Annual National Report 2012

Pensions, Health Care and Long-term Care

Slovenia

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On behalf of the
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DG Employment, Social Affairs and Inclusion

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1 Executive Summary

Following the rejection of the pension reform on the June 5 referendum, the Government has refrained from any activity with regard to pension legislation. The only exception is the emergency law, freezing all indexation of social benefits, pensions and public sector salaries for the first 6 months of 2012. This law was passed unanimously by the newly elected *Državni zbor* on December 23, 2011.

The new government, sworn in on February 10 is rather vague in its intentions regarding social policy. The section of the coalition agreement devoted to the pension system lacks coherence and consistency: it is also fairly non-committal. True, the coalition agreement does state that a greater emphasis will be placed on the individualisation of insurance and the strengthening of prefunded pension schemes. Some commentators have launched an early attack, stating that the ruling party of the coalition (SDS) will propose a transformation of the existing classical Bismarckian pension system into an NDC (notional defined contribution) system. Though the SDS – which opposed the pension reform in 2011 – has been strongly supportive of a move toward the NDC system, it is not at all clear how the new government will proceed, i.e. how it will tackle the pension issue. However, some members of the government suggested that a pension reform will be implemented in 2013.

In 2011, no structural reforms occurred in Slovenia in the field of health and long-term care.

As stated in the previous ANR, the Minister of Health prepared a document entitled The Health care system upgrade until 2020. This document was subject to a public debate in spring 2011, and an amended version was prepared in June 2011. The main goal of this document is to provide the basis for changing the set of basic health system laws, effectively resulting in a reform of the health care system in Slovenia.

In the field of long-term care, Slovenia is still facing status quo and the Law on Long Term Care is still under preparation.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2011 until February 2012)

2.1 Overarching developments

The economic and financial crisis, coupled with the Eurozone crisis, severely affected Slovenia and its economic activity, employment and fiscal position. After the fall in tax revenues in 2009, these seem to have stabilised (see Table 1). However, the expenditure side has – predictably – reacted counter-cyclically, as seen from Table 2. The result has been a large increase in the fiscal deficit. Unemployment has been continuously increasing up to the beginning of 2011. Since then, it has stabilised, but at a rather high level.

Following the fall of the pension reform in the June referendum, the only noteworthy measure of the outgoing Government was an emergency law freezing all indexation of social benefits, pensions and public sector salaries for the first 6 months of the year 2012. *Državni zbor*[1], in its first session on December 23, 2011 unanimously approved and passed this emergency law.

Table 1: Tax revenues (in million EUR), 2008 - 2011

	All tax revenues	**Personal income tax**	**Corporate income tax**	**VAT**	**Social contributions**
2008	13,937	2,184	1,257	3,145	5,095
2009	12,955	2,093	712	2,838	5,161
2010	12,848	2,039	449	2,941	5,234
2011 (1-10)	10,910	1,580	548	2,497	4,094
Index 2009/2008	93	96	57	90	101
Index 2010/2009	99	97	63	104	101

Source: Bulletin of Public Finance, Ministry of Finance, January 2012.

Table 2: Revenues and expenditures of the General Government (in million EUR), 2008-2010

	Revenues	**Expenditures**	**Surplus/deficit**
2008	15,339	15,442	-103
2009	14,408	16,368	-1,960
2010	14,794	16,693	-1,899

Source: Bulletin of Public Finance, Ministry of Finance, January 2012.

[1] The National Assembly of the Republic of Slovenia. See page 8 for further details on the current composition of the *Državni zbor*.

Table 3: Registered unemployment in Slovenia, December 2006 to December 2011

Month, Year	**Registered unemployment**	**Unemployment rate (reg. unemployment), in %**
December 2006	78,303	8.6
December 2007	68411	7.3
December 2008	66,239	7.0
December 2009	96,672	10.3
December 2010	99,591	11.8
December 2011	112,754	

Source: Employment Service of Slovenia.

2.2 Pensions

2.2.1 The system's characteristics and reforms

The public pension system (first pillar) is a PAYG system. The system has gradually evolved in time and this "incrementalism" has been present for the past 30 years. The pension reform, introduced in 1999 (and effective from January 1, 2000) tightened eligibility criteria by increasing the retirement age and lowering the value of the entry pensions. The latter was achieved through the decrease of the accrual rates and increase in the number of years used in the calculation of the pension assessment base. Early retirement is possible, but is subject to pension deductions (negative accrual rates), whereas later retirement is stimulated through higher accrual rates for each additional year after the statutory retirement age. The basic features of the reformed pension system, introduced in the 1999 Pension and Disability Insurance Act (ZPIZ-1), are presented in Table 4.

Table 4: Characteristics of the current public pension system (first pillar) in Slovenia (ZPIZ-1)

	Men	**Women**
Retirement age	63	61
Minimum insurance period (required for retirement at ages 63 (m) and 61(w))	20	20
Minimum conditions for early retirement	Age 58 with 40 years of insurance	Age 58 with 38 years of insurance
Pension assessment base	Best 18 year average of (net) wages, using valorisation coefficients	
Computation of pension	Pension assessment base multiplied by accumulated accrual rates	
Accrual rates	35% for first 15 years, 1.5% for each additional year	38% for first 15 years, 1.5% for each additional year
Pension indexation	Growth of wages	
Minimum pension assessment base	Set nominally	
Maximum pension assessment base	4 times minimum pension assessment base	
Incentives and disincentives	Higher accrual rates for later retirement, negative accrual rates for early retirement	

Source: Own composition.

Table 4 requires some further clarification. The parameter values for men have been reached in 2009. However, the parameter values for women are being increased more gradually, as the retirement age 61 will be reached in 2023 and the minimum age requirement (58 years) for early retirement will be reached in 2014. The accrual rates stated in the Table refer to insurance years

following the adoption of the reform; for years before 2000 the accrual rates which are applied are actually higher[2]. The valorisation coefficients, used in computing the pension assessment base, amount to somewhat less than 80% of the nominal wage growth. This simply means that, in calculating the pension assessment base, past wages are not indexed according to the growth of average wages, but are indexed with only approximately 80% of the growth of average wages. In effect, this produces the same result as if (in calculating the pension assessment base) past wages would be indexed with nominal average wage growth, but the accrual rates would be "only" 80% of those stated. This would mean that the effective accrual rate under ZPIZ-1 is not 1.5% but 0.80 x 1.5% = 1.2%.

ZPIZ-1 also retained the option of retirement with a smaller insurance period, but requiring a higher retirement age. Thus, persons who do not satisfy the condition of minimum insurance period of 20 years can retire at a later date: men at 65 and women at 63, but they must have at least 15 years of insurance.

For certain groups of insured persons, early retirement is possible without deductions (i.e. negative accruals). This is possible for men who have accumulated 40 years of work; for women the corresponding value is 38 years, the minimum retirement age being 58 years. The retirement age can be reduced for child-rearing. ("child's bonus"). This measure is being phased in: by 2014 the reduction for two children will amount to almost 19 months! Paradoxically, as this "sweetener" was gender-neutral, it is being used mostly by men, who were faced with a more rapid increase in retirement age. The negative accrual rates, applied for early retirement, are rather small and do not exceed 3.6% per year[3]. Similarly, the additional accrual rates for postponing retirement are also rather low; they are digressive and do not exceed 3.6% per year.

Finally, ZPIZ-1 also contains an article (article 151), which decreases the annual nominal increase of pensions for existing pensioners, in line with the decreasing accrual rates for new entrants[4]. This in effect means that in February each year, pensions are being increased by the growth of wages in the past year minus 0.6 percentage points. For example, as the nominal growth of average wage in 2008 was 3.5%, pensions (for most pensioners) were increased in February 2009 by 2.9%.

The second pillar was (in effect) introduced in ZPIZ-1[5], and some two-thirds of all employees are now enrolled. These pension schemes are DC (defined contribution) schemes and fully funded. The third pillar in Slovenia consists of various saving instruments. Unlike the second pillar pension contributions, premia to third pillar saving schemes are not subject to a favourable tax treatment upfront, i.e. there is no tax deduction for these premia. As for participation in the second pillar, it is mandatory only for public employees and for persons employed in arduous occupations. These two groups are enrolled in two closed pension funds, the ZVPSJU (Zaprti vzajemni pokojninski sklad za javne uslužbence) and the SODPZ (Sklad obveznega *dodatnega pokojninskega zavarovanja),* respectively. *Kapitalska družba (KAD),* a state-owned pension managing company, manages both of these funds. Apart from these two mandatory schemes,

[2] For men, the accrual rate under the 1992 Pension and Disability Insurance Act was 35% for the first 15 years of insurance and 2% for each additional year (above 15 years). For women the accrual rate was 40% for the first 15 years and 3% for each additional year up to 20 years of insurance, followed by 2% for each additional year up to 35 years of insurance.

[3] The value of this deduction (negative accrual rate) depends on the actual retirement age. Thus, for a person retiring at age 58, the negative accrual rate is 3.6% per each year of early retirement, meaning the total accumulated negative accrual rate to be 5 times 3.6% = 18%, so that his entry pension will be decreased by 18%. For a person retiring at age 59 the negative accrual rate is 3.0% per each year of early retirement.

[4] It will be recalled that the »new« accrual rates are 1.5% per year, whereas the »old« accrual rates are 2% (or higher) per year.

[5] Strictly speaking, the second pillar was introduced in the 1992 Pension and Disability Insurance Act , but due to the lack of tax incentives, the number of enrolled participants did not exceed several hundred.

participation in second pillar pension schemes is voluntary, in that an employer can enroll his workforce in a pension scheme, but is not required to do so.

Even for the mandatory insured persons the second pillar contributions are low. For example, in the pension fund for government employees (ZVPSJU), the average amount of assets per member is some EUR 2000, and the corresponding figure for SODPZ is some EUR 6,400 per member. The low value of accumulated assets, even taking into account that these funds have been in operation at most 9 years, do indicate that the pensions from the second pillar will not be able to compensate for the shortfall in the public pension. Contributions to the ZVPSJU are low because only a small part of labour remuneration is channeled into this fund; its introduction was a clever manoeuvre by the government to prevent wage increases at a very delicate time of pre-accession to the Eurozone. As for the second group, the contributions to SODPZ are also low. The 1999 reform resolved the problem of insured persons working in arduous occupations by pushing them out of the public system, which previously provided sufficient solidarity to ensure the adequacy of pensions for this group of insured persons. This "inadequacy" problem of occupational second pillar pensions erupted in 2010, when the first occupational pensions from this fund were disbursed.

The Government started the new reform process in March 2009. After one year of preparations, the Government presented the draft Pension and Disability Insurance Act (ZPIZ-2) in March 2010. Negotiations with social partners did not produce results, as the trade unions did not negotiate in good faith. This was visible particularly in their demands. In a nutshell, they proposed more favourable conditions for retirement than those that are stipulated in the current Pension and Disability Insurance Act! The Government decided to "go it alone" and presented ZPIZ-2 to the *Državni zbor* in September 2010. The act passed (with amendments) on December 14. This act introduced gradual changes in the pension system – increasing the statutory retirement age, tightening eligibility conditions and greatly improving transparency of the pension system. A very important feature of the new pension legislation was the stabilisation of replacement rates. These were set at 60%for 40 years of work for men and 38 years of work for women: this provision would prevent a further down-sliding of effective replacement rates[6].

The passage of ZPIZ-2 predictably triggered the reaction of the trade unions, who made good on their threat of a referendum: in record time they collected the required 40,000 signatures. *Državni zbor* responded by formally asking the Constitutional Court whether such a referendum would be in accord with the Constitution. The Constitutional Court delivered its opinion on March 14, unanimously ruling that such a referendum would not be unconstitutional. The referendum was held on June 5, 2011 and the new pension legislation was rejected by a large margin of voters (with 72.2% against the new Pension and Disability Insurance Act and 27.8%in favour). Thus, the current pension legislation still remains in force.

What are the prospects for a renewed push for pension reform? In their pre-election programs, all political parties have declared themselves in favour of pension reform, without providing many specifics. Only *DeSUS* (The Pensioner's party) set out in more detail certain conditions which would have to be met. It seems that a change in referendum rules is also on the table; these rules would significantly curtail the power of various interest groups in calling for referendums. Thus, the new rules would prevent the impasse which occurred when legislative acts were rejected at referendums and would prevent serious macroeconomic costs[7] associated with the "referendum playground". The change in referendum rules would require a constitutional (two thirds) majority

[6] This down-sliding is caused by the gradual decrease in the valorisation coefficients and gradual application of lower accrual rates.

[7] We have in mind in particular the rejection of the new Pension and Disability Insurance Act in the June 2011 referendum.

in the *Državni zbor.* Most parties are well aware that this is the only path available to prevent another showdown with the trade unions.

2.2.2 Debates and political discourse

The snap elections, held on December 4, changed the political landscape considerably, with a strong showing of two new parties, established only several weeks before the elections. A new party, *Pozitivna Slovenija* (Positive Slovenia) emerged as the largest party, taking 28 of the 90 seats of the *Državni zbor.* Janša's *SDS* (The Slovene Democratic Party) came in second, taking 26 seats. *SD* (Social Democrats), the winning party in the 2008 elections, came in third with 10 seats, whereas the fourth position was taken by a new party *Državljanska lista Gregorja Viranta* (The Citizen's List of Gregor Virant) with 8 seats. 6 seats each were taken by *DeSUS* and *SLS* (Slovene's People Party), with 4 seats for *NSi* (New Slovenia) and two seats reserved for the Italian and Hungarian national minorities.

The political programs presented to the electorate are quite diverse; one doubts whether these programs actually had much impact on voting decisions. Thus, the program of *Pozitivna Slovenija* is presented on only 14 pages. On the other side of the spectrum is the program of *SDS*, comprising a full 153 pages! Most of the programs were written in haste, without even formal editing. With regard to the pension reform, the program statements do not reveal much. The program of *Pozitivna Slovenija* supports "a stable pension system for all citizens" and is in favour of a pension and health-care reform as "the condition for providing social protection and solidarity". The program of *SDS* is only slightly more specific, in that it "supports long-term financial sustainability of the system and adequate pensions". It is also in favour of a tighter link between contributions paid and pensions received. As stated in the program, this tighter link is necessary as a stimulus for greater savings and increasing trust in the system. Thus, the party has done some backpedalling, refraining from openly advocating the NDC (notional defined contribution) system, which it did when opposing the pension reform in public debates prior to the June referendum. The program of *SD*, still healing its wounds after the June referendum, does not contain a single word on pension reform! *Državljanska lista Gregorja Viranta (DLGV)*, with its neo-liberal team of economic experts, has, not surprisingly, pronounced itself in favour of a greater individualisation of pension insurance and an enhanced role of pre-funded pillars (the second and third pension pillar). Somewhat surprisingly, it suggested that pensioning conditions should include only the insurance period and not the age condition. The program of *DeSUS* has – quite according to expectations – devoted much space to the pension reform (more than a full page!). It contains conditions for pensioning (40 years of insurance period or age 65), indexation rule (70% growth of wages, 30% price inflation), and the value of minimum pension (80% of the minimum wage). It also suggests abolishing the second pillar; however, this poorly worded and confusing section might imply that only the mandatory part of the second pillar (for arduous occupations) should be abolished. The program of *SLS* contains a single sentence devoted to the pension reform: "We will enact the pension reform, with a prior social agreement which would be based on the force of arguments". The program of *NSi* gives support to some pension system changes (increasing the retirement age, changing the pension calculation rule and changing the indexation rule) but only on the condition that these changes would equalise the burden across generations (??). It is also strongly supportive of adequate minimum pensions.

The coalition agreement, signed by the leaders of *SDS, DLGV, NSi, SLS* and *DeSUS* on 28 January, is written on a full 69 pages, of which one page is devoted to the modernisation of the pension system. This page represents a copy-paste exercise of the election programs of *SDS* and *DLGV*, with some additional features. Among these features, we would stress the new indexation rule, to be applied from 1 January 2013 (60% growth of wages, 40% increase in the cost-of-living index) and a gradual increase in the replacement rate (conditional on favourable economic

growth). Though the coalition agreement states that a greater emphasis will be given on the "individualisation of insurance", there is no explicit mention of the introduction of the NDC system.

2.2.3 Impact of EU social policies on the national level

The European environment and activity in the field of pensions had a negligible impact on the pension reform debate, which took place in 2010 and 2011. True, comparisons with other EU member states with regard to statutory retirement age, effective retirement age, activity rates etc. were frequent, in order to demonstrate how Slovenia is lagging behind in the necessary adaptation to demographic change. However, the relevant documents at the EU level have never been invoked during the pension debate. Thus, the EU Green paper on pensions and the EU 2020 strategy have never been even mentioned. It would also be difficult to assess the influence of the OMC on the formulation of the pension reform, as there was no explicit mention of this procedure during the pension reform process. Furthermore, in the detailed statement of reasons and motives[8] for the ZPIZ-2, presented to the *Državni zbor* in September 2010, the only "European" documents explicitly mentioned were the 2009 Ageing Report (by the European Commission), the 2010 Interim EPC-SPC Joint Report on Pensions (by the European Commission) and the National Reports on Strategies for Social Protection and Social Inclusion (2006-2008), and even these were used only as sources for comparative analyses and parameter comparisons.

In its assessment of the National Reform Programme 2011 of Slovenia, the Council in its recommendation of 12 July 2011 (OJ 2011/217/01) noted the low employment rate of older workers in Slovenia, "due to the low retirement age and insufficient incentives for active ageing". Considering that the new pension legislation was rejected on the 5 June referendum, the recommendation suggested that "(…) other ways of resolving (the problem of sustainability of the pension system) (…) will need to be found" (Council of the European Union, 2011). Also, according to the Commission's assessment, "the risks with regard to long-term sustainability of public finances appear to be high" (Council of the European Union, 2011). It is not possible to predict whether this assessment and recommendation of the Council will be invoked during the new "push" for pension reform.

2.2.4 Impact assessment

The labour market participation of the elderly has been increasing throughout the first decade of 2000, though the gap between EU averages and Slovenia still remains large, as seem from Table 5.

Table 5: Employment rate of age group 55-64, 2010

	All	Men	Women
EU27	46.3	54.6	38.6
EU15	48.4	56.2	40.9
Slovenia	35.0	45.5	24.5

Source: Eurostat.

The ratio between the average old-age pension and average net wage has been steadily decreasing, as seen in Table 6. This decrease up to 2010 is caused not only by indexation rules stipulated in the pension legislation, but also through emergency legislation, with a partial freezing of indexation for 2010 and 2011.

[8] When the Government presents a law to the *Državni zbor*, it is preceded by a detailed statement of the reasons and motives for the law.

Table 6: Average pension as percentage of average net wage, 2001-2010

year	Average old-age pension in %	Average disability pension in %	Average survivors' pension in %	Average pension in %
2001	73.2	59.4	51.4	66.3
2002	72.8	59.1	51.1	65.9
2003	71.1	57.6	49.9	64.5
2004	70.2	56.7	49.2	63.7
2005	69.1	55.4	48.0	62.7
2006	68.6	55.1	47.8	62.5
2007	67.1	53.7	46.0	61.3
2008	67.1	53.8	46.3	61.6
2009	66.6	53.4	46.0	61.3
2010	64.7	51.8	44.5	59.7
2011	63.4	50.6	43.4	58.6

Source: 2011 Annual Report (draft), ZPIZ.

The at-risk-of-poverty rate for pensioners and the elderly is fairly high. Table 7 provides some relevant data. In Slovenia, some 65% of all pensioners live in pensioner households. These are households with at least one pensioner and without any active persons; in effect, pensions are the only income source for these households. It is therefore not surprising that the poverty rate for these pensioners is even higher than for the total population of pensioners.

Table 7: At-risk-of-poverty rate (in %), 2005-2007 and 2008-2010

	2005-2007	2008-2010
All persons	12.4	15.5
Pensioners	19.3	22.7
Pensioners living in pensioner households	25.4	27.3
Elderly (60+)	21.7	24.7
Children (0-18)	10.1	13.2
Unemployed	38.1	41.5

Source: Kump and Stanovnik (2011); based on Household Expenditure Surveys.
Note: poverty threshold set at 60% of median equivalised household disposable income.

A high at-risk-of-poverty rate of the elderly and subgroups of the elderly is also visible from other statistical sources, most notably EU-SILC (see Table 8), which also subdivides according to gender. The gender gap is quite large; depending on the statistical source (EU-SILC or HES) and age group (65+, 75+), the relative poverty rate for women is two to three times as large as that of men. This large gender "adequacy" gap is mainly due to three factors: a gender wage gap, lower insurance periods of women and household composition. The first two factors translate into a lower entry pension. However, the gender wage gap is rather stable and small, only some 10% for full-time wage earners. Considering that the actual insurance period achieved by new pensioner entrants – women is increasing at a faster rate than that of men, the gender pension gap is narrowing, i.e. the relative income position of women pensioners is improving[9]. However, the third factor, the household composition effect, is quite dominant: most women-pensioners live in

[9] In 2001, the achieved insurance period for new pensioners was 37 years and 1 month (men) and 33 years and 11 months (women). In 2010 the corresponding values were 38 years and 0 months (men) and 35 years and 6 months (women). This increase in the insurance period also contributed to a relative increase in entry pensions for women: in 2001, the entry pension of women represented 85% of the entry pension of men; by 2010 this value increased to some 93%.

single-person households and this has a strong influence on the computed poverty rate for elderly women[10].

Table 8: Adequacy indicators, EU-SILC (2010) and HES (2008-2010)

	EU-SILC			HES		
	total	**men**	**women**	**total**	**men**	**women**
Median relative income of people 65+ as ratio of income of people 0-64	87	96	81	79	85	74
At risk of poverty rate 65-	11.3	11.5	11.2	13.3	13.3	13.3
At risk of poverty rate 65+	20.2	9.5	27.1	26.7	17.4	32.8
At risk of poverty rate 75+	26	10.7	34	31.3	19.6	36.8
S80/S20: 65-	3.4	3.4	3.3	4.9	4.9	4.9
S80/S20: 65+	3.6	3.2	3.6	2.3	2.4	2.2

Source: HES refers to the Household Expenditure Survey, the joint sample covering the years 2008, 2009 and 2010.

2.2.5 Critical assessment of reforms, discussions and research carried out

The coalition agreement of the new government is fairly noncommittal with regard to the pension reform course. In fact, it does not even mention the term "pension reform", but speaks of "modernisation of the pension legislation". In spite of the incoherent and inconsistent section on social security, written in the coalition agreement, some commentators have already launched an early attack. Namely, the wording in this agreement: "The pension system will to a greater degree be based on the individualisation of insurance (...)" (Coalition agreement on participating in the Government of Slovenia for the mandate 2012-2015, 2012) might be understood to mean that the government wishes to introduce the NDC system. Urša Marn (2012) in Mladina (February 3) expressed strong criticism of this concept. In our view, the inconsistent and incoherent pronouncements in the coalition agreement do not merit much attention, and the intentions of the new government will be soon be visible. We would recommend that some decisions and actions be taken early on. Of particular importance is the need to impose restrictions (higher hurdles) on the possibility to call for a referendum. There is a majority view even among leading legal experts that referendums have become a playground for special interest groups and that these referendums have not enhanced the democratic decision process. Such restrictions and curtailments would – quite possibly – prevent future impasses and result in more responsible negotiations between social partners (the trade unions, employer associations and the government). Concurrently, the Government would also have to prepare the "ground" for the "new" pension reform. Here, national experts differ in their preferences and views: it would be of utmost importance that a "new" pension reform would be implemented swiftly and that this "new" reform (which could also be a slightly modified pension reform rejected in the June 2011 referendum) improves transparency and the medium-term sustainability of the pension system.

[10] This even more so considering that the equivalence scale used in computing the poverty rates by Eurostat is the »steep« modified OECD equivalence scale.

2.3 Health Care

2.3.1 Overview of the system's characteristics and reforms

Slovenia has a Bismarck type of social insurance system, based on a single national provider of compulsory health insurance – the Health Insurance Institute of Slovenia (HIIS). Compulsory health insurance entitles the insured to certain rights, which are defined in Article 23 of the Health Care and Health Insurance Act (ZZVZZ) and further specified by the Regulation on Compulsory Health Care Insurance, issued by HIIS. ZZVZZ defines certain population groups (students, children, pupils, pregnant women) and certain diagnoses and conditions (cancer, multiple sclerosis, rehabilitation for blind etc) that are fully covered by compulsory health insurance. All other services are in a certain defined share covered by voluntary complementary health insurance (VHI), which covers these health care services up to the full value of the service. The share covered from VHI ranges from 5% up to 95% and basically depends on the seriousness of the condition. The more serious the condition the higher share of the health care service is covered from VHI. VHI is offered by three companies in Slovenia – these are the mutual fund Vzajemna and two insurance companies Adriatic and Triglav. These three companies offer voluntary supplementary health insurance as well, which constitute 3% of all voluntary health insurance (Vzajemna, 2012). Majority is hence devoted to complementary health insurance.

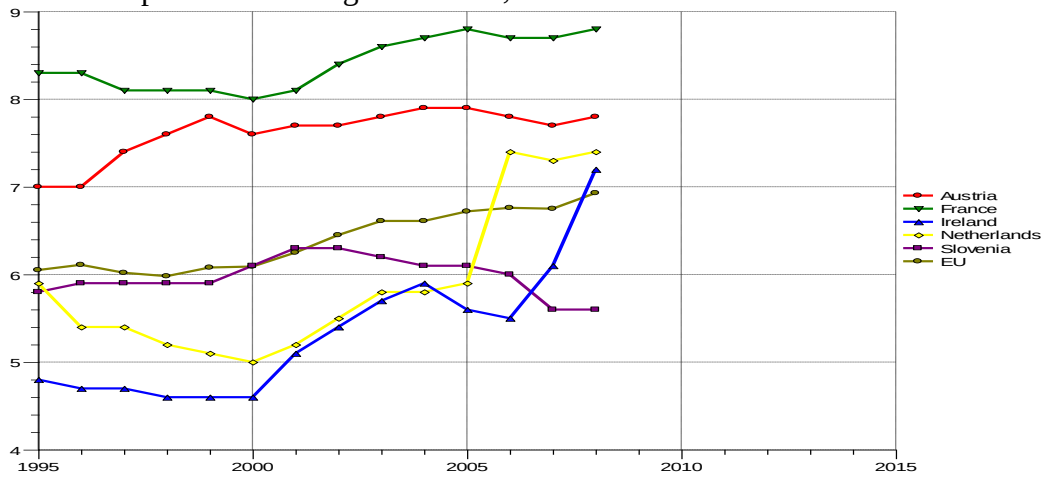
Table 9: Health Care Expenditure in mio EUR, structure and as % GDP

	mio EUR		**Structure**		**% GDP**		**Average annual growth rate 2004-2010**
	2004	**2010**	**2004**	**2010**	**2004**	**2010**	
TOTAL EXPENDITURE	**2,274.2**	**3,220.8**	**100.0**	**100.0**	**8.4**	**9.06**	**6.0**
PUBLIC EXPENDITURE	**1,665.8**	**2,292.9**	**73.2**	**70.7**	**6.2**	**6.4**	**5.5**
Central budget	101.1	90.9	4.4	2.8	0.37	0.25	-1.8
Local budget	14.3	27.5	0.6	0.8	0.05	0.08	11.5
HIIS	1.494.0	2.096.1	65.7	64.7	5.52	5.86	5.8
PRIVATE EXPENDITURE	**608.4**	**927.9**	**26.8**	**29.3**	**2.25**	**2.65**	**7.3**
Insurance VHI	288.9	432.2	12.7	13.3	1.07	1.21	6.9
Out of pocket	266.6	419.6	11.7	12.9	1.0	1.17	7.9

Source: HIIS, Annual Reports for years 2004 and 2010.

The growth of the total health expenditure (THE) amounted to 6,0%, while GDP growth in the period was 4,8%. While public health care expenditure average annual growth was 5,5%, the private health care expenditures average annual growth was 7,3%. The ratio of out-of-pocket payments as a percentage of final household consumption amounted to 2%, which is not high in comparison to other OECD countries; however, despite the system of complementary health insurance it is already close to the level of countries that do not have such private insurance arrangements. The trend that can be observed in Slovenia in private/public financing mix is quite opposite to other countries (Figure 1) and the share of public expenditures tends to be relatively low, which is a cause of concern regarding access to health care. The share of GDP spent on health is close to the average of OECD countries.

Figure 1: Public/private financing mix trends, 1995-2015



Source: HFA DB, 2011

The compulsory health insurance contributions of the employed are 13.45% of their gross income and shared between the employer (6.56% + 0,53% for work related injuries and occupational diseases) and the employee (6.36%).

The premium for complementary health insurance is flat and same for all and amounts to EUR 25.

At the primary level a few changes in organisation, have been proposed. The idea is to link public institutions by ensuring the performance of certain functions in a single location, e.g. establishing central emergency centres and create networks among primary health centres, which was done in five regions of Slovenia. The plan is to construct ten emergency centres by 2014. This will guarantee the patients better access to health care services (laboratory and radiology services), while treatment can be more effective and of a better quality. In June 2011, the first 40 reference study primary care centres started to operate with different program of work and hence different skill mix, that both reflect the turn from acute care to chronic illnesses and will presumably be followed by further 60 in 2012. In 2011 the project of introduction of rural primary care centres prepared, and the primary care centers will start with their work in 2012.

On secondary level, a merger of individual activities (e.g. merging of activities performed by different hospitals, like non acute care, management, internistics) in a form of specialisation was implemented in three regions in 2011. The aim is to enable higher specialisation of these hospitals and hence prevent centralisation.

The National Development Program states that the Republic of Slovenia allocates too much resources for the modernisation of the existing public health service, mainly by expensive reconstruction of old buildings and building extensions.

Therefore in 2011 MoH prepared the concept of ”typical hospital“ for the organisation of health service network on secondary level. The existing capacities would be replaced by standardised regional general hospitals and old capacities will be offered to potential buyers for other purposes.

The stronger emphasis (organisationally, financially) was put on prevention, health promotion and on primary care, and the trends observed according to the purpose of use are expected to continue (decrease of the expenditures for pharmaceuticals and medical devices and administrative costs and increase in the diagnostics, curative care, preventive care and long term care expenditures).

As stated in the previous ANR 2010, the Regulation on evaluating and financing drugs was accepted at the end of 2010 by HIIS. The protocols of Health Council responsible for introducing new technologies changed as well: since 2011 the cost effectiveness analysis is required for the

introduction of new technologies. Biologic drugs and medical devices do not adhere under the Health Council any more, their evaluation is transferred to HIIS. A special fund was created within Ministry of Health budget for financing new ideas with the potential to develop into cost effective health care programs. Also, in 2011, first hospital based HTA organisational unit in the general hospital Izola was established.

No further changes regarding entitlements to health care services, coverage, benefit package and co-payment were observed in 2011.

2.3.2 Overview of debates/the political discourse

The main debate in Slovenia in 2010 and 2011 followed the issuing of the strategic document "Upgrading Health Care System by 2020" (hereinafter Upgrade), which concentrated on the reform of compulsory and complementary health insurance. Due to high increase in demand for health care services that are mostly cost-inefficient and hence covered mainly from complementary health insurance it was estimated that the current system of complementary health insurance drives up demand for unnecessary services. The change was suggested in which the basic benefit package (BBP) would be formed that would contain clinically effective and cost effective health technologies while the rest would not be included in BBP. The Upgrade suggests that BBP would be fully financed from public funds. The rest of the services would be covered in voluntary supplementary health insurance. The reform of creating BBP from public funds logically faced strong opposition from the side of voluntary health insurance companies as well as from the side of Ministry of Finance that would need to increase the contribution rate accordingly to the formation of BBP. On the other hand, the net available income of the whole population would be higher as some unnecessary services would not need to be paid for neither from VHI, so the change was widely supported among population. A further solution was found in cooperation between Ministry of Health and Ministry of Finance in the introduction of a special levy that would compensate the loss of funds with the cessation of complementary health insurance. The levy would be lower for everybody than is premium for VHI and was again supported by the population, but never came into force due to change of government (Nadgradnja, 2010; Cok & Majcen, 2010).

Such a change in health care insurance would also solve the European Commission suit against Slovenia on complementary health insurance which was sent to European Court of Justice (ECJ) in 2011 and decided on January 26, 2012. The suit was on five issues, on three the decision was taken by ECJ and the legislation needs to be changed: These are the obligation of a priori approval of premium increase by actuary, the obligation to inform when the insurance conditions are new or changed and the obligation of approval by the Minister of Health of general conditions for management of complementary health insurance. The two further issues in legal suit (foreign insurance companies who want to carry out complementary health insurance in Slovenia need to name their representative to be confirmed by Ministry of Health; half of profit made from complementary health insurance need to go back into management and development of complementary health insurance) will undergo the process of EU pilot.

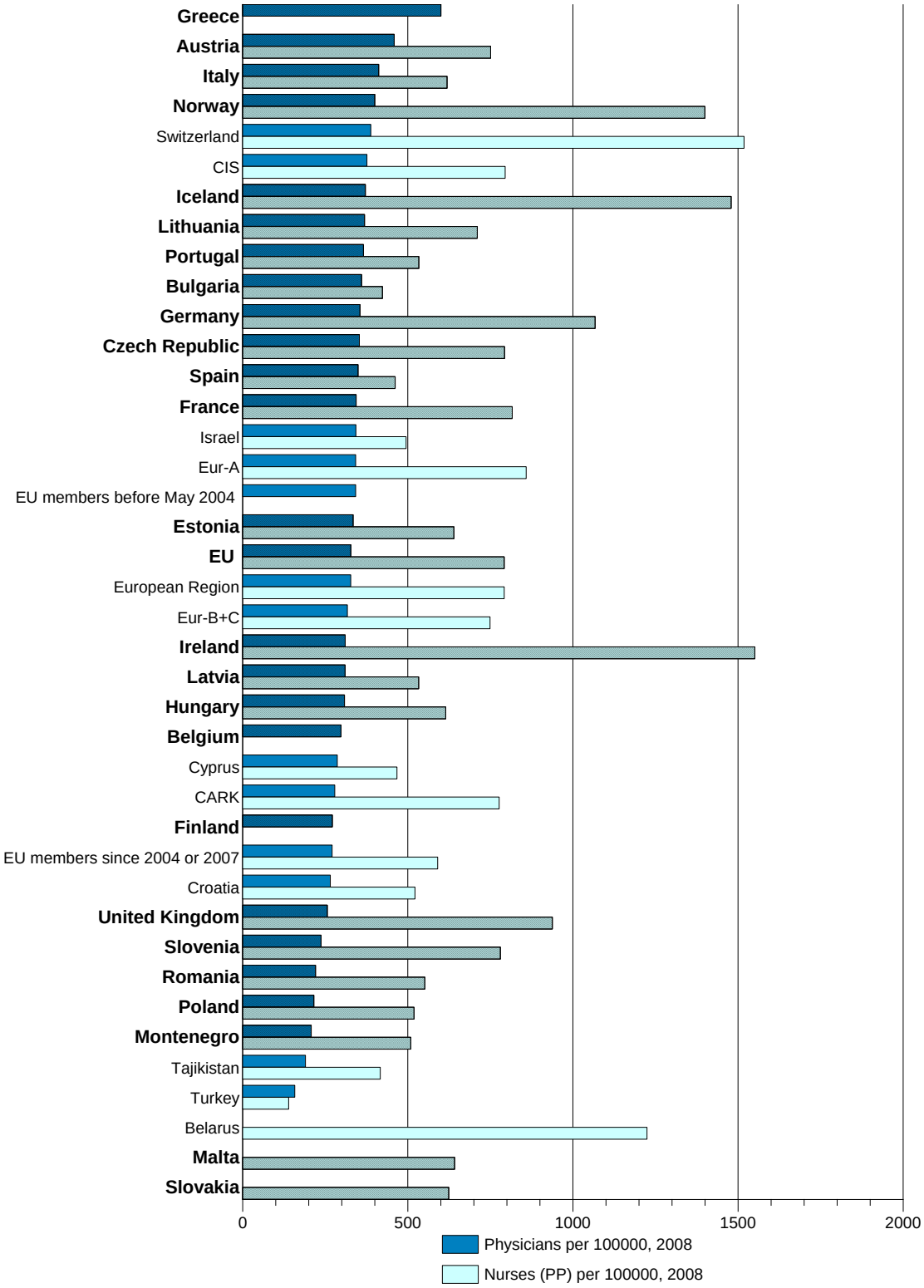
On the three issues on which Slovenia was given official warning by European Commission but were not yet included in the suit due to their high complexity (these are the obligation of contracting any interested person and prohibition of its cessation unless the premium is not paid; the obligation of charging equal premium no matter the risk profile of the insuree; obligation of the insurance company to take part in equalisation scheme) Slovenia can expect further EC action.

The discussion regarding **shortages of medical staff** was very intense during 2011. As the Minister of Health stated at the Human Resource Conference at Brdo on June 23, 2011, Slovenia has never had a systematic human resource strategy in health care. Human resources are the most

important input factor in health care and consume around 60% of all resources. As Minister of Health Dorjan Marušič said for the TV channel A Kanal at the press conference after the conference at Brdo: "It is often said that the biggest problems in the area of human resources in Slovenia is the lack of physicians, who are overburdened. The "right" number of physicians depends on tradition of organising care, habits of the population, geographical condition of the country and many other factors. Pure and simple international comparisons of number of physicians or number of procedures per physicians are meaningless. I strongly believe that the problem of the number of physicians in Slovenia lies in their structure according to the levels and specialties – if primary care had 50% more physicians the number of physicians would be just right."

According to Večer (December 21, 2010) there is a lack of physicians in anesteziology, family medicine, radiology and paediatrics. The measure of increasing enrolment for the study of medicine at both Medical faculties (Ljubljana and Maribor) in 2010 was well received, however the results will not be immediate. According to an article in Delo (December 21, 2010) the 330 places per year is the upper limit as more students cannot be offered adequate practical education and experience within the health care system. On December 20, the Parliament adopted the Act on professional qualifications of physicians. The goal of the Act was to shorten the procedures for hiring foreign physicians from countries outside the EU. All parties supported the law. The Social Democrats (*SD*) still argued for systemic solution, while *SLS* and *DeSUS* were worried about the quality of these physicians. The debate following the passing of the law concentrated on the knowledge of the Slovenian language, which is to follow strict procedures, the same as for physicians coming from EU countries (Minister of Health on TV Kanal A, November 24, 2010, 18.26). The share of foreign physicians in Slovenia is 5,2%. On January 14, the results of a regular questionnaire, conducted by the Ministry of Health a few times a year, were presented, which showed that Slovenia lacks 550 physicians. In January 2011 hospitals invited foreign physicians of certain specialities to Slovenia (invitation is a precondition for a fast track procedure). The debate also touched the inequality for getting work as a physician: Slovenian doctors are supposed to be in a worse position relative to foreign as invitation to foreigners guaranteed them employment (Delo, November 25, 2011). The results showed that due to open competition and employment of 19 foreign physicians the number of required physicians in January 2012 fell from 550 to 53 physicians – the needs in 2010 were obviously overexpressed. Figure 2 below shows the number of physicians and nurses in the EU.

Figure 2: Number of physicians and nurses, 2008



Source, HFA-DB, 2011

Discussion regarding **health quality/performance** was on one hand the discussion following the publishing of Manual on Quality Indicators (featuring 73 indicators) and National Strategy on Quality and Safety in Health Care 2010-2015. Most discussion in this area focused on accreditation. On November 10-11, 2011 an international conference on excellence in health was held in Slovenia, organised by Ministry of Health. Many good practices for achieving good results

in ensuring quality and patients' safety were presented. In 2011 three hospitals (URI Soča, GH Jesenice and KOPA Golnik) gained accreditation according to Det Norske Veritas National Integrated Accreditation for Healthcare Organisations (DNV NIAHO) standards. Five other hospitals are in the process of obtaining DNV-NIAHO accreditation, one hospital is aiming for JCI standard (Večer, November 15, 2011). At the conference it was conclude that accreditation (internal as well as external) is urgent to achieve better competition and trust in providers after the Directive on Patient's Rights in Cross Border Health Care (Directive 2011/24/EU, OG EU 88/45) is implemented. In the newspaper Dnevnik (November 14, 2011) the Minister of Health Dorjan Marušič stated that the interhospital comparisons should be published, however, the quality indicators are not yet sufficiently reliable. The need for reporting adverse events was expressed by Espen Cramer, director of health unit in DNV Norway. Niek Klazinga, the coordinator of the OECD project on quality indicators also mentioned the need for strengthening the reporting on patients' experience in various providers. The Minister of Health emphasised that accreditation could be a condition for signing contracts with HIIS (Dnevnik, November 14, 2011).

Discussion regarding **health inequalities and access to health care** was very intensive in 2011. The Ministry of Health in cooperation with the National Institute of Public Health, World Health Organisation and Center for Health and Development Murska Sobota issued a book (report) on Health Inequalities in Slovenia in January 2011, followed by an international conference on February 1, 2011 in Slovenia. The report presents inequalities in health between different groups in Slovenia and identifies some of the comparisons between Slovenia and other EU countries. Minister of Health, Dorijan Marušič exposed in the interviews (Delo, February 2, 2011; Dnevnik, February 17, 2011; Večer, February 1, 2011), that socioeconomic determinants affect life styles, morbidity and life expectancy as well as mortality.

In the interviews following the conference Tatjana Buzeti, the editor of the report, exposed that age-standardised mortality in Slovenia was 680 per 100000 inhabitants, which is lower than the EU average. This conceals the fact that in Slovenia there is a significant difference between the populations of municipalities with the highest and lowest income per capita. Slovenia also ranks among the countries with the lowest mortality rates in the EU, yet the mortality rate of infants born to mother with at most primary school education is 2.6 times higher than that of infants born to mothers that have tertiary education. According to injury-related mortality figures, Slovenia ranks in the middle third among EU countries however there is a significant difference between the municipalities with the highest and lowest income per capita. Moreover, injuries are a significant cause of premature mortality in Slovenia (Buzeti et al, 2011).

Socioeconomic conditions significantly affect the lifestyle and morbidity of the population. These conditions also affect life expectancy and mortality. In the journal Zdravstveno varstvo (2012:51) Buzeti and Gobec also stressed that health care system and Ministry of Health can significantly affect the inequalities in health by preventive and other public health programmes. However, we must take into account that socioeconomic determinants are affected by other policies outside health care system as well.

Regarding accessibility Slovenia adopted the issue of effective accessibility; this is not the accessibility to health care services as defined in legislation but also in actual waiting times. The Regulation on longest allowed waiting times (2010) that basically demanded monitoring and reporting on waiting times by all health care providers had a tremendous effect on accessibility to health care services (Table 10). It was estimated on October 1, 2011, that elimination of waiting lists above those allowed would demand an investment of EUR 5.6 million.

Table 10: Number of patients waiting total and number of patients waiting above waiting time allowed

Date	No. of waiting	No. of waiting above waiting time allowed
1.9.2010	83,642	
1.1.2011	73,062	14,443 (19.8%)
1.10.2011	39,484	2,913 (7.4%)
1.1.2012	39,038	2,544 (6.5%)

Source: NIPH report on waiting lists, November 2011, January 2012

On average, the Slovenians rank their Health related quality of life (HRQoL) lower than in other EU countries (Koenig et al, 2005). Klemenc-Ketis et al. (2011) show that the HRQoL is affected by older age, lower education, more frequent usage of health services and the presence of chronic condition. They conclude that the low HRQoL of Slovenian population is surprising and also worrying, as no firm reasons can be found for this findings. Nevertheless, the findings of the study point out to the need for the establishment of effective programs on a national level that would improve HRQoL of the Slovenian population.

2.3.3 Impact of EU social policies on national level

The European environment was very active in the preparation of Health Care Reform in Slovenia, mostly through direct involvement and comments on the strategic documents prepared by the Ministry of Health. WHO, European Commission and Observatory all gave remarks and evaluation of the strategic document. In the preparation of the document the main direction of EU 2020 as well as WHO Health 2020 were studied and taken into account. These documents were brought up in the political debate by the Ministry of Health, also in the presentation of the documents by the Government in June 2011. Except for data and international comparisons the international strategic document were rarely brought up by the opposing sides, which were the trade unions and insurance companies carrying out complementary health insurance. The impact of OMC in the field of health care is difficult to evaluate as it was never mentioned in the process of preparation and presentation of the reform.

In the National Reform Program of Slovenia there is a commitment to reduce the number of people at a high risk of poverty and social exclusion by 2020 as part of one of the five key development objectives. To tackle poverty, deprivation and social exclusion more cooperation is needed between various ministries, especially between social and health departments, as well as housing. Slovenia is committed to ensure health care to the poor and deprivileged. Growth and development also depend to a great extent on efficient governance, therefore, it is vital to modernise the public administration by implementing information and communication technology projects that increase competitiveness (e-government, e-justice, e-health, e-social care, and e-education). Other health policies mentioned in National Reform Program are public health and mental health programs implementation.

2.3.4 Impact assessment

No impact assessment of the health care policy has been systematically performed in Slovenia, neither by ministries nor by research institutes, individual researchers or international organisations. In 2012 NIPH plans to perform impact assessment of four basic measures from 2011: introduction of rural primary practices, introduction of reference primary practices, impact

of new health technologies implemented in the health care system in 2010 (one year gap for implementation and data collection) and impact of financing pilot projects on new technologies.

The access and provision of health care services was not affected by financial crisis due to some measures taken during 2011 although the revenues (due to lower contributions) of HIIS were falling due to measures implemented. The program used reserves and introduced price standards for some overpaid, not highly cost effective services at the providers' level. However, no new technologies (except biological drugs) were introduced in 2011 and the investment fund (from central budget) was reduced, which made some planned investments in health care network impossible to carry out.

All population groups are covered by health system. Some gaps in health care insurance legislation (that entitled children of persons not paying contributions only to urgent care were eliminated in 2011). The entitlement follows the nationality, residence permit and payment of contribution. De facto access is in some areas limited by waiting lists.

Regarding inequalities, the overview in the area was prepared by the Ministry of Health, which was published in a form of report in January 2011. On the basis of the report the main issues in which research is to follow were identified and research proposals will be prepared by the Ministry of Health in 2012.

Gender generated inequalities in access and health outcomes were not seen as a major source of inequality and are not mentioned in the overview.

Waiting lists as well as increasing out-of-pocket payment and high premiums for complementary health insurance are major obstacles for access to health care. The shortening of waiting lists was achieved primarily through monitoring and additional financing of programs with longest waiting lists.

The health outcomes regarding quality indicators are collected but not yet used and assessed due to low data quality. Regarding health outcomes many disease specific scales and scores are used in different specialties. The pilot use of generic measure EQ-5D was initiated by HIIS in 2010. The comparison of health outcomes across countries show that mortality from all causes puts Slovenia on 18th place in EU, right below EU average. Regarding infant mortality Slovenia is ranked among the more successful countries (6th place). Regarding premature mortality due to unintentional injuries Slovenia is ranked in the middle third of the countries.

2.3.5 Critical assessment

In 2010 and 2011 health care policy was following priorities set also in Europe 2020 agenda as well as WHO Health care strategy. The approach was systematic with the overview of the area (financing, inequalities, quality, human resources) and the strategic direction was set. The main goal as defined in the Health Strategy by 2020 is setting up a flexible health care system that will through quality and safe health care services efficiently satisfy the needs of the Slovenian population.

Although some goals were achieved, many measures are still needed. As best practices I would expose the inequalities policy as well as the process of accreditation of health providers in Slovenia.

Information gaps are high in most areas due to low efficiency of information system and strategies, lack of data, inability of database connection and integration and proper use of data for analysis purposes. Data from exiting studies and databases do not provide complete information on access to health services. Although economic and gender equity of access is guaranteed through no additional payments at the primary level, physical and geographical access has become more difficult to provide. It would be worthwhile to carry out a survey on out-of-pocket

expenditures that are becoming increasingly significant. Reducing health disparities among regions must remain a key objective.

The reforms still needed are:

1. Reorganisation of HIIS in order to become an active buyer of health care services according to the needs of the population.
2. Reorganisation of health care insurance system through definition of basic benefit package by using HTA and by creating the financial incentives for use of most clinically and cost effective health care services.
3. Reorganisation of health care providers in order to assure networking, integration of services at all levels, specialisation and decentralisation.
4. Continue the process of acquiring accreditation of health care providers through provision of high quality services.
5. Enable competition of providers by taking into account competition clause and dividing public and private provision of services.
6. Ensure evaluation of health care policies, as without any evaluation and measuring the effectiveness of measures taken, there are no clear guidelines for the way forward.

2.4 Long-term Care

2.4.1 Overview of the system's characteristics and reforms

The main demographic developments in Slovenia show that in 1991 the proportion of citizens older than 65 years in the total population amounted to 11.2%, in 2002 already 14.7% and at the end of 2005 it represented 15.5% of the Slovene population.

According to the Ministry of Labour, Family and Social Affairs (MLFSA) (2010) the system of long-term care covers around 38,000 people. The development of LTC in Slovenia in institutional care has not developed much since the 1980s and is no longer responsive to present needs and future projections. The only significant change after the 1980s was granting concessions to private operators, which have provided LTC services at the same standards as the public network. The minimum quality of services is guaranteed and controlled by regular inspections. The prices of these services differ between public institutions and private concessionaires (basic daily care in homes for the elderly - a public institution is EUR 16, vis a vis concessionaire EUR 22).[11]

Funding of LTC in Slovenia is split between the social care sector, pension insurance and compulsory health insurance and private expenditures, and the provision of LTC is guaranteed in the following ways:

- Health care system finances institutional health care, prolonged hospitalisation and non acute care, community nursing at primary level.
- Social security system finances daily and whole-day forms of institutional care, service of (social) domestic help, home care assistance, care in sheltered housing and various social protection programmes for personal assistance for disabled persons.
- Cash benefits are covered form pension insurance: attendance and allowance benefit.

[11] Skupnost soicalnih zavodov Slovenije, 2010.

Table 11: Public expenditures for long term care in 2009

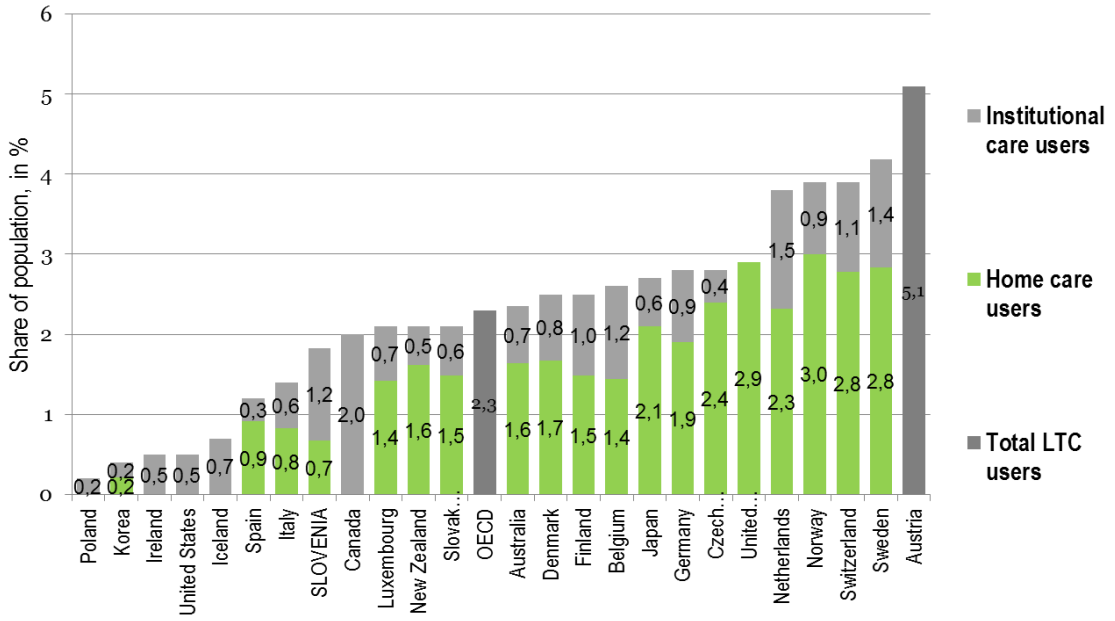
	Public LTC expenditure	**HIIS**	**Pension Insurance Fund**	**Central government**	**Local government**
Total in mio EUR	264.2	123.0	78.2	17.6	45.4
Share in %	100	48	29	7	17
Share in GDP in %	0.76	0.36	0.22	0.05	0.13

Source: Skupnost socialnih zavodov Slovenije, 2010.

In 2010, the Institute for Social Protection of the Republic of Slovenia (ISPRS) carried out a pilot project on direct payments in social care finding out that the costs of services are lower in community-provided structures. According to Urban (2011), home help is financed from municipal budgets (66.7%), state budget (10.8%), and by the contributions from the users (22.4%). According to Statistical Office of Slovenia the expenditures for LTC in 2009 amounted to EUR 268 million (SORS, 2011).

The share of population receiving LTC services in Slovenia amounts to 1.9% and is below the OECD average. The Figure below shows the share of population receiving home care services and institutional care services in the OECD countries for the year 2008.

Figure 3: Share of population receiving LTC services in OECD countries, 2008



Source: Zver E., Dolgotrajna oskrba, November 2011

In Slovenia no compulsory quality indicators exist on a national level in LTC. E-Qalin model enables the collection of quality indicators in 19 LTC institutions. No recent changes in the financing and organisation of LTC have been introduced.

As the sustainability of financing LTC will be difficult to achieve especially since the share of health care financing for LTC is decreasing through years and is being replaced by private funds, a solution in organisation as well as new sources of financing are being explored. The new legislation is tackling the fragmentation of the system and aims to connect all the providers in a single net, but is mostly concentrated on financing side. On the provision side it introduces case

manager, who is coordinating the care of the user based on the individual planof LTC services. Through the integration of the services the higher coordination, effectivenessand rationalisation of the services is expected to be achieved as well as equality in accessibility and regional imbalances eliminated. The primary idea on the financing side was to affix premium for LTC to complementary health insurance carried out by private insurance companies but was abandoned in 2011 when the Government adopted the health care strategy where complementary health care was to be abandoned. As in health care a new levy was supposed to be introduced from net wages as replacement source of fund for eliminating complementary health insurance (and strengthening supplementary health insurance), an additional amount of levy was also foreseen for LTC. It is income related and the amounts according to income classes are shown in Table 12. In the Act proposal it was estimated that new Act will need EUR 44 million per year for its implementation to cover the needs for LTC, this is why this final number was targeted in the calculation of levy.

Table 12*:* Levy in monthly amount for health care (HC) and LTC in EUR

Income classes	**HC**	**LTC**
Up to 60% of average wage	12	2
60-140% of average wage	15	2.5
140-200% of average wage	20	4.5
Higher than 200% of average wage	25	5
TOTAL ANNUAL AMOUNT (mio EUR)	264.2	46.2

Source: Ministry of Health: Levy to assuring part of financial means for health care (replacing complementary health care insurance) and long-term care, 2011

Although some researchers (Hvalič Touzery 2004) assume that informal care is widespread in Slovenia, they cannot rely on any "real" data, since there hasn't been any research conducted on the national level. There have been however some small sample (N=50) studies carried out by researchers (Hojnik-Zupanc et al. 1996, Hojnik-Zupanc 1997, Hvalic Touzery, Felician, 2004, 2003) where some information can be obtained. These studies show that close relatives, especially children and partners are the first to help older people with problems. Children and children in law account for 35% of informal care giving, partners - mostly spouses for 24%, other relatives for about 17% while others (not related) provide the rest. More specifically daughters aged 33 – 55 and sons belonging to age group 40 – 49 were found to be most in touch with their elders. A recent study by Habana and Lahe (2012, in press) was exploring if older people less exposed to abuse in nursing homes as compared to community-based settings. The authors concluded that spouses and sons were revealed as the most regular perpetrators of physical and financial abuse. They produced evident results that frail older people living in unsafe home environments may find better protection from physical and financial abuse in institutional custody.

The austerity programme had no real impact on the arrangements of LTC. The waiting lines due to slower financing of capacities are getting longer; however, no real data on national level is available.

2.4.2 Overview of debates and political discourse

The debate in the field of LTC is concerned with the lack of financing and regulation of the field. In February 2010 the Act was presented by MLFSA and Minister Ivan Svetlik at the press conference, but demanded EUR 230 of co-payment for LTC by the insured. Due to this high sum the Act is still under preparation. On July 18, political party *ZARES* posed a question to the minister when the Act will finally be prepared. On November 11, 2011 the Association of social

institutions of Slovenia posed an appeal to MLFSA to finally start with the preparation of the Act, where they are prepared to cooperate. The appeal was also intended for all political parties in Slovenia who blocked the pension reform and some other proposed changes in the Parliament. These appeals show that the level of public awareness with regard to the evolution of LTC is high and the demands on defining the course of development of the area are loud. However, since no new solutions were offered since beginning of 2010, there was no intensive contextual debate on the issue.

2.4.3 Impact of EU social policies at the national level

Except international comparisons the EU social policy documents were never brought up in the debate. The impact of OMC in the field of health care is difficult to evaluate as it was never mentioned in the process of preparation and presentation of the reform.

2.4.4 Impact assessment

In March 2010 a research was performed by the Faculty of Economics on LTC (Jaklič M, Pustovrh A, Petrič M., 2010). It found out that the field of LTC is underfed. Not only that the systemic regulation of the field and the forthcoming act is taking too much time for its development, but also the whole service delivery is not being managed properly. Since the beginning of granting concessions for institutional care the capacities of homes increased to almost 3.400 beds in the end of 2008 or 485 beds per year. In the last 2 years the private capacities increased even at faster rate than long term demand for LTC, which lowered the excess demand in the market. Due to high share of financing health care in these institutions from health care budget it is questionable whether such growth can continue. This is especially exposed in the financial crisis when the health care programs are not given additional funds and reserves are seeked within the system – this also means no new programmes for LTC.

The new Act on LTC should enable more foreign investments in the field. The elderly dependency rate is projected to more than double over the next half century to almost 90% by 2050. This means that the number of elderly will increase sharply. Slovenia is expected to be among those countries where the increase will be most pronounced. Moreover, over 40% of these senior citizens will be 75 years of age or older. The total dependency ratio will increase less. It is expected to reach over 100% in 2050. In the short term, the most important observation is that elderly dependency ratios will begin to increase sharply as early as between 2010 and 2020, when more retirements are expected.

There are no shortages of medical staff in the field of LTC. The biggest information gaps are quality indicators as well as estimation of needs for LTC. Regarding home care (formal and informal) no regular assessment is performed.

2.4.5 Critical assessment of reforms, discussion and research carried out and policy recommendations

The biggest issue in the discussion and political debate was the late preparation of the legislation. While it was planned to be passed in 2010, now it is expected to be changed only in 2013.

The field of LTC is critically underfed. Not only that the systemic regulation of the field and the forthcoming act is taking too much time for its development, but also the whole service delivery is not being managed properly. So far, Slovenia has somehow been able to deal with the way that LTC is organised, but we are lagging far behind the more developed countries and building the system on pilot projects like IRIS (Independent residing enabled by intelligent solutions (Dom IRIS, 2012), a smart housing solution that enables people with disabilities and the elderly to see and test various technical aids and technologies in order to find solutions for independent life in

their home environment, is by far not enough. The ideas for the preparation of LTC Act were included in the original proposal 10 years ago when the Act was in the first phase of the preparation. The demographic situation and trends have changed significantly since then. The proposals of MLFSA aiming for more funds from health care system and introducing new levy as additional sources without and contextual changes (meaning new sources of funds, new organisational forms and higher level of inclusion of family members into LTC provision) are not sustainable and are starting to affect the availability of funds for health care sector. The system changes and regulation is needed urgently. As the main focus of the last government, especially MLFSA, was the pension reform, LTC still remains as a field that needs to find an epilogue.

2.5 The role of social protection in promoting active ageing

2.5.1 Employment

The outgoing government has prepared two documents related to the 2012 year of active ageing. Both of these documents are still in draft form. The first, *Programme of activities and priorities of the Republic of Slovenia during the European year of active ageing and intergenerational solidarity 2012,* anticipates an opening event in February 2012, to be held in the *Državni svet* (State council). This is to be followed by numerous other activities, with each month devoted to one topic. The other document, *A Strategy for quality ageing, solidarity and coexistence among generations in Slovenia,* specifies a number of measures to improve the employability of the elderly workforce, with a quite ambitious target: To achieve an employment rate of 43.5% for the age group 55-64 and employment rate of 75% for the age group 20-64, both by 2013. These figures are to be compared with the 2010 figures from Table 3. This document states that Slovenia has a fairly high inclusion of the population in the age group 24-64 in life-long learning but this share is rather low in the age group 55-64: Only 5.4% of all workers in this age group are included in life-long learning.

2.5.2 Participation in society

Active ageing is not only the domain of government institutions, but also of non-governmental institutions. Thus, the Anton Trstenjak Institute specialises in the study of quality ageing and publishes a quarterly Kvalitetno staranje (Quality ageing)[12]. Numerous institutions offer courses to the retirees (language courses, computer literacy courses, various courses in art and craftsmanship etc). One must mention that Slovenia is also included in the SHARE project, and the first (interview) wave took place between 1 July and end of October 2011. This statistical source will be extremely valuable for the analysis of active ageing.

2.5.3 Healthy and autonomous living

With regard to healthy and autonomous living, one attempt to improve this field is the already mentioned House IRIS (Independent residing enabled by intelligent solutions (Dom IRIS, 2012), demonstration apartment and clinical research facility, which is located in the Institute for Rehabilitation. The main idea is that it conditions which enable the elderly and persons with disabilities to achieve the highest level of functional independence and independent residing. It is equipped with technical aids and contemporary electronic systems, which enable the user to control the living space (e.g. opening doors and windows, media control, turning the heating, lights on and off) in various manners, especially through remote control, voice control, wheelchair joystick, eye control etc.

[12] Some of the more relevant research results, published in *Kvalitetno staranje* has been summarised in section 3.

In addition to this, researchers at Jožef Stefan Institute developed a prototype elderly-care system. It detects falls and elderly persons' behavior changes and learns from experience. The prototype is based on intelligent interpretation of movement patterns. Experimental results showed that an intelligent system coupled with advanced location sensors can achieve the level of performance needed in real life. The system offers significantly better performance than commercially available solutions, and once the price of sensors decreases, its widespread application seems likely (Dovgan et al, 2011; Pogorelc et al, 2011). The barrier that has been identified is the current cost of ca. EUR 10,000 currently, which renders the prototype unsuitable for mass use (Dovgan et al, 2011). However, the researchers are optimistic, that with the rapid progress in electronics, it might take only a few years to achieve widespread adoption.

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3 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[R2] Belopavlovič, Nataša (2011). "Pred referendumom o ZPIZ-2", Pravna praksa 30 (20)

"The ZPIZ-2 referendum"

Nataša Belopavlovič, a distinguished legal expert on labour relations and pension issues, succinctly presents the main features of the new pension legislation (ZPIZ-2), stressing the important improvements and how the new legislation retained some flexible arrangements, such as purchase of insurance years, extending possibilities for voluntary entrance into pension insurance and more flexible part- work, part-pension arrangements. Overall, she comes out strongly in support of the new legislation.

[R2] Berk Skok, Aleš (2011). "Uspehi reformatorjev pokojninskega sistema", Bančni vestnik 1-2

"The successes of the pension system reformers"

The author, a financial expert, advocates the introduction of the NDC system, stating that the reform proposals in the new pension legislation (ZPIZ-2) are too modest and provide only a short-term solution. His assessment of the proposed changes in the second pillar are more favourable, in that it provides greater choice for the insured person, in terms of "riskiness" of pension plans. The insured person will also be able to choose among three pension funds.

[R2] Brščič, Bernard and Kožuh Novak, Mateja (2011). "Je prav, da Slovenija ostane brez državnih pokojnin?" Večer, December 12.

"Is it fair to abolish state pensions?"

In this pro&contra column of the Maribor daily Večer, Bernard Brščič pronounces himself strongly in favour of abolishing state pensions, as these pensions are not based on contributions and thus have nothing to do with the insurance principle. He is also in favour of "cleaning-up" the pension system of other privileged pensions (army personnel, MPs etc), showing the amount of savings which would be realised by abolishing these pensions. Mateja Kožuh Novak is strongly supportive of state pensions, explaining that recipients of these pensions are among the poorest part of the population, mostly women who have never been employed. Though these persons

could – under the new social assistance legislation – apply for social assistance, the criteria for social assistance are more stringent than the current criteria for granting state pensions. This will only increase the hardship of poor elderly households.

[R1] Dolenc, Primož (2011). "The pension system in Slovenia in light of current international macroeconomic changes and trends". The South-East European Journal of Economics and Business, 6(1).

This paper proposes some policy recommendations for future reforms of the pension system in Slovenia, such as the introduction of a basic pillar ("zero pillar"), improving actuarial neutrality and strengthening the role of the second pillar.

[R5] Hlebec Valentina, Kavčič Matic, Filipovič Hrast Maša, Vezovnik Andreja, Trbanc Martina (2010). Samo da bo denar in zdravje: življenje starih ljudi. Fakulteta za družbene vede: Ljubljana.

"Money and health is all we need: the lives of the elderly"

This monograph deals with the deprivations of the elderly and their coping strategies. It deals with the domestic (home) environment and not with the long-term care or institutional care. The most interesting part of this monograph consists of 30 in-depth interviews with the elderly poor, where various strategies are presented, showing how the elderly use them to mitigate the effects of low income. These strategies include active strategies such as the search for additional financial sources, own production of food, economising with food, maintaining a social network and contacts etc. Also, passive strategies are explored, i.e. various self-imposed constraints with regard to, say, maintenance costs, "luxury" items, leisure activities (that involve financial costs), purchase of clothing etc.

[R5] Kump Nataša, Stanovnik Tine (2011). Socialno-ekonomski položaj upokojencev in starejšega prebivalstva v Sloveniji. Inštitut za ekonomska raziskovanja: Ljubljana.

"The socio-economic position of pensioners and the elderly in Slovenia"

This research updates researches undertaken in 2003, 2005, 2007 and 2008. Based on the household expenditure survey and other statistical data available from the Institute for Pension and Disability Insurance (ZPIZ) it documents changes in the socio-economic composition of households, changes in activity levels of the elderly, changes in the income position of pensioners and pensioner households etc. Pensioner households are defined as households with at least one pensioner and without active persons. These households are further subdivided into single male, single female, pensioner couple and other pensioner households. The largest risk of income poverty is among single female pensioner households. Pensioners have a much higher risk of income poverty than the whole population, with pensioners living in pensioner households having a higher incidence than the whole population of pensioners. The relatively high poverty incidence of the elderly population in Slovenia is also confirmed by other statistical sources (for example, the EU-SILC).

[R1] Stanovnik, Tine (2011). Slovenia, in Kenichi Hirose (ed) "Pension reform in Central and Eastern Europe". ILO: Budapest.

This study covers eight countries, together with an overview chapter. The country chapters have a similar structure: (a) overview of the current public pension system, (b) coverage, compliance and

collection issues, (c) benefits disbursed (including adequacy of pensions), (d) the basic characteristics and performance of the second pillar pension funds, (e) expenditures and financing of the public pillar, (f) social dialogue and pension reform and (g) recent developments.

[R5] Saražin Klemenčič Ksenija (2011). "Socialno-ekonomski položaj starejših ljudi v Sloveniji". Kakovostna starost 14(4).

"The socio-economic position of the elderly in Slovenia"

This paper presents some results from the survey of the elderly (50+) in Slovenia, carried out by the Anton Trstenjak Institute and with assistance from the Statistical Office of Slovenia. The sample consists of 1,047 interviewees, representative of the elderly population of Slovenia. The study shows that job satisfaction is highly correlated with adequate remuneration and with receiving support in delicate situations at the workplace. The paper also presents some results on intrafamily cash transfers, wealth (homeownership) and consumption. The answers to the consumption questions revealed that some 25% of all respondents could not save for any non-necessity (daily trip, holiday vacation, unnecessary purchase, saving for a "reserve").

[R2] Škoberne Bubnov Anjuta, Strban Grega (2010). Pravo socialne varnosti. GV založba: Ljubljana.

"Social security law"

This textbook provides an introduction to social security law. A 50 page section of the book is also devoted to pension insurance. In this section, some basic features of European pension systems are described, followed by a detailed description of the Slovene pension system. This covers not only old-age pensions, but all social rights defined in the current pension legislation: widows and survivors pensions, disability pensions, the state pension and other pension-related rights.

[H] Health

[H1] Ministrstvo za zdravje (2011). *Nagradnja zdravstvenega sistema do leta 2020.* Republika Slovenija. Ministrstvo za zdravje.

"Health care system upgrade until 2020"

The solutions presented in the Ugrade have been searched in:- enabling a high level of awareness among the population on how to manage one's own health by promoting preventive measures and a healthy way of life;- modifications, rationalisation and a sufficient development of a network of health care providers at primary, secondary and tertiary levels:- modifying the system of financing of health care rights, increasing the public share of health care funds to at least 80%, and increasing the scope of those means to 10% of gross domestic product by 2020.

[H2] Klemenc-Ketis Z, Smogavec M, Softic N, Kersnik J (2011). Health-related quality of life: a population based study from Slovenia. Central European Journal Of Public Health. Vol. 19 (1), pp. 7-12

Objectives: Health status is represented by people's subjective assessment of their sense of well-being and ability to perform social roles and has been well accepted as a health indicator of different populations. The aim of this study was to determine health-related quality of life in Slovenian population.

Methods: We performed a cross-sectional postal survey in a random stratified sample of 1,000 adult Slovenian inhabitants. The questionnaire consisted of the respondents' demographic data (sex, age, education level, employment status, living environment), self-reported chronic conditions, self-reported use of health services and EQ-5D instrument for measuring quality of life.

Results: The response rate was 41% (53.1% men, mean age 51.5 years). Respondents reported most problems in the pain dimension of EQ-5D (59.3%), following by mobility (30.4%), anxiety/depression (30.3%), daily activities (29.8%) and self-care (9.0%). At least one moderate problem was reported by 272 (66.3%) respondents. Independent factors, associated with problems in any EQ-5D dimension were primary and vocational education, older age, high blood pressure, rheumatic diseases, back problems, anxiety/depression, a visit to the emergency department in the past year, and a house visit from a family doctor in the past year.

Conclusions: The present study showed that the health-related quality of life of the Slovenian inhabitants is lower than the one found in some other European countries. This finding is surprising and also worrying. Because we cannot find any perceptible reason for this observation, larger and prospective studies are needed to confirm those results and to determine the reasons for that.

[H3] Buzeti Tatjana et al. (2011). Health inequalities in Slovenia. Ljubljana. National Institute of Public Health of Slovenia, Ljubljana.

The publication is an analysis of life expectancy and selected health indicators with regard to health inequalities in Slovenia. It outlines the main public health indicators regarding chronic diseases-diabetes, CVD, cancer and mental health. It shows that the health of groups with higher socioeconomic status improves faster and that individuals from different socioeconomic groups achieve their health potential to different degrees. Determinants (such as education, employment, income, social security and social networks) affect lifestyle, risk factors, use of health services, as well as other services. The publication outlines the approaches and policies for tackling social inequalities in health and emphasises the major challenges.

[L] Long-term care

[L] Železnik Danica (2010). "Ocena samooskrbe starejših ljudi – pomemben dejavnik za njihovo obravnavo". Kakovostna starost 13(4).

"Assessment of self-care of the elderly"

This research aimed to establish the types of self-care of the elderly, living at their homes. Based on a sample survey, which included persons 75 years and more and who were able to communicate and did not have hearing and mental problems, this research classifies elderly persons into one of the four types of self-care: (1) responsible self-care, characteristic of persons with a positive attitude toward ageing; (2) formally guided self-care, characteristic of persons with a slightly negative attitude toward ageing and who blindly accept any instruction by physicians; (3) independent self-care, characteristic of persons with a desire to remain as independent as possible, and with a skeptical attitude toward the medical profession; (4) neglected self-care, characteristic of persons with a negative attitude toward ageing, unsatisfied with their live and ready to abandon self-care, expecting that others will assume this responsibility.

[L] Habjanic Ana, Lahe Danica. (2012). Are frail older people less exposed to abuse in nursing homes as compared to community-based settings? Statistical analysis of Slovenian data. Archives of Gerontology and Geriatrics. In press

Introduction: Although international research in recent years has often focused on elder abuse, its extent is not clear in community-based settings and even bigger mystery in nursing homes. Background: Until now in the literature it has in most cases only been assumed that nursing homes offer better protection from abuse for frail older people. Methods: A cross-sectional research design was applied by use of structured interviews. Those involved were frail older people (n = 300) who were in need of some sort of professional nursing assistance. Results: Nursing home accommodation was extracted as the strongest predictor, significantly reducing the risk of physical abuse (odds ratio, OR 0.1, 95% confidence interval, 95% CI 0.0–0.3) and financial abuse (OR 0.2, 95% CI 0.1–0.4). Spouses and sons were revealed as the most regular perpetrators of physical and financial abuse. The results showed no statistical significance between settings as predictors of the occurrence of mental abuse (OR 0.9, 95% CI 0.5–1.6). Discussion: Results of the statistical analysis add to the general assumption that nursing home accommodation offers protection for frail older people in escaping physical and financial abuse. Conclusion: In their clinical practice, community nurses should give special attention to frail older people who, besides their health care needs, are also heavily dependent in the activities of daily living (ADLs). In order to combat elder abuse, conditions in the family should be regularly verified.

[L, H7] Pogorelc Bogdan, Bosnić Zoran, Gams (2011). Automatic recognition of gait-related health problems in the elderly using machine learning. Multimedia Tools and Applications (12 November 2011), pp. 1-22

This paper proposes a system for the early automatic recognition of health problems that manifest themselves in distinctive form of gait. Purpose of the system is to prolong the autonomous living of the elderly at home. When the system identifies a health problem, it automatically notifies a physician and provides an explanation of the automatic diagnosis. The gait of the elderly user is captured using a motion-capture system, which consists of body-worn tags and wall-mounted sensors. The positions of the tags are acquired by the sensors and the resulting time series of position coordinates are analyzed with machine-learning algorithms in order to recognize a specific health problem. Novel semantic features based on medical knowledge for training a machine-learning classifier are proposed in this paper. The classifier classifies the user's gait into: 1) normal, 2) with hemiplegia, 3) with Parkinson's disease, 4) with pain in the back and 5) with pain in the leg. The studies of 1) the feasibility of automatic recognition and 2) the impact of tag placement and noise level on the accuracy of the recognition of health problems are presented. The experimental results of the first study (12 tags, no noise) showed that the k-nearest neighbors and neural network algorithms achieved classification accuracies of 100%. The experimental results of the second study showed that classification accuracy of over 99% is achievable using several machine-learning algorithms and 8 or more tags with up to 15 mm standard deviation of noise. The results show that the proposed approach achieves high classification accuracy and can be used as a guide for further studies in the increasingly important area of Ambient Assisted Living. Since the system uses semantic features and an artificial-intelligence approach to interpret the health state, provides a natural explanation of the hypothesis and is embedded in the domestic environment of the elderly person; it is an example of the semantic ambient media for Ambient Assisted Living.

[L, H7] Dovgan Erik, Luštrek Mitja, Pogorelc Bogdan, Gradišek Anton, Bruger Helena, Gams Matjaž (2011). Intelligent elderly-care prototype for fall and disease detection. Zdrav Vestn 2011;80: 824–31.

Background: The number of elderly people in need of help with the activities of daily living in the EU is rapidly increasing, while the number of young workers is decreasing. Elderly care will, therefore, also have to be provided by intelligent computer systems. Methods: A prototype elderly-care system, developed at the Jožef Stefan Institute, mostly as part of the Confidence project, is presented. The prototype detects falls and behavior changes in the elderly. It learns from experience and is based on intelligent interpretation of movement patterns. Three sets of tests were performed to evaluate its properties on various subjects when engaged in normal activities, falling and imitations of several health problems under medical supervision. The key novelty was in locationbased sensors and advanced intelligent methods. Results: The prototype using the Ubisense sensor system, which detects the locations of tags worn on the body, correctly recognized 96% of falls, significantly outperforming simple accelerometer-based systems. In addition, it recognized up to 99% of abnormal behavior. Conclusions: Experimental results showed that an intelligent system coupled with advanced location sensors can achieve the level of performance needed in real life. The system offers significantly better performance than commercially available solutions, and once the price of sensors decreases, its widespread application seems likely.

4 List of Important Institutions

Zavod za pokojninsko in invalidsko zavarovanje – Institute for Pension and Disability Insurance

Address: Kolodvorska 15, 1000 Ljubljana
Contact person: Jože Kuhelj, jkvod@zpiz.si
Webpage: http://www.zpiz.si

The IPDI is the social insurance institution responsible for the disbursement of pensions and pension-related benefits. It has a strong statistical unit, which publishes a monthly bulletin on pension-related statistical data. The IPDI also publishes an Annual report, containing a rich set of financial and economic data.

Zveza društev upokojencev Slovenije – Association of Pensioners of Slovenia

Address: Kebetova 9, 1000 Ljubljana
Contact person: dr. Mateja Kožuh Novak, predsednica@zdus-zveza.si
Webpage: http://www.zdus-zveza.si

This is an »umbrella« organisation, joining associations of pensioners at regional and local level. It endeavours to affirm itself as an important partner of the civil society, vis-à-vis the Government. A meeting with high officials of the Ministry of Labour, Family and Social Affairs this year resulted in a joint communiqué, stating the need for greater cooperation in preparing the necessary strategic documents, as well as legislation.

Ministrstvo za delo, družino in socialne zadeve – Ministry of Labour, Family and Social Affairs

Address: Kotnikova 5, 1000 Ljubljana
Contact person: Jana Lovšin, jana.lovsin@gov.si
Webpage: http://www.mddsz.gov.si

The ministry is directly responsible for preparing strategic and other documents pertaining to pension issues. It is also responsible for preparing the necessary legislation. Thus, the working group for the modernisation of the pension system is chaired by a high official of the ministry.

Ministrstvo za zdravje – Ministry of Health

Address: Štefanova 5, SI - 1000 Ljubljana
Phone: 00386 (0) 1 478 60 01
Webpage: http://www.mz.gov.si

The Ministry of Health deals with matters relating to health care and health insurance. These include: health care activities at the primary, secondary and tertiary levels; monitoring of the nation's state of health and the preparation and implementation of health improvement programmes; economic relations in health care and tasks relating to the founding of public health care institutions in line with the law; health measures to be taken in the event of natural and other disasters; protection of the population against addiction-related health problems; protection of the population against infectious diseases and HIV infection; food safety and the nutritional quality and hygiene of food and drinking water with a view to preventing chemical, biological and radiological pollution and conducting a general policy on nutrition; the production of, trade in and supply of medicines and medical products; the production of and trade in poisonous substances and drugs; the safety of products intended

for general use; health and ecological issues relating to the environment,; problems related to drinking water, bathing waters, air, soil and vibrations; waste management from the health protection aspect; protection against ionising and non-ionising radiation in residential and work environments; the formulation and implementation of international agreements on social security.

Inštitut za ekonomska raziskovanja – Institute for Economic Research

Address: Kardeljeva ploščad 17, 1000 Ljubljana
Contact person: Vlado Lavrač, lavracv@ier.si
Webpage: http://www.ier.si

The Institute is involved in research pertaining to the economic and social consequences of ageing. It produces (biannually) a research report The socio-economic position of pensioners and the elderly population in Slovenia, commissioned by the Institute for Pension and Disability Insurance. It has extensively analysed the long-term consequences of ageing, using an overlapping-generations computable general equilibrium model (OLG-CGE). The institute is also strongly involved in the EU Share Project.

Ekonomska fakulteta Univerze v Ljubljani – Faculty of Economics, University of Ljubljana

Address: Kardeljeva ploščad 17, 1000 Ljubljana
Webpage: http://www.ef.uni-lj.si

A number of faculty members are involved in research, such as generational accounting and other research on the demographic consequences of ageing, ageing and the labour market, the financial market and development of second-pillar pension funds.

Urad RS Za Makroekonomske analize – Institute for Macroeconomic Analyses and Development

Address: Gregorčičeva 27, 1000 Ljubljana
Contact person: Nadja Brezavšček, gp.umar@gov.si
Webpage: http://www.umar.gov.si

The Institute of Macroeconomic Analyses and Development of the Republic of Slovenia is an independent government institution. Its director answers directly to the president of the Government. The main function of the Institute is to forecast macroeconomic trends.

Institut za varovanje Zdravja RS – National Institute of Public Health

Address: Trubarjeva 2, 1000 Ljubljana
Webpage: http://www.ivz.si

The National Institute of Public as it is known today, was established by the Government in 1992. It is, thus, a government institution whose mission is to contribute to the overall health care system through health care promotion, extensive research and public awareness as well as many other services.
The Institute is divided into five centres. The Health and Health Research Centre collects, organises and analyses health related statistical data in the fields of diagnosis. It also collects data and makes it available to users at home and abroad. The Centre for Health Care Organisation, Economics and Informatics prepares the content for legislation in the field of health care. There are also centres for Environmental Health and Communicable Diseases. The Centre for Health Promotion develops and implements many preventive programmes and

projects. Finally, the Outpatient Facility provides outpatient services like vaccinations for persons travelling abroad.

Inštitut Antona Trstenjaka – Anton Trstenjak Institute
Address: Resljeva 7, 1000 Ljubljana
Contact person: Jože Ramovš, joze@inst-antonatrstenjaka.si
Webpage: http://www.inst-antonatrstenjaka.si
The Anton Trstenjak Institute of Gerontology and Intergenerational Relations was founded in 1992 as the first scientific, educational and managerial-advisory institution in independent Slovenia in the field of interpersonal relations, health strengthening and resolving of personal and family distress. The Institute was co-founded by the Slovenian Academy of Sciences and Art in 1992. In 2004, the Government of the Republic of Slovenia co-founded the area of gerontology and good intergenerational relations, which made the Institute the national scientific social gerontology institution. The Anton Trstenjak Institute works in three main areas: gerontology and good intergenerational relations; humanistic psychology, logotherapy and preventive anthropohygiene, addictions.

Statistični urad RS – Statistical Office of the Republic of Slovenia
Address: Vožarski pot 5, 1000 Ljubljana
Contact person: Andreja Hočevar, andreja.hocevar@gov.si
Webpage: www.stat.si
The Statistical Office of the Republic of Slovenia is the main producer and cordinator of carrying out programmes of statistical surveys. In addition to linking and cordinating the statistical system, its most important tasks include international coperation, determining methodological and classification standards, anticipating users' needs, collection, processing and dissemination of data, and taking care of data confidentiality. The Office carries out activities of national statistics on the basis of the National Statistics Act (1995, 2001) together with authorised producers determined by the Medium-term Programme of Statistical Surveys 2003-2007. With the help of authorised producers, the Office provides to public administration bodies and organisations, the economy and the public, data on the status and trends in the economic, demographic and social fields, as well as in the field of environment and natural resources.

Zavod za zdravstveno zavarovanje Slovenije – Health Insurance Institute of Slovenia
Address: Miklošičeva 24, 1000 Ljubljana
Webpage: www.zzzs.si
The Health Insurance Institute of Slovenia (HIIS) was founded on 1 March 1992, according to the Law on Health Care and Health Insurance. HIIS conducts its business as a public institute, bound by statute to provide compulsory health insurance. In the field of compulsory health insurance, the HIIS's principal task is to provide effective collection (mobilisation) and distribution (allocation) of public funds, in order to ensure the insured persons' quality rights arising from the said funds. The rights arising from compulsory health insurance, furnished by the funds collected by means of compulsory insurance contributions, comprise the rights to health care services and rights to several financial benefits (sick leave pay, reimbursement of travel costs and funeral costs, and insurance money paid in case of death).

Zdravniška zbornica – Medical Chamber of Slovenia

Address: Dalmatinova 10, p.p. 1630, 1000 Ljubljana
Webpage: www.zzs-mcs.si

The Medical Chamber of Slovenia has the public authority of licensing professionals and maintaining their register. The membership is obligatory for physicians. The Chamber represents both medical doctors, as well as patients to provide a guarantee of quality and responsible work of doctors. In the past 15 years, it has been gradually establishing a register of doctors and began to grant medical licenses. It also gives expert medical advice and manages the postgraduate training of doctors.

Inštitut Republike Slovenije **za socialno varstvo –** Social Protection Institute of the Republic of Slovenia

Address: Rimska cesta 8, 1000 Ljubljana
Webpage: http://www.irssv.si/portal/

The IRSSV was established in 1996 as a laboratory for verification and improvement of the proposed solutions in the field of social protection. It serves as an information hub, which is to support and develop the suggestions by and for the Ministry of Labour, Family and Social Affairs. In addition, the IRSSV acts as a liaison between competent ministries and the national and international research area of social protection, and also the area of children and youth. The IRSSV is targeting to analyse models of good practice in other EU countries, which may be useful for the Slovenian social environment. This includes in particular the practices and models from the National Programme for Social Protection, the fight against poverty and social exclusion and the National Action Plan on Social Inclusion.

Jožef Stefan Institute

Address: Jamova cesta 39, 1000 Ljubljana,
Contact person: Polona Strnad, polona.strnad@ijs.si
Webpage: http://www.ijs.si/

The Jožef Stefan Institute is the leading Slovenian scientific research institute, covering a broad spectrum of basic and applied research. The staff of more than 930 specializes in natural sciences, life sciences and engineering. The subjects concern production and control technologies, communication and computer technologies, knowledge technologies, biotechnologies, new materials, environmental technologies, nanotechnologies, and nuclear engineering. The mission of the Jožef Stefan Institute is the accumulation - and dissemination - of knowledge at the frontiers of natural science and technology to the benefit of society at large through the pursuit of education, learning, research, and development of high technology at the highest international levels of excellenc.

Fakulteta za družbene vede – Faculty of Social Sciences, University of Ljubljana

Address: Kardeljeva ploščad 5,1000 Ljubljana
Webpage: http://www.fdv.uni-lj.si

The Faculty of Social Sciences takes it as its main concern, as well as an obligation, the need to create and pursue an academic atmosphere in which intellectual fulfilment thrives and knowledge is abundant. 17 research centres initiate and conduct basic applied and developmental research projects in the social sciences. These are: Centre for Welfare Studies, Centre for Political Science Research, Defence Research Centre, Centre for Theoretical Sociology, Centre for Organisational and Human Resources Research, Social Communication Research Centre, Centre for Methodology and Informatics, Public Opinion and Mass Communication Research Centre, International Relations Research Centre, Centre

for Social Psychology, Centre for Cultural and Religious Studies, Centre for Social Studies of Science, Centre for Spatial Sociology, Centre for Policy Evaluation and Strategic Studies, Centre for Comparative Corporate and Development Studies, Research Centre for the Terminology of Social Sciences and Journalism, Centre for Critical approach to Political Science.

Fakulteta za socialno delo – Faculty of Social Work, University of Ljubljana
Address: Topniška 31, 1000 Ljubljana, Slovenia
Webpage: http://www.fsd.si/

As a research institution, the Faculty of Social Work advances the profession and science of social work, conducts basic, applied and developmental research, publishes research findings and implements them in practice and pertinent policies. This institution has been a pillar (in some periods the only one) of the development of Slovenian social work and the field of social care in general. It has achieved a high level of teaching, based on its own scientific and research activities (over 70 projects), as well as on good knowledge of international trends. The forms and methods it has developed are the basis of contemporary social work: counselling, group work, community work, work with families etc. Its achievements in voluntary work action research and qualitative research in general have played an important role in Slovenian social sciences. It has developed special fields, such as working with elderly people, women, young people, people in mental distress, disabled people, ethnic minorities, etc. Most importantly, it has greatly contributed to innovative solutions in the field of social care (social first aid, home help, group homes, safe houses, etc.).

Skupnost centrov za socialno delo – The Community of Centres for Social Work (CCSW)
Address: Dimičeva 12, 1000 Ljubljana
Webpage: http://www.gov.si/csd/

The CCSW takes care of the formation and checking of the findings, points of view and claims, coming to The Community from local, regional and state level; it organises various kinds of meetings and workshops to facilitate the exchange of experiences and to familiarise with the professional execution of various activities of the centres; it represents the common interests of the members in forming legislation, sublegal acts and other regulations that affect the activities of the members, and it cooperates in the preparation of proposals for programmes, standards and prices of services, staff, standard activities, etc.; it provides initiatives for various social care programmes and cooperates in the preparation of proposals for new social care programmes; it represents members in dealing with the Government of the Republic of Slovenia and in dealing with the competent ministries in order to secure material conditions for the work of the members and to form proposals for financing activities of the members; it cooperates and represents members in the permanent expert bodies of ministries and social chambers; it cooperates with members of parliament, other collective associations and with communities; it cooperates in preparing and enforcing collective agreements representing the interests of the members, etc.

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(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en