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on the Socio-Economic Impact
of Social Protection Reforms

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Pensions, Health Care and Long-term Care

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On behalf of the
European Commission
DG Employment, Social Affairs and Inclusion

Gesellschaft für Versicherungswissenschaft und -gestaltung e.V.
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1 Executive Summary

The Government introduced the Pension and Disability Insurance Act (ZPIZ-2) to the *Državni zbor* (National Assembly) in September 2010, without reaching agreement with the social partners. The act was passed (with amendments) on 14 December. Trade unions reacted by immediately collecting the required 40,000 signatures for a referendum. *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 14 March, unanimously ruling that such a referendum would not be unconstitutional.

ZPIZ-2 represents a parametric reform, improving the transparency of the system, improving actuarial fairness and also improving solidarity among insured persons. The most important features of ZPIZ-2 are: gradual increase of the retirement age (65 years for both men and women), less favourable indexation of pensions, stabilising the replacement rates for new pensioners and improved actuarial fairness. The latter is achieved by increasing the period relevant for computing the pension assessment base from the best consecutive 18 years to best consecutive 30 years (with three "worst" years taken out). Stabilisation of the replacement rate will be achieved, and thus the gradual relative decline of entry pensions stopped, by (a) "freezing" the accrual rates at 80% for 40/38 years of insurance for men/women, and (b) by "freezing" valorisation coefficients, used for the valorisation of past wages. In ZPIZ-2 they are fixed and amount to 75.5% of nominal wage growth. This in effect means that at retirement the pension would amount to 60% of one's wage (for 40 years of work for men and 38 years of work for women). There will be uniform penalties for early retirement, amounting to 3.6% per "missing" year. Early retirement will be possible (with sufficient years of insurance) at the age of 60. The statutory retirement age for men can be decreased for military service, whereas for women there is a bonus for child-rearing: the retirement age can be decreased by eight months for each child, up to a maximum of 24 months. A study by Čok, Sambt and Majcen has shown that ZPIZ-2 would result in stabilising pension expenditures for the next 15 years.

ZPIZ-2 has been rejected by the referendum on 5 June, by a large margin (contra 72.2%, pro 27.8%). This means that the current Pension and Disability Insurance Act (ZPIZ-1) will remain valid, as well as the emergency measures approved by the *Državni zbor*. These will prevent growth of pension expenditures in the short term, most effectively by extending the emergency measures on indexation of social benefits (currently valid till the end of 2011). This essentially means a semi-freeze of pension indexation. This could result in some collateral damage, i.e. a non-negligible decrease in the relative value of new entry pensions (pensions disbursed to new pensioners).

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

In health care, the main document prepared by the Ministy of Health is the "Health care system upgrade until 2020", which has been under public debate in spring 2011. The main goal of this document is to set the basis for changing the set of basic health system laws, on which the reform of the health care system in Slovenia will take place. The Health care system upgrade until 2020 mainly focuses on granting accessibility,

In the field of long-term care Slovenia nothing much has changed and up to now, the Law on LTC is still under preparation.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011)

2.1 Overaching developments

There have been several important changes in the social protection system since the start of the financial and economic crisis. Two laws on emergency measures, setting new indexation rules for social benefits, were passed - the first law in December 2009 (Official Journal 98/2009), stipulating reduced indexation of pensions for 2010, i.e. indexation amounting to 50% of nominal wage increase. The second law was passed in November 2010 (Official Journal 94/2010), stipulating further reduced indexation of pensions in 2011, i.e. indexation amounting to 25% of nominal wage increase.

A law on social assistance benefits and a law on rights stemming from public sources were passed in July 2010, to be applied from 1 January 2012. Both of these laws improve the transparency, hopefully also resulting in improved efficiency and less abuse of the social assistance system.

With regard to pension reform, the government started preparations in March 2009. The legislative process was completed with the passing of the new Pension and Disability Act (ZPIZ-2) in December 2010. However, the trade unions have initiated a referendum, which was held on 5 June, resulting in a resounding rejection of the pension legislation (72.2% against, 37.8% in favour). The main features of this reform will be explained in section 2.2. The health care reform is not in such an advanced stage: The cornerstone of this reform is the abolishment of complementary health care insurance, which is privately managed, and transferring it back into the main, mandatory health care social insurance. A previous attempt in 2003 failed.

All the social protection reforms are being pursued against the backdrop of an economic and financial crisis, which still has a profound impact on the population. This crisis started being felt in autumn 2008, with a contraction of industrial production and a gradual rise in registered unemployment (shown in Table 1). The contraction of industrial production is to a large degree due to the strong export orientation of the Slovene economy. The manufacturing index (taking the 2005 average as 100) was 123 in March 2008, 92 in February 2009, 92 in February 2010 and 98 in February 2011.

Table 1: Registered unemployment in Slovenia, December 2006 to April 2011

Month, Year	**Registered unemployment**	**Unemployment rate (reg. unemployment), in %**
December 2006	78,303	
December 2007	68,411	
December 2008	66,239	7.0
December 2009	96,672	10.3
December 2010	99,591	11.8
January 2011	115,132	12.3
February 2011	115,608	12.3
March 2011	113,948	
April 2011	111,561	

Source: Employment Service of Slovenia.

The contraction of GDP is seen in Table 2. Of course, government revenues were also affected, though to a varying degree. As can be seen from Table 3, the largest decrease was in revenues collected from the corporate income tax, with the large drop in 2009 continuing in 2010. Overall, tax revenues decreased by some 7% in 2009, and by a further 1% in 2010. Collected social contributions have remained stable.

Table 2: GDP in current prices (in million EUR), 2006-2010

	GDP	**Index on previous year**
2006	31,050	-
2007	34,568	111
2008	37,305	108
2009	35,384	95
2010	36,061	102

Source: Statistical Office of the Republic of Slovenia, 2011.

Table 3: Tax revenues (in million EUR), 2007-2010

	All tax revenues	**Personal income tax**	**Corporate income tax**	**VAT**	**Social contributions**
2007	12,758	1,804	1,113	2,907	4,598
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
Index 2009/2008	93	96	57	90	101
Index 2010/2009	99	97	63	104	101

Source: Bulletin of Public Finance, Ministry of Finance, April 2011.

The public finance position has deteriorated along the familiar lines: reduced fiscal revenues, following closely the drop in GDP. Fiscal expenditures have acted anti-cyclically, the net result being the increase in the fiscal deficit, as seen in Table 4.

Table 4: General government revenues, expenditures and deficits (as % of GDP) 2006-2010

	Revenues	**Expenditures**	**Surplus (+)/Deficit(-)**
2006	41.7	42.5	-0.8
2007	40.5	40.3	0.3
2008	41.1	41.4	-0.3
2009	40.7	46.3	-5.5
2010	41.0	46.2	-5.2

Source: Bulletin of Public Finance, Ministry of Finance, April 2011.

2.2 Pensions

2.2.1 The system's characteristics and reforms

An overview of the pension system and some relevant developments since 2000

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 a decrease of the accrual rates and an 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, henceforth denoted as ZPIZ-1, are presented in Table 5.

Table 5: Some 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(f))	20	20
Minimum conditions for early retirement	Age 58 with 40 years of insurance	Age 58 with 38 years of insurance
Computation of 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:The 1999 Pension and Disability Insurance Act (ZPIZ-1).

Table 5 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 of 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.[1] 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 times 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 fulfil the condition of the 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.

[1] 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.

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. Second, 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.[2] 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.[3] This, in effect, means that in February of each year, pensions are 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[4], some two-thirds of all employees are now enrolled. Participation in the second pillar is mandatory for public employees and for persons employed in hazardous 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. The inclusion of public sector employees, which took place in April 2004, was a noteworthy example of "seizing an opportunity". Namely, wages and salaries of public sector employees were to be increased by 2.4% in August 2003. The government, fearful of the potential inflationary effects[5], proposed a conversion of this increase into premia for the second pillar. It was jointly agreed upon – by the government and representatives of the public sector trade unions – that *Kapitalska družba (KAD),* a state-owned pension managing company, would manage this fund. As seen from Table 6, in spite of the wide coverage of employees, the amount of assets per member is quite low. For example, in the pension fund for government employees (ZVPSJU), the average amount of assets per member is some 2,000 EUR, and the highest average amount is in the SODPZ, with 6,400 EUR per member. The low value of accumulated assets, even taking into account that these funds have been in operation at most nine years, do indicate that the pensions from the second pillar will not be able to compensate for the shortfall in the public pension.

[2] 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/her 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.

[3] 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.

[4] Strictly speaking, the second pillar was introduced in the 1992 PDIA, but due to the lack of tax incentives, the number of enrolled participants did not exceed several hundreds.

[5] The government was quite determined to succeed in joining the Eurozone at the earliest possible date and was very concerned about achieving the inflation target.

Table 6: Data on mandatory and voluntary supplementary pension schemes, 31 December 2009

	Number of insured persons	Assets (in million EUR)	Share (in %)	Assets per insured person (in EUR)
ZVPSJU	193,235	385.80	21.67	1,996
SODPZ	40,750	259.90	14.60	6,378
Voluntary supplementary pension schemes	334,327	1,134.26	63.72 (100.00)	3,392
Pension management companies	154,779	551.0	(48.58)	3,560
- Skupna	74,957	273.4	(24.11)	3,647
- Pokojninska družba A	47,000	181.3	(15.98)	3,856
- Moja naložba	32,822	96.4	(8.50)	2,936
Mutual pension funds	53,532	252.1	(22.23)	4,709
- KVPS	35,485	180.7	(15.94)	5,093
- Banka Koper	6,022	29.7	(2.62)	4,935
- Generali	4,772	19.5	(1.72)	4,080
- A Banka	2,997	14.8	(1.30)	4,938
- Probanka	4,256	7.4	(0.65)	1,732
Insurance companies	126,016	331.0	(29.19)	2,627
- Prva osebna zavarov.	78,890	172.1	(15.18)	2,182
- Triglav	44,698	154.0	(13.58)	3,445
- Adriatic Slovenica	2,428	4.9	(0.43)	2,026
Total	568,312	1,779.90	100.00	3,132

Source: 2009 Annual report of Skupna.

Note: For Triglav the assets are estimated. For voluntary supplementary schemes their shares (shown in brackets) are calculated within these schemes.

Overall, the pension reform produced some visible and positive results. Table 7 shows the increase in the effective retirement age, whereas Table 8 shows the gradual decrease in the replacement rate and fairly stable pension expenditures (measured as percentage of GDP), hovering around 10%. The increase in the effective retirement age is more pronounced for women, not least because their statutory retirement age (and required insurance period) is still increasing.

Table 7: Effective retirement age by gender, 2000-2010

	MEN		WOMEN	
	Year	**Month**	**Year**	**Month**
2000	61	0	56	1
2001	62	0	56	2
2002	62	2	56	5
2003	62	2	56	6
2004	62	6	57	3
2005	61	9	57	3
2006	61	8	57	4
2007	61	10	57	7
2008	61	11	57	7
2009	62	0	58	1
2010	61	10	58	5

Source: 2009 Annual Report; Institute for Pension and Disability Insurance; for 2010, Monthly Statistical Bulletin, April 2011, Institute for Pension and Disability Insurance.

Table 8: Average old-age pension/average net wage ratio and pension expenditures as percentage of GDP, 2000-2010

Year	**Average old-age pension/average net wage (in %)**	**Pension expenditures as percentage of GDP**
2000	75.3	-
2001	73.2	11.00
2002	72.8	10.84
2003	71.1	10.64
2004	70.2	10.44
2005	69.1	10.36
2006	68.6	10.17
2007	67.1	9.71
2008	67.1	9.87
2009	66.6	10.91
2010	64.7	11.10

Source: Monthly Statistical Bulletin, April 2011, Institute for Pension and Disability Insurance.
Note: Due to (upward) revision of GDP data, the figures in column 3 are lower than those presented in previous annual reports and statistical bulletins.

Particularly noteworthy is the increase in activity of the elderly population. In the previous annual report, we have shown the results based on Household Expenditure Surveys; here, we will show the increase based on Eurostat figures, obtained from the Labour Force Survey (LFS).

Table 9: Employment rates (in %), age group 55-64, annual averages, Slovenia, 2000-2009

year	males	females	all
2000	32.3	13.8	22.7
2001	35.9	15.8	25.5
2002	35.4	14.2	24.5
2003	33.2	14.6	23.5
2004	40.9	17.8	29.0
2005	43.1	18.5	30.7
2006	44.5	21.0	32.6
2007	45.3	22.2	33.5
2008	44.7	21.1	32.8
2009	46.4	24.8	35.6

Source: Eurostat.

The income position of pensioners has been gradually deteriorating, as seen by the decreasing pension/wage ratio in Table 8. Other statistical sources confirm these findings. The relative risk of income poverty is much higher for pensioners than for the total population, and is even higher for pensioners living in pensioner households – meaning households with pensioners but without labour-active persons. This can be seen in Table 10.

Table 10: Percentage of persons with equivalent income below 0.4. 0.5 and 0.6 of median equivalent household income

	0.4 median	0.5 median	0.6 median	0.4 median	0.5 median	0.6 median
	% of persons with equivalent income below given threshold			Relative risk of income poverty		
1997-1999						
All persons	4.0	8.2	14.4	1.00	1.00	1.00
Pensioners	4.6	9.0	17.2	1.15	1.10	1.19
Pensioners in pens. households.	5.7	11.6	21.1	1.43	1.41	1.47
elderly (>=60)	6.1	11.9	22.4	1.53	1.45	1.56
Children(<=18)	3.7	8.1	13.6	0.93	0.99	0.94
Unemployed	15.1	25.8	39.5	3.78	3.15	2.74
2005-2007						
All persons	3.1	6.5	12.4	1.00	1.00	1.00
Pensioners	3.7	9.1	19.3	1.19	1.40	1.56
Pensioners in pens. households	4.7	12.0	25.4	1.52	1.85	2.05
Elderly (>=60)	5.0	10.9	21.7	1.61	1.68	1.75
Children (<=18)	1.8	4.9	10.1	0.58	0.75	0.81
Unemployed	16.3	26.0	38.1	5.26	4.00	3.07

Source: Kump and Stanovnik (2008).

The pension reform process in 2010 and 2011

The Government first presented the draft Pension and Disability Insurance Act (ZPIZ-2) in March 2010. Negotiations with social partners did not produce tangible results and the Government decided to "go it alone" and presented ZPIZ-2 to the *Državni zbor* in September 2010. The act was passed (with amendments) on 14 December. Trade unions reacted by immediately collecting the required 40,000 signatures for a referendum. *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 14 March, unanimously ruling that such a referendum would not be unconstitutional. The parameters of ZPIZ-2 are presented in Table 11: These are to be compared with the currently still valid

ZPIZ-1, and the parameters proposed in the draft ZPIZ-2, presented in March 2010 (and shown in the previous annual report).

Table 11: The parameters of ZPIZ-2, passed by the *Državni zbor* in December 2010, the public pension system (first pillar)

	Men	**Women**
Retirement age	65	65
Minimum insurance period	15	15
Minimum conditions for early retirement	Age 60 with 40 years of insurance	Age 60 with 38 years of insurance
Computation of pension assessment base	Best 30 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 up to 24 years, then 2% for each additional year	39% for first 15 years, 1.5% for each additional year up to 24 years, then 2% for each additional year
Pension indexation	70% of wage growth and 30% of inflation	
Minimum pension assessment base	Set nominally	
Maximum pension assessment base	4 times minimum pension assessment base	
Incentives and disincentives	Negative accrual rates for early retirement (3.6% per year)	

Source: The 2010 Pension and Disability Insurance Act (ZPIZ-2).

ZPIZ-2 stipulates a gradual increase in the statutory retirement age to 65 for both men and women. The length of the transition period varies; for example, for women with 38 years of insurance[6] - this consists of "real" and purchased years of insurance - the retirement age will increase from 58 in 2011 to 65 in 2025. The retirement age for women can be decreased for each child by eight months, with a maximum decrease of 24 months. For men the retirement age can be decreased for military service (which amounts to at least 12 months). There are no penalties for retirement prior to the normal retirement age, provided the insured person has a sufficiently long period of insurance. Thus, men will be able to retire without penalties at the age of 60 if they acquire 43 years of "real" insurance (here, purchased years of insurance are not counted), and women will be able to retire at the age of 58 with 41 years of "real" insurance (again, purchased years of insurance are not counted).

Early retirement is possible at the age of 60 with 40 years of insurance for men and 38 years of insurance for women. Penalties for early retirement for every "missing" year up to 65 amount to 3.6% per "missing" year. Overall, this represents a considerable tightening of conditions for early retirement, as compared to ZPIZ-1. As a concession to the trade unions, persons who have fulfilled conditions for early retirement but continue to work full time will be able to claim 20% of their pension, until the retirement age of 65.

[6] ZPIZ-2 retains the possibility of purchase of insurance periods. An insured person can purchase up to five years of insurance (!), not counting the period of military service. ZPIZ-2 still retains the term "pension qualifying period", which includes not only years of insurance (real or purchased) but also credited years. However, crediting of active insured persons in the Slovene pension system is negligible and at present includes only a category of civilian victims of WW2. One could thus equate the term "pension qualifying period" with the internationally more acceptable term "insurance period".

The pension assessment base will be gradually extended from the best consecutive 18 years to best 30 year period of average wage, with the added proviso that the three "worst" years are not taken into account. This assessment base will be computed using fixed valorisation coefficients, which amount to 75.5% of the nominal wage growth. As seen from Table 7, the accrual rates are not uniform. The accumulated accruals for men/women for 40/38 years of insurance amount to 80%. The replacement rate for men/women with 40/38 years of work is 60%. Alternately, an equivalent result would be obtained if the pension assessment base is computed using revalorisation of wages according to nominal wage growth, with the accumulated accruals equal to 80% x 0.755 = 60.4%, which give approximately 1.51% of average annual accrual for men, and 1.59% of average annual accrual for women.

By stabilising revalorisation coefficients and accrual rates, the values of entry pensions are also stabilised. This is a very important improvement, as according to ZPIZ-1 valorisation coefficients are variable and not set in the law, but decreed annually (based on the annual growth of pensions). Also according to ZPIZ-1, the accumulated accruals are being gradually decreased from 85% in 2000 to 72.5% in 2024 (for 40 and 38 years of pension qualifying period for men and women, respectively). This "stabilisation" of accruals at 80% (for 40/38 years of insurance for men/women) according to ZPIZ-2 has important consequences for the formation of the minimum pension assessment base. The minimum pension base is used for the computation of the minimum social insurance pension – both in ZPIZ-1 and ZPIZ-2. Thus, if one's computed pension assessment base is lower than the minimum pension assessment base, his/her pension is computed from the minimum pension assessment base. This minimum pension assessment base has been gradually decreasing (due to the decreasing revalorisation coefficients), so that its value fell from 64% of net wage in 2000 to 56% of net wage in 2010.

The indexation of pensions according to ZPIZ-2 will be somewhat less favourable than according to ZPIZ-1. It will be 70% of nominal wage growth and 30% of inflation; in the 2012-2015 period it will be somewhat less and will amount to 60% of nominal wage growth and 40% of inflation.

Social assistance benefits related to pensioners were "traditionally" included in the Pension and Disability Insurance Act. ZPIZ-2 broke with the past and these benefits are to be included in the appropriate social assistance acts.

As a concession to the employers' association, ZPIZ-2 stipulates that the government budget is to finance 30% of the employer's pension contribution for all workers of age 60 and above. This means that the employer's contribution rate will be 30% lower.

The second pillar

There have been two important second pillar developments not directly related to the pension reform.[7]

First, there was a change in contribution rates, paid by employers to the Compulsory Supplementary Pension Insurance Fund (SODPZ). This fund includes some 41 thousand workers in hazardous occupations (policemen, firemen, pilots, miners etc.), who are entitled to a professional (occupational) pension upon meeting conditions for "special" early retirement. These pensions are disbursed till these persons fulfil conditions for "normal" early

[7] According to Slovene legislation the second pillar comprises both collective and individual pension schemes. Enrolment in these schemes is subject to membership in the mandatory public pillar. Premia paid to the second pillar pension funds are subject to considerable tax reliefs. The third pillar consists of various life-insurance policies and other saving vehicles, which are not subject to favourable tax treatment and where enrolment is not conditional on being in the mandatory public pillar.

retirement.[8] Up until 2010, there were five different contribution rates, dependent on the category of the insured person. Interestingly enough, the question of whether these contribution rates would be sufficiently high for the accumulation of pension wealth and consequently, the disbursement of benefits, was never really asked. The problem erupted in 2010, and in June 2010 the contribution rate has been – in haste – set at a uniform rate of 10.55%.[9] Somewhat paradoxically, differential pensionable age has been retained, though the other required conditions remain the same.[10]

Other developments concern an important institutional change within KAD. Following pressures from the European Commission and the OECD (in particular), KAD was restructured in September 2010 and a new insurance company has been formed (The Blue Insurance Company). This insurance company will manage all pension funds of KAD, except for the SODPZ. This development is still in a rather early stage.

Overall, ZPIZ-2 did introduce some important changes with regard to the management of second pillar pension funds. The collective and individual pension schemes are now completely separated and premia for collective pension schemes are to be paid exclusively by the employer, whereas for the individual pension schemes premia are to be paid exclusively by the employee. The investment policy is – compared to ZPIZ-1 – less prescriptive, with fewer quantitative criteria for investments in financial instruments. ZPIZ-2 also introduced the concept of life-cycle funds, permitting the insured person to choose one among three pension sub-funds, within the umbrella pension fund. If the insuree does not choose, they will be assigned – depending on their age - to the relevant pension sub-fund. A minimum guaranteed rate of return is now set only for the sub-fund which corresponds to the oldest group of insured persons; in ZPIZ-1, the minimum guaranteed rate of return applied to all pension funds.

2.2.2 Debates and political discourse

From September 2010, when the draft ZPIZ-2 was presented to *Državni zbor* one could (in all honesty) say that there has not been much debate on the pension reform. However, pension experts, trade union representatives and political leaders did express their views in different fora. Thus, in an interview to the weekly *Mladina* (26 November 2010) Stanovnik strongly supported the pension reform, i.e. draft pension legislation. He was critical of the Governments' very weak PR campaign and of the initial idea of a two-phased reform, with the NDC system to be introduced in the second phase since this would add an unnecessary confusion and bewilderment among the reform supporters. He pointed out that the retirement age in Slovenia is unreasonably low, by the example of the pilot Chesley Sullenberger, the Hudson river hero, who retired at age 58, whereas the effective retirement age of Adria Airways pilots is 54.5 years. He was also very critical of the trade unions' main argument, that older workers deprive younger job seekers of work. Economists give short shrift to this argument, labeled the "lump-of-labour" fallacy.

In an interview to *Mladina* (18 February 2011), the Minister of Labour, Family and Social Affairs, Ivan Svetlik, argued that the Government has done all that was possible to take account of the trade unions' demands, but that some of their demands, such as the statutory retirement age, were simply unacceptable. He further took issue with the trade unions'

[8] According to which a person can still receive a reduced professional pension, on top of their "normal" early retirement pension.

[9] However, employers who paid a higher rate – 12.6% – would continue to pay this higher rate.

[10] These include the requirement that a person can retire only if there are sufficient funds on his/her account and that he/she has acquired at least 40/38 years of service – these include insurance period and added period, which amounts to ¼ of the insurance period.

assertion that sufficient financial means could be assured by increasing the employers' contribution rate or from general taxation. With regard to the assertion of Dušan Semolič (president of the largest trade union organisation – ZSSS) that the Government is more concerned with the country rating by rating agencies than the rating it has among its own people, Svetlik responded that rating among international agencies is quite important, as it has a direct consequence on the cost of debt. He further pointed to certain inconsistencies in the trade unions arguments, such as requiring jobs for young job seekers but at the same time standing firm and not willing to relinquish any right bestowed to the most protected group of workers – the elderly with a permanent job contract.

In an interview to *Mladina* (15 April 2011), Miroslav Stanojević, a professor at the Faculty of Social Sciences in Ljubljana, argues that due to radicalisation and lack of trust among social partners, the divide among social partners has been getting deeper. Social dialogue has become a power game. He argues that the trade unions in general have – with the demise of social democracy – been deprived of the frame of reference, so that at present they occasionally even assume the role of political parties. He points out that the main – actually only – veto point now is the referendum. Strikes are not on the agenda, due to intimidation of workers and fear of loss of one's job.

In a interview to *Mladina* (13 May 2011), Mitja Gaspari, the Minister for Development and European affairs gave a tour d'horizon of some economic issues. With regard to the pension system, he depicted it with a health analogy: it is similar to high blood pressure – you do not feel anything is wrong, and then you get a stroke. He stated that those who rush into retirement have actually willfully chosen lower pensions.

The referendum campaign started rather late, in May. In a lead article in *Sobotna priloga Dela* (14 May 2011) Tine Stanovnik unleashed a sharp, all-out attack on the trade unions, openly accusing them of not negotiating in good faith. He questioned the wisdom of the governments' negotiation strategy, stating that the original proposals of the trade unions were even more favourable than the retirement conditions according to current pension legislation – hardly a good starting point for negotiations. Furthermore, the trade union officials have time and again shown – in their various TV appearances – a disturbing lack of understanding of the most basic features of the new pension legislation. In his opinion, both of these factors could signify that the trade unions' decision to demand a referendum was taken very early on, so that following this internal decision the trade unions were completely oblivious to arguments and ignorant of the facts. Stanovnik also pointed out that some important features of the new legislation have been completely disregarded – in particular, that the accrual rates and valorisation coefficients have been "frozen", which in effect fixes the pension/wage ratio; under the current legislation both accrual rates and valorisation coefficients would continue to decrease.

In an article in *Dnevnik* (20 May 2011), Igor Masten from the Faculty of Economics at the University of Ljubljana responds to the reaction of readers of his first article, published on 6 May. In that article, entitled "The pension reform goes to the junkyard", Masten made a mockery of the opponents of the pension reform, using irony and twisted logic to show how meaningless their arguments are. For example, he "suggests" the retirement of 125 thousand workers so that 125 thousand unemployed could find work. The irony has been lost on most readers, so that he had to respond in a second article, exposing these fallacies and showing how easy it is to manipulate the public with false "arguments".

Sobotna priloga Dela (21 May 2011) published an interview with Dušan Semolič, president of the largest trade union organisation – ZSSS (*Zveza svobodnih sindikatov Slovenije).* He argued against the increase of the retirement age, stating that it does not take account of the

actual conditions on the labour market, with a high number of elderly unemployed and the possibility of increased disability pensioning. He stated that Slovenia is highly ranked with regard to intensity of work. Semolič also complained that the government did not consider the trade unions as an equal partner, and that the government was willing to yield only on cosmetic adjustments.[11] In this interview, Semolič revealed a glaring ignorance of retirement conditions valid under the current pension legislation.

In the same issue of *Sobotna priloga Dela*, an interview with Peter Pogačar, director of the Directorate for Labour Relations at the Ministry of Labour, Family and Social Affairs, and chief negotiator with the trade unions commented on the proposal of the main opposition party SDS. SDS proposed a paradigmatic change, i.e. moving the system from a classic Bismarckian one to the NDC system. He mocked their proposal ("it was concocted two weeks ago") and explained the severe implementation problems (the need to devise special solutions for the disability insurance system etc.) and problems of assuring solidarity within such a system. As an illustration of the social dialogue and "quality of debate", Pogačar mentioned the following incident: On the initiative of the trade unions, a research report was prepared by researchers at the Faculty of Economics and Institute for Economic Research, showing the with/without reform scenarios. Upon presenting the main findings of the report, a trade representative commented these results with the word "gibberish".

In the *Sobotna priloga Dela* (28 May 2011) Igor Guardiancich, a researcher at the European University Institute in Florence and with in-depth knowledge of pension processes in new EU Member States, explained that the pension reform is a social compact and that unilateral change (without the consent of the trade unions) is the worst possible option, i.e. option of last resort. He explained that a serious error of the government was that it relied too much on macro-economic consequences, without knowing what is actually going on at the workplace; the trade unions are more concerned with their workers and their actual conditions than with macro-categories such as pension expenditures. The attempted Blitzkrieg by the Government is doomed to fail, also because all three social partners have suffered much during the crisis: The trade unions have lost some legitimacy, employers are saddled with insolvency, and the ruling coalition and opposition are not capable of or reaching an agreement on the issue of pension reform. Consequently, this enfeeblement of all partners also resulted in their entrenchment.

In the same issue of *Sobotna priloga Dela* Stanovnik, in a letter to the editor, exposed the glaring ignorance of the leader of ZSSS, stating point by point the deceptions and misconceptions of Semolič. He concludes that, whereas the article of 14 May laid bare the complete ignorance of Semolič with regard to the new pension legislation, the interview by Semolič in *Sobotna priloga Dela* has shown that the leader of ZSSS is also completely ignorant of the existing pension legislation.

In an article in *Dnevnik* (28 May 2011), titled *Whom to believe?* Tine Stanovnik exposed one of the arguments of the trade unions, that extending the retirement age will deprive the young of jobs. This "lump-of-labour fallacy" shows the mindset of a static and bureaucratic view of the economy, unthinkable to economists. He pointed out that a "no" vote might result in serious international consequences, eventually causing an increase in the cost of debt.

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. True, comparisons with other EU Member States with regard to

[11] All evidence shows that this statement does not accord to facts.

statutory retirement age, effective retirement age, activity rates etc. were frequent, so as to show 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[12] 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.

2.2.4 Impact and critical assessment of reforms, discussions and research carried out

In spite of the fact that most economists and prominent persons from the academia have pronounced themselves in favour of the pension reform, the peoples' verdict delivered a clear rejection. It would have been difficult to pass such a reform even in the best of times; under current conditions of general public malaise and widespread discontent with the government, the passage of the reform was next to impossible. The political economy of the pension reform process will doubtlessly be the subject of research; here we will only briefly touch upon some issues and describe the positions of the main "veto" actors.

The Government has been (wrongly!) accused of ignoring the social dialogue. This accusation does not correspond to the facts. The evidence shows that the Government has tried to accommodate the demand of trade unions as much as possible, in certain instances even putting in jeopardy the consistency of the pension system.[13] The Government has also been frequently accused of being arrogant. However, one could ask how congruent are arrogance and "caving-in" to the demands of trade unions.[14] The PR campaign of the Government has been a failure from the very start. One video spot, involving Urška Čepin as "the stupid blonde", tried to mock the views of the opponents of the pension reform. However, this spot backfired and produced a public uproar, not only because of the disparaging attitude toward the opponents of the pension reform, but also because of the frivolous treatment of such a "serious" issue.

The trade unions were beset by their own agenda. They were "behind the curve" in the last two years, with a number of wild-cat strikes organised without the knowledge of the trade union organisation, with local trade union representatives cosying up to the employers. By setting completely unreasonable demands with regard to retirement age – the retirement conditions set by trade unions were even more favourable than the current pension legislation

[12] 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.

[13] The trade unions in effect demanded that the "normal" retirement age be set at 60 years and that working past this "normal" retirement age would entail an increase in a pension by 6% for every year of work past 60 (but only up to 65). The government negotiators acquiesced to this demand, but lowered the amount from 6% to 3.6%. The working group gave this "caving in" short shrift and stroke out the relevant Article 41(3), stating that it is completely inconsistent with the concept of early retirement and that it would also result in gross inequities in the system.

[14] In fact, there seems to be some merit in the "arrogance" argument. A number of sources have complained of the arrogance of some high government officials, surmising that this might also have contributed to the staunch opposition by the trade unions, very early on in the negotiation process.

– the leaders decided to be "ahead of the curve" and radicalise the trade union movement. Judging by the complete ignorance of existing pension legislation and ignorance of the basic features of the pension reform, the leaders of the trade unions have probably reached a decision to block the reform very early on, possibly even as early as September 2009.

The largest opposition party, the SDS (*Slovenska demokratska stranka)* opposed the reform under the tacit slogan: The worse, the better. It was betting on early elections. Interestingly, their leader, Janez Janša, made no public pronouncements during the referendum campaign. High officials of the SDS expounded the completely new proposal for a NDC system. Their public appearances were pathetic, demonstrating their ignorance of the NDC system, and lines memorised – and rehearsed - in haste.[15]

The "party of pensioners" – Desus (*Demokratska stranka upokojencev Slovenije)* – which has recently changed seats and has moved from the government coalition to the opposition, also opposed the reform, mostly because of the unfavourable indexation rule for pensions (??!).

Another opposition party, SLS (*Slovenska ljudska stranka)* has consistently supported the pension legislation. This is not the first time this party has been supportive of important national projects.

2.3 Health Care

2.3.1 The system's characteristics and reforms

The health care system in Slovenia is provided through the public health service network. The rights arising from the health care system are mainly exercised in public institutions or with private practitioners holding a concession for performing treatment financed by public funds. The insured are entitled to free choice of a personal GP on the primary level and, in the event of hospital treatment, the right to freely choose the hospital and specialist outpatient facility.

Since 1992, Slovenia has had a Bismarckian type of social insurance system, based on a single insurer for statutory health insurance, which is fully regulated by national legislation and administered by the Health Insurance Institute of Slovenia (hereinafter HIIS). Under the compulsory health insurance, the insured are entitled to certain rights up to the amounts specified by law (Article 23 of the Health Care and Health Insurance Act). The insured are entitled to: preventive services (general health check-ups, measures for preventing contagious diseases, measures for early detection of certain diseases, etc.), treatment and health care at home and in special social institutions and elderly homes, transport by rescue vehicles (up to 60% of the value), medicinal products (from the positive and intermediate list) and medical devices. In terms of finance, the rights to prescription-only medicinal products represent one of the demanding issues of compulsory health insurance in Slovenia. Compulsory health insurance provides prescribed medicinal products classified into one of the lists (positive, intermediate) with a required 15% or 50% co-payment or supplementary health insurance. This is not required for children, pupils and students, and in the event of certain diagnoses and conditions.

[15] It is not possible to establish how the idea for a NDC system surfaced at the SDS. SDS could have simply picked it up from existing government documents. Namely, in September 2009, the Government has – foolishly – proposed a two-phase pension reform, with the first phase being a parametric change within the existing system, and the second phase, an NDC system, to be applied from 2015. This was published in the Green Paper on the modernisation of the Slovenian pension system. The OECD picked this "floating" idea and gave it full support, in the country reports on Slovenia - OECD Economic Surveys, July 2009 and February 2011.

It can be said that the health system has transformed into a mixed system. Namely, in 2008 the share of health expenditure from private health insurance institutions was 13.1% and from direct payments by households 13.5%.[16]

Compulsory health insurance contributions constitute the major source of health care financing in Slovenia, with 67.2% of total health expenditure in 2008.[17] The core purchaser of health care services for insured individuals is the HIIS, which is an autonomous public body. The health insurance system is mandatory, providing universal coverage. Contributions are related to earnings from employment, although coverage is also provided for non-earning spouses and children of the contributing members. The compulsory health insurance contributions of the employed are 13.45% of their gross income and shared between the employer (6.56%) and the employee (6.36%). However, the employer pays an additional 0.53% to cover for workplace-related injuries and occupational diseases.[18]

The Ministry of Health (hereinafter MoH) is responsible for financing the health infrastructure for hospitals and other health services and programmes at national level, as well as covering health services of individuals without income.

The role of local municipalities in health financing is relatively small and limited to the provision and maintenance of health infrastructure at primary care level (i.e. primary health care centres, public pharmacies and health stations).

To avoid cream-skimming by voluntary health insurers and to equalise the variations in risk structure between private health insurance companies, a risk equalisation scheme was introduced in 2005 that ensured equal premiums for all insured individuals, no matter what age group they fall into.[19]

The nominal growth of health expenditure lagged behind the GDP growth, which resulted in a lower share of total health expenditure in GDP (8.7% in 2003 compared to 8.3% in 2008). With 8.3% of GDP health expenditure Slovenia ranks below the OECD average (Figure 1). As can be seen from Table 1, the total health expenditure in 2008 amounted for 3.1bn Euro and grew by 15.5% from the previous year.[20] The average annual growth of current expenditure on health from social security funds (7.5%) in 2003-2008 was lower than the growth of health expenditure from private sources (7.8%). As mentioned above, social security funds were the main source of funding health care in the period 2003-2008, and they represented 71% of funds for health care. In 2008, the share of health expenditure from private health insurance institutions was 13.1% and from direct payments by households 13.5%. It is interesting to observe that on the one hand the average annual growth of current expenditure on health from health insurance institutions (6.6%) was lower than the average annual growth of current expenditure on health from social security funds (7.6%), whereas the average direct payments by households (8.6%) were higher.[21]

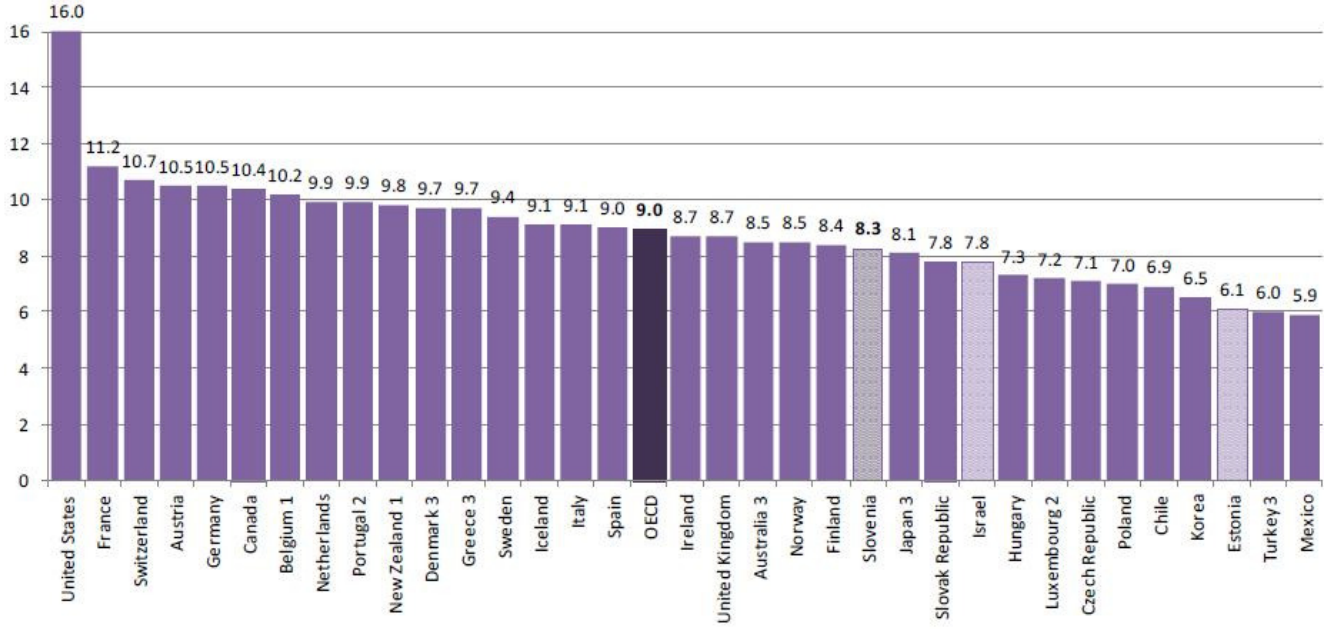
[16] SORS, 2010.
[17] SORS, 2010.
[18] ZZZS, 2010.
[19] Tajnikar, Došenovic-Bonča, 2010.
[20] SORS, 2010.
[21] SORS, 2010.

Table 12: Health expenditure 2005-2008

	2005			2006			2007			2008		
	Total	General government	Private sectors	Total	General government	Private sectors	Total	General government	Private sectors	Total	General government	Private sectors
	Thousand EUR						Thousand EUR					
Functions of health care and goods	**2,416,997**	**1,742,642**	**674,355**	**2,568,681**	**1,856,342**	**712,338**	**2,691,374**	**1,944,715**	**746,659**	**3,110,047**	**2,234,965**	**875,082**
Services of curative care	1,237,227	969,117	268,110	1,297,362	1,027,280	270,082	1,387,133	1,077,534	309,599	1,618,826	1,289,703	329,123
Services of rehabilitative care	53,211	30,781	22,430	54,453	30,028	24,424	60,604	33,106	27,498	66,924	37,916	29,007
Services of long-term nursing care	200,319	188,240	12,080	206,013	191,881	14,132	217,862	201,247	16,615	252,895	234,138	18,757
Ancillary services to health care	65,504	46,818	18,686	71,771	51,940	19,830	77,287	55,563	21,725	90,729	67,593	23,136
Medical goods dispensed to outpatients	562,997	316,880	246,117	588,964	333,454	255,511	609,630	332,357	277,273	674,414	357,085	317,329
Prevention and public health services	86,198	64,436	21,762	91,858	67,982	23,876	100,233	73,959	26,274	113,097	83,546	29,551
Health ad-ministration and health insurance	99,246	52,649	46,597	106,920	53,352	53,568	111,448	57,777	53,670	115,933	52,984	62,950
Capital formation	112,295	73,722	38,573	151,340	100,425	50,915	127,176	113,171	14,005	177,229	112,000	65,229

Source: SORS, 2010

Figure 1: Total health expenditure as % of GDP, 2008



Source: OECD, 2010

Slovenia's health care indicators are comparable to those in the EU countries. Table 2 shows that infant and child mortality show favourable outcomes, whereas developments in maternal mortality are more of a concern. Male life expectancy proves worse in comparison with that of females.

Slovenia's physicians per 100,000 population is with 238 in the year 2008 lagging far behind the EU-15 average of 348 (2008). In 2008, Slovenia had 780 nurses per 100,000 population,

which was slightly below the EU-15 average of 792 and much more than in the Member States since 2004 or 2007, where the average has been 590 nurses per 100,000 population (Figure 2). With regard to hospital beds per 100,000 population, Slovenia is at the lower end of the scale.[22]

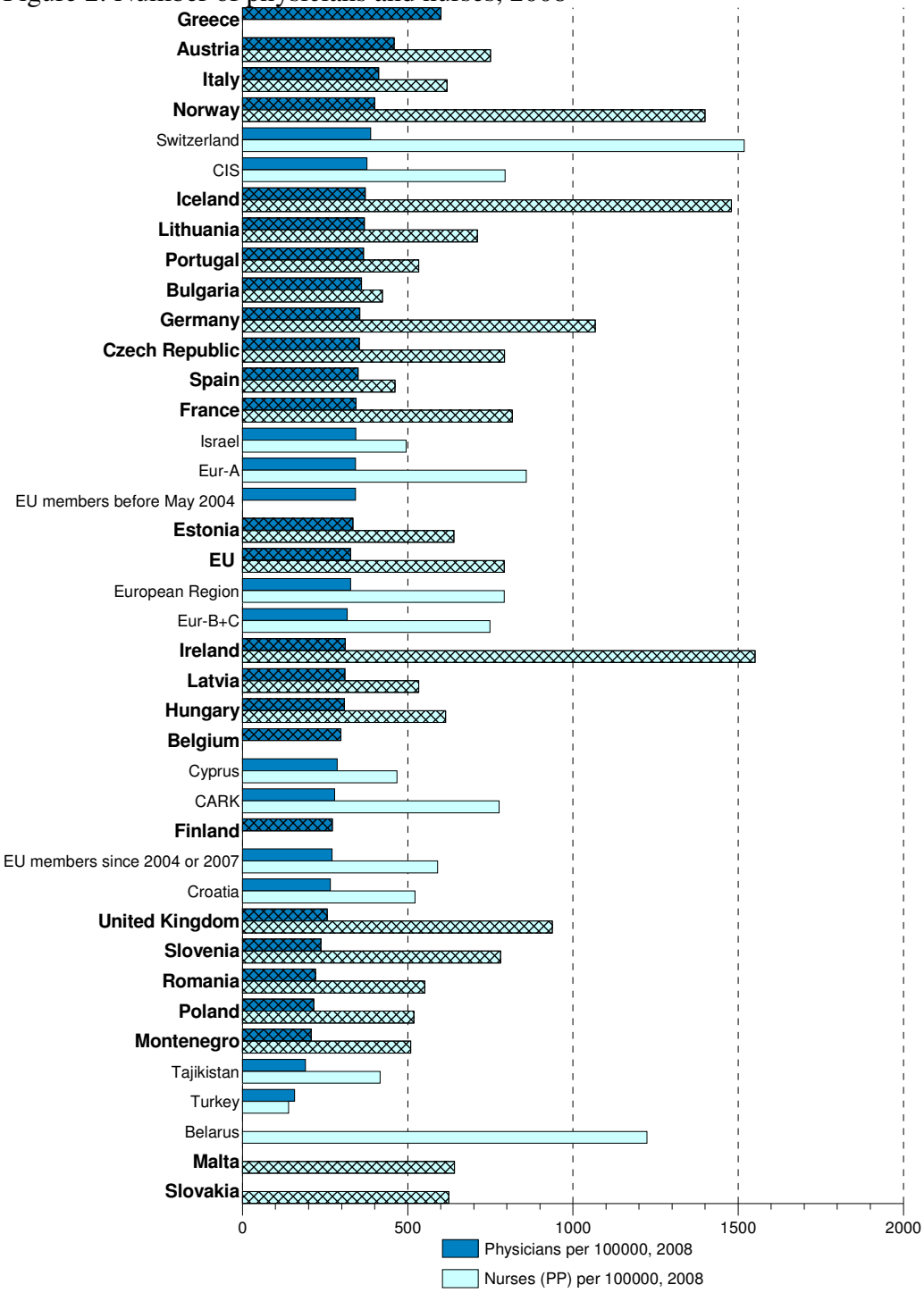
Table 13: Selected health indicators, 2008

	Life expectancy at birth, in years, male	**Life expectancy at birth, in years, female**	**Life expectancy at age 65, in years, male**	**Life expectancy at age 65, in years, female**	**Infant deaths per 1,000 live births**	**Maternal deaths per 100,000 live births**	**Hospitals per 100,000**	**Hospital beds per 100,000**	**Physicians per 100,000**
Slovenia	**75.73**	**82.7**	**16.55**	**20.64**	**2.62**	**10.09**	**1.42**	**470.04**	**238.01**
Austria	77.88	83.38	17.83	21.22	3.69	2.57	3.2	770.91	459.58
Bulgaria	69.84	77.11	13.58	16.75	8.6	6.43	4.6	649.41	360.47
Croatia	72.51	79.73	14.39	18.02	4.46	6.86	1.8		266.12
Cyprus	78.65	83.34	18.12	20.68	3.48	10.86	12.23		287.01
Czech Republic	74.16	80.61	15.39	18.9	2.83	5.85	2.44	718.37	354
Estonia	68.74	79.6	13.66	18.99	4.99	0	4.48	571.35	334.91
Finland	76.6	83.4	17.6	21.45	2.67	8.4	5.82	652.26	272.05
France	77.85	84.84	18.53	23	3.52	6.53	4.91	709.24	344.15
Greece	77.81	82.49	17.93	19.9	2.65		2.81		601.05
Hungary	70.02	78.32	14.01	18.19	5.58	17.15	1.75	704.45	309.06
Ireland	78.09	82.67	17.72	20.8	3.82	2.66	3.98		311.23
Latvia	67.01	77.84	13.09	17.95	6.72	12.53	3.88	746.09	310.67
Lithuania	66.35	77.73	13.43	18.18	4.91	8.56	3.36	683.66	369.64
Netherlands	78.57	82.59	17.5	20.79	3.78	4.33	1.11	425.29	
Poland	71.34	80.11	14.82	19.21	5.64	4.58	2.16	662.13	216.17
Portugal	76.24	82.47	16.93	20.4	3.31	3.82	1.78	336.67	366.51
Romania	69.77	77.29	14.07	17.22	10.97	19.83	2.21		221.43
Spain	78.35	84.67	18.22	22.22	3.35	4.62	1.68	322.27	349.83
Sweden	79.29	83.36	18.14	21.06	2.49	5.49			
United Kingdom	77.89	81.98	17.81	20.37	4.71	6.17		335.56	256.84
EU	**76.43**	**82.45**	**17.14**	**20.71**	**4.32**	**5.94**	**2.64**	**528.8**	**328.34**

Source: HFA DB, 2011

[22] ZZZS, 2011.

Figure 2: Number of physicians and nurses, 2008



Source: HFA-DB, 2011

The age-standardised mortality rate in Slovenia was 680 per 100,000 inhabitants (which is lower than the EU average). This masks the fact; however, that in Slovenia there is a significant difference between the populations of municipalities with the highest and lowest incomes per capita. [23]

As mentioned before, Slovenia ranks among the countries with the lowest infant mortality rates in the EU, yet the mortality rate of infants born to mothers with maximum primary

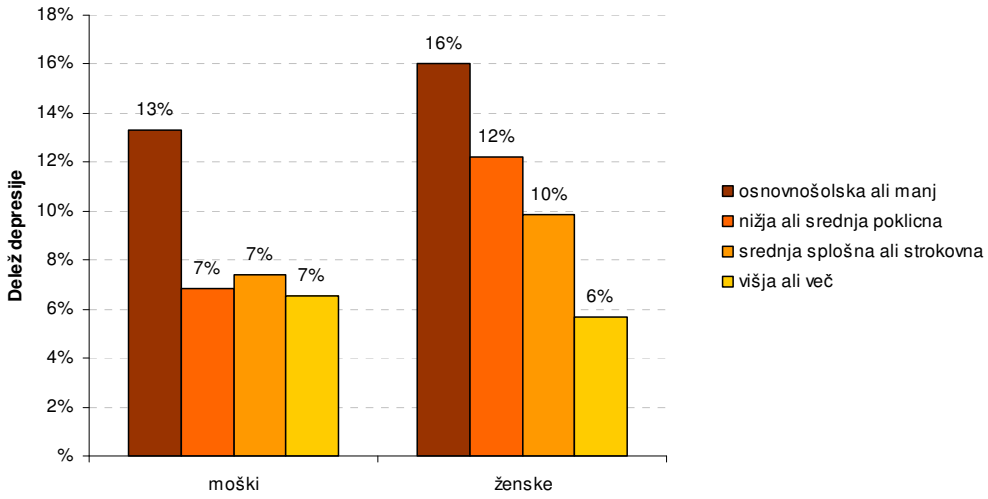
[23] IVZ, 2010 and Buzeti et al, 2011.

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, yet still with a significant difference between the municipalities with the highest and lowest incomes per capita.[24] Inequalities are a major issue, and there are big differences between regions in the access to treatment and services. The future crucial task is the achievement of equitable access.

In the field of mental health the data among the adult population show a difference in the occurrence of depression in relation to education in both genders. The difference in incidence of depression for women with the lowest and the highest levels of education is greater than for men (Figure 3). The results show that the incidence of depression is significantly associated with the level of education in people aged 25–44 years and 45–64 years, whereas insignificant for the older population group (65–74 years).[25]

Figure 3: Depression by gender relative to education in the age group 45–64 years



Source: CINDI Slovenia, 2008
Note: The data shown relate to the condition that the respondents declared having been diagnosed by a doctor.

Health Care System Upgrade by 2020

The current minister committed himself to introduce rational and cautious changes into the health care system. The main task is to ensure systemic sustainability and preserve or improve the high level of quality, safety and accessibility of health care services to all citizens. The main document from the current debates is the Health Care System Upgrade until 2020[26] (hereinafter Upgrade), and most of the proposals in this report base on this document.

The legislative proposals for the health care changing and upgrading are the rewriting Health Care and Health Insurance Act regulating the system of financing and the Health Services Act regulating the operation and management by health care providers. The strategic goal of the Upgrade is the establishment of a flexible health care system that will effectively fulfil the citizens' needs by offering them quality and safe health care services. The fundamental principles on which the Upgrade is based are above all ensuring the geographical accessibility

[24] IVZ, 2011.
[25] CINDI Slovenia, 2008.
[26] Health Care System Upgrade until 2020, 2011.

of health care services (decentralising and strengthening regionalisation and ensure the professional development, and transfer and linking among different levels); ensuring qualitative and financial accessibility.

Geographical accessibility

The health care system is organised in three separate levels:

- primary level representing a "gatekeeper" for entering the health care system;
- secondary level where the patient is referred to for specialised treatment;
- tertiary level bearing the responsibility for the professional advancement and development of Slovenian health care.

Currently, Slovenia has issues with accessibility, especially in remote areas; therefore the Upgrade proposes some solutions to increase the accessibility. At the primary level, it has been proposed 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. 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. Slovenia has been facing insufficient accessibility of health services in remote areas, and it is necessary to either stimulate rural practices in smaller places, or award stimulative concessions in cases of inability to ensure health care within public service. Two new ways of practices have been introduced in 2010. The first are so called *Learning practices*, where a trainee specialising in family medicine will be working under a mentor's supervision, administering patients and having a working space of his own. Those practices are physically separated from the mentor's practices. In general, that means that he/she will create his/her own list of patients with the help of the nurse. After concluding the specialisation, this kind of learning practice will contribute a new working team to the area of family medicine, together with a programme and allocated financial means to guarantee an undisturbed performance of tasks, as is the case with any other existing family dispensary. The working content in learning practice will be similar to that of referential practices (described below) when it comes to managing chronic patients according to protocols, creating databases and a proactive approach to prevention.[27] The second form of practice is the so-termed *Referential practices* where the physicians' working manner is founded on an integrated care approach, adhering to chronic patient treatment protocols, complete prevention, quality indicators, optimal use of laboratory services, performing optimal scope of services and procedures at primary level as well as the performance of certain activities on the part of the certified nurse in accordance with their jurisdiction and responsibilities. Referential practices have been introduced both in public institutions and with concessionaires. The aim of these dispensaries is to increase quality, safety and cost effectiveness in patient treatment by transferring the tasks to the primary level.

On secondary level, a merger of individual activities (e.g. merging of activities performed by various hospitals improves the quality of services due to a greater specialisation of individual institutions) is about to happen. Due to a higher concentration of services knowledge, quality, and safety of services are improved. Especially in gynaecology and obstetrics, there has been a strategy prepared by the MoH and experts from the field of gynaecology and obstetrics.[28] In the strategy, we can find an analysis that shows the rate of delivery per maternity hospital. Four departments show less than two deliveries per day (Brežice 1.1; Trbovlje 1.3, 1.5

[27] Health Care System Upgrade until 2020, 2011.
[28] Strategije razvoja in celostne ureditve ginekološko porodniške službe v republiki Sloveniji, 2011.

Jesenice, Koper 1.7); two to three deliveries per day take place in five of the maternity hospitals (2.1 Nova Gorica, Murska Sobota 2.3; Slovenj Gradec 2.5, 2.3 Ptuj, Novo mesto 3.0); four of the maternity hospitals (3.6 Kranj, Postojna, 3.7, 5.6 Maribor, Celje 5.2) have an average of three to six deliveries per day, while Ljubljana is far ahead with 15.8 births per day. Table 3 below shows the trend of deliveries in the Slovenian hospitals in the years 2002-2009.

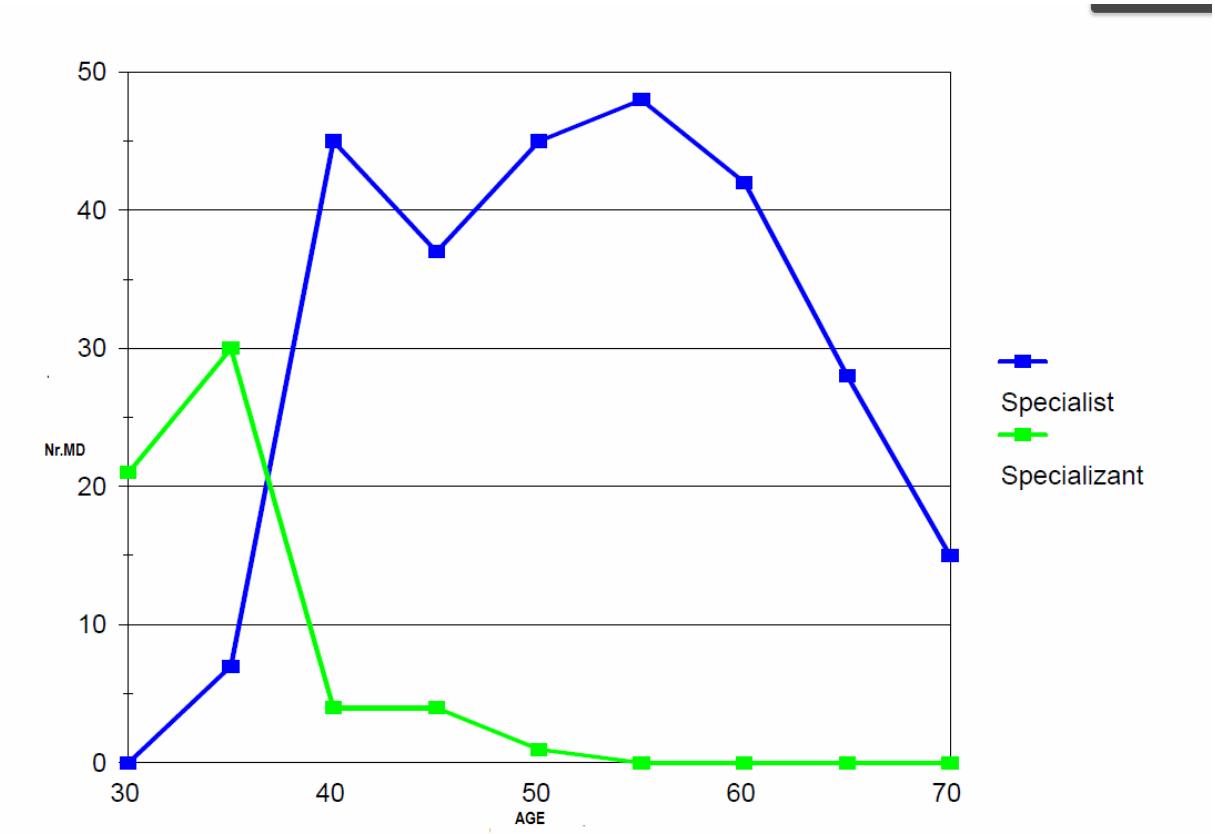
One of the difficulties maternity hospitals are facing is also night duties and on-call duties. This is mainly due to staff shortages, as for the past 15 years they have not been able to increase the number of specialists. Moreover, the baby boom generation is about to retire in the nearest future and many of the maternity hospitals have the majority of medical doctors in this generation. The age structure of gynaecologists and obstetricians specialists for the maintenance of continuity of health care is very unfavourable, namely 50% of all specialists are aged over 51 (Figure 3). However, in the past years, Slovenia has started with a rejuvenation of staff in this field.

Table 14: Deliveries in maternity hospitals 2002-2009,

	2002	2003	2004	2005	2006	2007	2008	2009	Total	per day
Br	410	346	362	382	445	397	486	429	3257	1.1
Ce	1799	1646	1691	1831	1902	2001	2218	2110	15198	5.2
Je	416	428	518	451	578	630	775	662	4458	1.5
Kp	580	572	628	614	602	690	621	752	5059	1.7
Kr	1286	1151	1261	1232	1157	1315	1463	1512	10377	3.6
Lj	5264	4968	5294	5501	5709	6128	6710	6636	46210	15.8
Mb	1978	1940	1937	2031	2012	1875	2244	2199	16216	5.6
MS	801	845	854	783	790	845	933	985	6836	2.3
NG	671	594	710	734	728	817	913	867	6034	2.1
NM	1014	994	1024	1035	1098	1130	1238	1247	8780	3.0
Po	1048	1336	1232	1249	1470	1481	1497	1622	10935	3.7
Pt	754	803	770	847	877	879	942	934	6806	2.3
SG	903	881	917	777	851	864	993	992	7178	2.5
Tr	423	401	431	420	442	532	512	536	3697	1.3
Total Slovenija	17347	16905	17629	17887	18661	19584	21545	21483	151041	51.7

Source: ZZZS, 2011

Figure 4: Age distribution of specialists and MDs in training



Source: ZZZS, 2010

Human Resources

Migration on a big scale among health workers is not typical for Slovenia. The brain drain among health workers has not been significant and the employment of foreigners is limited. However, in 2010 the MoH redefined the criteria for official recognition of diplomas obtained abroad, so anecdotal evidence shows an increase of application of medical doctors from the countries of Ex-Jugoslavia.[29] Human resource planning, which used to be limited in particular to ensuring a sufficient number of health care workers, has to consider various factors, such as requirements for new expertise, changed competences of individual health care profiles, demands for new technologies, changes in working performances and the international context. The present system of organisation of night duty and on-call duty shows many differences in payments for comparable posts in comparable specialties (in some cases they are 30-40% higher than in others). Therefore, in 2010 the MoH decided to restructure those services. The original idea was that there would be a reduction in the salary bonuses and in some cases the physical presence in the station would be replaced by stand-by arrangements.[30] The MoH proposed to reduce the number of posts with constant presence of medical doctors and to introduce more stand-by posts but to also have the possibility to organise duty services during daytime hours (6.00-22.00hrs). The latter was proposed for non-critical medical specialties. Moreover, standardising them should reform salary bonuses and supplements for duty and on-call services. The preparation of a new network of on-call and duty posts for the

[29] Personal communication GH Izola, 2011.
[30] Albreht, 2010.

entire country, taking into account improved physical accessibility of most general hospitals was seen as a solution. However there was a serious resistance from the medical doctors and threats for strikes or withdrawal of approvals to work over time, so the Minister took a step back and postponed this issue.

Qualitative accessibility

The Slovenian health care system is striving to adhere to international and European principles of quality and wider goals with a more extensive influence on the society as a whole, namely efficiency, safety, timeliness, effectiveness, equality, and a patient-focused approach. The main goals related to health care quality and safety are, above all, the development of a systematic quality and safety management, of a quality and safety culture; the establishment of a system for education and training in the field of quality and safety, and the development of systems for improving the quality of clinical work.

In 2010, a Manual on Quality Indicators was published.[31] The manual includes a widened range of quality indicators. The area needs to be monitored and developed further on the basis of established experience, since reliable data on the quality of individual health services as well as on the health care system operation as a whole can only be acquired this way. Measuring safety culture in hospitals is also one of the indicators.[32] Various activities will be dedicated to strengthening the patient's safety by further developing the system for reporting adverse events. The Ministry of Health already established the system of monitoring adverse events in 2002. However, the regulations on e.g. the handling of the most severe safety complications with treated patients are still deficient. A systematic and efficient monitoring of safety complications in hospitals to this date is still rare, and the national system for reporting warning signs of adverse events needs to be supplemented. Incentives for building the process continuously are needed in the organisational culture. In addition to the Manual, the MoH published the National Strategy on Quality and Safety in Health Care 2010-2015.[33] Accreditation will be implemented either in the form of self-evaluation or internal evaluation, or it will be conducted externally by an external organisation. External quality evaluation is mainly intended to serve as a stimulator and not as a means of supervision. Accreditation is an instrument, which enables the competitiveness of Slovenian health institutions to be significantly higher if they acquire accreditation, which is internationally recognised. Other aims of the strategy are to effectively develop systematic and professional activities and continued improvement of medical treatment and patient safety. That needs to be in line with the six principles of quality in health care: safety, effectiveness, timeliness, efficiency, equality, and focus on the patient, and taking into account the principles of quality management.

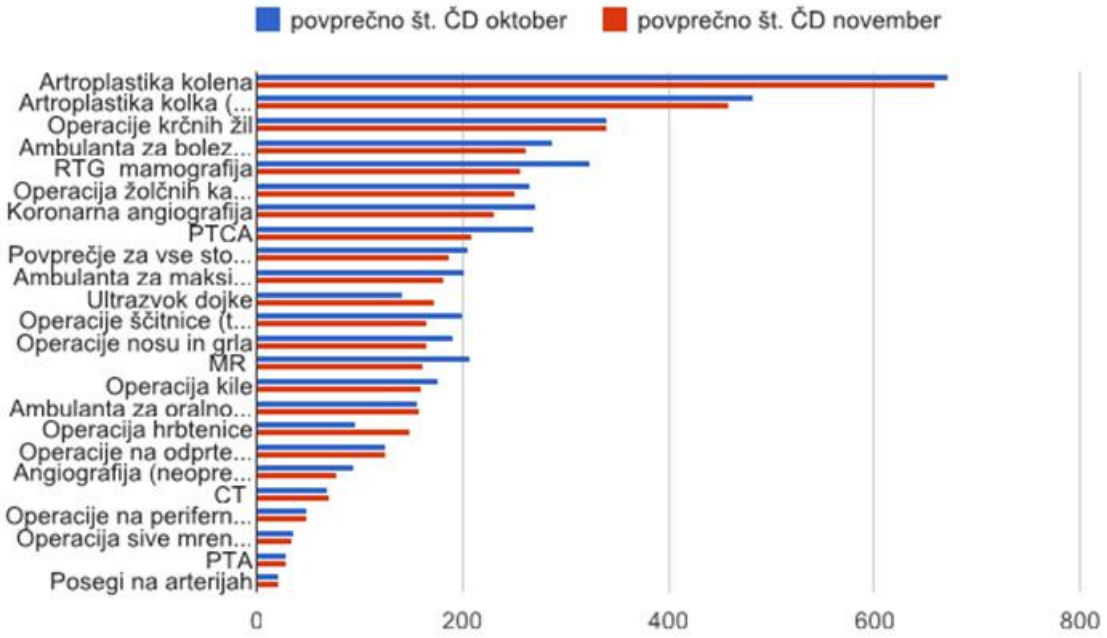
Waiting times

In August 2010, the government accepted rules on national waiting times.[34] The National Institute of Public Health (NIPH) publishes the current situation, which contains a statistical review of waiting times and numbers in line with a new list of health services, which was created by the NIPH and the Health Insurance Institute of Slovenia. Collected data on waiting times are presented in a comparative perspective with the results of the previous month. The figures below show the state of waiting times (days) in November 2010 (red line) compared to the previous month (blue line), with an additional graph to compare the development of

[31] Poldrugovac, Simcic, 2010.
[32] Poldrugovac, Simcic, 2010.
[33] Simcic, 2010.
[34] Pravilnik o najdaljših dopustnih čakalnih dobah za posamezne zdravstvene storitve in o načinu vodenja čakalnih seznamov (Uradni list RS, št. 63/2010).

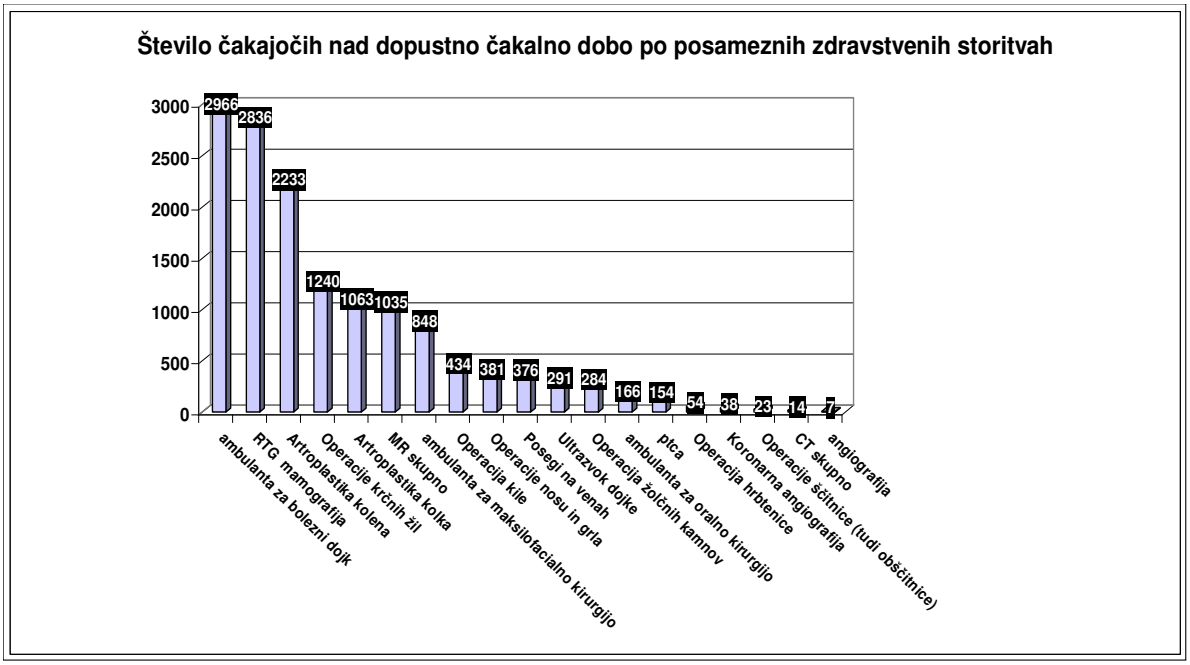
waiting times and numbers over the last year for a selected set of health services. From Figure 5, which compares the average waiting times in November 2010 compared to October 2010, one can observe the reduction of waiting times in general, with the highest reduction in waiting times in mammography, PTCA, and MR, while the waiting time for spine surgery has increased.

Figure 5: Average waiting times in November 2010 compared to the previous month



Source: IVZ, 2011

Figure 6: Number of waiting persons beyond the acceptable waiting time of 180 days



Source: IVZ, 2011

Figure 6 above shows the number of persons waiting for longer than the acceptable waiting time of 180 days (365 days in orthopaedics). Most patients waiting longer than the allowable waiting time are in the outpatient clinics for breast cancer (2,966), followed by RTG mammography and artroplastic of the knee, and at least on angiography, where seven patients have been waiting for more than 180 days. The total number of persons waiting for their treatment is currently 14,443.[35]

Financial accessibility and sustainability of the health care system

As mentioned earlier, the Upgrade centres a lot on financial sustainability of the health care system. It focuses on 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 living; modifications, rationalisation, and a sufficient development of a network of health care providers at primary, secondary and tertiary levels, as well as a modification of 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 the gross domestic product by 2020.

The Upgrade foresees that services included in the basic benefit package, which have been so far only partially covered by public funds, will be covered entirely from public funds. The main actors involved in this reform are the MoH, the HIIS and health care providers. One of the main points of the reform is the abolishment of the complementary health insurance, as it has been known for the past 20 years. With regard to the basic benefit package, the reform offers three scenarios.[36]

- Keep the widely defined benefit package unchanged, and provide the citizens with geographical and timely access to services of the benefit package: By publicly collecting funds that are currently collected through premiums in complementary health insurance (420m EUR; also the part that is currently spent on administration, reserves and profits of insurance companies). Funds collected as public funds would cause a significant increase in the contribution rate (2.4 percentage points), which would burden some population groups as well as pose a risk for the sustainability of public finances.
- Redefinition of the rights in the sense of ensuring a timely and geographically appropriate access to key health services on account of the elimination of unnecessary services for citizens as well as the rationalisation and reorganisation of the health care system. As premiums for complementary health insurance will be abolished, the necessary funds would have to be provided from public sources, either by raising the contribution rate for employees which needs to increase by 2 percentage points according to calculations, or it would be possible to cover the difference from the budget in case of a lower rise of the contribution rate.
- Redefinition of the benefit package omitting some social rights and health services not very necessary to the health of the citizens (non-urgent transport, health spa treatments, certain medicines on the interim list, etc.). In this case, the increase in the contribution rate as well as income tax loss of funds would be smaller.

Health technology assessment (HTA)

Slovenia is lagging behind other EU Member States in developing a formal basis for HTA development. After eight years of discussions, the MoH now proposed an organisational structure, which would represent the institutionalisation of HTA in Slovenia. A department to

[35] IVZ, 2011.
[36] Health Care System Upgrade until 2020, 2011.

coordinate and ensure the inclusion of cost effective health care technologies into the system of public financing will be established at the MoH. With regard to institutionalisation, two new bodies are to be formed - an HTA council (supervisory role) and an HTA network (technical role).[37] These two structures would form a service, which would both deliver HTA studies and carry priorities.The concept of combining a steering committee and a network of interested parties is a relative novelty and the proposed solution represents a significant change in the approach, compared to the way similar issues were solved in the past.[38] In pharmaceutical policy, MoH has prepared together with the HIIS four Rules on Pharmaceuticals.[39] These are rules on the classification of drugs on the list (in collaboration between MoH and HIIS), rules on the pricing of medicines for human use, rules on the detailed requirements and procedure for determining the interchangeability of medicines, and rules on advertising of medicines. These rules, that are the product strategy for the pharmaceuticals in the context of optimising the management of this area, enabling equal accessibility to drugs, establishing the criteria for interchangeability of medicines, and optimising the price difference between original and generic drugs on the market. Optimisation will bring savings that the ministry will shift to where there is the most acute lack of resources - to increase access to already established, as well as new, innovative medicines. With the publication of those rules and regulations and signed agreements between the Health Insurance Institute and pharmaceutical manufacturers, the MoH expects more efficient use of funds for medicines and a more competitive environment for pharmaceutical manufacturers. Financial effects of efficiency policies will lead to a better access to new hospital medicines. Within the scope of the new rules on the classification of drugs on the list in the future new, expensive hospital drugs will be considered by the health insurance's commission for drug classification, and not anymore by the Health Council, as previously. In this way, the two-tier introduction of the pharmaceuticals into the system was unified and brought in line with the common practice in other countries.

2.3.2 Debates and political discourse

Mostly debated was the Upgrade, which was in the public debate until end of March, 2011. The MoH received 49 comments, 35 from various institutions, and 14 from individuals. The public debate shows strong support for prevention and promotion of the pimary health care level.[40] Many of the comments also supported the foresen abolishment of the complementary health insurance, however, there is a considerable consideration how the foreseen change can be implemented. As expected, most of the criticism regarding the proposed abolishment of the complementary health insurance comes from the insurance companies, where they argue that the current organisation of complementary health insurance enables solidarity in accessing health services.[41] As the current proposal of the Upgrade exceeds the health care domain, the Minister presented it to the "crisis ministers" – Minister for Finance, Minister for Public Affairs, and Minister for Development, where, togehter with the Prime Minister, they reached a consensus to abolish the complementary health insurance. A working group to solve the open question of how to ensure financial sustainability and other technical questions will be formed from experts from MoH and the Ministry of Finance.

[37] Turk, Prevolnik- Rupel, 2010.
[38] Albreht, 2010.
[39] Pravilnik o oglaševanju zdravil (Uradni list RS, št. 105/2008, 105/2010); Pravilnik o razvrščanju zdravil (Uradni list RS, št. 110/2010); Pravilnik o cenah zdravil za uporabo v humani medicini (Uradni list RS, 99/2008) and Pravilnik o natančnejših pogojih in postopku za ugotavljanje medsebojne zamenljivosti zdravil (Uradni list RS, št. 102/2010).
[40] Dnevnik, 23 March 2011.
[41] Slovenian Insurance Association, 2011.

A lot of media attraction and strong resistance from the local inhabitans (mainly on accessibility issues) got the proposal to reorganise and merge obstetric departments in hospitals that have less than two deliveries per day. So far, no decision has been taken, however, it is to be expected that the Ministry will continue to work towards this reorganisation.

2.3.3 Impact assessment

The ongoing crisis has an effect on the health care system as well. The number of people, who have not paid contributions to the compulsory health insurance (mainly self-employed), and have therefore fallen out of the scheme, has increased from 1,778 in 2008 to 4,860 in 2010.[42] So far, there is no official explanation for such an increase of uninsured people, and the current legislation does not offer possibilities to include those individuals back into the scheme.[43]

A very important topic on the agenda is the fight against inequalities in health. The recent research carried out by the National Institute of Public Health[44], has shown the status quo and where the emphasis for future investment lies. Fight against inequalities in health is one of the priorities for the next period and, in May 2011, the MoH signed a bilateral agreement with Norway, where 10m EUR from the Norwegian Financing Mechanism[45] will be granted for the purpose of decreasing health inequalities in Slovenia.

The waiting lists remain an important issue and a political priority of additional sources of funding.[46] As mentioned above, Rules on national waiting times have been published, and the NIPH started to follow up the waiting times for all procedures in health care. Through monitoring of waiting lists, and referring the patients to health care providers with shorter waiting times, this issue is slowly being resolved.

2.3.4 Impact of EU social policies on the national level

The health care system still shows many inequalities in health and significant differences in health indicators between the populations of municipalities with the highest and lowest income per capita.[47] These inequalities need to be extenuated so that the health care system can become competitive and maintain the capacity to develop, also in the light of the challenges posed by the upcoming free flow of patients within the European Union.[48] As early as in Slovenia's development strategy dating from 2005[49], the reduction of health inequalities is set as one of the country's strategic priorities. However, operational measures that follow this priority are mainly restricted to sector policies (e.g. employment, social policies and social welfare policies). Nevertheless, it is very important that the decrease of health inequalities remains one of the priorities in Slovenia's Development Strategy. Following a decision by the Government of Slovenia, the updated strategy should be adopted by the end of 2011.

As stated in the 2010 asisp Annual National Report, in line with the adoption of the Mental Health Act in 2008, the national Mental Health Action Plan was prepared in 2010. The Plan is

[42] ZZZS, 2011.
[43] Dnevnik, 11 June 2011.
[44] Buzeti et al, 2011.
[45] Norwegian Financing Mechanism, 2011.
[46] Albreht, Klazinga, 2010.
[47] Hocevar-Grom, 2010 and Buzeti et al, 2011.
[48] Health Care System Upgrade until 2020.
[49] Šušteršič et al., 2005.

the first plan containing relevant numbers on capacities and funding.[50] The main objectives of the Plan are:[51] mental health promotion and prevention of mental illnesses of all population, mental health promotion and prevention of mental illnesses of the young, mental health promotion and prevention of mental illnesses of the elderly, destigmatisation of and fight against social exclusion, suicide prevention.[52] In addition to the Action Plan, the National Mental Health Programme was developed through the legislative framework of the Mental Health Act. The National Mental Health Programme is the first document to outline the future development of mental health care and services in Slovenia. Together with the action plan, it recognises the approaches set out in European strategies and declarations on mental health and seeks to implement a comprehensive public mental health approach.

As mentioned above, two documents on quality have been published recently. The Manual on Quality Indicators and the National Strategy on Quality and Safety in Health Care 2010-2015. The strategy is based on national documents, but also on documents of the European Union, documents of the Council of Europe, other European countries; and the scientific evidence in the field of quality medical treatment and patient safety. The emphasis in this strategy is the development of an accreditation system for Slovenian health institutions. That can significantly contribute to improving quality and safety in the health care system in line with OMC objectives.

In late 2010, Slovenia received the final notice from the European Commission (EC), where the EC expects Slovenia to harmonise their legislation with EU laws. The EC claims that certain provisions of the Slovenian Law on Health Care and Health Insurance on complementary health insurance is not in accordance with some of the basic freedoms of the Treaty on the functioning of the European Union and the EU's directives on non-life insurance, such as free movement of capital and provision of services. The EC believes that the current Slovenian rules may lead to distortions in the single insurance market and reduce consumer choice, because the current Law on Health Care and Health Insurance demands a nomination of the representative from foreign insurers in Slovenia (which is not necessary according to the EC).[53]

Two of the amendments to complementary health insurance, presented in the Upgrade, address the organisation, which is established by European directives. In another scenario, Slovenia might face the European Court.

2.3.5 Critical assessment of reforms, discussions and research carried out

As no structural changes have been implemented in the prevous decade, it is of utmost importance that Slovenia implements the reform of the health care system. A recent study[54] showed that the health related quality of life (HRQoL) of the Slovenian inhabitants is lower than the one shown in some other European countries. The reasons for this finding remain arguable, however, this points out the need for the establishment of effective programmes on a national level that would improve HRQoL of the population. Slovenia needs a well defined basic benefit package, which will be covered by compulsory health insurance, witout co-payments. The health system must reduce inequalities in health, and become competitive and development-oriented to be able to deal with the challenges that the free movement of patients within the European Union brings along.

[50] Jeriček Klanscek et al., 2009.
[51] Resolucija o nacionalnem programu duševnega zdravja 2011–2016.
[52] MoH, 2009.
[53] RTV SLO, 16 February 2011.
[54] KLEMENC-KETIŠ Z et al, 2010.

One of the most important changes in the previous year was the adoption of the above mentioned regulations for pharmaceuticals. One of the consequences of this will be a more transparent, cost-effective and evidence-based introduction of new pharmaceuticals. It is important that the development of the health technology assessment field goes in line with the European trend.

2.4 Long-term Care

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 Slovene population. Male life expectancy, in 2008, reached 74.5 years, while female life expectancy was 82 years of age. Table 4 shows the demographic trend in Slovenia until 2050.

Table 15: The number of population according to the age groups and share of age groups, 2000-2050

	2000	2010	2020	2030	2040	2050
P_{0-19}	456,145	388,471	385,146	360,368	324,376	320,135
$\%_{0-19}$	22.9	19.1	18.7	17.8	16.6	17.0
P_{20-64}	1,255,897	1,307,598	1,252,640	1,150,971	1,064,200	947,438
$\%_{20-64}$	63.1	64.3	60.9	56.9	54.4	50.4
P_{65+}	278,230	338,151	420,217	511,533	569,360	610,430
$\%_{65+}$	14.0	16.6	20.4	25.3	29.1	32.5
Total	1,990,272	2,034,220	2,058,003	2,022,872	1,957,936	1,878,003

Source: Eurostat projections, 2008, Statistical Office of Slovenia, Prevolnik Rupel 2009, own calculations

According to the Ministry of Labour, Family and Social Affairs (MLFSA) the system of long-term care covers around 38,000 people.[55] In recent years, the number of users of services and benefits for long-term care has been growing continuously. The need and demand for LTC is growing. However, mostly due to the problems associated with long-term care funding, the offer does not respond properly. This is resulting in lower availability and relatively long waiting times in some areas of the country.

The development of LTC in Slovenia in institutional care has not developed much since the 1980s and is no longer responsive to the needs of the present moment 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 quality of services is guaranteed in this way, however, the prices of these services fundamentaly differ when compared between public institutions and private concessioners (basic daily care in homes for the elderly - a public institution is 16 EUR, vis a vis concessionaire 22 EUR).[56] Such a disparity in prices can lead to unequal access to institutional care within the public network, where the access to the same services within the public network can be determined by the financing ability of the customers.

One of the main systemic failures of the implementation of long-term care is an underfed system of LTC provision at home, which is conducted on a modest scale. The current system provides the largest volume of assistance to those involved in institutions, whereas people who stay at home, are at a disadvantage, particularly because they are not integrated into the health and social care. Tables 5 and 6 below show the number of persons having used the institutional care and home care in the years 2006-2008.

[55] MLFSA, 2010.
[56] Skupnost soicalnih zavodov Slovenije, 2010.

Table 16: Number of users of institutional care in the years 2006-2008

	2006	2007	2008
all	16,440	16,660	18,012
elderly	14,089	14,277	15,937
adults with special needs	2,336	2,368	1,075

Source: Skupnost socialnih zavodov Slovenije

Table 17: Number of users of home care in the years 2006-2008

	2006	2007	2008
home help	5,250	5,595	5,780
family assistant	1,236	900	841
personal assistant	485	460	479
All	6,791	6,955	7,118

Source: Skupnost socialnih zavodov Slovenije

2.4.1 The system's characteristics and reforms

As stated in the previous asisp Annual National Reports, long-term care has been a long-standing problem in Slovenia. Funding is split between the social care sector, pension insurance and compulsory health insurance, and the provision of LTC is guaranteed in the following ways:

- Within the health care system: as institutional health care, nursing homes (non-acute hospitalisation treatment - mainly intermediate care, provided at nursing departments and as prolonged hospitalisation).
- On the primary health care level, long-term care is provided within the scope of community nursing care and home health care.
- Within the social security system: daily and whole-day forms of institutional care, service of (social) domestic help, the right to home care assistance, care in sheltered housing and various social protection programmes for personal assistance for disabled persons.
- Cash benefits: Beneficiaries of old-age and disability pensions, beneficiaries of cash social benefit, persons who are unemployed due to a high degree disability, war-disabled persons and war veterans

In the past years, some measures were taken to increase LTC capacities:

- In March 2006, the National Assembly adopted the Resolution on the National Social Protection Programme (NSPP) 2006-2010[57] which sets out several goals to increase provision of LTC: increasing provision of help at home and mobile help services for beneficiaries in their domestic environment; increasing capacities of institutional care services for elderly persons; increasing provision of care in another family as well as increasing capacities of care in sheltered housing for the elderly. Herewith, the priority is given to those regions of the country where the development of providers or users' accessibility to services is very poor.

[57] NSPP, Official Gazette of the Republic of Slovenia Nr. 39/2006.

- Also in 2006, a strategy for the protection of the elderly until 2010[58] has been introduced. The aim of the strategy is to harmonise the work of the different line ministries, enterprise sector and civil society. The purpose is to assure the conditions for intergenerational solidarity, qualitative ageing and care for the older population. A recent evaluation of the strategy shows that it is being implemented too slowly and that certain outlines of the Strategy are not taken into account by different sectors[59].

Compulsory health care insurance is the most significant payer of long-term care. However, there is no clear division between health care services which are supposed to be covered by compulsory health care insurance and other services in the long-term care setting (that are not considered a benefit under health care insurance). As a consequence of this confusion, financial burdens are shifted from social security to compulsory health insurance. Another problem concerning long-term care is the underdevelopment of home care, as stated above.

According to data from the SORS,[60] the LTC expenditure amounted to 260.017m EUR in 2003 and 353.673m EUR in 2007. Out of the latter, 266.542m EUR were public expenditure and 87.131m EUR private. There are mainly four ways of payment:[61]

- people in care themselves;
- people in care together with their relatives;
- people in care and the municipality;
- payment solely by relatives.

The percentage of people paying for themselves has been stable in recent years – about 35% – whereas the percentage of combined forms of payment has changed radically. The percentage of a combined payment by people in care and their relatives increased by more than 10%, while the combined payment by people in care and the municipality dropped by almost 10%. According to Hlebec (2010)[62] the difference between combined payments was about 20% in 2008. A slow increase is observed in payment exclusively by relatives. It can be observed that family members have a stronger involvement in paying for institutional care than municipalities and the recent economic crisis will probably be reflected in reduced payments by relatives.

In 2010, the Institute for Social Protection of the Republic of Slovenia (ISPRS) carried out a pilot project on direct payments in social care. The main findings of the project can be put together in Table 8 below.[63] In general, the costs of service is lower in community-provided structures, however, the figure below shows that the users of community-provided care is relatively lower than institutional. The main reason for this can be found in the poor regulation.[64] According to Nagode et al (2010), home help is financed from: municipal budgets (66.7%), state budget (10.8%), and by the contributions from the users (22.4%). In 2009, approximately 17m EUR were spent on home help.[65] Table 18 shows the average, maximal and minimal cost per hour of home care.

Table 18: Financing of home care

[58] MLFSA, 2006.
[59] MLFSA, 2009.
[60] SORS, 2010.
[61] Hlebec, 2010.
[62] Hlebec, 2010.
[63] Nagode et al, 2010.
[64] Flaker e tal, 2010.
[65] Flaker et al, 2010.

EUR per hour of service	Average	Min	Max
Total cost	16,5	9	24
Price for users	4,5	0	9.3

Source: Nagode M, Smolej S (2010)

Table 19: Direct Payments in LTC

	Living costs	**Services**	**Overheads**	**Total**
OPS (Personal package of services)	606.01	400.72	121.96	1,219.04
Costs in %	50.05%	38.60%	11.35%	100%
	Social care	**Health care**		
Average of care homes	836.51	609.65		1,446.15
Costs in %	57.84%	42.16%		100%

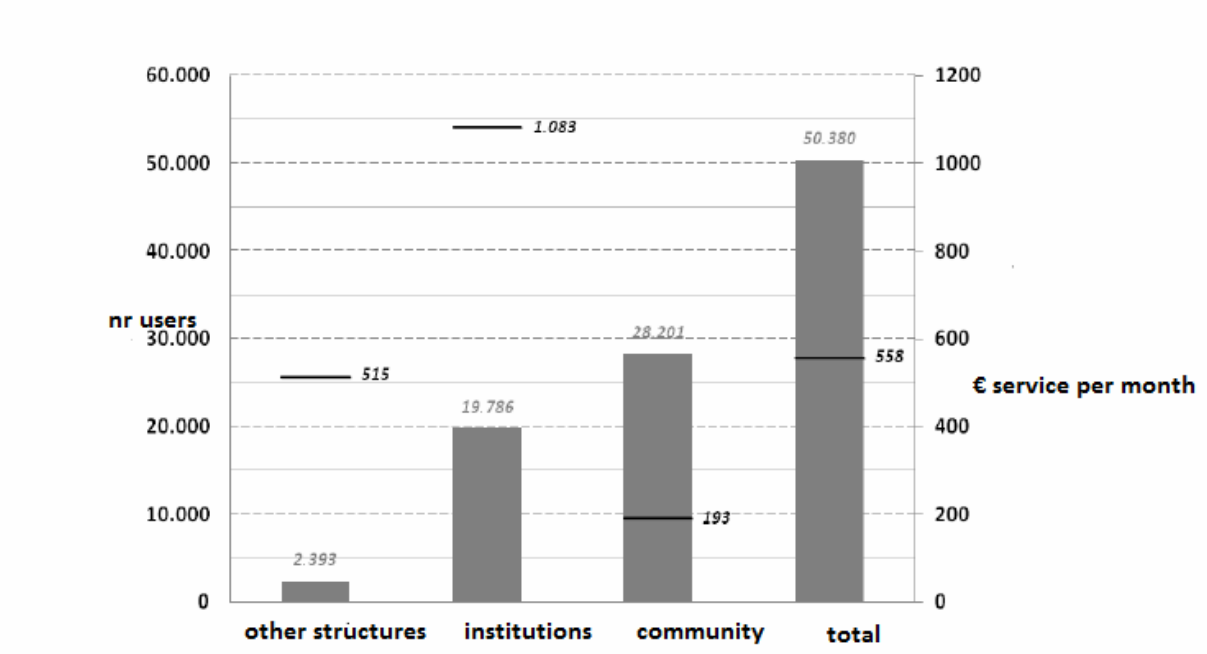
Source: Nagode Mateja, 2010

On the implementation level, a good example of how to handle LTC and rehabilitation has shown to be the so-termed Dom IRIS. The aims of Dom IRIS are to enable the elderly and persons with disabilities to view and test various technical aids and technologies in order to find solutions for independent life in their home environment and to advise them and their family members or caregivers on how to adapt their existing living space in the most rational and sensible (inexpensive) manner in regard to their special needs. So far, Dom IRIS has served as a way to offer equipment producers and service providers in the field of technological solutions for the elderly and persons with disabilities to demonstrate, test, upgrade and integrate their solutions.[66] Dom IRIS has been equipped with state-of-the-art communication technology which has been adapted to different levels and types of disability. Such equipment enables the elderly and persons with disabilities to communicate with the outside world, to receive remote care and remote monitoring of their health condition as well as to partake in studying, work, leisure and entertainment by means of electronic media.

Part of the integration of health care and LTC are departments of the extended hospital treatment. In the recent years, some hospital departments have been transformed into this kind of non-acute provision of services. The departments for extended hospital treatment are aimed at those patients who are still unable to continue a normal way of life outside the hospital after completing the diagnostic treatment.

[66] Jenko, 2009.

Figure 7: Number of users and monthly cost of the service per user with regard to common forms of service



Source: Flaker v et al, 2010

2.4.2 Debates and political discourse

The debate in the field of LTC is concerned with the lack of financing and regulation of the field. However, the debates remain rather on a theoretical level.[67]

The proposal for a Long-term Care Act and a Long-term Care Insurance Act has been in preparation since 2005. The long birth of this law is due to the transposition of responsibility from the Ministry of Health (MoH) to the Ministry of Labour, Family and Social Affairs (MLFSA). A new working group consisting of experts in the field of long-term care has been formed and the government anticipates that it will, most probably, be ready for parliamentary adoption in this year. Therefore, the proposal aims at rearranging the basic principles of LTC. Based on the proposal, a special compulsory insurance for long-term care would be introduced which would cover persons who require the assistance of others due to illness, disability or injury, thereby allowing them the same care at home as they would get in a care centre. Analogous to other branches of social insurance it would be financed by contributions. The act proposal anticipates that the HIIS would carry out the professional and administrative tasks for this new legal body. The introduction of long-term care insurance was part of the coalition contract of the government ruling in the period 2004-2008 .[68] However, the issue proved to be contentious with regard to how to finance the coverage of the new insurance, as some stakeholders oppose the introduction of a new compulsory insurance. Nonetheless, the act under preparation will create a system of insurance basis to provide long-term care services that are more accessible and of a better quality irrespective of where they are performed. The document is also to form the framework for the long-term financial sustainability of such a system. The intersectoral and interdisciplinary approach towards new legislation is favourable.

[67] 10. Festival za tretje življenjsko obdobje, 2010.
[68] MLFSA, 2006.

2.4.3 Impact assessment

As an overall national strategy on LTC is missing, also quality management in LTC is legally not settled. Quality indicators in LTC are missing and only via the E-Qalin model[69] in institutions that provide LTC this has slowly been introduced. In home care, no parameters for measuring quality of care exist. The only kind of quality assurance is with regards to community nursing; it has remained the same as written in previous reports, where the nurses have to provide care according to a protocol. However, in reality there are many complaints and cases of improper care and nursing in different forms of care, and such cases are simply not taken care of.[70]

A recent study by Mali (2010)[71] states that the development of Slovenian homes for older people involves a shift in the dynamics of the orientation of the homes from a medical to a social one. The author states that the theoretical conceptualisation of social work in homes for older people is only now coming into existence.

2.4.4 Impact of EU social policies at the national level

Currently, no documents where the impact of Europe 2020 and OMC would be seen have been published.

2.4.5 Critical assessment of reforms, discussions and research carried out

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 more developed countries and building the system on pilot projects like IRIS is by far not enough.

As the demographic data show, the growing number of persons 65+ calls for a systemic regulation of this field. The proposal of the act is based on the notion that the Slovene population is ageing and that there are more and more people who need the help of others when performing everyday activities. This group of the population is currently underserved. For some part of long-term care needs – in particular the most urgent needs – the health care services ensure health care at home or an extended treatment in hospitals, which is considered to be highly inefficient.[72] The other part of the needs is taken care of in nursing homes. Here people must pay for the services by themselves or their relatives must pay for them because compulsory health insurance covers expenditures for health care services only. In any case, resources for needs that are related to support persons to perform everyday activities are considered to be scarce and the subject of long-term care organisation and financing is underdeveloped.

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[69] Characteristic of E-Qalin® is the action-learning approach that includes all hierarchical levels of an organisation and promotes the active participation of employees. There are individuals (managers) has qualified, which set an organisation-wide learning for quality management in motion.
The main objectives, which are connected to all sectors with the introduction of e-Qalin®: increasing the quality of care and care for the clients are; Increased satisfaction of employees; Graceful ageing and Respect of ageing in our society, respectively appreciation for all forms of impairments and handicaps; Services and quality transparent and comparable; The education on quality management in its impact on improving competitiveness, entrepreneurship, resource optimisation, to strengthen self-reliant work; professionalism and attractiveness as an employer to increase; promote a positive image effect for the entire sector of the social institutions. More information: www.e-qalin.net.

[70] Turk, 2009.

[71] Mali, 2010.

[72] Flaker et.al 2008.

The most drastic decline will be in the working population, while the number of persons 60+ will increase. 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. The main focus of the current government, especially MLFSA, in the previous year was the pension reform, so the LTC still needs to find an epilogue.

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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

[R1] Belopavlovič, Nataša (2010), "Déjà vu pokojninske reforme", Pravna praksa, no.14.

"Déjà vu of the pension reform"

The author, who at the time of the previous pension reform (in 1999) was Secretary of State at the Ministry of Labour, Family and Social Affairs describes the reform process at that time, showing how pressure from the trade unions and political parties resulted in significant concessions. She expresses her doubts whether the draft Pension and Disability Act would be accepted, considering that the proposed changes are not popular.

[R2] Berk Skok, Aleš and Marko Simoneti (2011), Naložbeni pokojninski skladi, dolgoročna vzdržnost javnih finance in finančna stabilnost v Sloveniji, Management, 6(1). 61-83.

"Pension investment funds, long-term financial sustainability of public finances and the financial stability of Slovenia"

The authors argue for a stronger role of private pension funds from a macro-economic viewpoint, stating that these funds could improve the financing of Slovene companies by providing much needed equity capital and thus improving the financial stability of these companies. They also argue that the pension schemes ought to be simplified. They propose that members of collective pension schemes ought to be able to freely choose their pension fund. They also propose the abolishment of the guaranteed rate of return and complete separation of individual and collective pension schemes. Finally, they propose strong tax incentives for pension savings, arguing that individual savings ought to be virtually E E E (exempt, exempt, exempt). The first "E" signifies payment into the pension accounts, with the tax relief in the form of a tax credit (for personal income tax). The second "E" would be exemption of the returns to savings (if they remain in the account). The third "E" would refer to the disbursement of rents (annuities) - these would be exempt if the person is over 65 years or has been saving for at least 25 years.

[R1] Brščič, Bernard (2010) "Zablode slovenske pokojninske reforme", Demokracija 36(15):20-21.

"The delusions of the Slovene pension reform"

The author is highly critical of the Slovene pension reform, stating that the Government arguments on demographic change as causing the reform are not plausible, as demographic changes are gradual, whereas the deterioration of the system sudden, due to a large drop in GDP. According to the author, the main problems of the pension system are the stagnation of the Slovene economy and the "contamination" of the pension system with various benefits which are not insurance-based.

[R1, R3] Čok, Mitja., Jože Sambt and Boris Majcen (2010), "Ocena učinkov predlagane pokojninske zakonodaje",

"Estimation of the effects of the proposed new pension legislation, Faculty of Economics, Ljubljana"

This study provides a brief overview of demographic changes in Slovenia. Further, a comparison of the existing and proposed new pension legislation is presented. This is followed by showing replacement rates under the old and new pension legislation, taking various simple wage histories. This could be described as a "normative" approach. Using actual data of individual wage histories, the effects of extending the relevant period for calculation of the pension assessment base – from 18 to 34 years – is presented, showing that for men the decrease in the pension assessment base will be some 12.1%, for women it will be 10.5%. Finally, the macro effects of all the measures contained in the new pension legislation are shown (pension expenditures measured as percentage of GDP), showing that the new pension legislation will provide fiscal sustainability for the medium term, i.e. for the next 15 years.

[R2] Golovrški, Maja (2010) "Prostovoljno dodatno pokojninsko zavarovanje po pokojninski reformi", Pravna praksa, no.37.

"Voluntary supplementary pension insurance in the pension reform"

The author describes the main changes which were introduced in the new pension legislation. Thus, collective pension insurance is strictly separated from individual pension insurance. Premium for collective pension insurance will be paid exclusively by the employer, and the annual minimum amount is set at 240 EUR. There will be no lump-sum payments from the collective schemes and there will be no transferability from collective to individual schemes. The requirement of a minimum (guaranteed) rate of return has been abolished and instead an individual can choose between three different pension funds with different investment policies, according to the life-cycle concept. These three funds, characterised by different investment risks, would be managed by a single umbrella fund. Annuities would be gender neutral, i.e. there would be no gender differentiation of annuities.

[R1] Guardiancich, Igor (2011) "ILO survey on social dialogue and pension reform in times of crisis and beyond: Slovenia", mimeo.

This research paper, which was commissioned by the ILO, provides an in-depth analysis of the pension reform process and detailed chronological description of events, concluding with the passage of the Pension and Disability Insurance Act in December 2010. It describes the positions of the main actors in the process of social dialogue – the trade unions, employers' organisations and the Government and the main causes for the rupture of the social dialogue in Slovenia.

[R1, R5] Guardiancich, Igor (2011) "Penzije i socialna uključenost u tri zemlje bivše Jugoslavije: Sloveniji, Hrvatskoj i Srbiji", in D. Vuković and M. Arandarenko (eds), "Social reforms: contents and results", pp.228-251, Faculty of political sciences, Belgrade.

"Pensions and social inclusion in three countries of former Yugoslavia: Slovenia, Croatia and Serbia"

This research compares the pension "generosity" in three countries of the former Yugoslavia, through the study of the effects of various wage histories on pension benefits. Various couple-types and individual types are analyses, based on quite varied wage histories. These include periods of unemployment, period of maternity leave, period of university study, period of elderly care. It has been shown that the Slovene pension system is fairly generous and provides adequate treatment of various periods of out-of-work (unemployment, maternity leave, care of elderly). This is to be compared with Croatia and Serbia, where replacement rates are low and treatment of various out-of-work periods is not adequate.

[R1] Papež, Marijan (2010), "Aktualna vprašanja reforme pokojninskega zavarovanja", Delavci in delodajalci 2-3: 367-385.

"Current issues of the pension reform"

The author – Director General of the Institute for Pension and Disability Insurance – argues that modernisation of the pension and disability insurance system is of utmost importance, in order to ensure fiscal sustainability. He argues that it is necessary to adopt the new legislation in time, so that new conditions for retirement can be gradually phased in.

[R1] Pogačar, Peter (2010), "Pokojninska reforma: zagotovitev dostojnih pokojnin in javnofinančne vzdržnosti pokojninskega sistema", HRM 36:18-23.

"The pension reform: ensuring adequate pensions and fiscal sustainability of the pension system"

The author – director of the Directorate for labour relations and social benefits in the Ministry of Labour, Family and Social Affairs – describes the proposed changes in the pension and disability insurance system and why these changes are necessary.

[R1] OECD Economic surveys: Slovenia (2011).

This OECD deals with three topics: (1) the state of the economy in the aftermath of the crisis, (2) a detailed analysis of the educational system and possible reforms to improve educational performance and (3) foreign direct investment and measures to improve governance and economic performance. In the first part, the survey also briefly analyses the effects of the proposed pension reform, stating that it is a step in the right direction, but that it falls short of ensuring long-term fiscal sustainability. It argues in favour of a more comprehensive reform, stating that consideration should be given to transform the system into a notional defined contribution system (NDC).

[H] Health

[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.

[H2] ČOBAL Nadja, DERNOVŠEK Mojca Zvezdana, ZUPANČIČ Agata (2010). "Resolucija o nacionalnem program duševnega zdravja". Bilt-ekon organ inform zdrav 2010; (26)3:69-72.

"National mental health programme for Slovenia"

The purpose of the article is to present the National mental health programme for Slovenia, which has been under development in the recent years. It outlines the current situation of the field in questionin Slovenia, describes the European guidelines and trends and the process of development of the National mental health programme for Slovenia.

[H2] KLEMENC-KETIŠ Zalika, SMOGAVEC Mateja, SOFTIČ Nina, KERSNIK Janko (2010). Health-related quality of life: a population based study from Slovenia. Cent Eur J Public Health 2011; 19 (1): 7–12

The present study showed that the health-related quality of life of the Slovenian inhabitants is lower comparing to some other European countries. This fact is surprising and also worrying. As we cannot find any perceptible reason for this observation, larger and more prospective studies are needed to confirm those results and to determine the reasons for that.

[H5] TURK, Eva, PREVOLNIK RUPEL, Valentina (2010). "Vrednotenje zdravstvenih tehnologij (HTA) v Sloveniji- Status quo, izzivi, predlogi". Bilt-ekon organ inform zdrav; (26) 1:3-13.

"Health technology assessment in Slovenia: Status quo, challenges, suggestions"

The purpose of the article is to show how the field of health technology assessment (HTA) is organised in Europe and Slovenia and to propose the creation of HTA network in Slovenia. The article describes the scope of HTA, its development as a research discipline and the situation in this field in Europe and Slovenia. Moreover, the article proposes the creation of Slovene network for HTA (MreHTAS). In addition, the adaptation toolkit is presented as a basis and help in the transferability of HTA studies to Slovenia within the Slovene Network for HTA (MreHTAS).

[L] Long-term care

[L] HLEBEC Valentina (2010). *The Post-Socialist Transition and Care for Older People in Slovenia* . EUROPEAN PAPERS ON THE NEW WELFARE – The Counter-Ageing Society.

The article presents the development of institutional care and home care in Slovenia since the beginning of the transition in 1991. It presents the welfare system reforms concerning older people and the consequent development of their care in two main areas: institutional care as well as the development of social services for those living at home.

List of Important Institutions

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

Director: Marjan Papez
Address: Kolodvorska 15, 1000 Ljubljana
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,

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
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

Director: Boris Majcen
Address: Kardeljeva ploščad 17, 1000 Ljubljana
Webpage: http://www.ier.si

The Institute is strongly 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 analise – Institute for Macroecenomic Analysis

Address: Gregorčičeva 27, 1000 Ljubljana
Webpage: http://www.umar.gov.si

The Institute of Macroeconomic Analysis and Development of the Republic of Slovenia is an independent government office. 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

Director: Marija Seljak
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

Director: Joze Ramovs
Address: Resljeva 7, 1000 Ljubljana
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

Director: Irena Krizman
Address: Vožarski pot 5, 1000 Ljubljana
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 zdrastveno zavarovaje slovenije – Health Insurance Institute of Slovenia

Director: Samo Fakin
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

President: Gordana Zivcec-Kalan
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.

INERHC – Inštitut za ekonomska raziskave v zdravstvu – Institute of Economic Research in Health Care

Director: Ales Zivkovic
Address: Vojkova cesta 71, 1000 Ljubljana
Webpage: http://sl.inerhc.si

The INERHC is involved in offering services in the following fields: Economic research in the area of management of health providers; Consulting services in the field of management and organisation of health providers; health economic research related to medicines, medical programmes and burden of illness; economic research in the areas of health care, pharmaceutical and pharmacy sector.

Faukulteta za druzbene 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

Dean: Vito Flaker
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