia's "house" of public health was amended and refurbished, but a thorough reconstruction has not taken place. In order to face the future challenges in public health, the infrastructure will require increased efficiency, professional workforce development and better responsiveness.

Key words: Public health – Health policy – Health reform – Public health institutes.

Today's public health infrastructure in Slovenia is a result of a gradual development in the course of the 20th century. Two key policy concepts can be identified: the development of in-

terventions and strategies to deal with the public health problems and the development of the infrastructure to implement these interventions and strategies.

As described by Zupanič Slavec¹, in response to the lack of well-trained public health professionals in the period after World War 1, the Rockefeller foundation offered grants in the United States and Canada to a group of physicians with interest in public health. Inspired by their educational background and by the contemporary ideals, such as Štampar², they implemented the following ideas and priorities: 'socialisation' of medicine, mother and child health, workforce and working environment protection, general and housing hygiene, social diseases, and popularising health as a lifestyle concept.

The first public health institute (PHI) for Slovenia was established in Ljubljana in 1923³. Gradually a number of local and regional PHIs were established across Slovenia, defining loosely the boundaries of public health practiced there. Their efforts aimed at developing primary care and health care for the vulnerable populations and for specific public health problems. This approach was in clear contrast with the Semashko's SanEpid model, originating from the Soviet Union and established in the 1930s. The SanEpid model of public health infrastructure and primary care was implemented in all the countries of the Soviet block. Štampar's model of public health was centred on providing an outreach with specially trained primary care physicians, focusing on maternal and child care and supporting the development of environmental sanitation and hygiene. It was the PHIs who carried out these tasks, they were co-ordinating them and even provided some services (such as vaccination and several dispensaries – pulmonary, venereal, trachoma) and delivered field activities in hygiene. In the SanEpid model the whole system relied on the polyclinics, which served as the main provider of primary care and public health service. Due to its strong professional background and a positive historical experience, Yugoslavia did not follow that path after World War 2.

PHIs provided several service functions: social medicine, epidemiology of communicable diseases and hygiene and environmental health. They also assisted in the development and co-ordination of dispensary services for mother and child care, preventative dentistry, and the professional development of school medicine and general practice/family medicine. The period of social and political changes in the 1980s showed the first serious signs of financial insolvency in health care and structural problems⁴. The economic collapse of the previous system of health care financing was just one of the reflections of the distress in the social and political life in the former Yugoslavia. The MoH was hesitating between the two extremes, being either indifferent to intervening in the structural issues or, in taking the initiative to introduce organisational changes.

In this policy analysis we study the reshaping of Slovenia's public health infrastructure by exploring the positioning and actions of the main stakeholders in public health in the context of legislation and socio-political background.

Methods

This paper deals with the developments in Slovenia's public health infrastructure in the period between 1985 and 2006, which, for analytical purposes and clarity, has been subdivided further into four distinct sub-periods marked by different socio-political situations that ended with the introduction of a legislation or a national public health policy plan:

1. 1985–1992 (the adoption of the new legislation for health care in 1992)
2. 1992–2000 (the adoption of the National Health Plan in 2000)
3. 2000–2003 (the proposal of the Health Reform in 2003)
4. 2003–today (the draft proposal for a restructuring of the PHIs in 2006)

These milestones are displayed in more detail with some important contextual influencing factors in Figure 1. First, we carried out a search for the relevant documents to be analysed in our research. We based our search on the basic criterion that all the documents to be analysed need to have a specific segment focusing on the public health infrastructure. We included all the documents fulfilling the following criteria:

- i. giving an account of the historical developments in the public health infrastructure
- ii. providing a strategy for the organisational and professional development of the public health infrastructure
- iii. setting up a plan to restructure, reorganise or otherwise transform the public health infrastructure from the perspective of the national health policy

- iv. providing a legal base for the public health infrastructure
- v. researching the organisation of public health, providing a situational and qualitative analysis, including proposals for changes.

We specifically excluded documents, which were only intermediate draft documents, those dealing only with one specific service within the infrastructure, and those that provided only a personal view or an unstructured account about the public health infrastructure. Criteria for the selection of the papers were reviewed by two other external public health experts and they also reviewed the final list of the documents used.

Based on the criteria a list of documents was prepared and the analysis was carried out. It was prepared by one of the authors and the outcomes were reviewed by three other public health experts (two of them were the same as those reviewing the criteria, none belonged to the authors) who also confirmed the results of the analysis. This way external validation was added to the document selection process and to the inputs for analysis. The other author provided for the observer's insight and analytical input in processing of the results obtained by the selection of the documents.

In view of our research questions and goals, the analysis included:

1. an explorative analysis of the socio-political setting of each period with particular attention given to factors having an impact on public health,
2. an explorative analysis of the legal acts and other documents defining the legal background of the health care system and public health infrastructure,
3. an analysis of the policy documents defining roles and priorities of different elements of the health care system,
4. Description of the existing public health infrastructure in each period together with its main functions, missions, and objectives.

There was extreme scarcity of analytical work, in particular from the last category under the inclusion criteria and especially from the first period, so the main documents we had available were legal acts, together with the ministerial strategic and planning documents. The organisational changes and the legally prescribed context add to the inputs for the discussion, which follow the descriptive and explorative part in the section describing each of the observed periods.

We based our analysis in view of the following criteria, based around the dimensions, through which we are presenting our results:

1. the impact of the document on the socio-political context, in which the PHIs functioned in the respective periods,
2. the way the document explains the positioning of the identified key actors and adds to the development of health policy,

3. document's contribution to the legal framework as the key element in positioning and defining the PHIs,
4. information brought by the document to highlight the main characteristics of the public health infrastructure.

A summary classification of the selected and analysed documents is shown in Table 1.

Results

The period between 1985 and 1992 – Keeping the old house or tearing it down?

In 1985 the present set up of Slovenia's public health institutions was formalised and defined by the legislation in force until 1992⁵. Only some basic principles, such as international reporting and federal statistics, were still regulated by federal laws. Public health had an important, but insufficiently financed and inadequately defined role in health care.

Health policy was in the domain of the Ministry of Health and Social Care (MoHSC), which was also responsible for the development of the public health infrastructure. In this task MoHSC co-operated with the PHIs and the Department of Social Medicine of the Medical faculty in Ljubljana (then also located at the NIPH). After having given up on changes in public health and due to the lack of a consensus, the main partners opted for the *status quo* in which all the inherent problems remained. Within public health that was seen as a “better” option as compared with the officially proposed dissolution, which envisaged merging the former departments of the NIPH with other state administration's services.

- Limited role of the federal state (1985–1991) in regulating health care. With health care organisation and financing under the jurisdiction of the republics, federal legislation continued to regulate some public health priority areas, such as: communicable diseases, health reporting and health statistics, and registration of medications. Federal

Dimension	1985–1992	1992–2000	2000–2003	2003–today
Socio-political setting	2	2	1	1
Legal background	1	6	0	0
Policy documents	0	3	0	5
Description of the public health infrastr.	1	0	1	2

Table 1 Results of the document search

Within each of the described periods we present the results of our analysis for each of the elements, we discuss the interactions between the elements and the development of the public health infrastructure. We reflect on the findings by looking at trends in the most important general health status indicators.

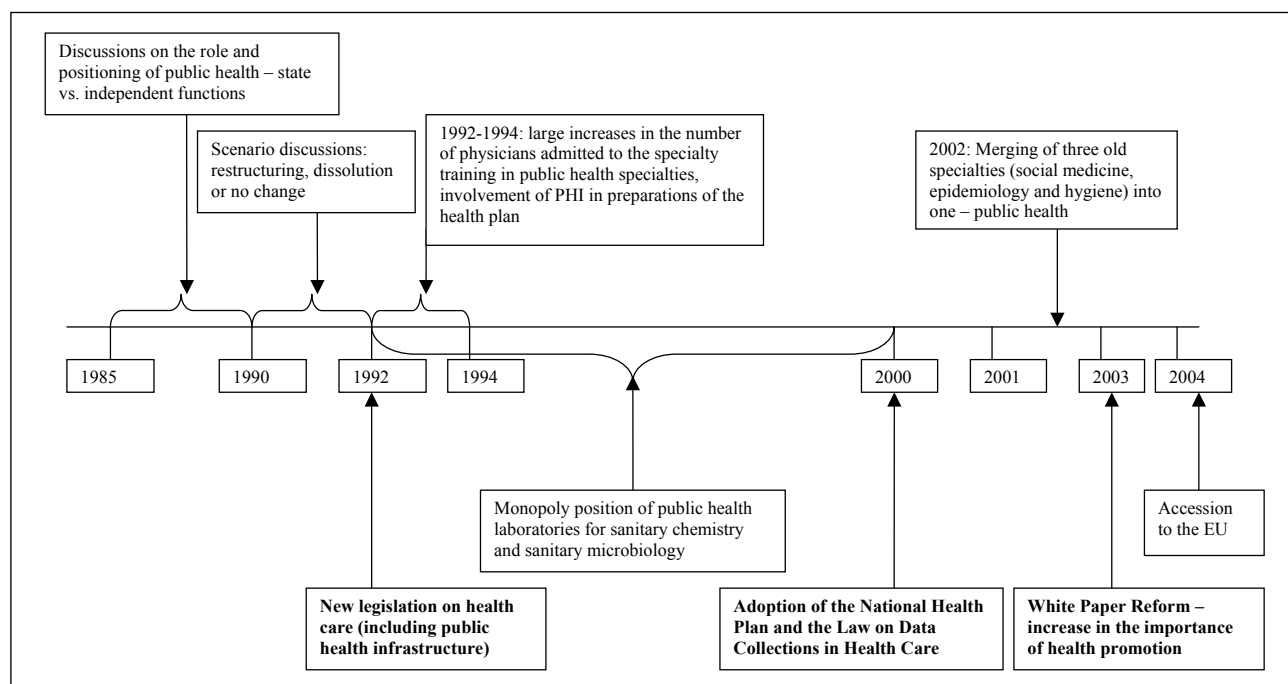


Figure 1 Milestones and the most important events and documents in the development of public health infrastructure in Slovenia 1985–2004.

level defined the normative aspects and the reporting lines leading to the Federal Institute of Health Care and to the Federal Statistical Office.

- Setting up a new health care system with the adoption of the new legislation in 1992. Simultaneously, the preparation of the National Health Plan 'Health for all by the Year 2004' (NHP) started⁶, a document embracing epidemiological evidence, public health priorities with a strengthened role of the public health infrastructure, health care financing and the national health care strategy.
- In general terms, in 1985 PHIs were defined in their present form with the national institute (then UIHSC) and nine regional institutes. Their services were financed partly by the Slovenian budget, as this had not been a federal task, and partly by health care.
- Inspired by the boards of health and welfare in the Nordic countries, the University Institute for Health and Social Care (UIHSC) was established, offering a close link between health and social care. It had two organisational units: the Institute of social medicine and social care (ISMSC) and the Institute of epidemiology. The ISMSC included several departments, dealing with health issues of different vulnerable groups and different levels of health care. Social care remained a part of the institute's structure until 1992, when it was merged with the new Ministry of Labour, Family, and Social Affairs. The UIHSC dealt with two issues of the health information system – the uniform definition of prescriptions and the uniform register of all physicians and dentists.
- The regional PHIs stayed with the classical framework of public health functions and continued having three main departments – social medicine, hygiene, and epidemiology of communicable diseases.

The organisation of the public health infrastructure was scarcely discussed scientifically. The most important analysis was prepared in 1990 by the Head of the ISMSC, Dr M. Kožuh⁷. This explorative analysis pointed the criticism to the knowledge gap and the lack of modern techniques and findings used in public health practice. Public health was supposed to enhance its initiative and involvement in the health issues, while health policy should be more open to take up public health's analytical and planning work.

The period between 1992 and 2000 – The old house gets redecorated and partly refurbished

The political priorities for the health care reform were in privatising health care delivery; decentralising and deregulating state-run administrative tasks; introducing a social health insurance system and introducing co-payments to attract more private sources of financing. The new Health Services Act⁸

confirmed the status and organisation of PHIs, but the MoH had to determine new public health priorities. PHIs were co-ordinating the preparation of the NHP (National Health Plan 'Health for all by the Year 2004' 2000⁶), which was blocked at the Parliament due to the conflict over the determination of the national network of health professionals and over the organisational aspects and privatisation of primary health care delivery.

The MoH preserved its role in defining public health priorities, this function being controlled through an evaluation process of activities by its advisory body, the Health Council, which confirms annually the PHIs programme, together with its financing. There were now two new key actors. The first, the Health Insurance Institute of Slovenia (HIIS) was able to provide an important source of financing of public health services due to its strong legal positioning, a clear strategic vision and financial strength (a budget 30 times the size of the MoH), the latter was maintained throughout the 1990s. The second, the Medical Chamber, became the most influential independent representative body for physicians and dentists (including those working in public health) after the adoption of the Medical Services Act⁹. Association of Public Providers of Health Care (APPHC) continued representing the public health infrastructure as their negotiator in the annual negotiations on the general agreement on services with the HIIS, defending tariffs for the public health services provided through HIIS financing.

In February 1992, the new health care legislation was adopted with the two basic laws^{8, 10}. The Health Services Act defines the setting for PHIs with the State in the key managerial position. The same Act describes the following functions of the PHIs:

- studies of the population's health, environmental health impact assessment and interventions aimed at improving, preserving or regaining health,
- evidence base for the development of an efficient health care system management and economics,
- educational, research and publishing work in the field of public health,
- planning and co-ordination of health education and health promotion programmes,
- Development and maintenance of the health care information system and environmental health information system.

The NHP and the Health Data Collections' Act¹¹ additionally defined tasks of PHIs and ended the period of re-defining the new health care system. The NHP was an opportunity providing an outline for a transformation of the public health infrastructure. Eventually, public health was to have a co-ordinating role in primary health care delivery and in preventative and health promotion services. The Plan defined the NHP's

role as the key institution responsible for the management of the national health information system.

With the legislation of 1992, a new typology of the PHIs was introduced. Most changes occurred at the national institute, where new organisational units – centres – were established: Centre for Population Health Research, Centre for Health Care Organisation, Economics and Informatics, Centre for Environmental Health, and Centre for Communicable Diseases, stressing the functions to be carried out exclusively at the national level. Even if the PHIs continued having additional sources of finance, apart from the national budget, there was tight budgetary and administrative control over the services at the national and regional PHIs. Evaluation of their annual work programmes and reports through the Health Council as a body for external validation of PHIs programmes was used. The State openly started to develop a two-tier system. Through a more stringent national fiscal policy more limitations were imposed on the financing of the public health infrastructure from the national budget. In compensation, financing of services was supplemented through the establishment of monopolies in sanitary chemistry and sanitary and medical microbiology. A part of these services was financed through direct payments by the users of these services in the economic sector. In response to soaring prices, several hospitals decided to open their own microbiology laboratories. These approaches introduced problems that would surface after the year 2000.

The period between 2000 and 2003 – The old house gets amended for the new family members

In the year 2000 Slovenia had three governments. The first was the one elected in 1996, losing the vote of confidence in April 2000, bringing to power the second one that ends the electoral term and the third elected in the general elections in October. The latter put forward the importance of public health as a lever to improve Slovenia's population health. The main public health targets were: socio-economic differences in access to health care, unhealthy lifestyles and premature mortality due to cardiovascular diseases. Public health received two mission messages – one, a need for analytical support to health policy and, two, development and implementation of new concepts in health promotion. That was reflected in a number of initiatives starting in 2001 and culminating in 2003 with the health reform proposal¹² (the Reform below), which included an entire chapter on public health.

The MoH got involved directly in the implementation and analytical projects and in carrying out intervention strategies that had its main focus at the regional and local levels. Implementation of strategies was handed over to the regional PHIs and in this respect the influence of the MoH and the CINDI (Countrywide Integrated Non-communicable Diseases In-

tervention) project team had become stronger than before. The most important new actor in public health was CINDI Slovenija, which brought new ideas to the area of health promotion; sometimes this involvement was at the expense of the public health infrastructure.

It was a turbulent period also for the MoH as in 2000 it had three consecutive ministers of health. The second government in that year decided on public spending cuts, where funding of public health infrastructure from the national budget was cut by 7% with respect to the year 1999¹³. The third term started with a more clearly defined national management role of the MoH with respect to public health and in 2001 the budgetary provisions for public health started to increase (at first by 20% with respect to 2000). For the first time, one of the state secretary's posts was dedicated only to public health and prevention.

There were no changes in the position, roles and functions of the PHIs. The Government did not follow the concepts outlined in the NHP, which required an enhanced role in the co-ordination of primary care and proposing workforce growth and development. Organisational changes were planned after the adoption of the Health Reform, which was never adopted. This meant there was going to be no formal change related to the concepts outlined in the public health chapter of the Reform. Indirectly, changes in the related legislation caused further reductions in generating income for the PHIs. These were in a drop in microbiology services offered by PHIs, caused by the abolishment of the compulsory regular medical check-ups defined by the occupational health requirements and in a different approach to the monitoring of drinking water and foodstuffs with the producers (introduction of the HACCP - Hazard Analysis and Critical Control Point - system). Compulsory medical check-ups were abolished as it became evident that primary and secondary prevention should be regular activities carried out with the GPs and there was no evidence that compulsory regular check-ups were superior in any way. Public health institutions started to fail financially as several regional PHIs had deficits in previously high income-generating services. In 2001, the MoH decided to commission a large cross-sectional survey on lifestyle habits of the adult population based on the FinBalt Health Monitor¹⁴ and CINDI Health Monitor¹⁵. The study was repeated in 2004 and an extensive report was prepared, providing evidence for a targeted public health intervention. The task was carried out by CINDI Slovenija and the regional PHIs, who undertook a part of the analysis and prepared public health intervention programmes adapted to their specific regional situation. CINDI brought in additional financial resources to the regional PHIs for the execution of the tasks described above and strengthened the resource base in health promotion.

The period from 2003 until today – Thorough refurbishment or a new house? The dilemma repeated

The current period is marked by criticism of the public health infrastructure's role and its contribution to the nation's health. This previously culminated in the Reform of 2003, which was dedicated to: a critical appraisal of the recent history of public health infrastructure, proposed contextual and organisational changes with the development of health promotion and announcing the new NHP.

The Reform of 2003 had as its main output the successful introduction of DRGs in all Slovenian acute hospitals. Other proposed actions, such as the abolishment of the voluntary health insurance as an independent source and its incorporation into the HIIS and restructuring primary health care with the central role of GPs largely failed. There were a number of reasons: a predominantly top-down approach, concentration of efforts within a relatively small group of experts and consequently, a low level of agreement on the most important priority problem areas, failure to prepare alternatives for some of the most controversial solutions, implicit shift to a pseudo-NHS system. A broader open discussion was impossible in an atmosphere of distrust, where several important collective and individual stakeholders felt excluded in the creation of the reform's draft. The following government elected in 2004, composed of the previously opposition political parties decided to abolish the previous health reform for conceptual differences. The new government proposed a series of structural reforms that were to culminate in revisions or total restructuring of the most important legal acts regulating the system. Public health infrastructure would be affected both directly and indirectly – directly, because of the redefined public health priorities and indirectly, through a comprehensive structural reform of the entire public sector.

An enhanced role for the non-governmental sector through involvement of several new and reinforcing some old stakeholders in the system is the most important change of the period. On the national level, that is definitely true of the CINDI Slovenija, which has become one of the key partners and stakeholders in health promotion, both through its innovative approaches at the national and regional levels, as well as through its additional sources of finance. Their role gradually went from the analytical involvement through the development of a programme of early detection of cardiovascular risk factors to the intervention projects at a regional level¹⁶. The latter involve professionals from regional PHI alongside local and regional institutions and NGOs. The failure of the Health Reform meant that the public health infrastructure reform was postponed yet again, but it has become the priority of the present government. The most important landmarks of these changes should be: redefinition of the PHIs tasks and

services, strengthening of the regional PHIs involvement with the future regions and the establishment of a School of Public Health.

Most of the legal changes are yet to be expected in this period as the plans for reforms and their execution through different legal acts unfold over the next months and years. Public health was partly influenced by those legislation changes where Slovenia had to comply with the requirements of the European Union (regarding competition in services). Other segments of public health, such as particular communicable diseases control, health reporting, health and safety at work, were also affected by the accession to the EU. In future, the basic health laws will be revised to implement new strategies following the social and structural reforms.

The new reality of reduced incomes, which used to represent important revenues for PHIs in the 1990s, and bringing forward the priorities of the MoH requires a more comprehensive reform of the organisational structure. Firstly, there was a reduction of laboratory tests for food producers, water supply systems and the catering industry. With the introduction of the HACCP system, it is the providers' responsibility to carry out monitoring of their own products. Secondly, there was a reduction of laboratory tests when obligatory six-monthly medical check-ups of professionals working in the catering industry and some others under medical supervision were abolished. In trying to overcome the lost income, some of the regional PHIs started acting as commercial providers and entered into competition with other regional institutes and the national institute.

A new opportunity of financing was offered by the inclusion of some of the public health services into the so-called 'programme of tertiary services'. Programme of tertiary services includes services delivered by clinical departments and research institutes, which are considered to be innovative and implementing new approaches to health care. This was the first time that a part of the public health services was regarded as equal to the most advanced types of health services.

Public health certainly had an impact in the past on the favourable development of some of the key health indicators. At the same time, there are new issues arising from the economic and social developments in Slovenia, like socio-economic differences in health and, in particular, the continued problem of preventable causes of premature mortality in men. As reported by Markota¹⁷, almost 40% of the premature mortality in men is attributed to suicides, traffic accidents and other alcohol-related deaths. (Table 2¹⁸)

Table 2 An overview of selected indicators in the period 1985–2005. Source: HFA Data for Slovenia for the respective years. WHO EURO, Copenhagen: January 2007.¹⁸

Indicator/Year	Measure	1985	1990	1995	2000	2005
Infant mortality	Deaths per 1,000 live births	13.08	8.36	5.53	4.9	4.21
Life expectancy (for both sexes)	Years	72.19	73.99	74.79	76.27	77.58
Cardiovascular mortality	SDR per 100,000	530	445	371	315	288
Cancer mortality	SDR per 100,000	212	209	218	205	197
Injuries and poisonings mort.	SDR per 100,000	105	88	83	70	62
Suicides	SDR per 100,000	33.6	28	27.4	27.1	22
Lung cancer mortality in men	SDR per 100,000	83.55	90.92	92.36	77.76	74.6
Liver cirrhosis mortality	SDR per 100,000	42.8	34.2	34.4	33.1	22

Discussion

PHIs in Slovenia have not seen any substantial organisational changes over the past 20 years. In the absence of a more radical reform, we can identify four key developments in each of the described periods:

1. maintaining the public health infrastructure in contrast with (political) demands for its restructuring,
2. changes to financing of PHIs that transiently solved the stagnant financing from the national budget,
3. health promotion and health intervention activities that brought public health to the agenda in health policy,
4. The start of a restructuring process with reform of the existing public health institutions.

Similarly to other countries and in contrast with the WHO priorities¹⁹, the reform of health care delivery in 1992 was at the top of the agenda. While many other countries of central and Eastern Europe sought a quick way away from the previous setting of public health²⁰, in the former Yugoslavia the situation was different. PHIs were seen also as co-ordinators of an integrated primary health care model approach implemented through primary health care centres. General practice training, development of school medicine, and community nursing, all have their roots in the national PHI. The challenge of HIV/AIDS saw a prompt and co-ordinated response by PHIs with intense promotion campaigns since 1986. They resulted in a rather slow growth in the number of HIV/AIDS cases in Slovenia and in solving some difficult issues like granting compensations to haemophiliacs infected in health care²¹. There were other successful initiatives where PHIs worked resulted in launching several new public health programmes:

- The national cervical cancer screening programme²²,
- The national programme of early detection and prevention of risk factors for cardiovascular diseases, based on the population survey results²³,
- The national programme on nutrition²⁴.

The responsible persons for public health at the MoH have always been public health professionals coming from public health practice (a professor of social medicine, a former director of the national PHI, a director of CINDI Slovenija, a former director of a regional PHI). This reflects both the importance given to the post as well as the small size of the country where the community of about a hundred medical professionals in public health traditionally covers all the functions. Public health is short of well-trained staff as training and continuous education lack a stable base with background in public health practice. A final decision needs to be taken on the study project²⁵ aimed at establishing a National School of Public Health, maybe also reviving the past collaboration in postgraduate education with the Andrija Štampar School of Public Health.

Tearing down the existing public health house was eventually not an option, but the chief architects continued to dwell on the discussions, which styles to apply and what should the size and the number of rooms be. In none of the periods we presented was there ever a single strategic document, which would comprehensively set out the national requirements for a future public health infrastructure. Guidance for the construction could be seen in the WHO categorisation of essential public health functions:

- Prevention, surveillance and control of communicable and non-communicable diseases
- Monitoring the health situation (health status, determinants, risks and interventions)
- Health promotion
- Occupational health
- Protecting the environment
- Public health legislation and regulations
- Public health management
- Specific public health services (school health, emergency services and laboratory services)
- Personal healthcare for vulnerable and high-risk populations

We can identify all of these functions as implemented in Slovenia, but resolving a stable longer term financial support for the PHIs is still an open issue.

One of the important limitations to our study lies in the fact that there is an evident lack of public health system's research and that most of the existing documents are either political or legal acts. PHIs were unable to identify explicitly their own priorities and to justify them, based on research results. A recent thesis by Seljak²⁶ presents the framework for some managerial and financial solutions of transforming PHIs in Slovenia (e. g. new services and public-private partnerships).

Conclusions

Our research explored the reshaping of Slovenia's public health infrastructure. Transformation has been incremental and is still ongoing but it brought most of the modern concepts, advocated by the WHO, into the PHIs' practice. Several successful initiatives resulted in programmes with long term effects and have persisted to date. In the absence of any implemented legal initiative the public health system's position did not change, even if the PHIs have not readily and adequately responded to the challenge of reduced incomes surfacing in a changed economic environment. We can summarise the findings from the analysed period into two main sets of issues:

1. health policy issues
 - a. lack of a long-term vision and lack of a multi-level strategy with explicit interventions and objectives planned and assessed,
 - b. 'how much do we leave of the old and how much do we take up of the new',
 - c. hesitation of the MoH to carry out a more radical reform in the public health infrastructure,
 - d. introduction of *ad hoc* partial solutions without clearer longer term objectives,
2. issues related to the PHIs'
 - a. poor own perception of their broader scope of tasks, for example challenges of the independence and accession to the European Union,
 - b. unmet expectations of the MoH for analytical outputs for health policy support,
 - c. high dependency on certain sources of funding (laboratory, vaccines) and the changing setting causing severe financial consequences,

- d. a possible (but not openly discussed) privatisation of PHIs or, at least, of their management,
- e. Introduction of new partners to the public health institutions and involvement of NGOs as a challenge for the existing institutes.

In spite of its historical advances in public health, Slovenia needed to bring public health in line with the modern international developments, especially modern epidemiology and health promotion. This imminent process was different from the other neighbouring countries. Even with increased efforts in educating many public health professionals in public health schools abroad, workforce deficits in the field became evident in this period. The public health institutions will make important decisions due to the forthcoming economic and social reforms. They could decide to continue as completely publicly owned institutes and provide services in the public interest, or alternatively, to develop as public-private partnerships.

Slovenia has preserved its public health infrastructure that has been in place for almost a century. As the MoH avoided an open confrontation with the PHIs and, in particular, avoided imposing a radical reform, there are still significant positive developments in some important indicators of the population's health and country's adherence to the WHO public functions was maintained. Through political priority setting several services and activities were added to the existing list. The PHIs can prosper through: enhancement of the overall level of knowledge and expertise, strengthened public health workforce and prompt responses to the priority development areas. The latter should be developed clearer in close co-operation with the MoH, irrespective of the future PHIs legal status. PHIs' role in serving as the base for health policy support and development of a modern health-driven public health focused on the development of health promotion and healthy choices needs to become a political priority.

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Zusammenfassung

Zielsetzung: In dieser Arbeit wird die Entwicklung der Infrastruktur des öffentlichen Gesundheitswesens in Slowenien im Kontext der sozio-politischen und gesetzlichen Änderungen im Laufe der letzten 20 Jahre untersucht. Die Studie untersucht die Reaktionsfreudigkeit der Institute für Public Health in Slowenien auf diverse gesundheitspolitische Pläne, die von den jeweiligen Entscheidungsträgern in der letzten Zeit entwickelt worden sind.

Methoden: Zunächst wurde von den Autoren eine detaillierte und extern validierte Suche nach Schlüsseldokumenten durchgeführt, außerdem wurden die Gesetzgebung, Unterlagen, Forschungsberichte, und andere gesundheitspolitische Arbeiten, die auf Infrastruktur der Public health in Slowenien bezogen sind, analysiert. Die Ergebnisse wurden durch drei externe Experten aus dem Gebiet public health in Slowenien validiert.

Ergebnisse: In dem behandelten Zeitraum wurden für die Gesundheitsförderung institutionalisierte Rahmenbedingungen entwickelt. Darüber hinaus wurden in diesem Bereich nur

wenige neue Leistungen eingeführt. Die Passivität der vergangenen Jahre hatte zur Folge, dass Entscheidungen bezüglich bereits etablierter Leistungen in einem ökonomisch veränderten Umfeld nicht getroffen wurden. Der Wandel von einer passiven Befürworterin vorhandener Infrastruktur zu einem aktiven Förderer von Reformen macht die Gesundheitspolitik zu der Hauptarchitektin des neuen Public Health Bauwerkes.

Schlussfolgerung: Das Slowenische "Public Health Gebäude" wurde in der Vergangenheit immer wieder ergänzt, geändert und aufpoliert, jedoch ist es nie zur einer ganzheitlichen Sanierung gekommen. Damit die neue Infrastruktur den öffentlich-gesundheitlichen Herausforderungen der Zukunft gewachsen sein wird, wird es einer erhöhten Effizienz, einer Weiterentwicklung der professionellen Arbeitskräfte, und einer verbesserten Reaktivität der Systeme bedürfen.

Schlüsselwörter: Public health – Gesundheitspolitik – Gesundheitsreform – Public Health Institute.

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