Supplementary health insurance						
year	number			index 1995=100		
	insurance policies	claims	claims per insurance policy per year	insurance policies	claims	claims per insurance policy per quarter
1995	1,355,356	20,109,504	14.84	100	100	100
1996	1,378,335	20,136,889	14.61	102	100	98
1997	1,251,458	20,781,930	16.61	92	103	112
1998	1,289,372	19,838,208	15.39	95	99	104
1999	1,334,680	20,030,432	15.01	98	100	101
2000	1,360,242	20,779,960	15.28	100	103	103
2001	1,372,933	20,882,206	15.21	101	104	103
2002	1,371,278	20,879,809	15.23	101	104	103

Source of data: statistical reports of the Agency for Insurance Supervision.

In Slovenia, **health insurance** is organised as **compulsory** social and **voluntary** health insurance. The main part of voluntary insurance is **supplementary** insurance, which covers the difference between the total cost of a health service and the cost covered by compulsory insurance. According to the current regulation, the uncovered cost is about 15% of the total price of a health service. The share of supplementary payments has increased since the Health Care and Health Insurance Act came into effect and reached the current level in 2000.

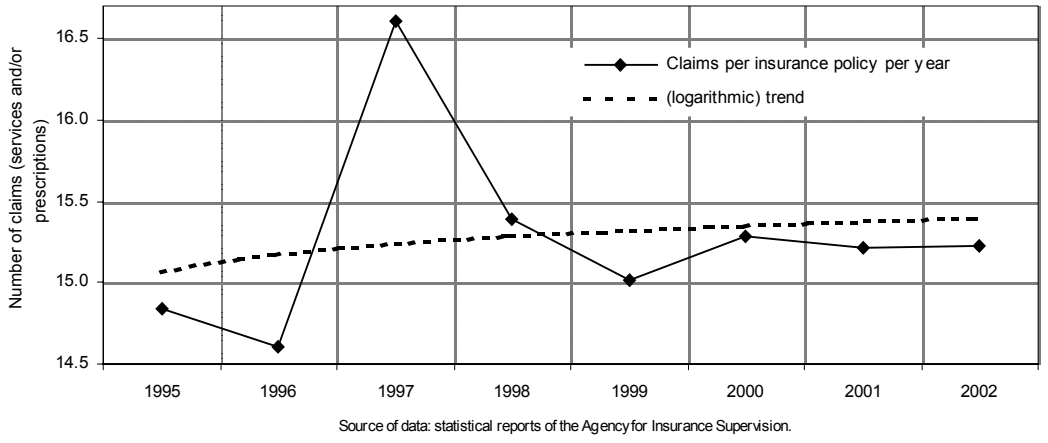
Supplementary payments for services of compulsory health insurance are a common way of combining the public and private financing of health care in Europe. Slovenia and France have introduced the possibility of taking out insurance for supplementary payments: the risk that the insured has to pay for the given service is assumed by the insurance company after the insured has paid the insurance premium.

Since supplementary health insurance is directly related to rights under social insurance, which is universal in Slovenia (practically all residents of Slovenia, people working in Slovenia and their family members are included in social health insurance), it is desirable that people who are not exempt from supplementary payments under compulsory health insurance take out supplementary insurance in order to allow all to have non-discriminatory access to health care.

From **1995 to 2002, the number of insurance policies** changed little. People left out of the system of supplementary health insurance are mainly those whose right to full coverage under compulsory health insurance expired and have not yet taken out supplementary insurance, while the rest remain excluded for reasons other than exclusively economic ones. No research is available to reveal what these other reasons are.

We can monitor the frequency of incidents where the contact of the insured with the health system results in a bill for a service or for materials. These incidents are treated and recorded as **claims**. In 1995-2002, an average of 15 to 17 bills were paid for services and other rights guaranteed by health insurance, whereas the reason for this high frequency was the large number of visits to doctors and prescriptions. Relatively low fluctuations from year to year suggest that the behavioural patterns of the insured change little, as do the doctors' issuing of prescriptions.

Graph: **Number of claims per insurance policy per year, 1995-2002**



Source of data: statistical reports of the Agency for Insurance Supervision.