Annual National Report 2009

(Pensions / Health and Long-term Care)

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Table of Contents

1 Executive Summary

The pension system of Slovenia did not undergo any changes in 2008. However, a working group has been established, with the task of suggesting proposals for the modernisation of the system. This group was formed in March 2009, so it is still too early for predictions on the course it will take. In spite of the worsening economic and social conditions, the pension system of Slovenia has been operating on a "business-as-usual" mode. Pensions were even increased in February, according to the established indexation rule. Also to be noted is the fact that worsening conditions have not yet had any impact on contribution collection. However, should any shortfall in revenue occur, the Government would be obliged (by law) to intervene and cover this shortfall.

Slovenia did not undergo any health or long- term care reforms in the year 2008 either.

In the first half of 2008, Slovenia, as the first new EU Member State, held the EU Presidency, where the issue of cancer was given the biggest emphasis. Another priority for the Slovenian Presidency, relating to health, was the reduction of alcohol use and the damage associated with excessive consumption, as well as the development of an IT system in health care.

Despite the Presidency, the developments in health care and long-term care in the past years have disclosed an obvious need for improvement of the Slovene health care system. For example, the privatisation of parts of the health care services at primary level is considered to be an efficiency-inducing measure, as the private providers compete with each other and with the public system for contracts with the HIIS. Controversies remain, however, as to the means of monitoring and adequately allocating financial resources through these processes.

Moreover, Slovenia's spending on health, as a share of GDP is currently as much as the EU average. The public part of health expenditures has been reduced over the last few years, causing some concern over the sustainability of such an approach. Nevertheless, the challenge for the future will be to improve the efficiency of the health system. The discrepancy between the needs and demands of new technologies and resources of their funding is constantly growing. Therefore, a critical and continuous assessment of the introduction of new methods of medical treatment is required. New technologies should include impact assessment on the health status of the population, and efficiency and effectiveness of the utilisation of the current and future investments in health care.[1]

Waiting lists for some health care services have become a serious political issue. An active approach to their resolution has resulted in important improvements in waiting times for certain interventions. The area of quality of care needs improvement and needs to be put higher on the political agenda.

Changes in demographic developments and an increased use of medicinal products imply a need for better organisation of long-term care in Slovenia. An integrated solution for health care and long-term care is lacking. Currently, there is no legislation for the financing, structuring and coordinating the organisation of long-term care. A proposal for a Long-term Care and Long-term Care Insurance Act has been in preparation. The financial risks associated with long-term care will be covered by a special long-term care insurance, which will be based on the same financing principles as the other branches of social insurance.

However, some successful legislative documents were adopted in the year 2008. Namely, the Resolution on the National Health Care Plan for 2008-2013. This resolution is an important

[1] Turk and Albreht, 2008.

document, as it represents a strategy which had been absent since 2004. It provides guidance in the development of health care delivery in Slovenia over the period of the next six years. Further important adopted legislative documents are the Patient Rights' Act, the Mental Health Act and the Amendment to the Health Care and Health Insurance Act. In line with the Lisbon Strategy of e-Government, the current Ministry of Health (MoH) is restarting the work on the e-Health project that had been hibernating for the past years.

2 Status and Development during 2008 and until April 2009

2.1 Pensions

The pension reform, launched in 1999 (and effective from 1 January 2000), introduced far-reaching 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 by decreasing the accrual rates and increasing the number of years used in the calculation of the pension 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 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
Calculation of pension base	Best 18 year average of (net) wages, using revalorisation coefficients	
Calculation of pension	Pension base multiplied by accumulated accrual rates	
Accrual rates	35% of the pension base for first 15 years, then 1.5% for each additional year	38% of the pension base for first 15 years, then 1.5% for each additional year
Pension indexation	Growth of wages	
Minimum pension base	Set nominally, but effectively at approx. 64% of national net wage	
Maximum pension base	4 times minimum of pension 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. The parameter values for men (stated in Table 1) have been reached in 2009. However, the parameter values for women are being increased more gradually, as the retirement age of 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[2]. The revalorisation coefficients, used in calculating the pension base, are rather low – they amount to only some 80% of the nominal growth of wages. This simply means that, in calculating the pension 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 base) past wages would be indexed with nominal average wage growth, but (in calculating the pension from the pension base), the accrual rates are "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 lower insurance period, but requiring a higher retirement age. Thus, persons who do not satisfy the condition of minimum insurance period of 20 years can retire at a later date: men at 65 and women at 63, but they must have at least 15 years of insurance.

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-raising. This measure is being phased in: upon completion in 2014, the reduction for two children will amount to almost 19 months. Paradoxically, as this "sweetener" was gender-neutral, it has so far been 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 year3. 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 reduces the annual nominal increase of pensions for existing pensioners, in line with the decreasing accrual rates for new entrants[4]. This in effect means that each year in February, for most pensioners, pensions are increased by the growth of wages in the past year minus 0.6 percentage points. For example, as the nominal growth of the average wage in 2008 was 3.5%, pensions (for most pensioners) were increased in February 2009 by 2.9%.

With regards to the second pillar, which was (in effect) introduced in the 1999 PDIA5, 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). 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 potential

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

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

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

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

inflationary consequences6, proposed a conversion of this increase into premiums 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 in 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, do 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)
PRVA OSEBNA	Total	76,504	140,316
SKUPNA	Total	73,036	227,000
POKOJNINSKA A	A	45,000	154,000
TRIGLAV	Triglav	44,200	123,930
KAPITALSKA DRUŽBA	ZVPSJU	187,191	282,840
	SODPZ	39,306	206,410
	KVPS	34,083	143,200
MOJA NALOŽBA	MN	31,207	78,400
BANKA KOPER	VPS Banke Koper	5,862	24,050
GENERALI	LEON 2	4,654	15,560
PROBANKA	DELTA	4,150	6,060
ABANKA	A III	2,871	11,440
ADRIATIC SLOVENICA	AS	2,317	3,770

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 has produced some visible and positive results. Table 3 shows the gradual increase in the effective retirement age, whereas Table 4 shows the decrease in the replacement rate and small decrease in pension expenditures (measured as % of GDP).

Table 3: Effective retirement age, 2000-2008

Year	MEN		WOMEN		ALL	
	Year	Month	Year	Month	Year	Month
2000	61	0	56	1	57	11
2001	62	0	56	2	58	2
2002	62	2	56	5	58	10
2003	62	2	56	6	58	10
2004	62	6	57	3	59	7
2005	61	9	57	3	59	5
2006	61	8	57	4	59	6
2007	61	10	57	7	59	8
2008	61	11	57	7	59	7

Source: Monthly Statistical Bulletin, February 2009; Institute for Pension and Disability Insurance.

[6] 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 4: Average old-age pension/ average net wage ratio and pension expenditures as percentage of GDP

Year	Average old-age pension/ average net wage (in %)	Pension expenditures as percentage of GDP
2000	75.3	11.08
2001	73.2	11.00
2002	72.8	10.84
2003	71.1	10.64
2004	70.2	10.44
2005	69.1	10.38
2006	68.6	10.18
2007	67.1	9.73
2008	67.1	9.91

Source: Monthly Statistical Bulletin, February 2009; Institute for Pension and Disability Insurance.

Particularly noteworthy is the increase in activity of the elderly population; this increase has also been documented by other statistical sources. Thus, 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 55-64 age group 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 female dependants has 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 years 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 in %, 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).

The income position of pensioners has been gradually deteriorating, as seen by the decreasing pension/wage ratio in Table 4. Other statistical sources are perhaps even more revealing. Thus, Table 6 shows the gradual deterioration of the income position of pensioners measured at the household level. We define pensioner households as households where the head of household is a pensioner and there are no active (labour-active or unemployed) household members. In other words, these households rely almost exclusively on pensions. Clearly, pensioners in these households (which comprise some 60% of all pensioners) are worse off than the group of all pensioners. Since the start of the reform in 2000, the income position of both groups have been deteriorating, as shown by an increasing share of pensioners in the bottom income group and decreasing share in the top income group. These movements can be explained by the lower nominal growth of pensions (due to negative annual accruals) and to "frozen" high pensions, as no indexation of these pensions was performed until they reached the lower ceiling (maximum pension base to be equal to 4 times the minimum pension base), prescribed by the 1999 PDIA.

Table 6: The share of (a) pensioners and (b) pensioners in pensioner households, by income groups (in %)

decile	All pensioners					Pensioners in pensioner households				
groups	1997-99	1999-01	2001-03	2003-05	2005-07	1997-99	1999-01	2001-03	2003-05	2005-07
1-3	**36.0**	**33.6**	**36.2**	**37.7**	**39.5**	**44.4**	**39.6**	**45.4**	**46.0**	**48.1**
4-7	**37.8**	**39.9**	**38.3**	**38.3**	**40.8**	**34.4**	**39.6**	**35.2**	**34.5**	**37.1**
8-10	**26.2**	**26.5**	**25.4**	**24.0**	**19.7**	**21.2**	**20.8**	**19.4**	**19.5**	**14.8**
All	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Kump and Stanovnik (2008).
Note: each decile group contains 10% of all households. The three groupings in the table, thus, consist of 30%, 40% and 30% of all households. Each person (pensioner or pensioner in pensioner household) is assigned the household equivalent income. The modified OECD equivalence scale is used.

Quite predictably, these developments resulted in an increase in the risk of income poverty for pensioners, as observed in Table 7. However, the income position of pensioners living in pensioner households has deteriorated even more, and during the 2005-2007 period, their risk of income poverty (taking the income poverty threshold at 60% of the median equivalent household income) was twice the overall national average. Among the socio-economic groups presented in Table 7, only the unemployed have a higher poverty incidence – amounting to more that 3 times the overall national average.

Table 7: 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).

2.2 Health

2.2.1 Health 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).

It can be said that the health system transformed into a mixed system with private insurance reaching already 27.8% in 2006.[7] Compulsory health insurance contributions constitute the major source of health care financing in Slovenia, with 67.1% of total health expenditure in 2006.[8] 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.[9]

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).

Voluntary health insurance (VHI) premiums and household out-of-pocket (OOP) spending represent private sources of funds and accounted for approximately 28% of the total health care funding in 2006.[10] 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. Table 8 shows the health expenditure from year 2000 to 2006 by sources of funding.

7 SORS, 2009.
8 ibid.
9 ZZZS,2009.
10 ZZZS, 2009.

Table 8: Health expenditure in Slovenia, sources of funding 2000-2006

	2000	2001	2002	2003	2004	2005	2006
Public expenditure on health (PHE) (million EUR)	1,125.7	1,305.5	1,449.5	1,564	1,665.8	1,751.7	1,858.4
PHE per capita (EUR)	566	655.4	726.6	783.6	834.2	875.4	925.5
PHE as % of THE	74	73.5	73.4	71.8	73.3	71.9	72.2
- Compulsory health insurance expenditure (% of total PHE)	94.5	93.5	93.3	92.9	93.1	93.7	92.9
- National government expenditure (% of total PHE)	4.6	5.3	5.6	6.2	6.1	5.6	6.5
- Local government expenditure (% of total PHE)	0.9	1.3	1.1	0.8	0.9	0.7	0.7
Private health expenditure (HE) (million EUR)	398.8	471.2	528.8	613.3	608.2	684.5	713.8
Private HE per capita (EUR)	200.5	236.5	265.1	307.3	304.5	342.1	355.5
Private HE as % of THE	26	26.5	26.6	28.2	26.7	28.1	27.8
- Voluntary health insurance expenditure (% of private HE)	51	52	48.3	45.9	47.5	45.6	47.1
- Out-of-pocket expenditure (% of private HE)	44.1	39.5	43.5	42	43.8	44.1	42.5
Total health expenditure (THE) by type of service (million EUR)	1,524.4	1,776.7	1,978.3	2,177.3	2,274	2,436.2	2,572.2
- curative care services (% of total)	n/a	n/a	51.9	50.9	51.7	51.2	50.8
- rehabilitative care services (% of total)	n/a	n/a	2.1	2.1	2.1	2.2	2.1
- long-term nursing care (% of total)	n/a	n/a	7.4	7.2	7.7	8.2	8
- Ancillary health care services (% of total)	n/a	n/a	2.5	2.4	2.7	2.7	2.8
- Medical goods dispensed to out-patients (% of total)	n/a	n/a	23.1	23.1	23.1	23.2	22.8
- Prevention and public health services (% of total)	n/a	n/a	3.6	3.6	3.7	3.7	3.9
- Health administration and health insurance (% of total)	n/a	n/a	4.4	4.5	4.1	4.1	4.2
- Gross capital formation (% of total)	n/a	n/a	5	6.2	4.9	4.8	5.4

Source: SORS, 2009

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, such that they are equally accessible to all people without discrimination. All people must be assured continuously accessible urgent medical attention and emergency services.

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 is 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) and a growing number of patients with chronic illness, the costs of health care are rising steeply.

2.2.2 Health policy

No structural reforms occurred in Slovenia in 2008 and early 2009. However, some successful legislative documents were adopted in 2008. The main activity in the legislative process in 2008 is outlined in Box 1.

Box 1: Main activity in legislative process in 2008

Resolution of the National Health Plan 2008-2013, addresses the issues of health care expenditures, health workforce planning, privatisation of health care services and demographic change.

Amendment to the Health Care and Health Insurance Act stipulates exemptions for low income groups from co-payments and introduces the liability of income from various forms of contract work for contributions to compulsory health insurance.

Patient Rights' Act identifies categories of patient rights and the means of their execution.

Mental Health Act defines the legal basis for the National Programme on Mental Health, the establishment of a network of mental health providers and the rights of patients in cases such as involuntary treatment.

In the first half of 2008, Slovenia held the EU Presidency. The main public health topic during the Slovene presidency was cancer, due to its increasing importance not only in terms of incidence and survival rates; but also the challenges that have to be faced in the organisation of care will be based on four pillars as proposed by the Slovene EU Presidency: primary prevention, screening, integrated care and research. [11][12] The presidency has been seen as very successful and the field of cancer research has been put higher on the public health agenda. Regardless of the Presidency, other burning issues remain and some of them were implemented in 2008.

After the non-realised "White Book"[13] reform proposal in 2003, Slovenia had remained without a national health care strategy until July 2008, when the Resolution on the National Health Care Plan for 2008-2013[14] was adopted. It provides guidance in the development of health care delivery in Slovenia over the period of the next six years.

11 Albreht T, 2008.
12 Coleman MP et al., 2008.
13 Keber D et al., 2003.
14 ReNPZV, Official *Gazette of the Republic of Slovenia*, No. 72/2008.

The main elements of the National Health Care Plan include:

1. A financial framework determining the health care expenditure for the next six years
2. A description of the main public health problems and challenges to be addressed
3. A commitment as to the pace of development in primary health care in the next years and an acknowledgement of the present structure of health care delivery at secondary level
4. A commitment to develop an IT infrastructure in the health care sector in order to promote better care and achieve better management of the processes involved in patient care
5. A reaffirmation of the EU's strategic principles for health care and presentation of a set of ethical guiding principles for the national level
6. An enforcement of the sustainability of the predominantly publicly financed health care
7. An improved management of all aspects of patient care
8. A finalisation of the existing national investments in health care and securing easy transfer of the key tasks to regional level.

In line with the Resolution on the National Health Care Plan for 2008-2013, the Government confirmed the amendment to the Health Care and Health Insurance Act[15] in August 2008. The main amendments to this include exemptions for individuals with low incomes from co-payments (will be covered from the municipality budget), increasing contribution rates for certain groups (e.g. self-employed, tradesmen, farmers) of individuals and liability of income from various forms of contract work for contributions to compulsory health insurance. Thus, the legislation allows for a more stable financing of health care, the formation of health programmes and services as well as prices through dialogue between the partners, thereby improving access to quality services for all insurance holders and greater rights for the most vulnerable groups (including through the payment of surcharges from the national budget). The act also limits the principle of solidarity for financing health care expenditures with regard to injuries of compulsorily insured individuals which occurred either due to their engagement in extreme sports (e.g. extreme skiing, extreme climbing and hang-gliding) or due to consumption of alcohol. Moreover, the act aims at decreasing the compensation for a temporary leave of absence from work and limits the compensation in case of sickness that exceeds one month. The trade unions were opposed to these proposals. The act also introduces novelties regarding partnership negotiation procedures, which are supposed to cover the area of pharmaceuticals and medical devices. Further amendments are concerned with strengthening the role of the Ministry of Health (MoH) and the national Government in the health care system, while limiting the competencies and autonomy of the HIIS. The current Minister of Health announced another amendment of the Health related legislation in his mandate. Foreseen are amendments of the Health Care and Health Insurance Act, but an even more burning topic is the amendment of the Health Services Act. At the time of writing, there was no public debate on the latter. However, considering demographic trends and the macroeconomic situation, some turbulent debates are to be expected later on this year. Recent developments show that additional financial funds will be necessary for larger infrastructural projects in health care.

Another important act, which was long under preparation and finally adopted by the parliament in 2008, is the Patient's Rights Act[16]. It aims at protecting the patient's integrity and clearly specifies procedures in the case of breaches of rights. A special feature of the act is the patient's right for respect of his/her time, which provides the legal base, to intervene in

[15] ZZVZZ-K. Official Gazette of the Republic of Slovenia No. 76/2008.
[16] ZPacP. Official Gazette of the Republic of Slovenia. No. 15/2008.

the cases of waiting lists.[17] The act is a result of more than a decade of experiences gained from the previous legislation. Expectations in the public have been high for quite some time for a more decided step forward in this field. Also, providers, including professional associations, clearly felt the need for the adoption of such an instrument. More specifically, the act aims at helping patients: to act according to their needs in cases when their rights are breached; when they face problems in using health care services; in the execution of basic human rights in health care; using and processing patient data; protecting individuals who are incapable of making their own informed decisions; choosing their doctor or provider; and regulating issues regarding waiting lists. Article 7 of the Act[18] in question states that every person regardless of their gender, age, ethnic group, socio-economic status has the right to equal health treatment. Although this was defined in the Patient Rights' Act for the first time, in Slovenia there were hardly any complaints of unequal treatment before this act. An important institution is the Office of the Ombudsman for Patient Rights, which settles most complaints and charges. Unfortunately, this office only operates in the City of Maribor and is not known enough to the wider public.

All in all, the system should become more accessible through the definition of patient time as one of the rights, which should contribute to the reduction of waiting lists, mainly in the field of orthopaedics, open heart surgery, cardiography and demanding diagnostic tests.

Determined by the political will, privatisation in health care in Slovenia has been a gradual process. In 2008, Slovenia's privatisation in health care still focused on primary health care. Namely, 30% of the primary care providers (GPs, paediatricians and school medicine doctors) work in a private setting.[19] Privatisation of parts of the health care services at primary level is considered to be an efficiency-inducing measure, as the private providers compete with each other and with the public system for contracts with the HIIS. Controversies remain, however, as to the means of monitoring and adequately allocating financial resources through these processes. However, only partial privatisation of health care delivery took place (primary health care), while other aspects (privatisation of hospitals) have not even started at a larger scale yet. Privatisation of the primary care infrastructure and allowing more space for private initiatives may become the areas receiving more attention in health policy in the future.[20,21] Health expenditures have been another focus of privatisation (privatisation of health insurance, including insurance to cover co-payments, and it represents 13.8% of the total health expenditure (THE), while out-of-pocket payments reached 12% of the THE)[22]. Controversies over its extent kept privatisation contained and controlled. Today's share of private provision of health services remains at the conservative end of the European Union. Private expenditures for health services increased considerably over the paste decade, while privatisation of health infrastructure and management has been limited. The Ministry of Health has to face concerns about the future course of privatisation related to the issues of equity, fairness, accessibility and solidarity.[23] At the time of writing no evidence-based evaluation had been published to approve or deny these concerns.

The Concession's Act has been under preparation in the previous political setting, but was never implemented. At the moment, the Health Services Act is under preparation. This Act will consider the issue of privatisation. The document had not been open to public debate at the time of writing.

17 ALBREHT, 2007b.
18 ZPacP. Official Gazette of the Republic of Slovenia. No. 15/2008.
19 IPH RS, 2008.
20 Albreht and Klazienga, 2009.
21 MOH, 2006.
22 SORS, 2008.
23 Albreht and Klazienga, 2009.

Quality has risen higher on the health policy agenda in Slovenia following proposals for health care reforms in 2003. However, quality and outcomes are not included in the current DRG system.

The National Policy for the Development of Quality in Health Care was published by the Department for Quality in Health Care in 2006.[24],[25] Its purpose is to encourage health care providers, managers of health care organisations, health care insurance companies, educational health care organisations, health care professionals, patients and other stakeholders to improve quality of care and patient safety. The National Institute for Quality in Health Care was also proposed (for coordination of introduction of clinical guidelines and pathways, standards and indicators, development, training and research, and accreditation of health care providers). At the moment, this Institute has not been established yet; however it is again on the health agenda.

The Department for Quality in Health Care is working on the formulation of clinical indicators for primary, secondary and tertiary health care. At the moment six indicators are to be reported to the Ministry of Health: falls, decubitus ulcers, waiting time for CT scans, waiting for hospital discharge after treatment, percentage of unplanned readmissions (same hospital within seven days due to the same illness), and presence of MRSA infection.

The Performance Assessment Tool for quality improvement in Hospitals (PATH) project is coordinated by The Institute of Public Health of Slovenia. This comprehensive tool is used 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. Currently, there are 11 hospitals participating in this project.

However, by early 2009 efforts to increase the quality of care 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. The current method of financing health services does not stimulate or recognise competition between private and public health care providers. Quality control of all offered services on the health care market and medicinal products market is lacking. In this way, consumers would be able to make their own conclusions on the quality of offered services. This could be viewed as a limitation of this system.

It can be observed that the discrepancy between the needs and demands of new technologies and possibilities of their funding is constantly growing. Therefore, a critical and continuous assessment, in form of a health technology assessment and the introduction of new methods of medical treatment, is required. The assessment for the suggested changes shall show impacts on the health status of the population, and, among other, efficiency and effectiveness of the utilisation of the current and future investments in health care.

With regard to efficient spending in health care and the area of pharmaceuticals and medicinal products, the lack of cost-effectiveness studies is a weakness of the system. The Medicinal Products Act[26] was adopted in 2006. This also resulted in the establishment of an independent national Agency for Pharmaceuticals and Medicinal Products (APMP) in 2007. The Act brings legislative modifications, necessary both to clarify certain existing national requirements and to provide a legal basis for planned initiatives, and it contains all the provisions of the new EU pharmaceutical legislation, such as the consolidation of pharmaceutical authorisation procedures and strengthening of pharmacovigilance.

[24] Robida 2006.
[25] Legido-Quigley, 2008.
[26] Medicinal Act, 2006.

Necessary modifications relate to an improved alignment of provisions on drug pricing with the concept of (generic) substitution of pharmaceutical products, retail sale of pharmaceutical products through the Internet, retail sale of over-the-counter (OTC) pharmaceutical products in pharmacies and specialised shops (an agency-controlled non-pharmacy distribution channel for selected OTC medicines) and the educational requirements for persons responsible for advertising pharmaceutical products, an activity that is limited to health care professionals holding a university degree.[27] As mentioned above, critical assessments, economic criteria and economic efficiency of medicinal products' price determination is missing in the system. Access to new, more expensive, innovative medicinal products need to be enabled with the introduction of economic efficiency-proving system and justification of the price, which is higher than the allowed price. In early 2009, a commission for approving higher prices for pharmaceutical products was established by the MoH.

Recently there were a lot of complaints about the lack of transparency in the system, and waiting lists in health care have become a very serious political issue. Namely, patients had no insight into which hospital would have the shortest waiting times for the treatment they require. Therefore, an online solution for the waiting lists was piloted in late 2007. The aim of this health policy tool is to form a national waiting list system, which would offer information on waiting list times to patients and their relatives as well as to their GPs, prevent repetition of input of the same patient, as well as set some benchmarking goals for hospitals among themselves in order to aim for reduction in waiting list times.[28]

A better cordination of access to certain procedures, which had the longest waiting lists in the past and a certain level of competition, is expected as a result of the online waiting list database.

Another area that is urging for improvement in recent years is the area of mental health. The Institute of Public Health of the Republic of Slovenia is putting a lot of effort into this field; however, there are no special assessment studies on availability and access to mental care in Slovenia. Due to the lack of a legal basis, which is a precondition for any national strategy or programme, for a long time there was no national programme on mental health. Nonetheless, the Mental Health Act[29] was adopted in 2008 and the National Mental Health Plan is in preparation. The latter is the first plan containing relevant numbers on capacities and funding.[30] The main objectives of the Mental Health Act are: Protection of human rights of mentally ill patients (including involuntary admissions and special methods of treatment), patient advocacy, establishment of an institutional and legislative framework for an integrated approach and development of community mental health services. The latter was given priority in the Resolution on the National Social Assistance Programme 2006 – 2010, the strategy called "Developing and Introducing New Models of Community Care".[31]

In line with the initiatives for e-Government and Slovenian public sector development, e-Health in Slovenia is gaining importance.[32] In the past years, Slovenia has successfully executed the first steps of information technology implementation in the health care system with the introduction of basic computer technology and computer exchange of information, definition of standards, setting-up of databases and the introduction of the health insurance card system. E-Health is being planned at the national level and is recognised as one of the major priorities in the health policy sector. To improve the efficiency and quality of e-Health

27 Turk, 2008.
28 Albreht, 2007a.
29 Mental Health Act, Official Gazette of the Republic of Slovenia No. 77/08.
30 Jeriček Klanšček et al. eds, 2009.
31 NSPP, 2006.
32 Kodele et al., 2005.

services the Government is paying much more attention to upgrading the structures and processes based on the introduction of advanced ICT. This can be concluded from the findings and reports of Health Informatics Council meetings, where these issues are addressed.[33] Many pilot projects are taking place, such as monitoring and treatment of chronic lung disease, the e-depression project, as well as e-birth and telemedicine projects.[34]

The increase of physicians' salaries is a measure adopted by the previous Government that will have a big impact on the HIIS funds.

For the past years, there was strong pressure by the physician associations and trade unions to conclude an agreement on increases in salaries of health care personnel. New arrangements and a salary system for all public employees were implemented in 2008.[35] According to the agreement concluded between the representatives of the Government (Ministry of Health and the Ministry of Public Administration) and the Medical trade union and the Medical Chamber, there should be the following measures:[36]

1. An increase in physician salaries ranging from 4 to 30%, depending on the length of specialty training and the workload according to the designated working posts.
2. This increase is completed through a set of a total of four instalments every 6 months from September 2008 on.
3. A new list of supplements to the basic salary, depending on the specific workload, special requests and additional exposures, has been adopted.
4. The recalculated new salary categories will be used for all public employees/civil servants, including medical professions.

Regarding health and long-term care expenditure, one of the problems consists in the collection of financial data and in the reporting of private practitioners. According to the System of Health Accounts (SHA) methodology it was not possible to obtain data on out-of-pocket payments. An estimation of those payments is included in the household survey and published by the Statistical Office (2008). However, further analysis is needed to show whether out-of-pocket payments have an impact on access for people with lower income. It is estimated that the public expenditure for health care and long-term care will increase gradually. In the table below, the projection by IMAD (2009) shows that public expenditure, as % of GDP, will increase from 7.1 to 12.5% by the middle of the century.

Table 9: Projection of Health Care and LTC expenditure as % of GDP

	2007	2020	2030	2040	2050	2060
Health Care	6.1	6,8.	7.8	8.8	9.6	9.9
Long-term Care	1.0	1.4	1.8	2.4	2.9	3.2
Total	7.1	8.2	9.6	11.2	12.5	13.1

Source: IMAD, 2009

A recent study[37] recognises the problem of inefficient use of public funds. Namely, demographic movements increasingly put pressure on the economy and limit highly necessary investments in the health care infrastructure. Additionally, the Slovenian health care system

33 Krapež and Kronegger, 2007.
34 MoH, 2008.
35 Albreht, 2008.
36 Agreement, 2008.
37 Živkovič et al., 2007.

faces a wide range of rigid instruments of economic and health care policies. The latter mostly includes the system of collective contracts, the determination of costs of medical services and medicinal products on centralised level, excluding applicable economic studies and activities of interest groups (various chambers and associations), which prevent the offer of medical services being adjusted to the actual demand.

2.3 Long-term care

Slovenia does not have a uniform system of long-term care (LTC). A variety of services and benefits are provided within the span of the existing social protection systems.[38]

The provision of LTC is guaranteed in the following ways:

Within the health care system: as institutional health care, nursing homes (non-acute hospitalisation treatment - mainly intermediate care, provided at nursing departments and as prolonged hospitalisation). On the primary health care level, long-term care is provided within the scope of community nursing care and home health care.

Within the social security system: daily and whole-day forms of institutional 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.

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

- In March 2006, the National Assembly adopted the Resolution on the National Social Protection Programme (NSPP) 2006-2010[39], which sets out several goals to increase the provision of LTC: increasing provision of help at home and mobile help services for beneficiaries in their domestic environment; increasing capacities of institutional care services for elderly persons; increasing provision of care in another family, as well as increasing capacities of care in sheltered housing for the elderly. Herewith, the priority is given to those regions of the country where the development of providers or users' accessibility to services is very poor.
- Also in 2006, a strategy for the protection of the elderly until 2010[40] was introduced. The aim of the strategy was to harmonise the work of the different line ministries, the 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[41].

Furthermore, the proposal for a Long-term Care and Long-term Care Insurance Act has been in preparation since 2005 and has entered its final stages.[42] The long birth of this Law is due to the transposition of responsibility from the Ministry of Health (MoH) to the Ministry of

38 NSPP, 2006.
39 NSPP, Official Gazette of the Republic of Slovenia No. 39/2006.
40 MLFSA(2006).
41 MLFSA(2009).
42 MLFSA, 2007.

Labour, Family and Social Affairs (MLFSA). A new working group, consisting of experts in the field of long-term care, has been formed and the Government anticipates that it will be sent for parliamentary passage in this year. The proposal is based on the notion that the Slovene population is ageing and that there are more and more people who need the help of others when performing everyday activities. This group of the population is currently underserved. For some long-term care needs – in particular the most urgent needs – the health care services ensure health care at home or an extended treatment in hospitals, which is considered to be highly inefficient.[43] Other needs are taken care of in nursing homes. Here, people must pay for the services by themselves or their relatives must pay for them because compulsory health insurance covers expenditures for health care services only. In any case, resources for needs that are related to support persons to perform everyday activities are considered to be scarce and the subject of long-term care organisation and financing is underdeveloped. Therefore, the proposal aims at rearranging the basic principles of LTC. Based on the proposal, a special compulsory insurance for long-term care would be introduced which would cover persons who require the assistance of others due to illness, disability or injury, thereby allowing them the same care at home as they would get in a care centre. Analogous to other branches of social insurance, it would be financed by contributions. The act proposal anticipates that the HIIS would carry out the professional and administrative tasks for this new legal body. The introduction of a long-term care insurance was part of the coalition contract of the 2004-2008 ruling Government.[44],[45] However, the issue proved to be contentious with regard to the question of how to finance the coverage of the new insurance, as some stakeholders oppose the introduction of a new compulsory insurance. Nonetheless, the act under preparation will create a system of insurance basis to provide long-term care services that are more accessible and of a better quality, irrespective of where they are being performed. The document is also to form the framework for the long-term financial sustainability of such a system. Recent conferences[46].[47]on the topic on LTC in Slovenia show that the society can successfully progress only by genuine mutual contact and cooperation among all generations. The intersectoral and interdisciplinary approach towards new legislation is favourable. The main criticism of the forthcoming act is that it is taking too much time for its development. Currently, the third version is being prepared and it is still not published for public debate.

Regardless of the legislative lack, the Institute for Social Protection of the Republic of Slovenia (ISPRS) carried out an analysis of the situation of home care in Slovenia. The study showed that home care is provided mainly by public agencies (i.e. centres for social work) and only few were private organisations with concessions.[48] The study shows further that more than 53% of the population above 80 years of age needs assistance at home. It is evident that the current set-up allows for very big discrepancies in accessibility to home care across Slovenia, where in some remote places home care almost does not exist and in bigger cities there is an enormous lack of human resources.[49]

With regard to palliative care in Slovenia, the number of palliative care experts who are willing to work in palliative care as providers and teachers is insufficient. Problems defined by a task group are: palliative care planning focuses too much on institutions and less on home care; financing and classification of palliative care standards at national level is not well

43 Flaker et al. (2008).
44 MLFSA, 2007.
45 Government Office For Growth, 2008.
46 Intergenerational Solidarity for Cohesive and Sustainable Societies, Brdo, Slovenia, 27-29 April 2008.
47 Okrogla miza: Dolgotrajna oskrba, 27 March 2009.
48 Smolej et al., 2008.
49 ibid.

established; there is not a good tradition of team work and collaboration in multidisciplinary teams. Although the EU is giving directions to the Government on the development of palliative care in Slovenia, the progress is very slow.[50]

3 Impact of the Financial and Economic Crisis on Social Protection

Since 1993, Slovenia has experienced steady economic growth, with the lowest annual GDP growth rate in this rather long period being 2.8%. As a matter of fact, 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 a rather high inflation rate, 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[51].

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 is shown in Table 10 and Table 11. The contraction of industrial production is quite understandable, considering the strong export orientation of the Slovene economy. Even GDP contracted in the fourth quarter, with growth of -0.8% as compared to 4/2007. However, overall GDP growth in 2008 was still positive, amounting to 3.5%.

Table 10: Contraction of industrial production (in percent)

Month, Year	Contraction of industrial production
March 08 / March 07	- 2.9
April 08 / April 07	+ 9.1
May 08 / May 07	- 0.8
June 08 / June 07	+ 2.3
July 08 / July 07	- 2.0
August 08 / August 07	- 6.8
September 08 / September 07	+ 5.5
October 08 / October 07	- 2.8
November 08 / November 07	- 13.9
December 08 / December 07	- 14.3
January 09 / January 08	- 17.4
February 09 / February 08	- 22.3

Source: Statistical Office of the Republic of Slovenia

[50] EAPC, 2005.

[51] 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 the support of the government coalition.

Table 11: Registered unemployment in Slovenia, August 2008 to March 2009

Month, Year	Registered unemployment
August 2008	60,669
September 2008	59,303
October 2008	62,621
November 2008	63,363
December 2008	66,239
January 2009	73,911
February 2009	77,182
March 2009	79,682

Source: Employment Service of Slovenia

The rapid spread of the crisis seems to have taken government institutions by surprise: the official government forecaster, the Institute for Macroeconomic Analyses and Development forecasted – as late as October 2008 - GDP growth for 2009 at 3.1%. These estimates have been continuously revised downwards, and the latest forecast (presented at the end of March) stands at -4%. However, the Bank of Slovenia is somewhat more optimistic, with its April forecast of GDP growth in 2009 standing at -2%.

The newly elected Government (installed in December 2008) acted swiftly, proposing a package of measures as early as December. This package contained an important measure aimed at supporting companies 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 companies that do not lay-off workers but rather reduce the weekly workload from 40 to 36 hours. For companies that reduce the workload from 40 to 32 hours the subsidy amounts to EUR 120 per worker per month. Of course, this subsidy does come with certain conditions attached:

The company 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 6 months. Some EUR 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 6 months for the employee. This period could be extended, with evidence from the employer provided for such an extension. For this measure, EUR 100 million are earmarked.

In view of the rapid deterioration of public finances, the Government started preparing (in January 2009) modifications to the already accepted government budget for 2009. This

rebalanced budget was passed at the end of March. However, by the end of April the Government has already been proposing a new rebalance, due to a larger-than-expected fall in tax revenues. At the same time, the Government proposed a modest cut in expenditures. In sum, the overall government budget deficit would – according to this recent proposed rebalance - amount to 4.9% of GDP. The previous (March) rebalance resulted in a somewhat smaller deficit of only 3.4% of GDP.

3.1 Developments in the pension system

In view of the fairly rapid deterioration of important economic indicators, the developments in the pension system seem to lack any sense of urgency. Not only that, even precautionary measures are completely absent. For example, in February 2009, according to the usual procedure (enacted in the PDIA) pensions have been increased by 2.9% (applicable from 1 January 2009)[52]. It is quite amazing that this measure has not been temporarily suspended, in view of the already visibly slide of the economy. However, this slide has not yet resulted in a decrease in social contributions collected. In the first quarter of 2009, pension contributions collected amounted to some EUR 819 million, representing an increase of EUR 53 million as compared to the same period of 2008. In other words, an increase of 6.9% over the same period in the previous year. Also to be noted is that – in case of any revenue shortfall – the Government must cover this 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 of 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[53]. 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 most certainly 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 IPDI, already exceeds the expected total annual increase in wages, there will be no increase in pensions in November, regardless of Government measures.

In March 2009, the Government appointed a working group on "modernising the pension system". The word "reform" was not used, perhaps to downplay the significance of this group or (possibly) to prevent any "unwarranted" excitement and animosity. At the moment, it is impossible to predict what the group will propose, as it has an open mandate. However, one must bear in mind that almost 10 years have passed since the pension reform, and that no substantial changes have been introduced since then – apart from the change in indexation rule, which occurred in 2005, when the growth of pensions was aligned with the growth of wages. The public pension system is extremely non-transparent, even within the dwindling category of pension systems where the pension is calculated using pension bases, accrual rates and revalorisation coefficients. Of course, a move towards a point system would markedly improve transparency, without unduly disrupting the present system of pension rights.

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

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

[53] 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 the cost of living.

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 returns 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 premiums 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 tackling 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.).

3.2 Health and long-term care

As a consequence of the economic crisis, lower cash inflows are to be expected for the health budget. The crisis may potentially reduce demand for health services and the supply of quality health services. Still, the field of health care has taken some time to address the challenges following the financial and economic crisis.

The first measure proposed is a cost-saving measure. In March 2009, the Assembly of the HIIS was presented with the impact of the new wage system, introduced in 2008. The new wage system is implemented step-by-step, and the first increase of salaries was in September 2008. Table 12 below shows an assessment of the impact of this new wage system according to function (e.g. salaries in primary health care, hospital care, social institutions, in the pharmaceutical sector etc.). The new wage system for medical professions, implemented in 2008, will have long-term impact on HIIS expenditure. Namely, the first assessment of the wage increase by the HIIS was based on previous years and has foreseen a ten times lower increase than the de facto one.[54] As one of the measures to mitigate the impact of the economic crisis on the HIIS, the representatives of the Government and trade unions came to the conclusion that they have to counteract the dynamics of the elimination of disparities of the new wage system and postpone it until 2010.

[54] HIIS, 2009.

Table 12: Impact of the new wage system 2008-2011[55]

Current prices, EUR 1,000	2008		2009		2010	2011
	1 estimated increase in salaries	2 included in expenditure of HIIS*	3 estimated increase in salaries	4 included in expenditure of HIIS	5 estimated increase in salaries	6 estimated increase in salaries
1.Increase of salaries in health care services	116,865	90,610	232,121	258,375	300,745	316,748
primary health care	16,334	10,143	41,142	47,333	60,964	64,907
hospital care	94,416	76,161	174,252	192,507	214,074	224,394
social institutions	5,678	4,059	15,742	17,361	24,325	25,976
spa treatments	436	247	985	1,174	1,382	1,417
2. Increase of salaries in pharmaceutical sector and other	1,549	890	3,271	3,930	4,729	5,038
3. SUM (increase of salaries)	118,413	91,500	235,392	262,305	305,474	321,786
4. SUM (increase of salaries) after Governmental measures	118,413	91,500	221,374	248,287	305,474	321,786

*HIIS excludes bonuses and increases of salaries due to promotion etc.
Source: HIIS, 2009

The measures foreseen by the HIIS are expected to be a hot topic in Slovenia.[56] Measures, concerning salaries in the public sector, and those foreseen in the first set of measures in health care to fight the economic crisis by the Government of the Republic of Slovenia include firstly, as mentioned above: postponing the elimination of disparities in wages for 2009 into 2010 and temporary abolishment of production or work productivity bonuses. Furthermore, the proposal to lower the prices for health services by 2.5% is adopted by the General Assembly of the HIIS. In addition, material costs will be lowered and providers of health care services shall not count on the HIIS regarding their promotion, but secure funds on their own.

Moreover, referrals to the secondary level are to be reduced. It has to be noted, that all measures are based on the assumption that the contribution rate stays the same and that the scope of the health care rights of the insured persons does not shrink. Nevertheless, some newspapers already state that the crisis will affect accessibility and patient benefits regarding health care services. [57],[58],[59]

Currently the media[60],[61],[62] report on additional measures to be introduced by the HIIS. It is foreseen that allowances for spa treatment will be reduced; instead of current coverage of 40%, the compulsory health insurance will cover only 15%. The difference will be covered by the voluntary health insurance. In addition, HIIS will reduce the reimbursement for

[55] Due to the wage reform in 2008, salaries in the health care sector (especially for medical doctors) rose by up to 30%.
[56] POP TV, 26 April 2009.
[57] POP TV April 2009.
[58] DNEVNIK, 25 April 2009.
[59] ZUPANČIČ M, April 2009.
[60] DNEVNIK, 12 May 2009.
[61] RADIO SLOVENIJA 1, 12 May 2009.
[62] FINANCE, 12 May 2009.

pharmaceuticals from the intermediate list. Instead of 25%, the compulsory health insurance will cover 10% of the cost; the remaining difference will be covered by the voluntary health insurance. HIIS is calculating to save additional EUR 25m p.a. due to this measure.

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4 Abstracts of Relevant Publications

[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.

[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 descripe 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] MAJCEN, Boris and VERBIČ, Miroslav, 'The Slovenian pension system in the context of upcoming demographic developments'. In: Robert Holzmann, Landis MacKellar and Jana Repanšek (editors), Pension Reform in Southeastern Europe, The World Bank, 2008.

This paper uses an overlapping-generations general equilibrium model (OLG-GE) to analyse the effects of different modes of financing public pensions on age cohorts. Quite predictably, a switch to financing the PAYG system through an increase in VAT would make present retirees worse off and future generations better off than the current mode of financing (levying social contributions on wages). The paper also analyses (by age cohorts) the required additional savings in the second pension pillar, required to compensate for decreasing pensions from the PAYG system.

[R4] OGRAJENŠEK Irena, VEHOVEC Maja, DOMADENIK Polona and REDEK Tjaša, 'Employer attitudes toward older workers: a comparative study of Croatia and Slovenia', New perspectives on a longer working life in Croatia and Slovenia, The Institute of Economics, Zagreb and Friedrich Ebert Stiftung, 2008.

This study is based on a detailed questionnaire for employers, in which they were required to evaluate various (perceived) characteristics of younger and older workers. It is interesting to observe that the difference between the mean values for younger and older workers is in virtually all cases statistically significant; for example older workers perform better in »willingness to work hard«, »reliability«, »attentiveness« etc. A principal component analysis (and using the varimax rotation) was used to extract relevant factors for old Slovenian and Croatian workers and young Slovenian and Croatian workers. Both for old and young workers, the extracted factors somewhat differ between Slovenia and Croatia.

[R1] SAMBT, Jože and ČOK, Mitja, 'Demographic pressure on the public pension system', Informatica, vol.32, p.103-109, 2008.

This article uses a cohort-based model to analyse the long-term effects of demographic changes on the public pension system. Based on the existing pension legislation, demographic projections (several variants) and macroeconomic variables (productivity growth, activity rates etc), the projections show (for almost all demographic variants) a large increase in pension expenditures (measured as percentage of GDP) over the next 40 years. It is shown that – should the Government decide to cap pension expenditures (fixing the pension expenditure/GDP ratio) – younger age cohorts would be worse off; the higher the cap, the greater the reduction in discounted pension benefits.

[R5] KUMP, Nataša and STANOVNIK, Tine, 'Socialno-ekonomski položaj upokojencev in starejšega prebivalstva v Sloveniji', Inštitut za ekonomska raziskovanja, Ljubljana, 2008.
"The socio-economic position of pensioners and the elderly population in Slovenia"

Based on household expenditure surveys, which are carried out by the Statistical Office of Slovenia, this study analyses the changing socioeconomic position of pensioners and the elderly population since 1997. It shows and analyses a number of important trends: increasing share of pensioners who live in pensioner households, decreasing relative income position of pensioners (relative to wage earners) and increasing risk of income poverty for pensioners and particularly for pensioners living in pensioner households. It also documents the positive changes in activity levels of the elderly population and large decreases in the number of elderly dependants (persons without own income sources).

[R3] POLANEC, Sašo and AHČAN, Aleš, 'Vpliv opcijske vrednosti na odločitev o upokojitvi v Sloveniji', research commissioned by the Bank of Slovenia, p.96, 2008, accessible at: http://www.bsi.si/publikacije-in-raziskave.asp?MapaId=1094.
"The options value model and its impact on the retirement decision in Slovenia"

The 1999 Pension reform introduced flexible retirement, with higher accrual rates for retirement after the »statutory« retirement age and deductions for retirement before the »statutory« retirement age. The aim of this research was to ascertain the significance of these incentives and disincentives on the retirement decision, i.e. whether the options value can explain the actual retirement decision. The analysis is based on logit and probit models. It has been shown that the impact of options value on the retirement decision is small, and that persons mostly retire when they reach the minimum statutory retirement age.

[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

[H2] ALBREHT T. (2008a), 'Cancer and the Slovenia's EU Presidency', Health Policy Monitor, April 2008, accessible at: http://www.hpm.org/survey/si/a11/5, accessed 21 April 2009.

Slovenia decided to present cancer as the main public health topic of its Presidency to the Council of the EU because of its increasing importance in terms of incidence and survival rates, the challenges it represents in organisation of health care, its delivery and financing as well as in the need for international collaboration and in ensuring the base for long-term care and sustainable and publicly funded research. The comprehensiveness of cancer needed to be addressed from different angles.

[H2] ALBREHT Tit (2008b), 'Increases in physician salaries', Health Policy Monitor, April 2008, accessible at: http://www.hpm.org/survey/si/a11/1, accessed 11 April 2009

Disputes between physicians and the Government go a long way back, to the beginning of the 1990s. Since physicians influenced the course of health care reforms, they also expected a rather intense rise in remuneration (as in 1996). Given the slowing down of salary rises in the public sector (where most physicians are still employed), there was a growing expectation that increases were overdue. Since 2007, there was a threat of a doctors' strike, which was overcome with a new salary agreement.

[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.

[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 sistem 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.

[H2, H3] LEGIDO QUIGLEY H et al., 'Assuring the quality of health care in the European Union. A case for action.', Slovenia, Pg. 169-173, WHO Regional Office for Europe, 2008, accessible at: http://www.euro.who.int/document/e91397.pdf, accessed 12.05.2009)

This book asks the question: can the citizens of the EU be assured of receiving high-quality care if they need health care beyond their national frontiers? It forms part of the Europe for Patients project, which was undertaken within the EU's 6th Framework Programme for Research (FP6).

The first part of the book is divided into three chapters. The first presents an overview of the concept, nature, methods and players involved in the assessment of quality of

care, thus identifying the main issues surrounding quality of care and providing the conceptual basis for the rest of the book. The second focuses on those strategies for promoting quality of care that already exist within the EU as well as on those being considered for the future. Furthermore it provides a description of the mechanisms to ensure quality of care in each EU Member State.

[H1, H2, H3, H4, H5] 'Resolucija o nacionalnem planu zdravstvenega varstva 2008-2013', Zadovoljni Uporabniki In Izvajalci Zdravstvenih Storitev, (renpzv), Official Gazette of the Republic of Slovenia No. 72/2008
"Resolution – The national health care plan 2008-2013"

The National Health Plan Resolution was adopted in July 2008. Adopting this plan, the parliament passed it as a legally binding document comparable to any other adopted piece of legislative act. The main changes concerned a clearer and more pronounced mention of the implications of ageing on health care, a milder definition of the changes regarding primary health care centres and the role the state would play in reforming and reconstructing the public health infrastructure. Some of the more controversial issues remained unchanged, such as: continued privatisation and the development of public-private partnerships, potential privatisation of hospital facilities and infrastructure, a slowly declining public share in financing of health care.

[L] MLFSA, Ministry of Labour, Family and Social Affairs, 'Report on realisation or the tasks of the Strategy of protection for the elderly until 2010 and Action plan for line ministries until 2010', 2009, accessible at:
http://www.mddsz.gov.si/fileadmin/mddsz.gov.si/pageuploads/dokumenti__pdf/strateg_starejsi_poroc_akc_nacrt.pdf, accessed 10.05.2009

This publication shows that the Strategy of protection for the elderly until 2010 is being implemented too slowly and that certain outlines of the Strategy are not taken into account by different sectors. Moreover, it serves as an action plan for future steps including all line ministries.

[L] FLAKER Vito, et al., 'Dolgotrajna oskrba. Očrt potreb in odgovorov nanje', Fakulteta za socialno delo, Ljubljana, 2008

This publication provides needs assessment in the field of LTC. The publication gives suggestions and answers to better provision of LTC in Slovenia. On the one hand, this publication summarises a range of situations, which people with LTC needs find themselves in, how they deal with limitation of activities of daily living. On the other hand, it serves as a guide through the possible needs within LTC. It presents the organisational structures of LTC. This publication serves as a good overview of LTC, which is observed from a wide angle. The attempt is to include a broad perspective of LTC.

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 the civil society, vis-à-vis the Government. A meeting with high officials of the Ministry of Labour, Family and Social Affairs this year resulted in a joint communiqué, stating the need for greater cooperation in preparing the necessary strategic documents, as well as legislation.

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

Address: Kotnikova 5, 1000 Ljubljana
Webpage: http://www.mddsz.gov.si

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

Ministrstvo za zdravje – Ministry of Health

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

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

work environments; the formulation and implementation of international agreements on social security.

Inštitut za ekonomska raziskovanja – Institute for Economic Research
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 – Institute of Public Health of the Republic of Slovenia
Address: Trubarjeva 2, 1000 Ljubljana
Webpage: http://www.ivz.si
The Institute of Public Health of the Republic of Slovenia, 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 coperation, determining methodological and classification standards, anticipating users' needs, collection, processing and dissemination of data, and taking care of data confidentiality. The Office carries out activities of national statistics on the basis of the National Statistics Act (1995, 2001) together with authorised producers determined by the Medium-term Programme of Statistical Surveys 2003-2007. With the help of authorised producers, the Office provides to public administration bodies and organisations, the economy and the public, data on the status and trends in the economic, demographic and social fields, as well as in the field of environment and natural resources.

Zavod za zdrastveno zavarovaje slovenije – Health Insurance Institute of Slovenia

Address: Miklošičeva 24, 1000 Ljubljana

Webpage: www.zzzs.si

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

ZDRAVNIŠKA ZBORNICA – Medical Chamber of Slovenia

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

Webpage: www.zzs-mcs.si

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

INŠTITUT REPUBLIKE SLOVENIJE ZA SOCIALNO VARSTVO – Social Protection Institute of the Republic of Slovenia

Address: 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, which is

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

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

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

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

Faukulteta za druzbene vede – Faculty of Social Sciences, University of Ljubljana

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

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

Fakulteta za socialno delo – Faculty of Social Work, University of Ljubljana

Address: Topniška 31, 1000 Ljubljana, Slovenia
Webpage: http://www.fsd.si/

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

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

Address: Dimičeva 12, 1000 Ljubljana

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

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

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

For more information see:
http://ec.europa.eu/employment_social/progress/index_en.html