# THE ANALYSIS OF SLOVENIAN POLITICAL PARTY PROGRAMS REGARDING DOCTORS AND HEALTH WORKERS FROM 1992 TO 2014

## ANALIZA PROGRAMOV SLOVENSKIH POLITIČNIH STRANK V LUČI VSEBIN, POVEZANIH Z ZDRAVNIKI IN ZDRAVSTVENIMI DELAVCI OD LETA 1992 DO LETA 2014

Alem MAKSUTI[1], Danica ROTAR PAVLIČ[2*], Tomaž DEŽELAN[3]

[1]Faculty of information studies, Novo mesto, Sevno 13, pp. 299, 8000 Novo mesto, Slovenia
[2]University of Ljubljana, Faculty of Medicine, Department of Family Medicine,
Poljanski nasip 58, 1000 Ljubljana, Slovenia
[3]University of Ljubljana, Faculty of Social Sciences, Kardeljeva pl. 5, 1000 Ljubljana, Slovenia

**ABSTRACT**

**Keywords:**
medical doctors,
health workers,
party programmes,
political parties,
Slovenia

**Introduction.** The study focuses on the programmatic bases of Slovenian political parties since independence. It presents an analysis of party programs and their preferences regarding doctors and other health workers, as well as the contents most commonly related to them. At the same time, the study also highlights the intensity of the presence of doctors on the policy agenda through time.

**Methods.** In the study, 83 program documents of political parties have been analysed. The study includes programmes of political parties that have occurred in parliamentary elections in Slovenia between 1992 and 2014 and have exceeded the parliamentary threshold. The data were analysed using the content analysis method, which is suitable for analysing policy texts. The analysis was performed using ATLAS.ti, the premier software tool for qualitative data analysis.

**Results.** The results showed that doctors and other health workers are an important political topic in non-crisis periods. At that time, the parties in the context of doctors mostly dealt with efficiency and the quality of services in the health system. They often criticize doctors and expose the need for their control. In times of economic crisis, doctors and other health workers are less important in normative commitments of parties.

**Conclusions.** Slovenian political parties and their platforms cannot be distinguished ideologically, but primarily on the principle of access to government. It seems reasonable to conclude that parties do not engage in dialogue with doctors, and perceive the latter aspassive recipients of government decisions—politics.

***IZVLEČEK***

***Ključne besede:***
zdravniki, drugi
zdravstveni delavci,
strankarski programi,
politične stranke,
Slovenija

***Izhodišča.*** *Študija se osredotoča na programsko podlago delovanja slovenskih političnih strank po osamosvojitvi. Predstavlja analizo strankarskih programov in njihovih stališč do zdravnikov in drugih zdravstvenih delavcev ter vsebine, s katerimi jih najpogosteje povezujejo. Ob tem študija izpostavlja tudi intenzivnost prisotnosti zdravnikov na dnevnem redu politike skozi čas.*

***Metode.*** *V študiji je analiziranih 83 programskih dokumentov političnih strank, ki so med letoma 1992 in 2014 nastopile na volitvah v Državni zbor in presegle parlamentarni prag. Podatki so analizirani s pomočjo metode analize vsebine, ki je primerna za analizo političnih besedil. Analiza je bila izvedena s pomočjo programskega orodja za analizo kvalitativnih podatkov ATLAS.ti.*

***Rezultati.*** *Rezultati so pokazali, da so zdravniki in drugi zdravstveni delavci pomembna politična tema v obdobjih, ko ni kriz. Takrat se stranke v povezavi z zdravniki največ ukvarjajo z njihovo učinkovitostjo in kakovostjo storitev v zdravstvenem sistemu, pri čemer se pogosto izpostavljajo tudi kritike zdravnikov in potreba po njihovem nadzoru. V času gospodarske krize se kaže manjša pomembnost zdravnikov in drugih zdravstvenih delavcev v normativnem delovanju strank.*

***Zaključki.*** *Slovenske politične stranke se v svojih programskih izhodiščih ne ločijo po ideološki liniji, temveč predvsem po načelu dostopa do oblasti. Zaključiti velja, da stranke dialogu z zdravniki ne posvečajo pozornosti in dojemajo zdravnike kot pasivne prejemnike odločitev vlade oziroma politike.*

***Corresponding author:** Tel: +386 41 338 405; E-mail: danica.rotar@gmail.com*

## 1 INTRODUCTION

Political parties are coalitions of people seeking to control the governing apparatus by legal means. They act solely in order to attain the income, prestige, and power which come from being in office (1). Broadly speaking, political parties are the main actors in the political life of a community, and their only goal is to reap the rewards of holding office. They treat policies purely as means to attain their private ends, which they can reach only through election. In other words, "parties formulate policies in order to win elections, rather than win elections in order to formulate policies" (2). The latter are therefore often tailored to public opinion, and the most influential forces in the party (politicians and their consultants) prepare them, rather than professionals, as is expected (3). Political parties have an important role in democratic governments in which two or more parties compete for control of the governing apparatus in every election. While parties that have lost elections stay in an opposition, winning (government) parties are the locus of the ultimate power in society (1).

Ever since Slovenia achieved independence, Slovenian politics (governments) have often been reproached for not being able to meet healthcare challenges and for preventing the introduction of healthcare reform and stabilization of the public healthcare system (4). Despite all of the strategies and measures implemented to date, the system continues to face basic challenges, such as increasing the efficiency of the healthcare system and subsequently maintaining a balance between increasingly greater needs for treatment and its costs and limited funding (5). In particular, the government was charged with the neglect of changed orientations in healthcare (e.g., changed demographic indicators, the changed workload of doctors and other health workers, and the absence of analyses (6) and a regulatory mechanism for making decisions regarding people's needs) and problems arising from the system of financing primary healthcare (7). Ever since the early stages of Slovenia's independence, politicians who have been making healthcare decisions have not shown a proper desire for change, which their acting according to the principle of "putting out fires" reflects (8).

Frequent generous promises and commitments reflect the lack of clear priorities in Slovenian politics and merely force doctors and other health workers into making unpleasant compromises and, subsequently, providing a lower level of service than professional guidelines envisage (9). Slovenian healthcare (medical community) has been drawing attention to these problems for quite some time now (8). Doctors' appeals for the political elite to be more open and prepared to engage in dialogue are the consequence of various problems piling up, such as the gap between the system's promised and actual capacity, lack of staff, and financial and infrastructural problems (9-12). Problems in healthcare system are reflected in the diminished prominence of the medical profession and healthcare in general and, also strongly interfere inter alia with the doctor-patient relationship because this relationship affects patients' trust in the professionalism of doctors and other medical staff (9).

The medical profession has called upon political parties and politicians multiple times to take a view on doctors' position in Slovenian society or to provide mechanisms that would enable doctors and other health workers, as the presumed providers of healthcare activities, to take part in shaping healthcare policies (8). However, the question that might prove key to the potential partnership between doctors and politicians is what kind of a partner politicians actually see in doctors.

### 1.1 Why Study Political Party Healthcare Programs?

As key actors of a representative democracy system (1, 13), political parties usually create their own programs based on their ideological orientations and preferences and use their programs to formally demonstrate their value starting points and views on individual public policies. The "semantic nodes" (14) in their program documents allow political parties to distinguish themselves from competitive parties and provide an opportunity to voters and various other organized interest groups[1] to grant them political support (15). Because this last process includes choice, the key component of obtaining voters' support is the focus on the differences in the material that the parties communicate during their election campaigns (15). In practice, this means that political party programs offer voters and interest-group representative's information on what course of action the party will pursue if it wins, but it also means that the voters withdraw their support if the party does not manage to fulfil the normative starting points set out in its program (15). Even though the majority of voters ignore political party programs, these programs nonetheless represent a comparable set of conceptual starting points that present the publicly declared objectives of political parties and are the only reliable proof of politicians' commitments at the normative level (1, 13, 15).

The basic purpose of analysing political party programs is thus to systematically monitor the information that the parties convey about their visions for regulating specific

[1] This applies especially to political systems with considerable neo-corporate components. Slovenia is a system with a considerable share of neo-corporate mechanisms (e.g., the second chamber of parliament, trade unions as large intermediary neo-corporatist interest organizations, government pacts with "social partners," etc.) (16-18).

public policy areas. By identifying the scope, order, and complexity of various public policy areas in the party programs, one can determine the party's priorities, which later usually find a place in government measures (15).[2] Therefore, studying political party programs is useful not only from the viewpoint of identifying the signals that parties send to voters and other important healthcare decision-makers but also from the viewpoint of predicting what they will do when (or if ) they come to power.

## 1.2 Contextualization in the Existing Body of Research on Healthcare and Politics

A number of researchers are studying the impact of healthcare policy on people's health, but only a few are dealing with the impact of party policy on healthcare policy and/or its results (19). Soroka and Lim (20) conducted one of the few studies of party programs from the perspective of healthcare policy, using the US and UK as examples and focusing on the general and specific healthcare policy goals as set out in party programs (20). Similarly, a study by Benrick and Myers focused on how much attention political parties dedicated to healthcare issues in their programs (21). In the US, this link between political parties and healthcare policy is strengthening, which is the result of Obama's planned healthcare reforms and the increased attention that other political actors have also begun to dedicate to these topics (22–25).

The majority of Slovenian studies dealing with conditions in the field of healthcare policy provide a chronological overview of the development of public health legislation (4, 26–28). These studies are primarily based on the analysis of public policy documents and draft reforms, and showboth unsuccessful and successful implementations of individual measures under various governments. Among other things, the analysis of the program identity of parliamentary parties in the first parliamentary elections in 1992 showed that the majority of parties included healthcare in their programs in one way or another, but the analysis did not indicate what position Slovenian political parties took on this public policy or its providers (29). However, the medical profession largely draws attention to the negative influence of party policy on healthcare and the work of the health ministry (30), but does not locate the origin of the issue itself within the operation of political parties.

This study fills the highlighted gaps and rectifies the lack of a comprehensive study of political party programs, as it focuses on the conceptual basis of parties' operations and reveals whether political parties create inappropriate conditions for the successful operation of public healthcare policy in their (normative) starting points or whether this is more a question of their operation and lack of fulfilment of their program commitments. This study thus offers the basis for correcting the political parties' problematic attitudes towards doctors and other health workers and provides an evaluation of the extent of attention that Slovenian political parties dedicate to this area.

## 2 METHODS

### 2.1 The Data

This study covers the period from Slovenia's first parliamentary elections until 2014, and it is the first Slovenian study of this type. It analyses 83 program documents of political parties that participated in the National Assembly elections between 1992 and 2014, and passed the electoral threshold. Of these, 47 are party programs that were mainly adopted at party congresses, and 36 are electoral manifestos that the parties used in the parliamentary elections. The study thus includes all relevant political parties' program documents and official positions. We employed a purposive sampling procedure that is virtually synonymous with qualitative research. We used the technique of "criterion sampling" (31) and selected cases (parties and their programs) that meet a certain criterion, which, in our case, is a leap of the electoral threshold in parliamentary election.

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[2] Both a test of individual governments' expenditures for individual areas and the final versions of the coalition agreements that the parties drew up based on their programs confirmed a connection between the party programs and the operation of governments (13).

**Table 1.** Analyzed political party program documents.

| Political party | Party acronym | The number of program documents | | | | Total |
|---|---|---|---|---|---|---|
| | | '92-'97 | '98-'03 | '04-'09 | '10-'14 | |
| The Alliance of Alenka Bratušek | ZaAB | 0 | 0 | 0 | 1 | 1 |
| The Democratic Party | Demokrati | 1 | 0 | 0 | 0 | 1 |
| The Democratic Party of Pensioners of Slovenia | DeSUS | 1 | 2 | 3 | 3 | 9 |
| The Civic List | DL | 0 | 0 | 0 | 3 | 3 |
| The Liberal Democracy of Slovenia | LDS | 2 | 1 | 3 | 2 | 8 |
| The Party of Miro Cerar | SMC | 0 | 0 | 0 | 1 | 1 |
| The Youth Party of Slovenia | SMS | 0 | 1 | 0 | 0 | 1 |
| The Positive Slovenia | PS | 0 | 0 | 0 | 3 | 3 |
| The Slovenian Democratic Party (formerly The Social Democratic Party of Slovenia) | SDS | 5 | 2 | 4 | 2 | 13 |
| The Slovenian People's Party* | SLS | 2 | 2 | 3 | 3 | 10 |
| The Slovenian National Party | SNS | 1 | 2 | 2 | 1 | 6 |
| The Slovenian Christian Democrats (The New Slovenia – The Christian Democrats) | SKD/NSi | 2 | 3 | 5 | 3 | 13 |
| The Social Democrats (formerly The United List of Social Democrats) | ZLSD (SD) | 3 | 1 | 3 | 3 | 10 |
| The Greens of Slovenia | ZELENI | 1 | 0 | 0 | 0 | 1 |
| The United Left | ZL | 0 | 0 | 0 | 1 | 1 |
| Zares – Social Liberals | ZARES | 0 | 0 | 2 | 0 | 2 |
| **Total** | | 18 | 14 | 26 | 26 | 83 |

\* The SLS+SKD coalition program from the national election in 2000

We divided the programs analysed into four periods based on the time of their creation: three six-year periods (starting in 1992) and one final period covering the election years 2011 and 2014. During this time, the parties participated in seven parliamentary elections using party programs or programs prepared especially for the elections.

## 2.2 The Instrument

We performed the first part of the analysis using the ATLAS.ti software tool and the keyword-in-context (KWIC) technique, through which one can use a selected keyword to capture the parts of a text around the keyword (32). By viewing the context of a selected part of a text, one can establish what a given word refers to in that part of the text. We defined the keywords used refer to doctors and other health workers and the roots of three words: zdravnik [zdravn*], "doctor;" zdravstveni [zdravstv*], "health;" and medicinski [medicin*], "medical." We coded all parts of the text manually in ATLAS.ti and excluded the parts of the programs analysed that did not refer directly to doctors and other health workers (zdravstveno varstvo, "healthcare," medicina, "medicine," etc.). The analysis thus included those parts of the text that mentioned health workers as part of the word phrase [zdravstv* "health" | delavec "worker" | osebje "staff" | tehnik "technician"] or [medicin* "medical" | delavec "worker" | osebje "staff" | tehnik "technician" | sestra "nurse" | brat "male nurse"] and doctors were mentioned as "doctors" or as "specialists" for a given area (e.g., GP, family doctor, surgeon, pediatrician, gynecologist, etc.).

## 2.3 The Content Analysis and Coding Process

We analysed the data using the content analysis method, which is one of the most robust methods for analysing political texts (15, 32). A quantitative content analysis method was used to identify the scope of the selected public policy segment in the parties' program documents (33), and a qualitative approach was used to define the content-related differences in the political parties' positions (34, 35).

We used qualitative or inductive content analysis (35) that included coding, creating categories, and abstraction—framing a general description of the research topic through generating categories. Two researchers independently coded political party program documents, and the third researcher supervised the process. For the study, we used a data-driven coding scheme (34) and formed codes sorted into 13 logical categories and 4 themes to identify patterns in analysed data and to explain political parties' attitudes towards doctors and healthcare workers. During the coding process, the two researchers sought consensus. If they did not reach consensus, we tried to achieve intercoder agreement (36) about differently perceived

parts of the analysed text to fit the created category (also known as "unitizing process") (34, 36).

The analysis process and the results are described and presented in sufficient detail so that readers have a clear understanding of how the analysis was carried out and it strengths and limitations. The latter means the dissection of the coding process and the validity of results. Elements of validity in the content analysis are "universal to any qualitative research design; there are additional factors to take into consideration when reporting the process of analysis and the results" (35).

We used a multi-level coding method to combine the selected parts of the text into categories and themes that we could methodically describe. We named the categories according to the content of the programs analysed, following the inductive content analysis method (35). We then combined the categories into themes that were more abstract than the categories created, and suitable for presenting and interpreting the results obtained. The data were visualized using heat diagrams, which show the weighted[3] occurrence of individual categories and themes in the program group observed (e.g. programs in an individual period or programs for individual parties).

## 3 RESULTS

By analysing the coded programs, we combined the identified codes that appear in the programs into 13 categories, namely: the autonomy and rights of doctors and other health workers; providing or improving the working conditions of doctors and other health workers; the education of doctors and other health workers; the human resources planning and measures; penalties and sanctions; the supervision of doctors and other health workers; complaints about doctors and other health workers; private interests of doctors; the responsibility of politics; taking account of patients' feedback in the evaluation of doctors and other health workers; measures for quality improvement; measures to improve efficiency; and the introduction of rewards depending on the quality of the work of doctors and other health workers. These categories were then further classified into four themes according to references to doctors and other health workers: 1) autonomy and working conditions; 2) human resources and education; 3) complaints; and 4) efficiency and quality.

### 3.1 The Main Party Program Themes over Time

The first theme identified refers *to human resources and the education of healthcare professionals*, and the second

refers to *the autonomy and working conditions of doctors and other health workers*. The third theme has a negative connotation and refers to *complaints about doctors and other health workers*. It also includes the parties' appeals for supervision of doctors and other health workers and incentives and proposals for penalizing errors in diagnostic procedures. The fourth theme includes *measures that will contribute to greater employee efficiency and improved service quality* in Slovenian healthcare. A diagram of the themes identified across the four periods studied is presented below.

| | '92-'97 | '98-'03 | '04-'09 | '10-'14 |
|---|---|---|---|---|
| Autonomy and working conditions | 0.56 | 0.36 | 1.08 | 0.19 |
| Human resources and education | 0.11 | 0.07 | 1.46 | 0.38 |
| Complaints | 0.33 | 0.71 | 1.31 | 0.42 |
| Efficiency and quality | 0.44 | 0.36 | 3.04 | 0.62 |

*Darker shades indicate higher frequencies and lighter shades indicate lower frequencies or an absence of references to a particular theme. White indicates the absence of the theme in the program, and black indicates that the theme occurs 3.04 times in a particular program.

**Figure 1.** Heat diagram of identified themes regarding doctors and other health workers in party programs*.

Figure 1 shows that the parties discussed all four themes in their programs to the largest extent in the period from 2004 to 2009, which corresponds to the beginning of Slovenia's European Union (EU) membership. During that time, the political elites (the coalition and opposition) stopped focusing on adapting their standards to those of the EU and were no longer subject to the strict supervision of the European Commission, which was typical of the integration period (1997-2003). The diagram also shows that, in contrast to the two preceding periods, at that time doctors and other health workers became an important political topic. In their programs, political parties most often highlighted measures for greater employee efficiency and improved service quality in the healthcare system, which clearly reflects the frequently emphasized inefficiencies of the healthcare system. These inefficiencies were high on the public policy agenda during the introduction of "lean economy" reforms and promotion of the private-public

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[3] The result for each program group observed is the ratio between the frequency of occurrence of individual categories and themes and the number of programs within the group observed by individual period.

partnership concept. This is followed by human resources and education of healthcare professionals, as well as complaints, supervisory measures, and sanctions against doctors, which says a great deal about how political actors viewed healthcare. We will discuss this further in the next chapter.

In contrast, in the two periods before 2004, especially between 1992 and 1997, political parties primarily focused on the need for autonomy and suitable working conditions for doctors and other health workers in their programs. This was a period of stabilization after intense social changes that introduced liberal values such as individuals' rights and freedoms. The parties also mentioned doctors and other health workers within this context, claiming that they have "a right to continuous professional training and fair evaluation of their work" (SKD, 1992) and "a right to refuse to take part in procedures that violate international medical and ethical rules and are against the will of an individual health worker" (SKD, 1994).

During the last period (i.e., from 2010 onwards), parties mention doctors and other health workers somewhat less frequently in their programs. This suggests that this theme is less relevant in the normative operations of political parties, which the global financial and economic crisis has strongly influenced. The latter is the reason why economic issues predominate in the political agenda. However (especially from the cost-savings perspective), the measures for greater efficiency of healthcare professionals within the existing capacities and the improved quality of healthcare services continue to be relevant; ultimately, all of this belongs to the context of this period. The Slovenian People's Party (SLS) highlights the following: "We'll increase the importance of family doctors and enhance the role of specialist clinics outside the cities. This will reduce the pressure on hospitals, which will increasingly admit only those patients that cannot be treated in their local environment" (SLS, 2014). Currently, parties are also highlighting the need for supervision of health workers, which one can ascribe to ongoing discussions in the media that negatively affect the image of all healthcare professionals.[4]

### 3.2 Key Categories within the Themes Identified over Time

As mentioned above, the programs most often refer to the theme "efficiency and quality of health workers," followed by "complaints, supervisions, and sanctions against health workers" and then "autonomy and working conditions." This last theme was more pronounced in the early periods observed, but taking a closer look at individual categories within the themes identified reveals a somewhat different picture. The post–EU-entry period

between 2004 and 2009 remains the most "fruitful" for doctors. Four main categories characterize this period. The most pronounced are "human resources planning and measures" and "measures to improve efficiency," which clearly point to the frequently highlighted tendencies of political actors towards neoliberal-agenda-induced processes of economizing healthcare and health workers (e.g., introducing the principles of new public management). The Social Democrats (SD) thus advocated "improving the operations of healthcare institutions by introducing managerial principles to management and economizing principles to the provision of healthcare services" (ZLSD/SD, 2004).

Within this context, the parties envisaged certain changes to the public healthcare system in order to shorten waiting periods and improve coordination between various healthcare levels; these changes sought to increase doctors' responsibilities, introduce public-private partnerships, and further privatize healthcare activities. The Slovenian Democratic Party (SDS) thus envisaged the following: "In order to shorten waiting periods, we will first define HR bottlenecks and make it possible for an individual doctor to engage in more than one programme" (SDS, 2004). On the other hand, the Liberal Democracy of Slovenia (LDS) emphasized this: "We will allow the specialist physicians at public healthcare institutions to also work for self-pay patients after they finish work at their public healthcare institutions. This will be made possible through the option of replacing collective agreements with an individual contract" (LDS, 2008). With regard to increasing private practice, the SDS similarly envisaged the following: "We will selectively shorten the waiting times to reasonable deadlines by introducing uniform organizational solutions at the national level and by defining priorities, reallocating funds, improving the network of GPs, increasing the number of hours performed as a part of private practice, and, if needed, increasing the number of programmes at specialist clinics" (SDS, 2004).

However, one must note that the following two categories, which are more pronounced, show the other side of the coin and focus on the working conditions of healthcare professionals ("providing or improving the working conditions of doctors and other health workers") and their motivation ("rewards based on the quality of work of doctors and other health workers"). In order to meet EU standards, the parties highlight in their programs the introduction of a system of rewards based on the quality of work, in which they emphasize equal working conditions for all doctors, which must be "EU comparable" (SLS, 2007). Within the context of rewards based on the quality of work, the LDS pointed out the following: "We will study the possibility of doctors' salaries being dependent on

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[4] Slovenian daily newspapers and magazines have published a series of articles on this topic in the last few years (e.g., 37, 38).

their productivity by defining a variable part of a doctor's salary: the part that will depend on his productivity, the quality of his work, and his efficiency" (LDS, 2008). Figure 2 shows the categories within individual themes by the four periods observed.

| | | '92-'97 | '98-'03 | '04-'09 | '10-'14 |
|---|---|---|---|---|---|
| 1. | Autonomy and rights of doctors and other health workers | 0.23 | 0.19 | 0.27 | 0.12 |
| | Providing or improving the working conditions of doctors and other health workers | 0.15 | 0.05 | 0.81 | 0.08 |
| 2. | Education of doctors and other health workers | 0.08 | 0.00 | 0.15 | 0.00 |
| | Human resources planning and measures | 0.00 | 0.05 | 1.31 | 0.38 |
| 3. | Penalties and sanctions | 0.00 | 0.00 | 0.04 | 0.04 |
| | Supervision of doctors and other health workers | 0.23 | 0.43 | 0.69 | 0.27 |
| | Complaints about doctors and other health workers | 0.00 | 0.05 | 0.42 | 0.00 |
| | Private interests of doctors | 0.00 | 0.00 | 0.15 | 0.12 |
| 4. | Responsibility of politics | 0.00 | 0.00 | 0.15 | 0.04 |
| | Taking account of patient feedback in the evaluation of doctors and other health workers | 0.00 | 0.00 | 0.46 | 0.08 |
| | Measures for quality improvement | 0.04 | 0.10 | 0.27 | 0.08 |
| | Measures to improve efficiency | 0.19 | 0.14 | 1.31 | 0.38 |
| | Introduction of rewards depending on the quality of the work of doctors and other health workers | 0.08 | 0.00 | 0.85 | 0.04 |

*Darker shades indicate higher frequencies, and lighter shades indicate lower frequencies or the absence of references to a particular category. White indicates the absence of the theme in the program, and black indicates that the theme occurs 1.31 times per program.

**Figure 2.** Heat diagram of categories identified within the theme occurrences regarding doctors and other health workers in party programs*.

Nonetheless, among the categories of the post-EU-entry period that stand out the most, one can find the tendency to suggest "supervision of doctors and other health workers," which might imply that political actors do not trust the health workers, especially in terms of their professionalism. The Slovenian People's Party (SLS) proposes the following as a part of supervisory measures: "The scope of work of a specialist physician that works as a concessionaire should be defined in great detail and it should be ensured that everyone in the chain that treats an individual patient does his or her work, and does not only do the easier part and leave the rest to someone else" (SLS, 2008). Moreover, this is a category that persists across all of the periods observed and has been one of the most stable in terms of occurrence and intensity in party programs since Slovenia's independence (see Figure 2). However, one should note that supervision of doctors' work may also refer to the public-private relationship. For example, the SLS highlights the following: "Concession contracts should accurately define the scope of work of a specialist physician that works as a concessionaire" (SLS, 2004).

It is interesting that the supervision category, which occurs in the party programs as a category with markedly negative connotations, has been defined differently over time. Immediately after Slovenia's independence, the parties perceived supervision of healthcare professionals as a "national responsibility" (SKD, 1992), whereas later on they viewed it as keeping an eye on the professionalism and ethics of healthcare professionals. The right-oriented parties (i.e., the SLS and SKD, 2000) especially highlighted this.

In addition to the supervision of healthcare professionals, only "autonomy and rights of doctors and other health workers" and "measures to improve efficiency" seem to be similar constants in the party programs over time, even though the first has become significantly less intense over time, and the second much more volatile over time.

### 3.3 Main Themes in Party Programs by Individual Political Parties over Time

The study showed that the programs of parties with the longest presence in Slovenian politics most frequently

mention doctors and other health workers. These include LDS, SDS, SKD and its successor NSI, SLS, DeSUS, ZL, ZLSD and its successor SD, and SNS. In addition, parties that played an important political role in Slovenia for a short while, usually as parties in the governing coalition (e.g., ZARES; PS; DL; and ZaAB), also mentioned doctors and health workers.

In general, one can say that Slovenian political parties begin dealing with doctors and health workers when they gain important influence in the political environment or become a part of the government coalition. Thus one can see a considerable mention of doctors in the ZaAB, DL, and ZARES programs, even though the parties themselves were not necessarily among the largest in the National Assembly. In this regard, one should note that the capacities that the parties had in healthcare at the given moment also played an important role in this. Accordingly,

parties with the longest traditions dealt with doctors and health workers to the largest extent in their programs, especially if they were part of the government coalition during the periods observed. The former SKD thus focused the most on doctors immediately after Slovenia's independence, when it was also the strongest party. The LDS did this from 1998 to 2009, the SDS also did this from 1998 onwards, and the SD did so primarily between 2004 and 2009, when it became the largest government coalition party after the 2008 parliamentary elections (the only time ever). Based on this, one can conclude that in their programs, parties dedicate attention to doctors following the pattern of "when you have power, then you deal with doctors." Smaller opposition parties do not mention doctors in their programs at all and frequently do not even mention healthcare in general (see Figure 3).

| | DeSUS | LDS | SDSS/ SDS | SKD/ NSi | SLS | SNS | ZLSD /SD | Demo- krati | ZELE- NI | SMS | ZARES | DL | PS | SMC | ZaAB | ZL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1992-1997** | | | | | | | | | | | | | | | | |
| Autonomy and working conditions | 0.00 | 0.50 | 0.60 | 2.00 | 0.00 | 0.00 | 0.33 | 1.00 | 0.00 | | | | | | | |
| Human resources and education | 0.00 | 0.00 | 0.00 | 1.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | | |
| Complaints | 0.00 | 0.00 | 0.00 | 3.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | | |
| Efficiency and quality | 0.00 | 0.00 | 0.80 | 0.00 | 2.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | | |
| **1998-2003** | | | | | | | | | | | | | | | | |
| Autonomy and working conditions | 0.50 | 0.00 | 0.50 | 0.33 | 1.00 | 0.00 | 0.00 | | | 0.00 | | | | | | |
| Human resources and education | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.50 | 0.00 | | | 0.00 | | | | | | |
| Complaints | 0.00 | 5.00 | 1.00 | 0.00 | 1.50 | 0.00 | 0.00 | | | 0.00 | | | | | | |
| Efficiency and quality | 0.50 | 3.00 | 0.50 | 0.00 | 0.00 | 0.00 | 0.00 | | | 0.00 | | | | | | |
| **2004-2009** | | | | | | | | | | | | | | | | |
| Autonomy and working conditions | 0.33 | 4.00 | 1.25 | 0.80 | 1.00 | 0.00 | 0.33 | | | 0.00 | 1.00 | | | | | |
| Human resources and education | 0.33 | 3.33 | 2.00 | 1.20 | 2.00 | 1.00 | 1.33 | | | 0.00 | 0.50 | | | | | |
| Complaints | 0.67 | 3.00 | 1.50 | 1.40 | 2.00 | 0.00 | 0.67 | | | 0.00 | 1.00 | | | | | |
| Efficiency and quality | 0.33 | 5.33 | 6.25 | 2.60 | 4.00 | 0.00 | 3.33 | | | 1.00 | 0.50 | | | | | |

| | DeSUS | LDS | SDSS/ SDS | SKD/ NSi | SLS | SNS | ZLSD /SD | Demo- krati | ZELE- NI | SMS | ZARES | DL | PS | SMC | ZaAB | ZL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2010-** | | | | | | | | | | | | | | | | |
| Autonomy and working conditions | 0.00 | 0.00 | 0.00 | 0.67 | 0.00 | 1.00 | 0.00 | | | | | 0.67 | 0.00 | 0.00 | 0.00 | 0.00 |
| Human resources and education | 0.33 | 0.00 | 1.50 | 0.00 | 0.33 | 1.00 | 0.00 | | | | | 0.33 | 0.33 | 0.00 | 2.00 | 0.00 |
| Complaints | 1.00 | 0.50 | 0.50 | 0.00 | 0.00 | 2.00 | 0.33 | | | | | 0.33 | 0.00 | 1.00 | 1.00 | 0.00 |
| Efficiency and quality | 0.00 | 0.50 | 1.50 | 0.67 | 1.00 | 1.00 | 0.33 | | | | | 1.33 | 0.00 | 0.00 | 1.00 | 0.00 |

*Darker shades indicate higher frequencies, and lighter shades indicate lower frequencies or the absence of references to a particular category. White indicates the absence of the theme in the program, and black indicates that the theme occurs 6.25 times per program.

**Figure 3.** Heat diagram of identified theme occurrences regarding doctors and other health workers in party programs by period*.

During the first period after Slovenia's independence, the SKD, which was then in the coalition, largely mentioned doctors and other health workers in terms of "complaints, supervision, and sanctions" and "autonomy and working conditions." From 1998 to 2003, the largest coalition party, the LDS, was also the party that most frequently took a position towards doctors in its programs, especially from the viewpoint of "complaints, supervision, and sanctions." In addition, it began heavily highlighting doctors' "efficiency and quality." Within the context of achieving higher quality, the LDS was first to begin mentioning the introduction of new technologies and telemedicine in doctors' work, which was also included in the SDS program later on.

The situation of doctors can most easily be gathered from the party programs that were drawn up between 2004 and 2009, when "efficiency and quality of doctors and health workers" was notably at the forefront. In terms of efficiency, the parties especially emphasized the reorganization of work and better cooperation between primary- and secondary-level doctors, including "fewer referrals from the primary to the secondary level, and establishing a connection between referral doctors and specialists" (SDS, 2008); moreover, "certain procedures should be transferred from the secondary to the primary level because doctors at the primary level are qualified to perform them" (SDS, 2004). In terms of quality, the inadequate personal relationships between doctors and patients began to be highlighted during this period. The LDS stated that "the quality of treatment is becoming increasingly poor. This is partly due to the poor organization of the healthcare system and the poor managerial skills of the public health institutes' executive staff, but primarily due to the deteriorating relationships between the users

and providers" (LDS, 2008). The SD extended the issue of quality even more: "The things that bother the people that come in contact with the healthcare system the most include the staff's unfriendliness, poor work organization, poor quality of services, and inappropriate facilities" (SD, 2008).

During the general economic crisis that occurred in 2010 and lasted until 2014, all of the parties mentioned doctors and other health workers to a lesser degree in their programs. They mostly mentioned them in connection with "human resources" and promised doctors that they would provide "good employment prospects for them at home" (DL, 2014) and better conditions for "hiring young doctors" (ZaAB, 2014). Party programs from this period also include complaints about doctors' private interests and appeals for "changes in the practice of inefficient investigation of medical errors" (SD, 2014). Especially recently, the parties have ascribed the responsibility for failed attempts to sort things out in healthcare to "a wide range of medical, pharmaceutical, and other lobbies that successfully block this" (SDS, 2011), or have drawn attention to the ineffective operation of the public healthcare system due to the personal interests of "doctors and the pharmaceutical industry" (LDS, 2011).

There are generally no serious differences between the parties' programs despite their different ideological affiliations, but some differences do show up with regard to the proposed supervisory measures. Left-oriented parties (as ideological opponents of privatization) appeal to the need for supervising and prohibiting "practicing medicine simultaneously as part of a public service and private practice" (DeSUS, 2009), and right-oriented parties transform the ideological reproach into an ethical

one by mentioning the uneconomical prescription of drugs (SDS, 2004) and advocating the introduction of clear criteria for supervising the quality of doctors' work. Among the supervisory mechanisms they suggest is "monitoring the number of surgeries and diagnostic procedures per doctor" (SLS, 2004) as an indicator of the quality of doctors' work, which corresponds to the ideas of new public management, which is closer to the ideas of right-oriented parties.

# 4 DISCUSSION

One could say that the problems related to healthcare policy in Slovenia do not merely have to do with its implementation. One can trace the origins of these problems back to the party programs themselves, in which parties shape their positions on doctors and other health workers based on the external environment rather than the healthcare situation itself. The analysis of party programs over time showed a shift from emphasizing "autonomy and working conditions" to emphasizing "efficiency of healthcare professionals and improving the quality of health services." The chronological comparison also showed a relative absence of addressing doctors and other health workers during the financial and economic crisis. When parties did focus on them, they did so only from the viewpoint of economizing.

Doctors and other health workers are an important political topic primarily during periods of economic growth and optimism, in which the larger and coalition parties dedicate their attention to policies outside economics and finances. Given that smaller and opposition parties do not include doctors in their programs, one can conclude that parties begin dealing with doctors when they cross the coalition threshold, and once the larger parties cross this threshold, they focus on the efficiency of doctors and the quality of their services.

In addition, the differences mentioned above in the political parties' approaches to doctors are stronger than the ideological differences, which barely show up in the programs within this context. One can observe the only ideological difference in the case of privatizing healthcare and its connection with supervising doctors' private practices. Within this context, left-oriented parties demand a definition of the obligations and responsibilities of private medical practitioners (e.g., DeSUS, 2002), whereas right-oriented parties advocate that concessions should continue to be granted and promote the idea of "free doctors" (e.g., NSi, 2004; SLS, 2004). It is important to note that the analysis of party positions on healthcare privatization is a special topic in Slovenia that demands an analysis of entire programs—which, however, was not the primary goal of this study.

# 5 CONCLUSION

In their programs, Slovenian political parties are often critical of doctors and other health workers. They mistrust them, reproach them with making errors, demand responsibility from them, and call for supervision over the professionalism and ethics of their work. These notably negative elements do not provide a good starting point for solving the problematic attitude towards doctors and other health workers. On the other hand, the appeals for a dialogue between politics and doctors are overlooked, as are the needs of healthcare professionals and the contribution of doctors and other health workers to reducing the gap between the desired and actual situation in this area. Hence, one can conclude that doctors and other health workers are being denied the role of agency and are defined as passive "recipients" of set-out policies. Without a doubt, all of this is a bad sign for the much-needed dialogue and political deliberation.

## CONFLICTS OF INTEREST

The authors declare that no conflicts of interest exist.

## FUNDING

## ETHICAL APPROVAL

Not required.

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