Annual National Report 2010

Pensions, Health and Long-term Care

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Equal Opportunities

Table of Contents

1 Executive Summary

On 24 March 2010 the Ministry of Labour, Family and Social Affairs presented a draft law on pension and disability insurance. This draft law proposes quite important changes in the public pension system. The possibilities for early retirement will be reduced, mostly by increasing the minimum retirement age (to 60) and by abolishing the child bonus. The retirement age will also increase, for men from 63 to 65 and for women from 61 to 63. There will be further improvements in the link between contributions paid and pensions received, as the period relevant for computation of the pension assessment base will increase from the best 18-year period to best 34-year period. The draft law also provides for greater financial sustainability of the system, by introducing the Swiss indexation rule, which is less favourable than the present one. As the trade unions are demanding substantial easing of conditions for early retirement, the outcome of these negotiations is difficult to predict. However, the stakes are high, as the prime minister is personally chairing the meetings with the trade unions. Unyielding trade unions might provoke a collapse of negotiations, with far-reaching consequences for the credibility of the present government. The modernisation of the pension system and proposed draft law were not received with acclaim by social security experts. In particular, legal social security experts had reservations with regard to the value of negative accruals for early retirement. The public debate has almost exclusively revolved around the public pension pillar, with almost no attention given to solutions proposed in the second pillar. At least a partial explanation is that changes in the second pension pillar are more modest and mostly involve measures to increase participation and contributions to this pillar.

As in previous years, also in 2009 and early 2010 no structural reforms occurred in Slovenia in the field of health and long-term care.

However, the centre-left government elected in 2008 set as one of its most important goals a health care reform, which looks likely to happen with the change of the Minister for Health in April 2010[1]. The goal is to revise the set of basic health system laws on which the reform of the health care system in Slovenia will take place. So far, changes have been discussed; however the actual implementation is missing. Challenges that remain are how to tackle the lack of health care personnel and long waiting periods for some services. In the field of LTC, the introduction of home-care services for long-term care patients (including respective changes in the insurance system) still has not been carried out.

This report presents the novelties of 2009 and early 2010.

Most debated and criticised throughout the year 2009 was the proposal of the Health Services Act[2], which was consolidated after a long public debate, but was removed from the parliamentary procedure with the change of the Minister for Health in early April, 2010.

Several National Plans were adopted, among them the Strategy of Protection against HIV Infection for the period 2010 to 2015[3], the National Plan to Control Diabetes[4], the National Cancer Control Plan[5] and the Plan for Palliative Care[6] which are described in detail below. The working group is still working on the Act on Long-term Care and Long-term Care Insurance and trying to consolidate it. An optimistic forecast is to have the Act in public debate before summer.

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1 Successor of the previous Minister for Health, Mr. Borut Miklavčič, is Mr. Dorjan Marušič.
2 MoH, 2009a.
3 MoH, 2009b.
4 MoH, 2009c.
5 MoH, 2009d.
6 MoH, 2009e.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2009 until April 2010)

2.1 Pensions

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

The pension reform, introduced in 1999 (and effective from 1 January 2000) introduced important changes in the pension system of Slovenia. It tightened eligibility criteria by increasing the retirement age and lowering the value of the entry pension. The latter was achieved through the decrease of the accrual rates and increase in the number of years used in the calculation of the pension assessment base. Early retirement is still 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 (PDIA) are presented in Table 1.

Table 1: Some characteristics of the current public pension system (first pillar) in Slovenia

	Men	**Women**
Retirement age	63	61
Minimum insurance period (required for retirement at ages 63 (m) and 61(w))	20	20
Minimum conditions for early retirement	Age 58 with 40 years of insurance	Age 58 with 38 years of insurance
Computation of pension assessment base	Best 18-year average of (net) wages, using revalorisation 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, but effectively at approx. 64 % of national net wage	
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	

The data in Table 1 require some further clarification. Thus, the parameter values for men (stated in Table 1) were reached in 2009. However, the parameter values for women are being increased more gradually, as the retirement age 61 will only 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[7]. The revalorisation coefficients, used in computing the pension assessment base, are rather low – they amount to only some 80 % of the nominal growth of wages. 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 were indexed with nominal average wage growth, but the accrual rates were "only" 80 % of those stated. This would mean that the effective accrual rate under the 1999 PDIA is not 1.5 % but 0.80 times 1.5 % = 1.2 %.

The 1999 PDIA also retained the option of retirement with a smaller insurance period, but requiring a higher retirement age. Thus, persons who do not satisfy the condition of a 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.

The reform introduced a number of sweeteners, to appease the trade unions. First, 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. Second, the retirement age can be reduced for child-rearing ("child 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. Here, one must mention that the negative accrual rates, applied for early retirement, are rather small and do not exceed 3.6 % per year[8]. Similarly, the additional accrual rates for postponing retirement are also rather low; they are digressive and do not exceed 3.6 % per year.

Finally, the 1999 PDIA 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[9]. This in effect means that in February each year, for most pensioners pensions are being increased by the growth of wages in the past year minus 0.6 percentage points. For example, as the nominal growth of average wage in 2008 was 3.5 %, pensions (for most pensioners) were increased in February 2009 by 2.9 %.

As regards the second pillar that was (in effect) introduced in the 1999 PDIA[10], 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 occurred 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

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7 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.

8 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 is 5 times 3.6 % = 18 %, so that his entry pension will be decreased by 18 %. For a person retiring at age 59 the negative accrual rate is 3.0 % per each year of early retirement.

9 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.

10 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 hundred.

potential inflationary consequences[11], 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,* a state-owned pension managing company, would manage this fund. As seen from Table 2, 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 EUR 1,500 and the highest average amount is in the SODPZ, with EUR 5,300 per member. The low amounts of assets, even taking into account that these funds have been in operation at most 8 years, does indicate that the pensions from the second pillar will not be able to compensate for the shortfall in the public pension.

Table 2: Pension funds in 2008

Managing company	**Pension fund**	**Number of members**	**Assets (in thousand EUR)**	**Assets per member (in EUR)**
PRVA OSEBNA	Total	76,504	140,316	1,834
SKUPNA	Total	73,036	227,000	3,108
POKOJNINSKA A	A	45,000	154,000	3,422
TRIGLAV	Triglav	44,200	123,930	2,804
KAPITALSKA DRUŽBA	ZVPSJU	187,191	282,840	1,511
	SODPZ	39,306	206,410	5,251
	KVPS	34,083	143,200	4,202
MOJA NALOŽBA	MN	31,207	78,400	2,512
BANKA KOPER	VPS Banke Koper	5,862	24,050	4,103
GENERALI	LEON 2	4,654	15,560	3,343
PROBANKA	DELTA	4,150	6,060	1,460
ABANKA	A III	2,871	11,440	3,985
ADRIATIC SLOVENICA	AS	2,317	3,770	1,627

Source: Annual Report 2008, Prva osebna zavarovalnica
Note: Triglav, Generali and Adriatic Slovenica are insurance companies; Banka Koper, Probanka and Abanka are banks; Prva osebna, Skupna, Pokojninska A, Kapitalska družba and Moja naložba are pension managing companies.

Overall, the pension reform produced some visible and positive results. Table 3 shows the increase in the effective retirement age, whereas Table 4 shows the gradual decrease in the replacement rate and fairly stable pension expenditures (measured as percentage of GDP), hovering around the 10 % mark. The increase in effective retirement is more pronounced for women, not least because their statutory retirement age (and required insurance period) is still increasing.

[11] The government was quite determined to succeed in joining the Eurozone at the earliest possible date and was very concerned about achieving the inflationary target!

Table 3: Effective retirement age by gender, 2000–2009

	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

Source: 2009 Annual Report; Institute for Pension and Disability Insurance.

Table 4: Average old-age pension/ average net wage ratio and pension expenditures as percentage of GDP, 2000–2009

Year	**Average old-age pension/ average net wage (in %)**	**Pension expenditures as percentage of GDP**
2000	75.3	10.40
2001	73.2	10.28
2002	72.8	10.22
2003	71.1	10.04
2004	70.2	9.86
2005	69.1	9.76
2006	68.6	9.60
2007	67.1	9.20
2008	67.1	9.43
2009	66.6	10.25

Source: 2009 Annual Report; 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; this increase has also been documented by other statistical sources. Table 5, which is based on the Household Expenditure Surveys, shows a large increase in activity levels for women in the 50–54 age group, with a smaller increase for men in the age group 55–64 years. However, activity levels for women in the age group 55–64 are still low. It is important to note that unemployment in the 50–54 age group has actually decreased, whereas unemployment in the 55–64 age group was only slightly higher in the 2005–2007 period as compared to the pre-reform period, 1997-1999. Furthermore, the share of women dependants decreased between these two periods (i.e. between 1997–99 and 2005–07), as younger female cohorts have higher labour participation and are thus retiring with their own pension. As for the age group 65 and above (65+), the introduction of the means-tested state pension (in the 1999 PDIA) has considerably reduced the number of elderly women in this age group without their own income sources.

Table 5: The socio-economic structure of Slovene households, by age groups and gender

	1997–1999							
	50–54		55–64		65–74		75+	
	M	F	M	F	M	F	M	F
Employees	61.0	33.1	16.5	2.5	0.9	0.0	0.0	0.0
Active in agriculture	3.2	0.7	2.9	0.5	0.0	0.0	0.0	0.1
Self-employed	6.2	2.6	3.1	0.2	0.0	0.0	0.0	0.0
Persons with occasional income sources	0.4	1.0	0.1	0.0	0.0	0.0	0.0	0.0
Unemployed	12.0	14.9	6.2	1.3	0.4	0.3	0.0	0.0
Pensioners	16.0	35.5	70.2	79.9	97.7	83.1	96.1	88.4
Dependants	0.8	11.8	0.4	15.3	0.4	15.8	3.2	11.4
Other	0.5	0.5	0.7	0.3	0.6	0.7	0.7	0.0
All	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	2005–2007							
	50–54		55–64		65–74		75+	
	M	F	M	F	M	F	M	F
Employees	67.0	55.0	26.0	8.0	1.6	0.1	0.0	0.0
Active in agriculture	2.8	1.8	2.9	0.9	0.0	0.1	0.0	0.0
Self-employed	8.7	3.4	5.2	0.7	0.2	0.0	0.0	0.0
Persons with occasional income sources	0.3	0.6	1.0	0.3	0.0	0.0	0.0	0.0
Unemployed	10.2	11.4	8.8	2.3	0.1	0.0	0.0	0.0
Pensioners	10.5	19.0	55.1	80.6	98.1	96.3	99.4	96.7
Dependants	0.3	8.5	0.7	7.3	0.0	3.5	0.4	3.3
Other	0.2	0.3	0.3	0.1	0.0	0.0	0.2	0.0
All	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Kump and Stanovnik (2008).

So much for activity levels. The income position of pensioners has been gradually deteriorating, as seen by the decreasing pension/wage ratio in Table 4. Other statistical sources confirm these findings. Here we will only present the relative risk of income poverty, showing that it 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 is seen in Table 6.

Table 6: 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.h.	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.h.	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).

2.1.2 Developments in the pension system in 2009 and 2010

In view of the fairly rapid decline in economic activity, the developments in the pension system seemed to lack any sense of urgency. Not only that: even precautionary measures were absent. Thus, in February 2009, according to the usual procedure (enacted in the PDIA) pensions were increased by 2.9 % (applicable from 1 January 2009)[12]. It is quite amazing that this measure has not been temporarily suspended, in view of the already visible slide of the economy. However, this slide did not yet result in a decrease in social contributions collected; also to be noted is that – in case of any revenue shortfall – the Government must cover this social contribution shortfall from its own sources (taxes). This is explicitly stated in articles 233 and 234 of the PDIA. Needless to say, this requirement places the burden on the Government, not on the Institute for Pension and Disability Insurance (IPDI).

In haste, the Government prepared its Stability Programme for the period 2009–2011, unveiled on 24 April 2009. It proposed a freeze on wages for government employees, pensions and social transfers[13]. The baselines for this "freeze" are wages, pensions and social transfers at the level of the first half of 2009. Even without this measure, pensions would not experience any further increase in 2009. Namely, pensions are adjusted according to the growth of wages and these adjustments take place in February and November. As the pension increase in February (2.9 %), passed by the Board of the Institute for Pension and Disability Insurance (IPDI), already exceeded the expected total annual increase in wages, there were no increases in pensions in November.

In March 2009, the Government appointed a working group on "modernising the pension system". The word "reform" was not used, perhaps to prevent any "unwarranted" excitement and animosity at the very start. At its meetings during the March–October period, the group discussed various features of the public pension system and offered some specific proposals. In September 2009, the Ministry of Labour, Family and Social Affairs published a brief position paper: *Modernisation of the pension system in the Republic of Slovenia: a secure ageing for all generations*[14]. To a large extent, the position paper was based on proposals of the working group; however, this paper also contained some features that clearly reflected the position of the Ministry. In particular, the paper proposes a two-phased reform, with the "modernisation" as the first phase and the system based on NDC as the second phase (to be introduced as early as 2015!). It seems that this position paper was to serve mainly as a platform for negotiations with the trade unions and simultaneously as a blueprint for the preparation of the draft law on pension and disability insurance. No meetings of the working group took place from October to April; instead, the Ministry opted for "intensive" (but quite futile!) discussions with the trade unions. In other words these six months were not time well spent, as the negotiations did not result in any agreement or breakthrough for the advance in the legislative process. The draft law, without the "blessing" of the trade unions, was presented to the public on March 24, after which the mood of the trade unions became combative, with threats of a general strike and referendum. The leading party of the ruling coalition – the Social Democrats (SD) – met on Šmarjetna gora on 10 April to debate the pension reform proposals. There was dissent within the party, with some demands to postpone this reform, possibly motivated by a very tangible fear of losing votes from its core electorate – workers. Ignoring this dissent, Prime Minister Borut Pahor (who is also president of the

[12] Some types of pensions disbursed by the Pension and Disability Insurance Institute were subject to higher increases, i.e. 3.5 %.

[13] As stated, pensions are adjusted in February and November, according to wage growth. Social transfers are also adjusted semi-annually, in January and July. The valorisation is according to costs of living.

[14] It would be misleading to describe this paper as a White Paper; as the document (position paper) does not contain any analytical argumentation for the proposed solutions.

Social Democrats) decided to raise the stakes and personally chair negotiations with the trade unions; it remains to be seen whether this will result in any breakthrough. At present, it seems that the priority demand of the trade unions is the requirement for pensioning with an insurance period of 40 years for men and 38 years for women, without any minimum age condition and without negative accruals (pension deductions). This would be similar to the *seniority pension*[15], which is still in existence in Italy. Following the public presentation of the draft law on pension and disability insurance, the working group also reconvened, on 8 April. It quickly uncovered two serious design faults within the draft law – the first was an "incentive system" for workers having a long insurance period and working past the minimum age for early retirement. The second design fault concerns the new rule for pension indexation, based on the Swiss indexation. This new rule also has consequences for other elements within the pension system. Succinctly, the preservation of the principle of horizontal equity with such a method of indexation would result in a fairly rapid decrease in valorisation coefficients and thus in a decrease in entry pensions. This would become (socially) untenable.[16]

It is impossible to predict the outcome and the fate of the pension reform, i.e. draft law on pension and disability insurance. Obviously, failure to pass this legislation would, now that the stakes are so high, completely paralyse the current government. With the next parliamentary elections to be held as late as October 2012, this could have far-reaching consequences on the general conduct of government affairs. That is why the Prime Minister has also launched a barely veiled threat to the trade unions that if no progress were reached in negotiations, the draft law would be presented at the cabinet meeting and passage of the legislation would be linked to a vote of confidence[17].

In Table 7 we present the main features of the pension reform, which are to be compared with the 1999 pension reform parameters (shown in Table 1).

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15 The *seniority pension* in Italy is an old-age pension granted only on the basis of a sufficient insurance period, without the retirement age condition.

16 To put it simply, the principle of horizontal equity means that persons retiring in different years have equal pensions, provided they have the same "relevant characteristics", such as same wage history, same contributory period and same retirement age. If the indexation rule is the Swiss indexation, this would mean that the revalorisation coefficients used in forming the pension assessment base would have to take account of this new rule for pension indexation in order to fulfill the principle of horizontal equity. This would actually mean that the pension assessment base would decrease fairly rapidly. There are countries which have this double "Swiss formula" – for pension indexation and for pension assessment base valorisation – such as Croatia (see Anusic et. al., 2003, p.28). Anušić labels this "double Swiss formula" the "Croatian formula". One would hardly wish to emulate such solutions!

17 This tactical manoevre has also been used in the previous reform. In July 1998, Anton Rop, the Minister for Labour, Family and Social Affairs, who was in charge of the 1999 reform, put the draft law for government approval, thus exerting pressure on the trade unions to come back to the negotiating table. (see Stanovnik, 2002, p.51)

Table 7: The proposed new parameters of the draft law on pension and disability insurance, the public pension system (first pillar) in Slovenia

	Men	**Women**
Retirement age	65	63
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 34-year average of (net) wages, using revalorisation 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	Swiss formula	
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 (3.6 % per year), negative accrual rates for early retirement (3.6 % per year)	

According to the 1999 PDIA, years of university study and years of military service could be taken into account for satisfying entry conditions for retirement. However, this period was not included in the pension assessment base (and the accrual rate for these years was 0 %) unless these years were purchased, in which case they were included in the insurance period. According to the draft law, these years are not to be taken into account in assessing entry conditions for retirement, but these years can be purchased (in which case they are included in the insurance period). The "child bonus", i.e. the lowering of the retirement age for each child, has been discontinued. This measure was introduced in the 1999 PDIA; as it was "gender neutral", parents could decide who would take up this benefit. We have already remarked that the benefit has mainly been taken up by men; it is, according to the Institute for Pension and Disability Insurance (IPDI), the main "culprit" for the modest increases in retirement age[18]. The *Modernisation* position paper proposed equal retirement age for men and women (65); we note that the draft law proposed a somewhat lower retirement age for women (63).

Probably the most contentious issues in the draft law are conditions for early retirement and the duration of the transition period. According to the draft law, early retirement is possible at age 60 and an insurance period of 40 years (men) and 38 years (women). We have already noted that the draft law contains some inconsistent modes of early retirement. In actual fact, there are three modes:

1. Early retirement, with negative accruals of 3.6 % per year prior to statutory retirement age (63 for women, 65 for men).

[18] "Child bonuses", i.e. decrease in retirement age for child-rearing is quite rare; to our knowledge, only the Czech republic has retained this feature in the pension system, whereas the Slovak republic is gradually disbanding it and equalising the statutory age for men and women.

2. If a person meets the qualifying conditions for early retirement, but decides to continue working, he may also keep receiving 20 % of the early retirement pension, but only up to the normal retirement age.

3. If a person meets the qualifying conditions for early retirement, but decides to continue working, he may also receive a permanent increase of 3.6 % for each year of additional work past the early retirement age

Modes 2 and 3 are quite unusual; particularly mode 3 is contrary to the concept of early retirement and the working group proposed that it be struck down.

Social assistance benefits related to pensioners were "traditionally" included in the law on pension and disability insurance. The draft law also broke with the past with regard to this treatment and these benefits are to be included in the appropriate social assistance acts.

2.1.3 The reform debate

Following the publication of *Modernisation of the pension system in the Republic of Slovenia: a secure ageing for all generations,* social security experts and others expressed their opinions in professional journals and other media. In an interview to *Mladina* and in an article in *Dnevnik*, Stanovnik pronounced himself strongly in favour of the proposed changes, arguing that they are in line with similar reform measures undertaken in a number of Central European countries with a Bismarckian model. However, he opposed the "two-phase" concept, particularly the proposal to introduce the NDC system in the second phase of the reform[19]. Another member of the working group, Aleš Berk Skok, in an article in *Dnevnik* argued in favour of the introduction of a NDC system. Grega Strban (2009), from the Faculty of Law of the University of Ljubljana, argued in favour of retaining the present system of linking the age of retirement with the insurance period (the smaller the insurance period, the later the retirement), questioning the possible constitutionality of negative accruals for early retirement. He pronounced himself in favour of extending the period relevant for the computation of the pension base and for a complete gender equalisation of conditions for pensioning, as well as abolishing the "child bonus"[20]. He also opposed the NDC system, arguing that it is unacceptable from the legal point of view and pointed to some merits of the point system. Marjan Papež (2009), director general of IPDI, confined himself mostly to an exposition of the main features of the *Modernisation* position paper and some observations with regard to the functioning of the current system; in particular, he exposed problems that were the result of different indexation rules for pensions and social transfers. He also pronounced himself in favour of the points system, due to its transparency and simplicity. Papež also stressed the need for a stronger role of the second pillar.

After these opening shots there was calm – until the draft law was "unveiled" in March 2010. The debate continued with an interview by Peter Pogačar, the chairman of the working group (and Director General of the Directorate for Labour Relations and Labour Rights at the Ministry for Labour, Family and Social Affairs), to *Delo (*March 27, 2010). He presented the main elements of the proposed draft law, stating that these solutions are not final and are still subject to negotiations with the trade unions. He also expressed himself in favour of the NDC system, to be introduced as the "second phase" of the reform. Anjuta-Bubnov Škoberne, from the Faculty of Law of the University of Ljubljana, pronounced herself in favour of gender

[19] It is interesting to observe that the first appearance of the NDC proposal for Slovenia was in the OECD report, which suggested such a reform of the public pillar in its economic survey of Slovenia (see OECD, 2009, p. 63–65).

[20] All these three measures were in the *Modernisation* package.

equalisation of pensionable conditions, also referring to relevant EU directives. She expressed strong disapproval of "high" negative accruals for early retirement, stressing that they ought to be lower by at least a half (meaning presumably 1.8 % per year or less). She also pointed out that an important element is missing, in that there is no mention of a "target" replacement rate[21].

2.1.4 The second pillar and beyond

Pressing need for changes and decisions are also present in the second pension pillar. In 1999, legislation on the second pension pillar was bundled with legislation on the first pension pillar into a single act – the 1999 Pension and Disability Insurance Act (PDIA). This bundling was required in order to assure the passage of the complete legislation – separate legal acts could (possibly!) result in the blocking of legislation on the second pillar. We have seen that, in spite of the large coverage, the second pillar is quite "shallow", so that rents and annuities from the second pillar pension schemes will in no way be able to compensate for the smaller public pension from the first pillar. It seems that not even very favourable tax treatment for second-pillar premia provided a sufficient incentive for employers and employees. In other words, measures to increase the "attractiveness" of second-pillar schemes are required, as well as a number of other quite urgent tasks (such as setting separate legal acts for the public pension system and second pension pillar, legislation on the disbursement of pension annuities from the second pillar etc.). The draft law is rather modest in this area and has retained this "bundling". In order to boost the second pillar, article 260 of the draft law proposes government subsidies for collective pension schemes, "topping-up" the premia by up to one-third of the amount contributed by the employer and employee[22].

In the meantime, a proposal with regard to the third pillar has been in circulation. Based on the initiative of Marko Simoneti from the Faculty of Law and Aleš Berk Skok from the Faculty of Economics, both from the University of Ljubljana, a favourable tax treatment of third-pillar contributions is proposed. Its signatories are important bankers, persons from the financial sector and some academic economists. What is surprising about this proposal is that it suggests that contributions and rents from this pillar be given a most favourable tax treatment, i.e. E E E (exempt-exempt-exempt); this is completely unacceptable from the point of view of public finance theory and doctrine.

2.2 Health

2.2.1 System characteristics

The health care system in Slovenia is a public service provided through the public health service network. This network also includes, on an equal basis, other institutions, private physicians and other private service providers on the basis of concessions.

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 (HIIS).

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[21] When the working group resumed its consultations on 8 April, it was proposed that the target replacement rate (for 40 years of work for men and 38 years of work for women) be 60 %. Thus, the working group "anticipated" this criticism by Anjuta Bubnov Škoberne.

[22] Government subsidisation of the second pillar was also present in the Czech republic, with mixed success.

2.2.2 Health care financing

Although it is defined as public, it can be observed that the health system transformed into a mixed system in the past years. Namely, in 2007 the share of health expenditure from private health insurance institutions was 13.6 % and from direct payments by households 14.5 %.[23]

Compulsory health insurance contributions constitute the major source of health care financing in Slovenia, with 69.4 % of total health expenditure in 2007.[24] 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 are 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.[25]

The Ministry of Health 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.

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 7.8 % in 2007) The share of current expenditure – i.e. total health expenditure excluding capital formation – as a proportion of GDP decreased from 8.1 % in 2003 to 7.4 % in 2007.[26]

In the 2003–2007 period the average annual growth of current expenditure on health from social security funds was lower than the growth of health expenditure from private sources (5.4 % vs. 7.7 %). Average annual growth of current expenditure on health from health insurance institutions (5.5 %) and from direct payments by households (9.6 %) was higher than average growth of expenditure from social security funds. In this period social security funds were the main source of funding health care; in 2003 they represented 71 % and in 2007 70 % of funds for health care. In 2007 the share of health expenditure from health insurance institutions was 13.6 % and from direct payments by households 14.5 % (Table 1).[27] A worrying factor in this context is that the most and a growing share of these expenses represent out-of-pocket expenses (households) rather than expenses from voluntary health insurance.

[23] SORS, 2010.
[24] SORS, 2010.
[25] ZZZS, 2010.
[26] SORS, 2010.
[27] SORS, 2010.

Table 8: Health expenditure in Slovenia 2000–2007

	2000	2001	2002	2003	2004	2005	2006	2007
Public expenditure on health as % of total health expenditure	73,97	73,52	73,39	71,83	73,25	71,90	72,25	71,60
Public expenditure on health (PHE) (million €)	**1,13**	**1,31**	**1,45**	**1,56**	**1,67**	**1,75**	**1,86**	**1,94**
PHE per capita (€)	565,95	655,36	726,55	783,58	834,16	875,41	925,48	967,53
- Compulsory health insurance	94,52	93,46	93,31	92,92	93,07	93,68	92,88	92,71
- National government expenditure (% of total PHE)	4,60	5,28	5,61	6,25	6,07	5,63	6,46	6,54
- Local government expenditure (% of total PHE)	0,88	1,26	1,08	0,83	0,86	0,69	0,66	0,75
Private health expenditure as % of total health expenditure	26,03	26,48	26,61	28,17	26,75	28,10	27,75	28. 4
Private health expenditure (billion €)	**0,40**	**0,47**	**0,53**	**0,61**	**0,61**	**0,68**	**0,71**	**0,76**
- Voluntary health insurance expenditure (% of total private HE)	51,01	52,01	48,35	45,95	47,51	45,57	47,07	45,36
- Out-of-pocket expenditure (% of total private HE)	44,11	39,51	43,49	42,03	43,83	44,09	42,46	48,61
Total health expenditure (THE) by type of service (billion €)	**1.5**	**1.8**	**2.0**	**2.2**	**2.3**	**2.4**	**2,60**	**2,70**
- curative care services (% of total)	-	-	51,90	50,90	51,69	51,16	50,83	51,90
- rehabilitative care services (% of total)	-	-	2,07	2,10	2,10	2,20	2,11	2,20
- long-term nursing care (% of total)	-	-	7,44	7,19	7,74	8,22	8,01	8,10
- Ancillary health care services (% of total)	-	-	2,50	2,41	2,67	2,69	2,79	2,90
- Medical goods dispensed to out-patients (% of total)	-	-	23,12	23,15	23,05	23,18	22,85	22,30
- Prevention and public health services (% of total)	-	-	3,6	3,6	3,7	3,7	3,9	3,8
- Health administration and health insurance (% of total)	-	-	4,4	4,5	4,1	4,1	4,2	4,2
- Gross capital formation (% of total)	-	-	5,0	6,2	4,9	4,8	5,4	4,7

Source: SORS, 2010 and WHO HFA, 2010

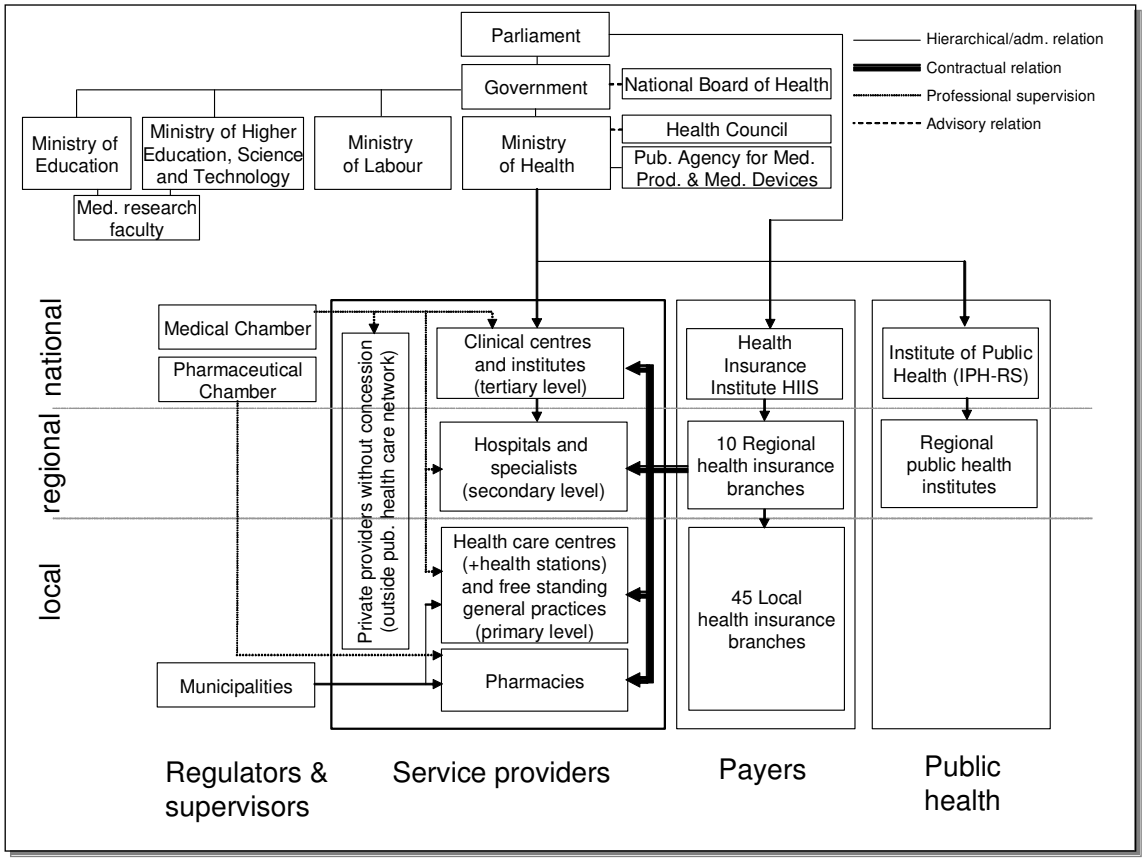
2.2.3 Health care organisation

The Slovene health care system is fairly centralised and the responsibility of municipalities is limited. The Ministry of Health has the task of planning health care for the entire area of the state and for the entire health care system. Also all administrative and regulatory functions of the health system take place at the national level and the local levels have mainly executive duties. Compulsory health insurance is also centrally managed and administered, whereas the local levels conduct only those tasks and activities that are previously assigned to them from the central level. The professional chambers and organisations also operate at the state level or through their regional branches.

Local governments are also said to make limited use of the autonomy they gained in planning health services. Thus, the de facto degree of devolution in planning primary health services

from the central government to local communities cannot be qualified to date. Moreover, considering the size of the country the economic benefits of further decentralisation of the health care system are rather limited. The organisational structure as of 2009 of the health care system is shown in Figure 1.

Figure 1: Organisational chart of the Slovene health care system



Source: Health Systems in transition, 2009

Privatisation within the health care system has taken place gradually and at a constantly increasing pace. It is developing towards the termination of the employment relationships for medical doctors and other medical workers in the public service by encouraging establishment of their own practices.

2.2.4 Health care provision

Regarding the provision of health care services, primary health care services within the public health care network are paid for through a combination of capitation and fee-for-service payments; while outpatient specialist care is paid for by fee-for-service payments only.

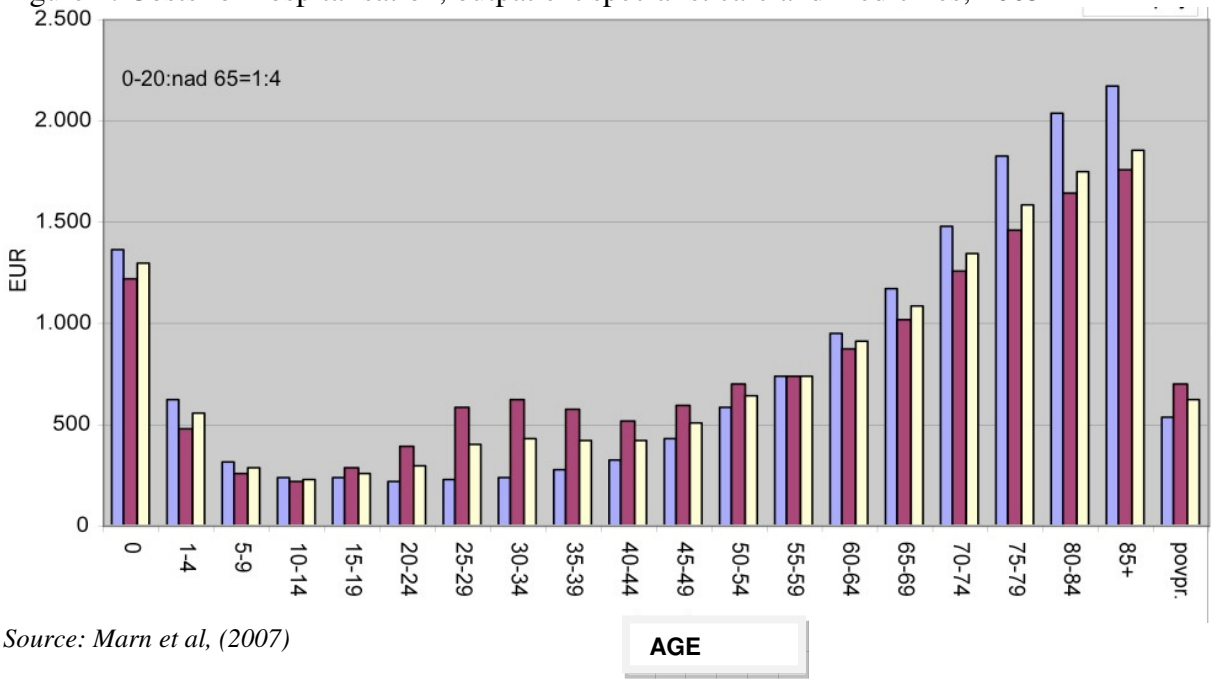
Primary health care services are organised on the local level, so that they are equally accessible to all people without discrimination. For all people, continuously accessible urgent medical attention and emergency services must be assured.

Payment for acute inpatient care is based on diagnosis-related groups (DRGs), whereas payment for non-acute inpatient care is calculated by the number of bed-days per stay. The

volumes of these programmes of services are prospectively determined, hence the payment for the respective services is constrained by this. The new DRG payment model for acute inpatient health care was introduced gradually. In 2003, the payment model on the basis of DRGs was introduced and 10 % of resources allocated to acute inpatient health care providers.

A more detailed classification of DRGs (in 2003 the system contained 661 DRGs) and a unified price list for all the providers were developed. The new model enabled more detailed comparison of the individual provider performance and more transparent evaluation. Due to the rapid development of science and technology, an increasing proportion of elderly people in the population (demographic changes in Slovenia are among the least favourable in the EU, see Table 2: The number of population according to the age groups and share of age groups, 2000–2050) and a growing number of patients with chronic illness, the costs of health care are rising (Figure 2).

Figure 2: Costs for hospitalisation, outpatient specialist care and medicines, 2005

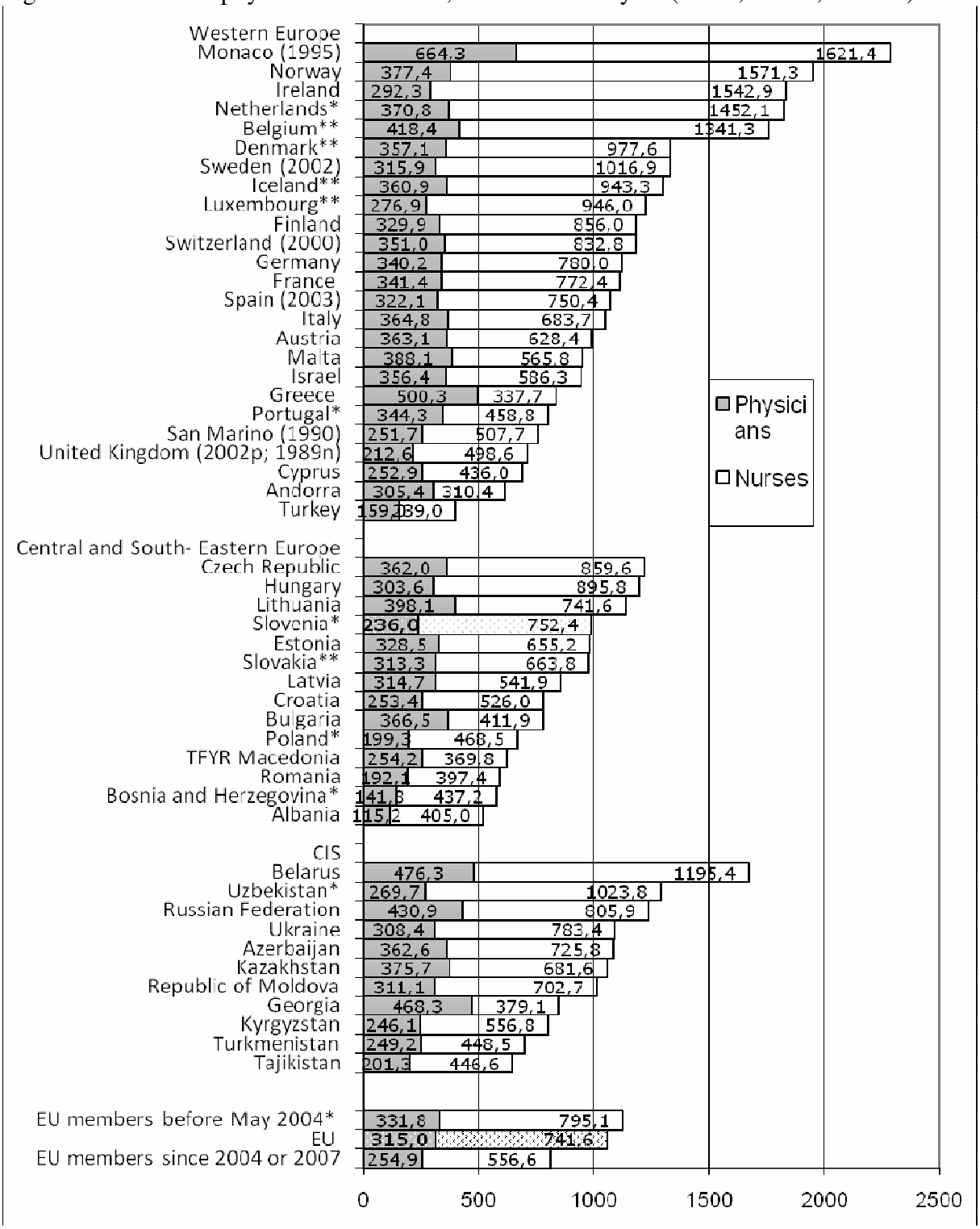


Source: Marn et al, (2007)

With regard to human resources in health care, Figure 3 shows the number of physicians and nurses. In Slovenia a steady increase of physicians' numbers is present, amounting to 237 per 100,000 population in 2006 compared to 199 per 100,000 in 1990[28]. However Slovenia is still lagging far behind the EU-15 average of 338 and the EU-27 average of 322 (2007). In 2006, Slovenia had 765 nurses per 100,000 population, which was below the EU-15 average of 805 and slightly more than the EU-27 average of 746.[29]

[28] WHO HFA 2009.
[29] WHO HFA, 2010.

Figure 3: Number of physicians and nurses, latest available year (2006 ; *2005; **2004).



Source: WHO Regional Office for Europe health for all database, 2010.

According to the calculations of the Medical Chamber[30], 2,284 medical doctors are lacking in Slovenia. The calculation included the needs of health centres, hospitals and needed replacement for retiring concession-holders. Moreover, the needs to increase the number of

[30] Medical Chamber, 2010.

doctors due to an expected reduction in rates at the primary level have been included in the calculation. To restore the existing health network the number of MD's needed in towns all over Slovenia varies from 26 to 578. In 2010 the first 80 graduates from the Medical faculty in Maribor will enter the health care system. However, in the long term, the Medical Chamber is proposing to expand the numerous clausus of the university medical training.

The feminisation of medicine can be observed in Slovenia, namely 82 % of GPs are female and 60 % of all doctors are female[31]. The problem of feminisation of the profession is evident in maternity leave and sick leave. Since the method of obtaining a licence for doctors, in particular from outside Europe, is rather lengthy, a reduction of time in the bureaucratic procedure has been proposed by the Medical Chamber. However, currently there is no national strategy for tackling this issue.

2.2.5 Overview of reforms and strategies

No structural reforms occurred in Slovenia in 2009 and early 2010. However, the centre-left Government elected in 2008[32] set as one of its most important goals a health care reform. The idea is to propose a completely revised set of basic health system laws, which would then represent the basis of the new, reformed health care system in Slovenia. So far, many changes have been discussed, but the actual implementation is missing.

2.2.5.1 Health Services Act

Slovenia has had the same Health Services Act since 1992. As the health reform of 2003 was not implemented (due to change of the Government)[33], only minor amendments of the Act appeared in the past decade. In 2009, the new Health Services Act was open for public debate. The main aims and strategic goals of the Act are:

- reduced influence of the professional associations. There has been a lot of controversy over their role and over the problems caused by their insistence on restricting available posts in some specialties (the Medical Chamber). The idea, much rejected by the current Medical Chamber, is the introduction of a non-mandatory membership.
- introducing a central agency for quality control and safety. The field of Health Technology Assessment within the agency remains poorly described and defined. The role of the MoH seems more of a moderator with the key institutional arrangement remaining open.
- remodelling hospitals by abolishing the former principles of general hospitals as the minimum setting for any hospital in order to reduce pressures on small hospitals to have obstetric and paediatric departments as compulsory structures and introducing nursing departments in all general hospitals in order to alleviate the burden of chronic, palliative and temporary care for seriously ill patients.
- the role of the private sector and the processes of coordination of care at all levels at an institutional base (e.g. the role of coordinating primary care by primary health care centres)

[31] Medical Chamber, 2010.

[32] The current Government was appointed on 21 November 2008. The Government consists of the Prime Minister, 15 ministers and 3 ministers without portfolio. The coalition government led by Prime Minister Borut Pahor comprises the Social Democrats, the Zares party, the Democratic Party of Pensioners of Slovenia and the Liberal Democracy of Slovenia.

[33] Keber et al, 2003.

2.2.5.2 Health Care and Health Insurance Act

With regard to Health Care and Health Insurance Act, in February 2010 the Ministry of Health published the starting points of the forthcoming Act. The emphasis is on rights of citizens under the compulsory health insurance scheme. In the upcoming law a special emphasis will be devoted to the diction that solidarity, in addition to rights, means obligations, which can be achieved in providing sufficient funds for the smooth work of the health system. The idea is that the contribution for the health insurance will be calculated according to the income and ability to pay. Therefore the upcoming law will include amendments. These are mainly:

- the basis for the contribution calculation will include, in addition to salaries, also income from individual contracts, overtime work, night shifts, benefits from work in executive boards, rents etc.
- self-employed would not have the option to choose the basis for the contribution themselves. Currently, the Social Security Act enables such a calculation.
- the acquisition of the status "family member" of the insured person will be modified. Currently this status applies to children, parents, siblings, husbands/wives etc., who cannot hold an insurance according to the provisions. The socio-economic status of the families is not considered. In the future, only children (until 18 years) and students (with valid student status), will be treated as family members, the rest only if the socio-economic status of the family is in line with the social benefits. The modification will include also farmers. According to the current regulation, farmers not included into the pension insurance need to pay solely a contribution of the cadastre income of the household, and not according to the material situation of the farm.

2.2.5.3 National Cancer Control Plan

In 2009, the Health Council adopted the National Cancer Control Plan, with its main goals:

- to reduce age standardised incidence rates of cancer (5 % in men with respect to the rates of 2004/2005; 8 % in women with respect to rates of 2003/2004,
- to reduce age standardised mortality rates in men and women by 10 % with respect to the rates of 2004/2005,
- to increase the 5-year relative survival in both sexes (10 % in men; 12 % in women (between 2001–2005 and 2011–2015),
- to increase the quality of life of patients through psychosocial and physical rehabilitation and to increase the share of those patients with advanced disease who get palliative care.

Main measures to achieve these goals include activities in the field of primary prevention, secondary prevention, diagnostics and specific oncological treatment, integral rehabilitation, palliative care, education, informatics, cost efficiency, participation of the civil society and coordination and control.[34]

The National Cancer Control Plan had been in preparation for more than 10 years. A change of government and the Slovene presidency with the main topic "Fighting together against

[34] Albreht, 2009b.

Cancer" were an incentive for acceleration of the process.

The main points of the Plan are:

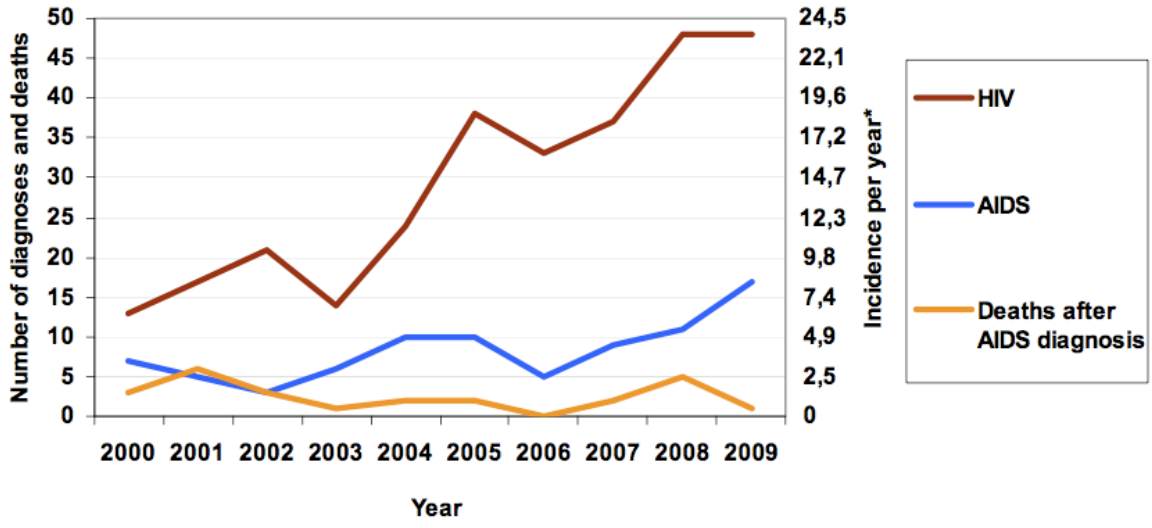
- the organisation of health care and care services with regard to cancer care shall be in a few certified quality-controlled centres, centres of excellence,
- processes of care need to be improved and evaluated for quality and cost-effectiveness,
- prevention of cancer and
- rehabilitation and palliative care.

Despite the long birth of the Plan, a thorough economic evaluation is missing. The new approach is estimated to be more cost-effective, as the present approaches are fragmented, costly and inefficient.

2.2.5.4 Strategy for Protection against HIV Infection for the period 2010 to 2015

In late 2009, a Strategy for Protection against HIV Infection for the period 2010 to 2015 was adopted. The key focus of the strategy is prevention and prevention of infections. The trend shows an increase of HIV infections in the past decade (Figure 4).

Figure 4: Diagnosed cases of HIV infection, AIDS and death after diagnosis of AIDS Slovenia, 2000–2009



Source: UNGASS COUNTRY PROGRESS REPORT, 2010

The most common way of HIV infection in Slovenia is unprotected sexual intercourse. To prevent transmission, it is crucial to ensure awareness about HIV infection and promote responsible and safer sexual behaviour in the whole population, young people and groups with higher-risk behaviour for infection – especially among men who have sex with men, who carry the greatest burden of infection. A special emphasis of the Strategy is on prevention of new infections with earlier detection and counselling to prevent further transmission. In order to reduce the proportion of late diagnosis, the strategy foresees increasing the volume of testing in groups with a greater likelihood of infection. Because of the need for destigmatisation and normalisation of HIV testing, the most recommended way to test is

confidential testing.[35]

2.2.5.5 National Plan to Control Diabetes

Diabetes is already a heavy burden for the Slovenian health system. According to data from the Health Insurance Institute of Slovenia on the use of drugs and medical devices, in 2007 about 53,000 patients were treated with drugs that are consumed in the form of tablets, only about 16,000 patients with insulin, and approximately 10,500 patients with insulin and tablets. Costs of medicines for diabetes accounted for 6.5 % of the cost of all drugs and in 2007 amounted to a total of EUR 20 million and for medical devices EUR 13.5 million. According to international estimates, at least 40 % of the costs of diabetes are indirect and caused by temporary absence from work and lost future earnings.[36]

The National Plan represents a strategic basis for action in the field of prevention, early detection and treatment of diabetes and monitoring, research and education in this field. The entire programme is based on collaboration between partners in health care and outside health care. The objectives in Slovenia in the field of diabetes management are to:

- reduce the incidence of type 2 diabetes by providing conditions for healthy lifestyles, by raising public awareness of the causes of diabetes, by encouraging individuals to lead a healthy lifestyle and take responsibility for their own health and by providing access for all population groups to programmes of health promotion and prevention of chronic diseases;
- prevent or delay type 2 diabetes in people at high risk for this disease through identification of persons at high risk for developing type 2 diabetes and structured treatment of people with high risk for type 2 diabetes;
- improve early detection of diabetes via the active search for diabetes in people at high risk for type 2 diabetes and detection of active disease in children, adolescents and pregnant women;
- reduce complications and mortality associated with diabetes through access to coordinated, comprehensive, continuous, lifelong, efficient, safe, quality and patient-focused care, based on the appropriate organisation of care and the monitoring of its quality, on providing conditions for the patients' management of their diabetes, on continuous upgrading of professional knowledge and skills of health professionals and the education of interested parties outside the health system who may engage in activities that materially contribute to the care of diabetic patients.

The focus is on patients' ability to actively engage in the healing process and to take responsibility for their health and free of complications of diabetes and live a full life quality. Thus, prevention and treatment of patients with diabetes must be based on professional guidelines, standards and clinical pathways. The programme also envisages the establishment of a monitoring system that will allow the checking of the effectiveness of prevention and treatment of diabetes and improving the quality of treatment.

To implement the programme and to successfully achieve the objectives it is envisaged that the Ministry of Health's two-year action plans will be adopted by the health council and the processes and specific activities of key partners will be defined. Action plans will allow for better collaboration among partners and integration activities, monitoring the results of efforts

[35] MoH, 2009b.
[36] MoH, 2009c.

to contain the disease and the appropriate build-up in the future. [37]

2.2.5.6 National Mental Health Plan

In line with the adoption of the Mental Health Act in 2008, the National Mental Health Plan is in preparation. The first draft for public debate has already been published. The Plan is the first plan containing relevant numbers on capacities and funding.[38] The main objectives of the upcoming Plan are: mental health promotion and prevention of mental illnesses in the whole population, mental health promotion and prevention of mental illnesses of the young, mental health promotion and prevention of mental illnesses of the elderly, destigmatisation and fight against social exclusion, suicide prevention.[39]

2.2.6 Political discourse on the proposed Acts

The former Minister of Health announced the new Health Services Act to be adopted by the end of December 2008. However, the public debate on the Health Services Act proposal showed that several solutions were not well thought through and provided a wide range of critical comments. The latter ranged from total refusal by the Medical Chamber to moderate approval within a part of the governing coalition.[40] Comments, corrections and amendments have been incorporated into a revised proposal, which was sent to Parliament in March 2010. However with the change of the Minister for Health in early April 2010, it was removed from the legislation process so that additional changes will be introduced. It is expected that by autumn 2010 the Government finally adopt the Health Services Act.

According to Albreht[41] the Health Services Act is a controversial issue. The main concern of critics of the proposal is that of it gets modified to any greater extent, little will remain of the original ideas of the present coalition in bringing in more governance and state control. Moreover, he states two principal errors in the preparation of this act. First, he emphasises the lack of previous strategy or setting of the goals of this policy and second, as a consequence, there is little more than a political intention to change and little clear evidence.

So far, the public has not debated much the proposed Health Care and Health Insurance Act. The first comments came from the Sports Federation for Children and Youth of Slovenia, where they oppose the idea that co-payments of 60 % for treatment from injuries acquired during sports competitions and adrenalin sports (e.g.: sport climbing, mountain biking, skating, snowboarding, aviation, motor and car competitions, scuba diving, etc) will have to be paid out of pocket.[42]

Despite the prolonged activity in the field of basic health laws, several important issues were considered and discussed. The preparation of strategies and national plans was a lengthy process. In the preparation of these plans, not only experts from the respective fields were involved, but also patient associations and NGOs were included in the task force groups. Drafts were published for public debate and the comments and arguments were considered in the final documents. Therefore no major contributions have been made from the opposition side.

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37 MoH, 2009c.
38 Jeriček Klanscek et al, 2009.
39 MoH, 2009f.
40 Albreht, 2009a.
41 Albreht, 2009a.
42 ZSOMS, 2010.

2.2.7 Evaluation and impact assessment

The Resolution on the National Health Plan 2008–2013 adopted in 2007[43] is the strategic planning document for the further development of the health sector in the period 2008 to 2013. The main issues addressed are health care expenditures, health workforce planning, privatisation of health care services and demographic change. Currently, none of the main issues have been completely reached. Additional funding in the past years enabled better realisation of the health services. In the context of acute hospital treatment in 2009, the providers carried out 359,986 hospital treatments, which means 15.5 % more than in 2003. The number of patients waiting decreased until 2008. However, in the last year it grew again by 6.6 %.[44]

Health Technology Assessment (HTA) is underrepresented in Slovenia. The process of introducing new health programmes, pharmaceuticals and other technologies into the health system is performed in a fragmented, untransparent way, with several bodies being in charge. The Health Council is responsible for health programmes and technologies other than pharmaceuticals, the commission for reimbursement and listing medicines at the Health Insurance Institute of Slovenia (HIIS) is in charge of ambulatory pharmaceuticals and the Pharmaceutical Council, established in 2009 as a parallel body to the Health Council, deals mainly with hospital and biological medicines. This way of introducing new technologies into the health system seems to be inefficient and not based on all the evidence available. The National Institute of Public Health was in 2009 appointed by the MoH to be an associate partner of the EUnetHTA JA, where Slovenia is involved in development of cross-border HTA tools. Due to lack of human resources in the field of HTA, an agency for HTA is not the best option for Slovenia. Therefore, the establishment of an official network for HTA in Slovenia is proposed.[45] It is an interesting health policy observation that both the coalition and opposition experts in the field of health care support the idea of creation of a national network for HTA. So far, the main stakeholders in health policy have not put many efforts into this field; however with the ongoing cost containment pressure, the need for prioritisation of health technologies, and higher patient expectations, HTA will undoubtedly need to gain importance in the current health administration.

2.2.8 Critical assessment

The Slovene health care system is in need for serious reforms, as it has not been changed since 1992. Although Slovenia has a universal coverage system, access to the health services has worsened in the past years. Not only is the share of out-of-pocket payments increasing, which is challenging the equity issue, but also the waiting times for certain interventions have increased instead of decreased. Given the target waiting times defined in the Resolution on the National Health Plan 2008–2013[46] (non-chronic conditions: up to 3 months, chronic degenerative conditions: up to 6 months), in 2010 this goal has not been reached. Currently, the number of patients waiting over 6 months, is close to 10,000, and the financial burden, amounts to EUR 36.8 million. Of these patients, 6,000 are waiting for an orthopaedic treatment. The Government has taken an initiative to establish the national list of waiting times, to enable better transparency and efficiency of the health system.

The increase of waiting times is in line with the lack of medical doctors and the trend of

43 MoH, 2007.
44 NBOH, 2010.
45 Turk & Prevolnik Rupel, 2010.
46 MoH, 2007.

growth in demand in the period 2003–2009. Moreover, hospital treatment of non-acute services (nursing care and extended hospital treatment) has been increasing since 2004. A well-organised network of providers on the primary health care level is urgently needed. As stated above, the lack of general practitioners can be observed not only in rural areas, but also in mid-sized and smaller cities. The current minister notes that the incentives are to be sought already at the time of specialisation. In the future, primary health care will have to deal with many of the chronic patients and control examinations. How the current health administration will deal with this shortage of general practitioners remains an open question.

Tools to promote efficient and qualitative delivery of health programmes e.g. the first doctor visits, day care, specialist outpatient treatment, on-call optimisation, health technologies assessment on provider level, clinical pathways, and quality indicators, have not been implemented comprehensively. A strong emphasis of the current government is given to quality, accessibility and sustainability of the health care system.

Quality and outcomes are still not included in the current DRG system. The existing DRG model was introduced in 2003 and has not been updated since. It contains certain weaknesses that allow abuse, e.g. excessive lowering of costs by limiting the necessary examination and provision of less appropriate medications, unnecessary patient hospitalisation and showing false diagnoses and treatments of high prices. Therefore, the current DGR model requires a review. Financing with the DRG model directs the providers to cost-effective treatment, but not to qualitative provision. It is necessary to introduce quality implementation treatment based on clinical guidelines and clinical pathways. By extending the funding criteria of the providers, patient satisfaction and treatment outcomes for payment will gain a qualitative dimension.[47] Still, there are some attempts of measurement and monitoring the quality in some hospitals, especially with the PATH project already mentioned in ANR 2008[48]. However, efforts to increase the quality of care at the time of writing are still not an integral part of the system. Quality criteria are not included in the evaluation of work of health care providers in achieving certain health and economic outcomes. Health care services at the primary level partially represent an exception, since the capitation rate is connected to provision and performance of screening tests against risk factors (high blood pressure, lipids, cholesterol and blood sugar). If a private physician or public health care provider does not perform these tests with the respective patients who are at a certain age, they do not receive the entire amount of the contract from the HIIS. However, the current method of financing health services does not stimulate or recognise competition between private and public health care providers. This could be viewed as a limitation of this system. In addition, virtually all health care capacities are needed for carrying out the compulsory health care services programme, and HIIS is obliged to sign a contract with almost all health care providers. As mentioned before, an Agency for Quality and Safety is under consideration, however due to lack of human resources it is questionable if the establishment of such an Agency is feasible at the moment.

The "Association to Preserve and Improve Public Health"[49] criticises non-transparent waiting times for interventions, poor organisation of diagnostic clinics, and poor utilisation of diagnostic tools and argues that this leads to increasing absenteeism and related costs for

[47] Marušič et al, 2009.

[48] The Performance Assessment Tool for quality improvement in Hospitals (PATH). The PATH system is a comprehensive tool for hospitals to assess their performance, to question their own results and to translate them into quality improvement activities by using shared practices from other hospitals. By participating in PATH, hospitals join a network that shares a number of core values and commitments such as transparency, openness and collaboration and continuous improvement. See: www.pathqualityproject.eu.

[49] Društvo za ohranitev in izboljšanje javnega zdravstva (ZdraVi), 2010.

growing sickness compensation. The new Minister for Health appointed the National Institute of Public Health to be in charge of preparation of the detailed and comprehensive national waiting list. So far, many mistakes can be observed in the current list, as it has not been updated continuously.

Determined by the political will, privatisation of health care in Slovenia has been a gradual process. In Slovenia, only partial privatisation of health care delivery took place (primary health care), while other aspects (privatisation of hospitals) have not even started[50]. - Privatisation of the primary care infrastructure and allowing more space for private initiatives has stated strong concerns about the future course of privatisation related to the issues of equity, fairness, accessibility and solidarity.[51] At the time of writing no evidence-based analysis had been published to confirm or disprove these concerns. However, the experts share the opinion that a well-organised network of providers on primary health care level is urgently needed. The lack of general practitioners can be observed not only in rural areas, but also in mid-sized and smaller cities. The current minister notes that the incentives are to be sought already at the time of specialisation. In the future, primary health care will have to deal with many of the chronic patients and control examinations. How the current health administration will deal with this shortage of general practitioners remains an open question.

2.3 Long-Term Care

2.3.1 System characteristics

The main demographic developments in Slovenia show that in 1991 the proportion of citizens older than 65 years in the total population amounted to 11.2 %, in 2002 already 14.7 % and at the end of 2005 it represented already 15.5 % of the Slovene population. Male life expectancy, in 2006, reached 74.5 years, while female life expectancy was 82 years of age. Table 1 shows the demographic trend in Slovenia until 2050.

Table 8: The size of population according to 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

As stated in ANR 2008, Slovenia does not have a uniform system of long-term care (LTC). 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).

[50] Albreht and Klazienga, 2009.

[51] Društvo za ohranitev in izboljšanje javnega zdravstva (ZdraVi), 2010.

- 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 protection, 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.

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 the compulsory health insurance. Another problem concerning long-term care is the underdevelopment of home care. Flaker and Nagode[52] state that institutional care costs almost six times the amount of community care and is currently the dominant part of the LTC provision in Slovenia.

2.3.2 Evaluation and impact assessment

The Ministry of Health in the previous government was unable to achieve consensus around the proposal that they had prepared with the assistance of the participating key stakeholders. With the change of government this topic again achieved considerable policy attention.

The long process of passing the Act on Long-Term Care and Insurance for Long-Term Care is not over yet. The main move is the coordination role in the preparation of this law moving to the Ministry of Labour, Family and Social Affairs. The main ideas and approaches remain the same. It remains to be seen whether there will be a continuation of the same outlines proposed in the early texts or if there are going to be some additional solutions proposed. One of the most important goals of LTC is the connection of all LTC providers into a single and integral system to achieve higher effectiveness, quality of services and satisfaction of the users. The connections should be financial, professional as well as organisational.[53] The important goal of LTC is the assurance of stable sources of financing of LTC, including public and private financial sources. The transparency of all sources would be increased if all the LTC were financed from one source.

The main objectives of the Act are[54]:

- a form of special social insurance for long-term care is proposed that would be based on solidarity among all insured, the same as in the system of pension or health care. The insurance would be based on the satisfaction of needs and not on profit – this would be public, compulsory and non-profit insurance. In this sense solidarity would be introduced to intergenerational relations, based on the principle of contribution according to equal possibilities and rights according to the needs.
- with the introduction of the LTC insurance, it is assumed that the contribution rate for health care insurance and pension insurance would decrease, since some services provided now within those systems would be transferred under the system of LTC.
- the costs of dwelling and food will not be included.
- the additional rights or higher standard of care will be assured through voluntary

[52] Flaker, Nagode, 2009.
[53] Prevolnik Rupel,Ogorevc 2009.
[54] Draft Act on Long Term Care and Insurance for Long Term Care, version February 2010.

insurance.

- the right to LTC can be used if there is a need for care of other for more than 7 hours per week. And the users of LTC will be distributed into 5 categories of care depending on the severity of their needs. For this categorisation 15 criteria will be used.

Moreover, a case manager and a new work organisation are proposed. The user will be granted one entrance gate into the system, which will make the process easier and more transparent. Via the individual plan, the case manager will be in charge of guiding and advising the user through the whole process and plan and organising the provision of services.

The current situation in the field of home care is still not well organised. The goal of LTC is higher inclusion of families and their members and other non-professional providers into the provision of LTC. To achieve this, the special benefits and stimulus would be introduced. Home care is put in the forefront of providing LTC also for the reasons of rationality and accessibility.

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2.3.3 Critical Assessment of LTC in Slovenia

The current organisation of long-term care is poor and there are barriers for access to services or reducing their quality. One of most evident characteristics that causes the insufficient organisation of LTC in Slovenia is that the provided services and benefits are not integrated into a uniform system. In practice, due to the lack of experts and information, coordination between services providing long-term needs to be improved and the supervision and passive role of the user or the family care needs to be implemented. Moreover, services in the living environment (i.e. home care) are still relatively underdeveloped. This results in additional pressure on hospitalisations and the increase of institutional forms of care, which can sometimes cause (in)equity problems (i.e. financially caused inaccessibility for underprivileged persons)[55]. Due to the different scope of beneficiaries, those who stay in their home environment are disadvantaged as compared to those who receive institutional care, since the former are not provided with integrated health and social care. An important issue in local environments, is transitional help, such as day centres, transitional accommodation, and domestic help, which is still insufficient.

An overall national quality management strategy is missing and is legally not settled. Quality indicators in LTC are missing and only via E-Qalin model[56] in institutions that provide LTC, this is being slowly introduced. In home care, no such parameters exist. The only kind of quality assurance is with regards to community nursing, where the nurses have to provide care according to the protocol. However, in reality there are many complaints and cases of

[55] HiT, 2009.

[56] Characteristic of E-Qalin ® is the action-learning approach that includes all hierarchical levels of an organisation and promotes the active participation of employees. Individuals (managers) are qualified, who 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 aging and respect for the aged in our society, or 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.

improper care and nursing in different forms of care and such cases are simply not taken care of. [57]

The most apparent difficulty is the fragmentation of LTC among different sectors (health care, social care) and limited communication between the system that would assure efficient and transparent provision of the services.

Thewaiting lists for different kinds of care are useless, as they are not updated and even duplicated. There are no systematic data that would enable the estimation of needs or are only provided ad hoc through questionnaires for scientific research. The users therefore are not granted fast access to most proper services and are not informed properly of their options, since such information is simply not available in one spot.

With implementation of E-Qalin and needs assessment, Slovenia can improve the field of quality of LTC and work towards best practice approach.

Already in 2006, a Strategy for Protection of the Elderly until 2010 was introduced. [58] The aim of the Strategy was to harmonise the work of the different line ministries, enterprise sector and civil society. The purpose was 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]

Despite the poor quality management and organisation of the LTC field in Slovenia, some progress has been made. Early in 2010 the National Programme of Palliative Care has been adopted.

Palliative care services (PC) are needed for patients of any age with advanced chronic incurable disease and relatives. The current status palliative care in Slovenia shows that the number of palliative care experts who are willing to work in palliative care as providers and teachers is insufficient. The task group for palliative care remarked the following issues: palliative care planning focuses too much on institutions and less on home care; financing and classification of palliative care standards at the national level is not well established; there is not a good tradition of team work and collaboration in multidisciplinary teams. In Slovenia there is one inpatient palliative care department at the specialised hospital Golnik and three hospices in Ljubljana, Maribor and Celje, however with no beds. A number of hospital beds (20–30) at the Institute of Oncology Ljubljana are used for palliative patients. The palliative care department in Golnik is funded by government, while palliative care services in the three hospices are supported by a combination of private and public funds.[60] The patient needs to be as a minimum six days in non-acute treatment, so that the financing is classified as long-term care (LTC). With regard to quality of care, Golnik started with introduction of "care coordinator", who will in the end be responsible for quality surveillance.

Based on the needs of palliative care in Slovenia, the Government in April 2010 adopted the National programme of Palliative Care.

The Programme is based on setting the basis for integrated care, which should provide the legal basis, financial resources, organisation, and a network of people properly trained for palliative care. The document serves as the basis for the preparation of action plan for establishment of integrated palliative care in Slovenia.

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57 Turk, 2009.
58 MLFSA, 2006.
59 MLFSA, 2009.
60 Prevolnik Rupel,Ogorevc 2009.

The purpose of the Programme of PC is to improve the quality of life for patients and their relatives through preventive measures and facilitating the suffering, early detection, proper assessment and treatment. Compliance with applicable ethical and legal norms: human rights, justice and the dying patient need to be ensured.

The Programme states that for qualitative PC, a palliative team of experts, physician, nurse, home care nurses, social workers, clinical psychologists, occupational therapists, physiotherapists, dieticians, spiritual care providers and volunteers is required. The volume of their aid depends on the needs of the patient and is intensified with the progress of disease. The need for PC is increasing, especially with the growth of cancer and other chronic diseases. PC is an integral part of health and social welfare system at all levels and thus an inalienable part of rights to health and social care. [61]

3 Impact of the Financial and Economic Crisis

Since 1993 Slovenia experienced steady economic growth, with the lowest annual GDP growth rate in this rather long period being 2.8 %. Growth of GDP has even been accelerating in recent years, reaching 5.9 % in 2006 and 6.8 % in 2007. These high growth rates were also followed by rather high inflation rates, particularly in the first half of 2008. High inflation and, quite possibly, the approaching election in September 2008 caused the Government to introduce a law on lump-sum pension supplement. The law was passed in July 2008 and increased pensions for recipients of low pensions by a lump-sum amount, between EUR 80 and 150; the lower the pension, the higher the amount. For example, pensioners whose monthly pension was below EUR 404 received EUR 150, those whose pension was between EUR 404 and 450 received EUR 100 and those whose pension was between EUR 450 and 500 received EUR 80[62].

The impact of the economic and financial crisis started being felt in autumn 2008, with a contraction of industrial production and gradual rise in registered unemployment. This gradual rise in registered unemployment is shown in Table 8. The contraction of industrial production is quite understandable, considering the strong export orientation of the Slovene economy. Thus, the manufacturing index (taking the 2005 average as 100) was 123 in March 2008, 92 in February 2009 and 92 in February 2010.

The Health Insurance Institute feels the consequences of the economic crisis. Due to lay-offs and a reduction of number of hours worked, workers get lower wages, and consequently there is a reduction of the inflow of contributions into the fund. If the projections of the Health Insurance Institute (HIIS) regarding the health budget are accurate, at the end of 2010 a deficit of EUR 100 million is to be expected. The HIIS could cover slightly more than half of the deficit from its reserves, but over EUR 50 million will remain uncovered.[63]

[61] Turk, 2009.

[62] There was an attempt by the SDS (*Slovenska demokratska stranka)* to repeat such a measure in April 2009. The proposal by this party, now in opposition, did not gain support of the government coalition.

[63] ZZZS, 2010.

Table 9: Registered unemployment in Slovenia, August 2008 to February 2010

Month, Year	Registered unemployment	Unemployment rate (reg. unemployment), in %
August 2008	60,669	6.5
September 2008	59,303	6.3
October 2008	62,621	6.6
November 2008	63,363	6.7
December 2008	66,239	7.0
January 2009	73,911	7.8
February 2009	77,182	8.2
March 2009	79,682	8.4
April 2009	82,832	8.8
May 2009	84,519	8.9
June 2009	86,481	9.1
July 2009	88,457	9.4
August 2009	88,106	9.4
September 2009	88,366	9.4
October 2009	94,591	10.0
November 2009	95,446	10.1
December 2009	96,672	10.3
January 2010	99,591	10.6
February 2010	99,784	10.7

Source: Employment Service of Slovenia

Table 10: GDP in current prices (in million EUR), 2006–2009

	GDP	Index on previous year
2006	31,050	-
2007	34,568	111
2008	37,135	107
2009	34,894	94

Source: Statistical office of the Republic of Slovenia, 2010.

Table 11: Tax revenues (in million EUR), 2007–2009

	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
Index 2009/2008	93	96	57	90	101

Source: Bulletin of Public Finance, Ministry of Finance, 2010.

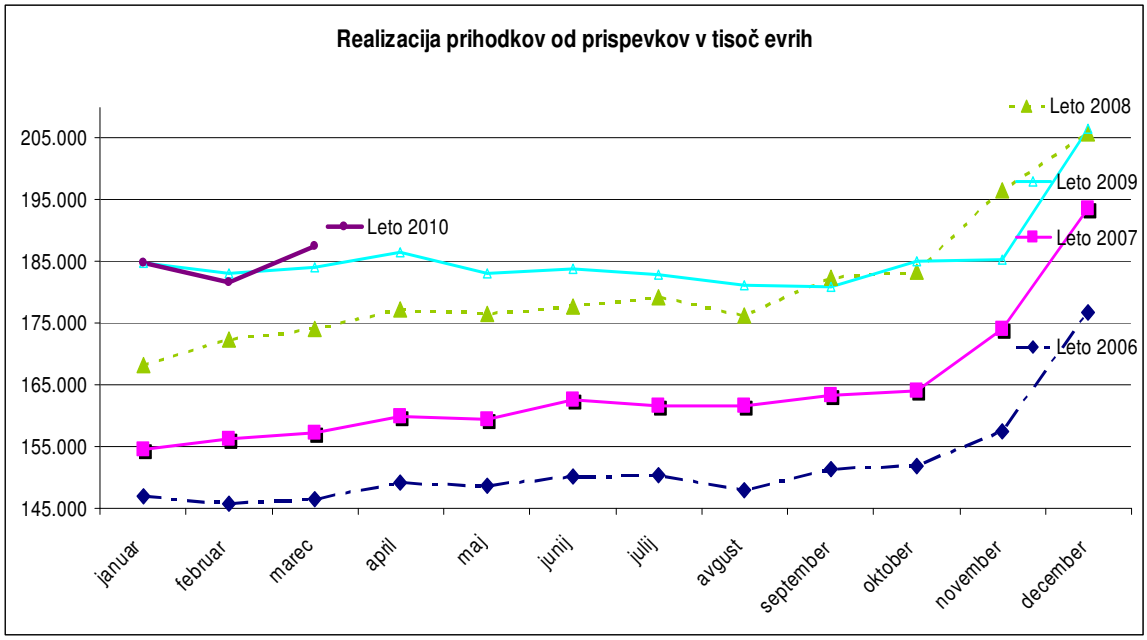
The newly elected government (installed in December 2008) acted swiftly, proposing a package of measures already in December. This package contained an important measure aimed at supporting firms that are experiencing reduced orders. The law on partial subsidisation of the full working time provides a subsidy of EUR 60 per worker per month for those firms that do not lay off workers but rather reduce the weekly workload from 40 to 36 hours. For firms that reduce the workload from 40 to 32 hours the subsidy amounts to 120 euros per worker per month. Of course, this subsidy does come with certain conditions attached:

- The firm must regularly pay wages and social contributions for workers for whom a subsidy is claimed;
- Laying off workers for business reasons is not permitted during the whole year (i.e. 2009);
- Higher workloads (i.e. more than 40 hours per week) are not permitted;
- The management and supervisory board must not receive bonuses in this year.

The duration of this subsidy is 6 months, with a possibility of renewal for an additional six months. EUR Some 230 million are earmarked for this measure, which is more than the total amount to be disbursed for unemployment benefits (EUR 150 million).

The second package of measures was passed in February 2009; it dealt mostly with the financial sector. The third package has been proposed at the end of April 2009; it also contains an important measure for preserving employment. The subsidy would cover some 25,000 workers, who would not be in work, but would still be retained by the employer. They would receive 85 % of their normal pay, with 50 % covered by the Government and 35 % by the employer; the maximum amount covered by the Government is not to exceed EUR 805 per month. The duration of such subsidisation would be six months for the employee. This period could be extended, with evidence from the employer provided for such an extension. Some EUR 100 million are earmarked for this measure.

Figure 5: Paid contributions for compulsory health insurance 2006–2009 per month and the first three months of 2010



Source: ZZZS, 2010

This is the worst scenario based on data and information on incoming and outgoing funds in the first three months of the year (Figure 6). [64] However, many, including the current Minister for Health, believe that these forecasts of HIIS are premature and that the situation may be rectified in the coming months and end in a smaller deficit. The main argument is that lower

[64] Marn, 2010.

inflows into health care budget in the first three months of the year may also be due to the fact that employers pay contributions at a later stage.

Providers of health care services are also facing higher costs in their organisations. One of the reasons is the rise in minimum wage at the state level, as this is the reason for higher prices of the suppliers.

In order to save costs, HIIS decided lower the price of all 661 DRGs by 2.5 %. This measure affected most those providers who already have tight DRGs, primarily major surgical procedures, such as heart operations. Moreover HIIS is suggesting to reduce the rate of hospitalisations. It is proposing to carry out as many procedures as possible in the form of ambulatory day treatments.[65] Some experts alert that measures in the health care need to be prudent and systematic. Control of salaries, redefining of the health basket and increasing of the contributions and re-introduction of co-payments are some potential measures that have been on the table currently.[66] , [67]

Čok[68] is arguing that with the increase of minimal wage, some additional funds will flow into the HIIS.[69] Moreover, he would propose all incomes (in addition to salaries, also individual contracts, profits from limited liability companies, dividends etc) to serve as the contribution basis. This measure would potentially bring EUR 31 million to the HIIS. This is shown to be a proposal based on solidarity and long-term sustainability; however it does not solve the current deficit of the HIIS.

The Government needs to tackle the issue of financing health care very soon. This can be done either through a more modest health spending, or through greater participation of those who contribute (too) little. To ensure consistent, long-term, internationally competitive financial arrangements, introducing a ceiling on contributions could be considered. It is evident that a high health basket and low contributions cannot exist at the same time. However, any interventions in the health system contributions must be strictly in line with pension contributions and income tax.[70]

65 Marn, 2010.
66 Čok, 2010.
67 Marn, 2010.
68 Čok, 2010.
69 Čok, 2010.
70 Čok, Prevolnik Rupel, 2009.

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Important links for documents

The Pension and Disability Insurance Act of 1999 (ZPIZ-1)

http://zakonodaja.gov.si/rpsi/r01/predpis_ZAKO1431.html

The draft law on pension and disability insurance (ZPIZ-2)

http://www.mddsz.gov.si/fileadmin/mddsz.gov.si/pageuploads/dokumenti__pdf/Predlog_ZPIZ-2_24.03.2010.pdf

Modernizacija pokojninskega sistema v Republiki Sloveniji - Varna starost za vse generacije

Modernisation of the pension system in the Republic of Slovenia: a secure ageing for all generations

http://www.mddsz.gov.si/fileadmin/mddsz.gov.si/pageuploads/dokumenti__pdf/word/Dokument_o_modernizaciji_25_9_09.pdf

4 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

[R1] ČOK, Mitja, J.SAMBT, A. BERK SKOK, M. KOŠAK (2008), "Long-term sustainability of the Slovenian pension system", *Economic and business review,* 10(4): 271-288.

The rapidly ageing population in Slovenia will exert serious fiscal pressures in the future. Though the 2000 pension reform is yielding results, further adjustments will be needed in order to avoid an unsustainable increase in pension expenditures. This paper develops long-term financial projections of the pension system, based on Eurostat demographic projections. The projections presented in this paper are based on the family of ILO models, and take into account the latest legislative changes and most recent data available. These projections show that the share of pensions relative to GDP exceeds a limit that can be maintained in the future.

[R1] HOLZMANN, Robert and Guven, UFUK (2009), "*Adequacy of retirement income after pension reforms in Central, Eastern and Southern Europe*", The World Bank, Washington, D.C.

This book analyses the pension system of eight countries: Croatia, the Czech Republic, Hungary, Poland, Romania, the Slovak Republic and Slovenia. The country chapters describe the main characteristics of the pension systems and assess its performance. The main part of each country chapter is devoted to an assessment of the performance of the system in terms of benefit adequacy and maintaining fiscal balance. For Slovenia, the authors suggests certain policy options, namely further increases in the retirement age and decreasing benefits. As they state, this could provide an opportunity for "broadening the reach" of the voluntary pension pillar.

[R1; R2] FESTIĆ, Mejra, Jože MENCINGER and Sebastijan REPINA (2009), "The perspective of pension system reforms in the New Member States", *Prague Economic Papers,* 18(4): 291:308.

This paper estimates a simple regression model, using pension expenditure/GDP ratio as the dependent variable, showing that this ratio increases with increasing old-age

ratio, development level (measured as GDP per capita) and replacement rate. It is negatively related to statutory retirement age. All EU member states for which data was available were included in the sample. The paper then proceeds to estimate an equation including only new member states, showing that the ratio of incomes of the elderly population as compared to the incomes of the labour active population is negatively associated with the Heritage Foundation index of economic freedom. It also expresses strong criticism of a "stampede" toward pension privatisation, pointing that this will exacerbate problems of social welfare.

[R2; R3] PAPEŽ, Marijan (2009), "Kakšne spremembe lahko pričakujemo z modernizacijo pokojninskega sistema", *HRM,* 7(30) : 13-20.
"What changes can we expect from the modernisation of the pension system."

The author describes the main features of the current pension system and deals with some proposals and suggestions for the modernisation of the system. He documents the unintended effects of earlier retirement (without deductions) for child-rearing, stating that this is the main reason for the very slow increase in effective retirement age. This the more so as the child bonus is increasing every year. The author further argues that the demand to move social assistance measures out of the caisse of pension and disability insurance is not a simple task, and that these rights would have to be placed in various other laws. In comparing the merits and weaknesses of the point system and the NDC system, the author comes out in favour of the points system, due to its simplicity and transparency and also due to a simpler transformation from the current system.

[R2; R3] STANOVNIK, Tine (2009), "Pokojninske reforme v centralni, vzhodni in jugovzhodni Evropi", *IB revija* 43(3-4): 19:30.
"Pension reforms in Central, Eastern and Southeastern Europe."

This paper presents a broad comparative analysis of pension reforms in eight countries of Central, Eastern and Southeastern Europe. These include seven new EU member states and Croatia. The main features and parameters of the public pension pillar are compared, showing that all systems are gradually improving actuarial fairness, by providing tighter links between contributions paid and pensions disbursed. Some weak design features of the pension reform are also shown, particularly with regard to the lack of attention to the rules for inclusion into the mixed system (i.e. system with a public pension pillar and a mandatory private second pillar). Also, evidence is presented to show that the increase in activity of the elderly age group (55 to 64 years), which is supposed to be the main success indicator of a pension reform, is not related to how fundamental or "systemic" the reform actually is. Very much depends on the steadfast political support and – consequently – the strict application of defined rules, i.e. no political "meddling". Also, the pension system must be perceived as fair.

[R2; R3] STRBAN, Grega (2009), "Pravna vprašanja predvidenih reform pokojninskega zavarovanja", *Pravna praksa,* 46: 9-11.
"Legal aspects of the proposed reform of pension insurance."

This paper presents some legal aspects of the proposed changes in the pension system. The author argues that the broadening of the contribution base is meaningful – provided that this is also taken into account when computing the pension assessment base. He opposes setting a ceiling on contributions, as well as deductions for early retirement, stating that persons with a sufficient working period ought to have the

right to retire without deductions. He is in favour of retaining the system of "differentiated" entry, permitting a lower retirement age for persons with a longer insurance period and vice versa. Support to increasing the period relevant for the calculation of the pension assessement base is also given, as well as support for equalisation of the retirement age for men and women. The author argues that a points system would improve transparency, compared to the current (and retained) system of valorisation coefficients. Strong opposition is expressed toward the "second phase" of the reform, i.e. the NDC system. According to the author, this system is unacceptable from the legal point of view, as it is based on individual financing, which is characteristic of private insurance; in other words, the NDC system denies the right to social security. Changes are meaningful if they preserve the system of social protection, which is based on solidarity and collective financing.

[R3] POGAČAR, Peter (2009), "Modernizacija pokojninskega sistema v Republiki Sloveniji z vidika finančne vzdržnosti sistema ter priložnosti za izboljšave sistema" *Delavci in delodajalci,* 4, 555-568.
"Modernisation of the pension system of the Republic of Slovenia with regard to financial sustainability and opportunities to improve the system."

The article presents some demographic and labour market features of Slovenia, followed by a description of the main elements of the position paper Modernisation of the Pension System in the Republic of Slovenia: Secure Ageing for All Generations, describing the main aims of the proposal: to secure adequate and decent pensions and to ensure financial sustainability of the system. The latter is to be achieved mostly by measures aimed at increasing labour activity of the elderly population – through the increase in the retirement age and incentives and disincentives for late and early retirement, respectively. Individuals will be better informed on their accrued rights, and a tighter link between contributions and pension rights will be established. Finally, social assistance measures will not be included in the pension insurance law, but are to be dealt with in relevant social insurance acts. The article also briefly deals with the introduction of a "new" system (NDC), from 1 January 2015.

[H] Health

[H1] ČOK Mitja, PREVOLNIK RUPEL Valentina (2009) "Solidarnost po slovensko", Sobotna priloga (Delo), 25.12.2009.
"Solidarity the Slovene way"

The article analyses health care financing in Slovenia, Health Insurance Institute, the relative contributions of individual persons and who should bear the largest (obligatory) financing burden. Data on health care contributions, as evidenced by the continuation of the article does reveal that the compulsory health insurance system contains distinct elements of solidarity. Asymmetry is not found only in the relationship between health care contribution payers and non payers, but also within groups of contributors.

[H2] JERIČEK KLANŠČEK, Helena, et al. (eds.), "Duševno zdravje v Sloveniji", Inštitut za varovanje zdravja, Ljubljana, 2009.
"Mental health in Slovenia"

An analysis of mental health in Slovenia. The publication gives an overview of the current situation of the area of mental health in Slovenia. It presents epidemiologic data, the organisation of the area, and shows the most important problems the system is

facing. Moreover, the publication is a needs assessment of mental health in Slovenia. In addition, it includes all stakeholders involved in the area of mental health and is aiming to prepare a national strategy in the field of mental health.

[H3] ALBREHT Tit, KLAZIENGA Niek, "Privatisation of health care in Slovenia in the period 1992–2008", Health Policy, Vol. 90/2., pp. 262-269, 2009

Discussing the background, nature and facilitating and hindering factors of the privatisation process in health care in Slovenia. Descriptive analysis of legal and policy documents mapping the situation in Slovenia against an internationally established taxonomy and typology. Description of the scope and volume of the different types of privatisation. Slovenia's privatisation in health care is focused on primary health care and on health expenditures. Controversies over its extent kept privatisation contained and controlled.

[**H4]** ALBREHT, Tit (2009). "Public debate on Health Services Act proposal ends". Health Policy Monitor.

The proposal of the new Health Services Act was finalised and presented for a public debate that took place between 10 June and 10 September 2009. The debate showed that several solutions were not well thought through and provided for a wide range of critical comments. The latter ranged from total refusal by the Medical Chamber to moderate approval within a part of the governing coalition. Comments, corrections and amendments will now be incorporated into a revised proposal for the next phase.

[H4] 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 the 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).

[H4] ALBREHT Tit, TURK, Eva, TOTH Martin, CEGLAR Jakob, MARN Stane, PRIBAKOVIC BRINOVEC, Radivoje, SCHAEFFER, Marco (2009). "Slovenia: Health system review. Health Systems in Transition." 2009; Volume 11(3): 1-168.

Health Systems in Transition publication are country-based reports that provide a detailed description of each health care system and of reform and policy initiatives in progress or under development.

[L] Long-term care

[L] FLAKER Vito, NAGODE Mateja, "Dolgotrajna oskrba. Stanje, izzivi, eksperimenti in reforma". Kakovostna starost. Let. 12, nr. 3, 2009 (24-37).
"Long term care. Status, challenges, experiments and reform"

Long-term care as an idea, insurance, system, method and form of organising services. LTC can be seen as a major innovation. LTC introduces new ways of understanding and conceptualisation of social security and social rights, their enforcement and the relationships between the users and their helpers, and of the position and status of professionals and other providers of care. The process of implementing new ways of organising and funding long-term care will be very demanding, since the new organisation requires many changes at different levels. This paper presents the current organisation of long-term social and health care in Slovenia. The pilot project for individual funding of social services is described, some solutions offered and obstacles encountered. It shows that the introduction of long-term care remains an important issue, which could profoundly change the social and health care.

5 List of Important Institutions

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

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 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

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 analize – 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

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

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

INŠTITUT ANTONA TRSTENJAKA – Anton Trstenjak Institute

Address: Resljeva 7, 1000 Ljubljana
Webpage: http://www.inst-antonatrstenjaka.si

The Anton Trstenjak Institute of Gerontology and Intergenerational Relations was founded in 1992 as the first scientific, educational and managerial-advisory institution in independent Slovenia in the field of interpersonal relations, health strengthening and resolving of personal and family distress. The Institute was co-founded by the Slovenian Academy of Sciences and Art in 1992. In 2004, the Government of the Republic of Slovenia co-founded the area of gerontology and good intergenerational relations, which made the Institute the national scientific social gerontology institution. The Anton Trstenjak Institute works in three main areas: gerontology and good intergenerational relations; humanistic psychology, logotherapy and preventive anthropohygiene, addictions.

STATISTIČNI URAD RS – Statistical Office of the Republic of Slovenia

Address: Vožarski pot 5, 1000 Ljubljana

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 cooperation, 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

Address: Miklošičeva 24, 1000 Ljubljana

Webpage: www.zzzs.si

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

ZDRAVNIŠKA ZBORNICA – Medical Chamber of Slovenia

Address: Dalmatinova 10, p.p. 1630, 1000 Ljubljana

Webpage: www.zzs-mcs.si

The Medical Chamber of Slovenia has the public authority of licensing professionals and maintaining their register. Membership is obligatory for physicians. The Chamber represents both medical doctors and 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 has begun to grant medical licences. 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: Rimskacesta 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 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 aims 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
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, pharmaceuticals and pharmacy sector.

Faukulteta za druzbene vede – Faculty of Social Sciences, University of Ljubljana
Address: Kardeljevaploščad 5,1000 Ljubljana
Webpage: http://www.fdv.uni-lj.si

The Faculty of Social Sciences takes 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: the Centre for Welfare Studies, Centre for Political Science Research, Defence Research Centre, Centre for Theoretical Sociology, Centre for Organisational and Human Resources Research, Social Communication Research Centre, Centre for Methodology and Informatics, Public Opinion and Mass Communication Research Centre, International Relations Research Centre, Centre for Social Psychology, Centre for Cultural and Religious Studies, Centre for Social Studies of Science, Centre for Spatial Sociology, Centre for Policy Evaluation and Strategic Studies, Centre for Comparative Corporate and Development Studies, Research Centre for the Terminology of Social Sciences and Journalism, Centre for Critical approach to Political Science.

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

As a research institution, the Faculty of Social Work advances the profession and science of social work, conducts basic, applied and developmental research, publishes research findings and implements them in practice and pertinent policies. This institution has been a pillar (in some periods the only one) of the development of Slovenian social work and the field of social care in general. It has achieved a high level of teaching, based on its own scientific and research activities (over 70 projects), as well as on good knowledge of international trends.

The forms and methods it has developed are the basis of contemporary social work: counselling, group work, community work, work with families etc. Its achievements in voluntary work action research and qualitative research in general have played an important role in Slovenian social sciences. It has developed special fields, such as working with elderly people, women, young people, people in mental distress, disabled people, ethnic minorities, etc. Most importantly, it has greatly contributed to innovative solutions in the field of social care (social first aid, home help, group homes, safe houses, etc.).

Skupnost centrov za socialno delo – The Community of Centres for Social Work (CCSW)

Address: Dimičeva 12, 1000 Ljubljana

Webpage: http://www.gov.si/csd/

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

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

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