Revenues of public health institutes in 2002[1]

Revenue sources	No. of public health institutes	Total revenues	Public sources		Other (private) sources			
			Public service activities				Market-oriented activities	
			Revenues from public finances		Other revenues to provide public services		Revenues from selling goods and services in the market	
		SIT million	SIT million	% share[2]	SIT million	% share[2]	SIT million	% share[2]
Public health institutes	125	322,287	234,278	72.7	58,847	18.3	29,162	9.0
- excl. pharmacies	101	249,854	199,037	79.7	35,113	14.1	15,703	6.3
Health centres	59	64,854	50,056	77.2	7,687	11.9	7,111	11.0
Hospitals[3]	26	169,728	145,811	85.9	21,414	12.6	2,503	1.5
IPH[4]	10	9,682	2,837	29.3	3,208	33.1	3,636	37.6
Other[5]	6	5,589	333	5.9	2,804	50.2	2,453	43.9
Pharmacies	24	72,433	35,241	48.7	23,734	32.8	13,459	18.6

Source of data: APLRS – cash flow statement of revenues and expenses; calculations by the IMAD.

Notes: [1] the analysis covers all public health institutes which are legal entities under public law and whose budget spending unit code given in the financial statement for 2002 is 3.2. These codes are taken from the list of direct and indirect budget spending units published as an annex to the Order on Direct and Indirect State and Municipal Budget Spending Units (Ur.l.RS, 46/03); [2] as a % of total revenues; [3] including the Clinical Centre, the Rehabilitation Institute and the Institute of Oncology; [4] IPH – regional Institutes of Public Health, including the Institute of Public Health of the Republic of Slovenia, which recorded a much smaller share of revenues from selling goods and services in the market than other IPHs; [5] others: the Blood Transfusion Centre of Slovenia, the Transplantation Institute, (Slovenia Transplant), the Association of Health Institutes (three), and the Youth Sanatorium of Rakitna.

A new paper will appear in the IMAD's **Working Papers** series in March: **Operations and Financial Sources of Public Institutes in 2001 and 2002** prepared by Eva Zver. The first part presents particular features of public institutes' operations, financing and accounting methods. The second part shows financial sources and financial results for 2001 and 2002 broken down by type of public service: education and sports, health, social protection, culture, and research.

Health as a public service is provided within the framework of the public health service network. Public health service providers offer services, medicines and medical devices under the health protection system and within the scope of rights guaranteed by law. A public health service can be provided by public health institutes as well as other legal entities and private individuals on the basis of a concession agreement. **Public health institutes** prevail among public health service providers, followed by private individuals holding a concession, commercial companies and private institutes holding a concession.

After the Public Finance Act and the Accountancy Act came into effect, the reporting and accounting procedures of public institutes underwent some profound changes, offering new opportunities for analysing financial results and financial sources of public institutes (see SEM 11/2003:18-19).

This **analysis** used financial statements of revenues and expenses compiled in accordance with the cash flow principle: public health institutes must break down all revenues into **public and other (mainly private) revenues**. Financial statements show separately: (1) revenues for providing a public service; and (2) revenues from selling goods and services in the market. Revenues for providing a public service are further divided into: (1a) revenues from public finances; and (1b) revenues from other (private) sources (see SEM 11/2003:19). This allows us to see the relationship between public and private sources either for total activities of the public health institute (including market-oriented activities) or its public service activities alone (see graph).

The table shows the three main sources of revenue for **2002**. **Revenues from public finances** represented **72.7%** of total revenues of public health institutes. Within this, funding provided through the Health Insurance Institute (HII) represented 90.5% (SIT 212 billion, which equalled 60.7% of the HII's total budget for 2002), 8.2% came from the central government budget, 0.7% from local government budgets and 0.6% from other public funds. The HII provides funding for services and other rights under Compulsory Health Insurance, while central and local government budgets provide funding for investment and the implementation of national public health programmes. **Other (private) sources** accounted for **18.3%** of total revenues for **providing public health services**. They mainly involved voluntary health insurance, in particular supplementary health insurance, which covers the difference between the total cost of a health service (medicines or medical devices) and the cost covered by Compulsory Health Insurance (see SEM 01/2004: 19). Other sources also included individuals' direct payments for health services, medicines and

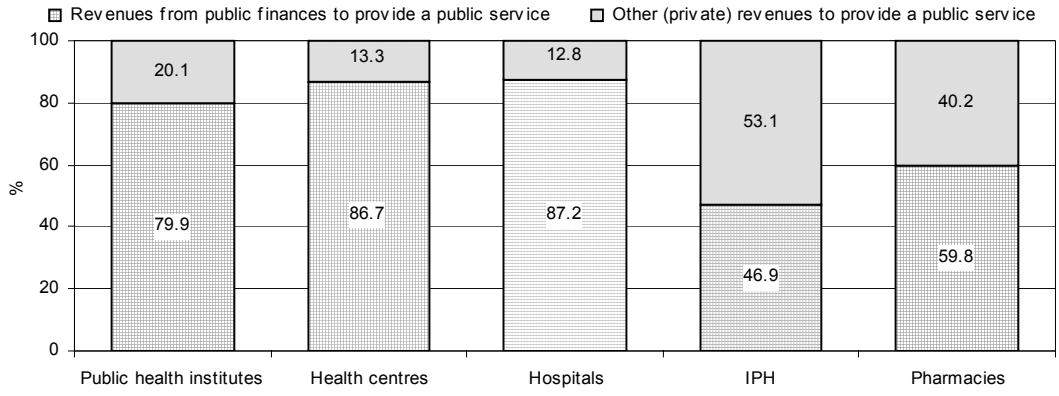
medical devices, donations from charity organisations and donors, and funding received from other public institutes (this is an important source of IPHs, the Institute of Public Health of the Republic of Slovenia and others; see table), i.e. all revenues that public health institutes received to provide public health services from non-public, mainly private sources. **Revenues from selling goods and services in the market** are shown as a separate item. In 2002, these revenues accounted for **9.0%** of total revenues of public health institutes. This share was 6.3% if pharmacies are excluded: market-oriented activities of pharmacies generated as much as 46.2% of all public health institutes' revenues from selling goods and services in the market. It should be noted that only these revenues are considered to be earned in the **market** because it is only the prices of goods and services **outside the scope of public service activities** that are shaped by market forces (see SEM 11/2003: 18). The table shows that Institutes of Public Health (IPHs) also recorded relatively large shares of revenues from market-oriented activities. These institutes, which were established to provide public services in the field of public health, significantly increased the scope of non-public services in the past few years with which they compete in the market along with other providers (e.g. microbiological and laboratory research, consultancy, water analysis etc). Given the large share of revenues earned in the market, it would seem reasonable to reorganise the IPHs as publicly-owned enterprises or commercial companies providing public health services on the basis of a concession agreement.

Funding received by public health institutes to provide public health services accounted for close to **two-thirds** (65.1%) of total **expenditure on health in 2002**, which equalled 8.5% of GDP, according to the IMAD's calculations. About **one-third of total expenditure** on health went to other health service providers (legal entities under private law) and organisations and regulators of the health protection system. The figure for public health institutes only covers funding provided for public health services (revenues from public finances plus revenues from other sources, excluding revenues from market-oriented activities), which amounted to SIT 293 billion, or 5.6% of GDP. Total expenditure on health is composed of Compulsory Health Insurance (total expenditure of the HII rather than just its allocations to public health institutes) and appropriations from the central and local government budgets. Private sources, on the other hand, include voluntary health insurance and individuals' direct payments calculated from the household budget survey. According to the IMAD's calculations, the **relationship** between **public and private expenditure on health** was 77.5 to 22.5 in 2002. In public health institutes, the relationship between revenues from public sources and other (mainly private) sources was 79.9 to 20.1 (see graph).

The calculation of Slovenia's expenditure on health does not yet follow the international classification of health expenditure according to the OECD's methodology because the international standard of collecting health expenditure data has still not been introduced. The OECD's methodology requires that health expenditure should be broken down by financing sources, health protection activity, and health service providers on the basis of the system of national health accounts. Data from public health institutes' annual reports, which were used in this analysis, will make an important contribution to building the system of national health accounts for Slovenia.

The **graph** shows the relationship between revenues from public and other sources received by public health institutes to provide public health services (the analysis excludes revenues from selling goods and services in the market because they are not part of the public service).

Graph: **Structure of public health institutes' revenues to provide public health services, %**



Sources of data: APLRS - Statement of revenues and expenses compiled in line with the cash-flow principle; IMAD's calculation using APLRS data. Note: see notes in the table.