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social protection reforms and
their socio-economic impact

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Pensions, health and long-term care

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1 Executive Summary

The new pension legislation, passed in December 2012, equalised the statutory retirement age for men and women and significantly reduced the complexity of the pension system. Some anomalies of the system were eliminated. Possible pathways to retirement prior to the statutory retirement age are reduced; however, the reduction due to child-rearing still remains, and the greater beneficiaries will be women. The link between contributions paid and pensions received has been tightened. The new legislation does not explicitly provide for a link between the statutory retirement age and life expectancy, so that the increase in the statutory retirement age (65), mandated in the pension legislation, will have to be reviewed after a certain time period, preferably when the transition period is completed.

The new rules for the computation of the pension assessment base will put a stop to the gradual decrease of entry pensions, as the valorisation of past wages will now depend only on the growth of nominal wages. This is important not only for ensuring the adequacy of pensions, but also for providing stable pension expectations.

Computations show that the new pension legislation will result in lower pension expenditures compared to expenditures under the previous legislation. Nevertheless, these expenditures (measured as % of GDP) will be gradually creeping up, due to population ageing. They will still remain below 12 % of GDP till 2023.

In health care there was no major reform since 1992. Although the draft acts and strategy for the development of health care system by 2020 were prepared in 2011, they were not enacted. In the last two years efforts of the main stakeholders have been concentrated on austerity measures increasing incomes and decreasing costs through cutting prices of health care services, increasing share of private funding and increasing contribution rates. The measures are short term and do not change any of the fundamental ingredients of the health care system. As a consequence, the accessibility to health care services has decreased (in financial and waiting lines terms), and the financial and human workforce sustainability of the system is decreasing. The need for health care system and health care insurance reform is pressing and expressed also in many civil initiatives.

Long-term care legislation has been in preparation since 2004, the last draft act was subject to public debate in 2010. Currently the area is still not regulated systematically but is scattered among various fields of social protection. Long-term care is oriented towards institutional care and is financed mostly from public sources. The system is financially unstable as it is mostly paid from health care and hence affected by measures undertaken in the health care system. The new draft legislation under preparation will define new criteria for care receivers, new rights in long term care, introduction of coordinator of care and introduction of long term care insurance. The details on new legislation are not yet publicly presented which is the reason that the reform debate has not yet started.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

The new pension legislation (ZPIZ-2) was passed by *Državni zbor* (national assembly) on December 4, 2012[1]. This pension act, which came into effect on January 1, 2013, can be considered to be a major reform, albeit a parametric one. The pension system retains the basic features of a Bismarckian social insurance system.

2.1.2 System characteristics

The basic system characteristics of the previous public pension system, as defined by the pension legislation (ZPIZ-1) are presented in Table 1, while the new system characteristics, as defined by the new pension legislation (ZPIZ-2) are presented in Table 2.

The public system is based on pay-as-you-go financing, financed by contributions and direct transfers from the central government budget. These government transfers currently amount to some 29 % of total revenues of the Institute for Pension and Disability Insurance (ZPIZ).

Supplementary pensions ("the second pillar") are mandatory and voluntary. For two groups of employees enrolment is compulsory. Thus, employers are required to enrol persons performing hard work and work harmful to health. Persons employed in the public sector are also compulsory enrolled. Apart from these two groups (each enrolled in a closed pension fund) there are several other supplementary pension funds, organised by employers. These are voluntary, i.e. not mandated by law or by collective agreements.

The new pension legislation (ZPIZ-2) marks a considerable improvement in the public pension system. Particularly noteworthy are the following changes:

- The transparency of the system is improved, by simplifying valorisation coefficients, which are used in computing the pension assessment base. These coefficients are now equal to the growth of nominal wages, so that the replacement rates can be eazily computed[2]. Under ZPIZ-1, the valorisation coefficients were computed by taking into account pension indexation. The most recent values of these valorisation coefficients were equal to some 0.75 of the growth of nominal wages. Thus, the high accrual rates under ZPIZ-1, presented in Table 1, actually give a false impression of the generosity of the system.
- Replacement rates have been stabilised and the gradual slide of entry pensions has been stopped[3].
- Some "idiosyncratic" features of the Slovene pension system have been discarded.

[1] The legislation was passed unanimously, 76 votes for, nil against and nil abstained. Much credit for this major success goes to the minister of labour, family and social affairs Andrej Vizjak (SDS), who – unlike the previous minister Ivan Svetlik - demonstrated great patience, diplomatic manouvering and resolution in negotiations with the trade unions.

[2] Thus, for men the replacement rate for 40 years of work is equal to 60% (=26% + 1.25% x 25), whereas for women it is somewhat higher, i.e. 63% (=29% + 1.25% x 25)

[3] The slide occurred because of the gradual taking into account lower accrual rates (prescribed by ZPIZ-1) and continuously changing valorisation coefficients, i.e. less favourable valorisation of past wages.

Further, ZPIZ-2 provides for a fairly short transition period, so that the final parameter values will be reached by 2022 at the latest.

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

	Men	**Women**
Retirement age	63	61
Minimum insurance period (required for retirement at ages 63 (m) and 61(w))	20	20
Minimum conditions for early retirement	Age 58 with 40 years of insurance[1]	Age 58 with 38 years of insurance[1]
Minimum conditions for early retirement without negative accruals	Age 58 with 40 years of work	Age 58 with 38 years of work
Pension assessment base	Best 18 years of net wages (wages valorised with valorisation coefficients)	
Computation of pension	Pension assessment base multiplied by accumulated accrual rates	
Accrual rates	35% for first 15 years, 1.5% for each additional year	38% for first 15 years, 1.5% for each additional year
Pension indexation	Growth of wages[2]	
Minimum pension assessment base	Set nominally	
Maximum pension assessment base	4 times minimum pension assessment base	
Incentives and disincentives	Higher accrual rates for later retirement, negative accrual rates for early retirement	

1. The years of insurance can also include the so-called added period. See text.
2. The indexation mechanism for pensions was quite complex. Suffice to say that this indexation was never equal to the growth of wages. Since the economic and financial crisis, indexation was further reduced: in 2010 it amounted to 50% of wage growth, in 2011 to 25% of wage growth and in 2012 pension indexation was "frozen".

Though the pension reform has greatly improved the transparency of the system, it nevertheless stopped short of moving to a point system. The system has retained some "socialist" features, in particularly the concept of net pensions; this can be observed by the way the pension assessment base is computed. An implicit recognition of this fact is that pensioners do not pay social contributions for health care and – through generous tax reliefs in the form of tax credits - only a small number of pensioners pay the personal income tax[4].

[4] Some 25'000 pensioners actually pay the personal income tax (out of some 530'000 old-age, disability and widow's pensioners). In Slovenia, the concept of gross pension is misleading, as gross pensions are – for most pensioners – equal to the net pensions. Social contributions are not paid out of pensions, but the Institute for Pension and Disability Insurance pays a corresponding sum out of the mass of pensions.

Table 2: Some characteristics of the new public pension system (first pillar) in Slovenia (ZPIZ-2)

	Men	**Women**
Retirement age	65	65
Minimum insurance period (required for retirement at ages 65 (m) and 65(w))	15	15
Minimum conditions for early retirement	Age 60 with 40 years of insurance	Age 60 with 40 years of insurance
Minimum conditions for early retirement without negative accruals	Age 60 with 40 years of work	Age 60 with 40 years of work[2]
Pension assessment base	Best 24 years of net wages (wages valorised with valorisation coefficients which are equal to the growth of average nominal wage)	
Computation of pension	Pension assessment base multiplied by accumulated accrual rates	
Accrual rates	26% for first 15 years, 1.25% for each additional year	29% for first 15 years, 1.25% for each additional year
Pension indexation	60% of wage growth and 40% price growth (inflation rate)	
Minimum pension assessment base	76.5% of average net wage	
Maximum pension assessment base	4 times minimum pension assessment base	
Incentives and disincentives	Negative accrual rates for early retirement, 3.6% per each year prior to 65, higher accrual rates for latter retirement[1]	

1. The annual accrual rate for latter retirement (article 37, ZPIZ-2) is 4%, up to a maximum of 3 years (i.e. 12%).
2. ZPIZ-2 actually does not use the term "years of work" but the term "pension qualifying period without purchased period". See footnote 7.

As can be seen from Table 2, the statutory retirement age has been equalised for men and women; for men this age will be reached in 2016, for women in 2020. Unlike the previous law (ZPIZ-1), the transition period to the new final values is – for most parameters - rather short.

There are a number of special provisions which enable the lowering of the statutory retirement age, without incurring negative accruals. The most important one is shown in Table 3, which refers to the decrease due to child-rearing.

ZPIZ-1 did not discriminate between gender – a father or mother could take up this provision; ZPIZ-2 has virtually limited this to women. In this sense it – somewhat belatedly – corrects an anomaly. Namely, this provision has previously been taken up mostly by men; this was due to the fact that under ZPIZ-1 the rate of increase of the statutory retirement age for men was much steeper than that for women[5]. This also explains (to a large degree) why the rise in the effective retirement age for men has been rather disappointing in the 2000-2012 period.

[5] Under ZPIZ-1, the statutory retirement age for men reached 63 years in 2009. For women, the statutory retirement age of 61 years was to be reached (in most cases) in 2023!

Table 3: The decrease in the statutory retirement age for child rearing (in months)

	ZPIZ-1	**ZPIZ-2**
1 child	8	6
2 children	20	16
3 children	36	26
4 children	Additional 20 months for each additional child	36
5 children and more		48

Note: The values in ZPIZ-1 refer to final values, which would have been reached in 2015. Both ZPIZ-1 and ZPIZ-2 stipulate absolute lower limits for retirement age. ZPIZ-2 also sets additional conditions, such as sufficient number of years of work, so that the allowance for child rearing cannot be used in full.

ZPIZ-2 provides one "sweetener" for men. Their retirement age can be decreased for 2/3 of the duration of the military service. We note that ZPIZ-1 also contained a special provision related to military service, in that the period of military service could be added to the insurance period. This added period did not contribute to a higher pension (i.e. the accrual rate was 0%); however, it enabled a person to satisfy the entry conditions for retirement.

ZPIZ-1 also contained an article providing for the lowering of the retirement age for women who started work before the age of 18[6]. ZPIZ-2 extends this provision also to men[7].

Insurance periods

The term insurance period ("years of insurance") includes: (a) years of work, (b) purchased years of insurance and (c) special period.

In establishing the entry conditions for pensioning, ZPIZ-1 also provided the opportunity to add to this insurance period an (d) added period[8]. Added period refers to non-purchased years of military service, tertiary education and registered unemployment spells. The added period was important only for satisfying entry conditions, so that the accrual rate for these years was 0%. ZPIZ-2 abolished this term (for old-age pensioning) and thus eliminated a very important pathway to early retirement.

With regard to (b), ZPIZ-2 simplifies the criteria, as article 136 stipulates that an insured person can – non-discriminately - purchase up to 5 years of insurance. ZPIZ-1 provided a specific list of periods, which could be purchased. These included: years of military service, years of tertiary education, years of child-rearing (up to the age of 3 years) and years of unemployment (with the person being registered at the Employment office).

With regard to the special period (c), this is a period credited to certain categories of insured persons (war veterans, WW2 victims etc), with the government assuming an explicit obligation to finance their pensions. These periods are stipulated in specific legislation; thus, for war veterans of the 1991 independence war, the period is defined in the law on war veterans.

[6] The statutory retirement age could be lowered for the period of work before the age of 18 years. However, this applied only to women with a sufficiently long insurance period. Additionally, a lower limit for the retirement age was also set (article 38, ZPIZ-1).

[7] Similarly to the arrangements in ZPIZ-1, there are important restrictions, so that this provision in fact applies only to persons with a sufficiently long insurance period (article 28, ZPIZ-2). The restrictions are more severe than those in ZPIZ-1.

[8] In ZPIZ-1, the sum of (a), (b), (c) and (d) is referred to as "pension qualifying period". In ZPIZ-2 the sum of (a), (b) and (c) is referred to as „pension qualifying period" (p.q.p.), as (d) has been abolished. We do not use the term „pension qualifying period" in order to avoid unnecessary complexity, but use the more acceptable term „insurance period" , which refers to the sum of (a), (b) and (c). Pension qualifying period without purchased period – a term used in ZPIZ-2 – refers to the sum of (a) and (c).

2.1.3 Details on recent reforms

Though minor adjustments of the new pension legislation (ZPIZ-2) cannot be ruled out, the new legislation ought to provide a stable pension environment for the next ten years. This is certainly a welcome development, as the pension reform has been in the limelight for too long, reaching a climax with the fall of the center-left government of Borut Pahor (SD) in September 2011. This fall was due to the rejection of the pension reform on a referendum, held on June 5, 2011; following this referendum *debacle*, the governing coalition virtually disintegrated[9]. Formally, a vote of confidence was held in *Državni zbor* on September 20, snap elections held on December 4, and a new (center-right) government of Janez Janša (SDS) voted into office on February 11, 2012[10].

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

Does the Slovene pension system ensure adequate pensions? The Slovene pension system is based on social insurance: low contribution density is thus translated into low entry pensions. Solidarity elements do exist, the most important one being the minimum pension assessment base and the maximum pension assessment base[11]. However, there are also rules whose effects are "negative" solidarity, i.e. acting to the detriment of low-income workers[12].

It must also be noted that the rules for computing the entry pension according to the previous ZPIZ-1 legislation were not transparent[13]. The new pension legislation (ZPIZ-2) made a radical departure, by completely decoupling the valorisation mechanism and indexation mechanism. If anything, this change will, together with the new indexation mechanism, improve the adequacy of pensions. Of course, this can only happen if both the effective retirement age and period of work are increased. The ratio between average net pension and average net wage is presented in Table 4.

The pension/wage ratio has been continuously decreasing, and this can be directly ascribed to the ZPIZ-1 pension legislation and to the pension indexation rules. Though pension indexation followed the growth of wages[14], toward the end of 2005 indexation was changed

[9] The events leading to the referendum are described in the 2011 and 2012 Annual National Reports. The referendum had a profound influence on the political body: following the referendum, the credit rating of Slovenia decreased. Out of frustration with referendums acting as playgrounds for special interest groups, the *Državni zbor* passed on May 24, 2013 a constitutional amendment severely limiting the possibilities for calling a referendum and also limiting the possible topics suitable for a referendum. Thus, all topics which have public finance consequences, topics on ratification of international agreements and topics related to human rights violations cannot be considered as appropriate for a referendum.

[10] This government was replaced by the center-left government of Alenka Bratušek (PS) on March 20, 2013.

[11] If a person's computed pension assessment base is lower than the normatively set minimum pension assessment base, her/his pension is computed using the minimum pension assessment base. Similarly, if a person's computed pension assessment base is higher than the normatively set maximum pension assessment base, her/his pension is computed using the maximum pension assessment base

[12] In computing one's pension assessement base, gross wages are decreased by the rate of social insurance contributions and the average personal income tax rate. Obviously, this is quite favourable to high-income earners and is an important disadvantage to low-income earners.

[13] In the "holier than Pope" attitude, valorisation of past wages depended on pension indexation. The rationale for this was the strict observance of the principle of horizontal equity, so that pensioners with equal wage histories and age of pensioning would have equal pensions, regardless when they actually retired.

[14] Pension indexation was never quite equal to the growth of wages, because there was an annual downward adjustment.

and was according to the growth of gross wages – previously it was according to the growth of net wages[15]. This eventually slowed down the decrease in the pension/wage ratio. However, the partial indexation freeze in 2010 and 2011, and complete freeze in 2012 accelerated the decrease.

Table 4: Pension/wage ratio and pension expenditures as % of GDP, Slovenia

year	**Pension/wage ratio (in %)**	**Pension expenditures as % of GDP**
2001	73.2	11.0
2002	72.8	10.8
2003	71.1	10.6
2004	70.2	10.4
2005	69.1	10.4
2006	68.6	10.2
2007	67.1	9.7
2008	67.1	9.9
2009	66.6	10.9
2010	64.7	11.2
2011	63.4	11.4
2012	62.1	11.7

Note: pension/wage ratio refers to net values.
Source: Monthly statistical bulletins of ZPIZ (available at www.zpiz.si).

A high at-risk-of-poverty rate of the elderly and subgroups of the elderly is visible from Table 5. Though the poverty gender gap is still quite large, it is decreasing through time. This gender "adequacy" gap is mainly due to three factors: a gender wage gap, lower insurance periods of women and household composition. The first two factors translate into a lower entry pension. The gender wage gap is rather stable and small, only some 10% for full-time wage earners. As the actual insurance period achieved by new pensioner entrants – women is increasing at a faster rate than that of men, this would result in a narrowing of the gender pension gap[16]. The third factor, the household composition effect, is quite important: most women-pensioners live in single-person households and this has a strong influence on the computed at-risk-of-poverty rate for elderly women[17].

[15] Net wages were computed by subtracting the employee social contribution rates and the average rate of personal income tax.

[16] In 2001, the achieved insurance period for new pensioners was 37 years and 1 month (men) and 33 years and 11 months (women). In 2012 the corresponding values were 37 years and 8 months (men) and 35 years and 5 months (women). This increase in the insurance period also contributed to a relative increase in entry pensions for women. In spite of these improvements a large number of women (31% of new women-pensioners in 2012) have their pension computed from the minimum pension assessment base. The corresponding percentage for men is 15%.

[17] This even more so considering that the equivalence scale used in computing the poverty rates by Eurostat is the ("steep") modified OECD equivalence scale.

Table 5: Adequacy indicators, EU-SILC (2012), Slovenia

	EU-SILC		
	total	**men**	**women**
Median relative income of people aged 65+ as ratio of income of people aged 0-64	87	96	82
At risk of poverty rate of people aged 65-	19.0	18.8	19.2
At risk of poverty rate of people aged 65+	22.8	14.6	28.4
At risk of poverty rate of people aged 75+	26.8	14.0	33.8
S80/S20 of people aged 65-	3.4	3.4	3.4
S80/S20 of people aged 65+	3.6	3.4	3.6

Source: Eurostat.

2.2.2 Sustainability

Sustainability can mean financial or social sustainability. A pension system which is financially sustainable can also result in large poverty risks for the elderly population and thus prove to be socially unsustainable. Increasing the retirement age and providing a better balance between the active working period and period of retirement can improve both financial sustainability and social sustainability of the system. That is why increases in the effective retirement age and increases in the employment rate of the elderly population are so important. The data on these two indicators are presented in Tables 6 and 7, respectively. As seen from Table 6, the effective retirement age for men has remained fairly constant in the past ten years, doubtlessly due to possibilities for using special pension provisions – in particular, reductions in statutory retirement age for child-rearing. The effective retirement age for women has been gradually increasing, in line with the gradual increase in the statutory retirement age; clearly, most women did not resort to the child-rearing provision, as it was limited to only one parent, and husbands were in greater "need" to use this provision. Though the employment rate has also been increasing, a downward turn occurred in 2010, when the effects of the economic and financial crisis started being felt in Slovenia. However, registered unemployment and registered unemployment in the age group 50+ increased significiantly already in 2009. Thus, the number of registered unemployed in this age group was 21,923 in 2008, 28,687 in 2009 and 38,925 in 2010. Since 2010, the overall increase in registered unemployment, and increase in this age group, were more modest.

Table 6: Effective retirement age by gender, 2001- 2012, Slovenia

year	**men** (years/months)	**women** (years/months)
2001	62/0	56/2
2002	62/2	56/5
2003	62/2	56/6
2004	62/6	57/3
2005	61/9	57/3
2006	61/8	57/4
2007	61/10	57/7
2008	61/11	57/7
2009	62/0	58/1
2010	61/10	58/5
2011	61/9	58/8
2012	61/10	58/11

Source: 2009 and 2012 Annual Report; Institute for Pension and Disability Insurance.

Table 7: Employment rates (in %), age group 55-64, annual averages, 2000-2012, Slovenia

year	men	women	all
2000	32.3	13.8	22.7
2001	35.9	15.8	25.5
2002	35.4	14.2	24.5
2003	33.2	14.6	23.5
2004	40.9	17.8	29.0
2005	43.1	18.5	30.7
2006	44.5	21.0	32.6
2007	45.3	22.2	33.5
2008	44.7	21.1	32.8
2009	46.4	24.8	35.6
2010	45.5	24.5	35.0
2011	39.5	22.7	31.2
2012	40.7	25.0	32.9

Source: Eurostat, data based on Labour Force Surveys.

A study by the Institute for Economic Research (Majcen et al., 2012) estimated the effects of the new pension legislation, using a dynamic microsimulation model. As compared to ZPIZ-1, ZPIZ-2 will reduce pension expenditures by approximately one percentage point every year, after the new parameter values have been mostly in place. However, the new pension legislation will not prevent the gradual creeping-up of pension expenditures (measured as % of GDP). According to projections, they are to remain below 12% of GDP till 2023.

2.2.3 Private pensions

The second pillar was introduced in ZPIZ-1[18], and some two-thirds of all employees are now enrolled. Participation in the second pillar is mandatory for (a) public employees and (b) persons employed in hazardous or arduous occupations. These two groups are enrolled in two closed pension funds, the ZVPSJU *(Zaprti vzajemni pokojninski sklad za javne uslužbence)* and the SODPZ *(Sklad obveznega dodatnega pokojninskega zavarovanja)*, respectively. These two pension funds are managed by *Kapitalska družba (KAD),* a state-owned pension managing company. 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 potential inflationary effects[19], proposed a conversion of this increase into premia for the second pillar. It was jointly agreed upon – by the government and representatives of the public-sector trade unions – that *KAD* would manage this fund. The origin of this fund also explains why the accumulated assets are small. As for the fund which covers workers employed in hazardous or arduous occupations, the amount accumulated in the individual accounts are bigger, as employers pay a contribution rate of 10.55% (of gross wages) into the fund. The accumulated pension wealth in these individual amounts must suffice for an "adequate" occupational pension, which can be considered to be a "bridging" pension, covering the period till a person reaches "normal" retirement age. According to the rules of the SODPZ pension scheme, a person cannot retire prior to the "normal" retirement age unless she/he has a sufficient amount of pension wealth in his individual account.

As can be seen from Table 8, the amount of assets per member is quite low, even in SODPZ. The low value of accumulated assets, even taking into account that these funds have been in

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

[19] The government was determined to join the Eurozone at the earliest possible date and was particularly concerned about the inflation target!

operation at most some twelve years, do indicate that the pensions from the second pillar will not be able to compensate for the shortfall in the public pension.

The new pension legislation (ZPIZ-2) significantly broadened the scope of employers who can enroll their workforce in a supplementary pension scheme – for example, under the previous rules, the self-employed had no particular incentive to enroll their workers in these pension schemes (as the self-employed employers were not permitted to join such a scheme). Also, there is no threshold (% of consenting workforce) which would act as an obstacle for enrolment; under the new legislation, workers who do not wish to be member of a pension fund organised by the employer have to provide a written statement of refusal.

In order to put the second-pillar pension fund assets in proper perspective: these assets amount to less than 50% of annual outlays (expenditures) of the Institute for Pension and Disability Insurance.

Table 8: Mandatory and voluntary supplementary pension schemes: insured persons and assets, 31 December 2012

	Number of insured persons	Assets (in million EUR)	Assets per insured person (in EUR)
ZVPSJU	205,699	611.1	2,971
SODPZ	44,466	469.7	10,563
Voluntary supplementary pension schemes	302,667	1,173.6	3,877
Pension management companies	137,685	564.1	4,097
- Skupna	64,712	245.9	3,800
- Pokojninska družba A	40,400	190.0	4,703
- Moja naložba	32,573	128.2	3,936
Mutual pension funds	45,933	221.4	4,820
- KVPS	28,303	141.5	4,999
- Banka Koper	5,963	31.3	5,249
- Generali	4,495	23.0	5,117
- A Banka	2,630	17.0	6,464
- Probanka	4,542	8.6	1,893
Insurance companies	119,059	388.1	3,260
- Prva osebna zavarov.	79.600	224.3	2,818
- Triglav	37,183	158.0	4,249
- Adriatic Slovenica	2,276	5.8	2,548
Total	552,842	2,254.4	4.078

Source: 2012 Annual report of Skupna.

2.2.4 Summary

Though the public pension system of Slovenia cannot receive high marks in terms of providing adequate income to the elderly, the pension system cannot take full "responsibility" for this unsatisfactory effectiveness. Labour market conditions, particularly low contribution density of certain population groups, also translate into low pensions. As for the standard measures of financial sustainability of the system – such as pension expenditures as % of GDP – the pension system is not under threat in the medium term, meaning for the next ten years. In spite of favourable tax treatment, second-pillar pension funds have not experienced strong growth and they cannot be relied upon to provide sufficient additional income to pensioners. As for the mandatory second-pillar schemes, the mandatory fund for workers in hazardous and arduous occupations has been poorly designed and would require a very thorough overhaul.

2.3 Reform debates

Currently, there are no pension reform debates. The pension reform was passed in adverse economic conditions, and only a return of satisfactory economic growth and employment will improve the functioning of the social security system. In our view, there is no need to "tinker" with the pension system parameters, apart from possibly freezing pension indexation, as an emergency measure. This emergency measure has been applied every year since 2010. Though one might lament the missed opportunity to move to a point system, the reformed pension system represents a vast improvement in comparison to the previous one.

3 Health care

3.1 System description

2.3.1 Major reforms that shaped the current system

The last major reform that shaped the current health care system was enacted in 1992. In that year two basic acts that defined the form of the health care system were passed by the Parliament. The first act is the Act on Health Care and Health Care Insurance (ZZVZZ) and the second - Health Services Act (ZZDej). These two basic acts have since undergone many alterations and changes but none of them changed the basic shape of the way health care services are provided and financed.

ZZDej defines that health care services in Slovenia are provided at three levels. These are primary health care level, which are services that are accessible to everyone without referral (family physicians, pharmaceutical care and some other areas like gynaecologist, paeditrician and dentist). Primary care physicans play a string role as gate keepers and are entry points to the higher levels in Slovenian health care system. The secondary care consists of specialist ambulatory care (polyclinics) and hospital care. Tertiary care consists of activities of clinics and institutes as well as other specially defined health institutes, which are active in social-medical, hygienic, epidemiologic and health-ecological activities. This legislation also approved the process for private practice and the re-introduction of professional associations.

ZZVZZ is the act that defines collection, pooling and reimbursement of funds to providers. Slovenia has a Bismarck type of social insurance system, based on a single national provider of compulsory health insurance – the Health Insurance Institute of Slovenia (HIIS). The act introduced co-payments and its coverage by complementary voluntary insurance. Complementary and supplementary voluntary insurance is offered by private insurance companies.

3.1.1 System characteristics

The steward of the health system in Slovenia is the Ministry of Health. The organisational structure is advanced and comprises many actors, including various agencies under the Ministry of Health (such as the Health Inspectorate), public independent bodies (Health Insurance Institute of Slovenia HIIS), Institute for Public Health of Republic of Slovenia (IPH-RS)[20], publicly owned hospitals and primary care centers as well as private providers of health services; and various non-governmental organisations and professional organisations (HIT, 2009).

Insured persons may exercise the right of compulsory health insurance in institutions or doctors who work in the public health service network . The network of public health services equally involves public and private health care providers based on concessions. According to the latest data (for 2011) in Slovenia the public network included 1,560 private doctors and 224 public institutions. In addition to public and private providers with concessions, health care services are also carried out by private providers, who are not included in the social health care insurance – for their services patients must pay by themselves.

The health care system in Slovenia is based on primary health care to which the insured have free access. It consists of family medicine health care centers, pediatric and gynecological clinics. Regional distribution of primary health care should ensure equal access for all

[20] IPH-RS is currently under the process of restructuring: it is being divided into two parts, the first one being public health activities and the second being laboratories.

residents, as well as plays an important role as gate keeping, limiting referrals to secondary and tertiary health care services. At the secondary level the providers can be divided into specialist clinics and hospitals, of which there are 29 in Slovenia. In clinics at the tertiary level most difficult patients are taken care of, tertiary institutions are also in charge of research and development and implementation of new knowledge and technologies to other health care providers through education. The health care system also includes dentistry, pharmacy and long- term care institutions and spas.

The health care system is a labour intensive industry, its efficiency is thus largely dependent on the quality and motivation of its staff. According to the latest data of the Institute of Public Health (2010) in Slovenia there were 4,979 doctors, which corresponds to 243 physicians per 100,000 population. This puts Slovenia on the tail among EU-27 countries, where the average is 330.5 physicians per 100,000 population. In 2010, a strong increase in the number of medical graduates became evident as the first graduates of medicine in Maribor, where the second Faculty of Medicine was open finished their studies. On the other hand, the number of registered nurses in Slovenia has been increasing rapidly due to a number of new medical schools. In 2010 60% more nurses than in 2005 graduated. The number of nurses per 100,000 population is 804, which is close to the EU-27 average (823 nurses / 100,000 population). A further indicator of the capacity of the health care system is the number of hospital beds which in all EU countries decline due to other modes of patient care (outpatient, day hospital). Thus, in Slovenia in 2000-2009 the number of hospital beds decreased by 16%. The rate of hospitalization for any diagnosis according to the latest data (2010) amounts to 159.96, the number of visits per capita in primary health care is steadily decreasing since 2000 and in 2010 was at 4.2 visits per capita (of which about 15% of preventive visits).

The health insurance system is mandatory, providing universal coverage (98.5% of the population). The compulsory health insurance contributions of the employed are 13.45% of their gross income and shared between the employer (6.56% + 0,53% for work related injuries and occupational diseases) and the employee (6.36%). Compulsory health insurance entitles the insured to certain rights, which are defined in article 23 of the Health Care and Health Insurance Act (ZZVZZ) and further specified by the Regulation on Compulsory Health Care Insurance, issued by HIIS. ZZVZZ defines certain population groups (students, children, pupils, pregnant women) and certain diagnoses and conditions (cancer, multiple sclerosis, rehabilitation for blind etc.) that are fully covered by compulsory health insurance. All other services are in a certain defined share covered by voluntary complementary health insurance (VHI), which covers these health care services up to the full value of the service. The share covered from VHI ranges from 5% to 95% and basically depends on the severity of the condition. The more serious the condition the higher the share of the health care service covered from VHI. VHI is offered by three companies in Slovenia – these are the mutual fund Vzajemna and two insurance companies Adriatic and Triglav. The premium for complementary health insurance is flat, the same for all and amounts to around EUR 27. These three companies offer voluntary supplementary health insurance as well, which constitute 3% of all voluntary health insurance (Vzajemna, 2012).

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

	mio EUR		% GDP	
	2009	**2012**	**2009**	**2012**
TOTAL EXPENDITURE	**3,279.63**	**3,140.92**	**9.22**	**8.86**
PUBLIC EXPENDITURE	**2,399.18**	**2,256.40**	**6.75**	**6.36**
Central budget	197.00	82.03	0.55	0.23
Local budget	32.09	25.67	0.09	0.07
HIIS	2,094.71	2,070.64	5.89	5.84
PRIVATE EXPENDITURE	**880.45**	**884.51**	**2.48**	**2.49**
Insurance VHI	410.33	418.34	1.15	1.18
Out of pocket	407.23	416.98	1.15	1.18

Source: HIIS, Annual Reports for 2012.

Primary health care services within the public health care network are paid for through a combination of capitation and fee-for-service payments. Outpatient specialised care is paid for by fee-for-service payments only. Inpatient care is based on DRGs (diagnosis related groups) and non-acute care by number of bed days per stay.

3.1.2 Details on recent reforms

The latest reforms since 2006 included the introduction of a DRG system, the development and implementation of patient pathways, and the introduction of risk-equalisation scheme for complementary health insurance. Regulation on evaluating and financing drugs was accepted at the end of 2010 by HIIS, demanding economic analyses for the introduction of new drugs to be introduced in the public system. In 2011, the upgrading of health care system by 2020 was prepared, which built on the integration of services among levels and skill mix introduction, higher automisation of health care providers, abolishment of complementary health insurance and greater decentralisation and specialisation. The prepared plan was not put into effect due to the change in the government.

In 2012, HIIS was not in a stable financial situation, the measures taken basically reffered to lower prices of services and change of share paid for services by compulsory and complementary voluntary health insurance – more of the costs were transferred to complementary health insurance. The consequence was an increase of VHI premiums, bad financial situation and longer waiting lines with the providers: this can be seen from aggregate data, no special analysis was performed that would evaluate the consequence of the measures taken. In 2012, the ZUJF (Act on stabilising public finances) was prepared by the Ministry of Finance, and defined some new contribution rates and bases for selected population groups. Also it introduced therapeutic groups for drugs – the first group was implemented in September 2013. The latest change, currently under preparation, deals with changes in contribution rates trying to attract more funds from selected population groups (particularly self-employed).

No further changes regarding entitlements to health care services, coverage, benefit packages and co-payment was observed. No reform that would touch the health care system organisation or any of its basic features was prepared in 2012 or 2013.

3.2 Assessment of strengths and weaknesses

3.2.1 Overview of debates/the political discourse

The last main debate in Slovenia about health care followed the issuing of the strategic document "Upgrading Health Care System by 2020" (hereinafter Upgrade), which concentrated on the reform of the whole health care system from organisational side coupled with the reform of the financial side (reform of compulsory and complementary health insurance). Due to the high increase in demand for health care services that are mostly cost-inefficient and hence covered mainly from complementary health insurance it was estimated that the current system of complementary health insurance drives up demand for unnecessary services. Changes were suggested in which the basic benefit package (BBP) would be formed that would contain clinically effective and cost effective health technologies while the rest would not be included in BBP. The Upgrade suggests that BBP would be fully financed from public funds. The rest of the services would be covered in voluntary supplementary health insurance. The reform of creating BBP from public funds logically faced strong opposition from voluntary health insurance companies as well as from the Ministry of Finance which would need to increase the contribution rate according to the formation of BBP. On the other hand, the net available income of the whole population would be higher as some unnecessary services would not need to be paid for from VHI, so the change was widely supported among the population. A further solution was found in cooperation between the Ministry of Health and the Ministry of Finance in the introduction of a special levy that would compensate the loss of funds with the cessation of complementary health insurance. The levy would be lower for everybody than is premium for VHI and was again supported by the population, but never came into force due to the change of government (Nadgradnja, 2010; Cok & Majcen, 2010).

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

In 2012 and 2013, there were no major changes in health care legislation that would improve the efficiency and effectiveness of health care or long term care system and no further steps were yet taken to ensure accessibility or increase quality of the services. All the measures in the last year were targeted towards increasing the incomes/ decreasing the outcomes of health care system to ensure financial sustainability, leaving inefficiencies in work organisation and financing untackled.

The debate in 2012 and 2013 was indeed centered more on the issue how big cuts in the prices of services can the providers still absorb, how to find additional funds for health care financing and lately, how to help providers with negative results. A big discussion developed around hospitals taking loans from the government not knowing how they will be repaid. The cuts took different forms from cutting down wages, margins for drugs, administrative costs, prices of health care services in % etc. In May 2012, a measure was taken to cut down prices of health care services for additional 3%. The cut was linear for all health care services. Also, the coverage of compensation for sickness leave was decreased. Financially, main measure for assuring sustainability of national health insurance fund was the change in % of coverage of health care services from compulsory and complementary health care insurance. The percentage of coverage from compulsory health care insurance was decreased for almost all health care services within the basic benefit package (ZUJF, OG RS, 20/2012). This makes the role of complementary health insurance in the system even larger. The latest measures taken in 2013 were increasing contribution rate for self employed and introduction of therapeutic groups of drugs. The first therapeutic drug group was introduced on October 1, 2013 for drugs for lessening gastric acid secretion. The drugs in a therapeutic group do not

have same effect or active ingredient, but are purposed for the treatment of the same disease. In November, the two further therapeutic groups are being implemented, these are statins and blood pressure medications. As the first group is on intermediate list it did bring 90% of the savings for VHI insurance company and only 10% of total savings to HIIS. Due to the iunsurance scheme implemented in Slovenia again all the savings measures implemented by HIIS produce high profits for VHI private insurance companies (Ferlič Žgajnar, 2013).

As there was no governmental proposal on systematic changes in health care to reduce inefficiencies and rationalise the system there were quite some civil initiatives that took place and prepared strikes and proposals on how to rationalise health care system to make it more accessible, efficient and sustainable. One of more visible was Iniciativa zdravnikov za strokovno in transparentno javno zdravstvo (http://iniciativa-zdravnikov.si/)[21].

3.2.2 Coverage and access to services

The universality of insurance in Slovenia is high. The centralised compulsory health insurance system virtually entitles all individuals whose permanent residence is in Slovenia to all health benefits covered under the scheme, either as contributing or dependant member. Basically, the whole population is insured, on December 31, 2012 there were 9,673 uninsured persons including temporarily uninsured (students who finished their study and have not settled their new status yet). The benefit package comprises the coverage of primary, secondary and tertiary services, pharmaceuticals, medical devices, sick leave exceeding 30 days, cost of travel and cost of funerals and supplement after death for dependants of deceased. For some services (family planning, prevention, screening, occupational diseases, donations and transplantations, long term nursing care) and for some population groups (pregnant women, children) health care services are 100% covered from compulsory health insurance. All other health care services involve cost sharing through co-payments. These co-payments are covered by complementary health insurance that is regulated as voluntary but is de facto compulsory as it covers also up to 95% of the service and represent high expense for the population. Since it is not possible to opt out of the compulsory health insurance, there are no other voluntary insurance schemes for full coverage. However, supplementary insurance exists for above standard health care services.

Regarding access to services, total expenditure for health care (THE) in 2012 continued to decrease. While THE amounted to 8.8% of GDP in 2011, it amounted to 8.9% of GDP in 2012. The increase measured as % of GDP is attributable to a decrease of GDP. Public expenditures for health care have been decreasing for the last three years, from 2010-2012 by 6.3%. The share of public expenditures in total health care expenditures in 2012 amounts to 71.8% (HIIS Annual Report for 2012).

Consequently, the share of private expenditures in total health care is increasing. In Slovenia, private health expenditures basically consist of two parts: complementary health insurance which insures a share of almost all services that are not covered from compulsory health insurance and out-of-pocket expenditures. As co-payments are high in absolute value (they range from 5% to 95% of the price of the health care services) for almost all services, almost all citizens of Slovenia have complementary health insurance, making it non-voluntary. Such organisation of payment for health care services also implies relatively low out-of-pocket

[21] Iniciativa zdravnikov is a voluntary and independent association of all who want to be actively involved in transforming and safeguarding the health care system in Slovenia. The main aim of this initiative is defined as: transparent public health care, clearly defined public and private health care sector, new definition of basic benefit package and socially just health care insurance system, user/patient to become a center of health care system, fair payment for performed medical work and work of other staff in health care.

expenditures. These amount to 13.2% of total health expenditures. (IMAD, Development Report for 2013).

One measure to check the access to health care services are waiting lists, where we can compare national waiting lists 2012/2011. In the end of 2011, waiting lists were monitored for 52 services and there were 39.090 patients waiting. In the end of 2012, the list of services was shortened to 46 services (6 health care services were excluded from the list and not monitored in 2012), and still the number of waiting increased and amounted to 62,135 patients. According to this indicator, accessibility to health care services decreased. (IPH, Monthly Report on Waiting Lists).[22]

Discussion regarding health inequalities and access to health care was very intensive in 2011. The Ministry of Health in cooperation with the National Institute of Public Health, World Health Organisation and Center for Health and Development Murska Sobota issued a book (report) on health inequalities in Slovenia in January 2011, followed by an international conference on February 1, 2011 in Slovenia. The report presents inequalities in health between different groups in Slovenia and identifies some of the comparisons between Slovenia and other EU countries.

In 2013, a special issue of the journal *Zdravstveno varstvo* was published that addressed gender and social economic inequalities in health care. The calculated gap in life expectancy at the age of 30 years between women with low and high educational attainment stood at 5.5 years. Women aged 0-84 years with low educational attainment had a statistically significant higher risk of death than women with high educational attainment (RR=1.65; 95% CI: 1.57-1.73). Educational inequalities in premature mortality were even greater (1.78; 1.65-1.93)[23] and were revealed in the majority of death causes, e.g. cervical cancer (1.99; 1.22-3.67), lung cancer (1.70; 1.30-2.26), cardiovascular diseases (3.02; 2.41-3.91), causes directly attributable to alcohol (7.34; 4.96-12.27), motor vehicle accidents (2.23; 1.21-4.45) and suicide (1.68; 1.19-2.41) (Rok Simon et al, 2013).

It was also observed that the 30 years trend found that women report poorer self-assessed health than men. In Slovenia, this gender gap was observed in both social classes, but was more pronounced for women in the lower educated population group. The higher prevalence of stress symptoms among women supports the theory of chronic exhaustion resulting from the dual-role strain. In Slovenia the welfare state was able to buffer the adverse effects of increased economic stresses to a significant extent after 1991, resulting in favourable health outcomes for both genders. Dismantling these arrangements may result in short-term financial gains but is likely to trigger long-lasting negative consequences for public health, especially in the case of vulnerable groups such as women (Malnar, Hafner-Fink, 2013).

[22] There are no regional variations in waiting lists as lists are formed on national level – the differences emerge only in a case when patients want to have a speicifc provider and sign that they do want to wait longer to have an examination for that single specific provider. For each service the waiting lists are measured according to the provider of each service. The waiting lists in number of days for each provider according to the services can be found at: http://nacas.ivz.si/. The sublaw on waiting lists defined maximum allowed waiting time for citizens according to the urgency of the procedure. Just to give an example, a waiting time for carpal tunnel release could be performed in 14 providers, and the waiting time in days ranged from 0 days to 180 days (http://nacas.ivz.si/Anonimni_CakalnaDoba_ProgramIzvajalec.aspx). Magnetic resonance of head and neck could be perfomed by 15 providers, the waiting time in days ranged from 15 to 240 days (http://nacas.ivz.si/Anonimni_CakalnaDoba_ProgramIzvajalec.aspx)..

[23] CI (confidence intervals), RR (relative risk)

3.2.3 Quality and performance indicators

Regarding health quality/performance the action was concentrated on one hand on the indicators presented in the Manual on Quality Indicators (featuring 73 indicators) and National Strategy on Quality and Safety in Health Care 2010-2015. The indicators are not publicly published but are reported regularly to the Ministry of Health. Most activities in this area were focused on accreditation. In the course of preparation for Directive 2011/24/EU on Patients' Rights in Cross-Border Healthcare the accreditations of the Slovenian hospitals has continued, mostly with NIAHO-DIAS standard, some also to JCI standard[24]. As of April 2013 there were 10 providers already accredited, the rest are in the process of accreditation (MoH, Quality and Accreditation, 2013).

In 2011, for the first time the analysis was performed on measuring patient related outcomes in four health care programmes within national tender for four programmes (hip replacement, hernia surgery, carpal tunnel release and veins surgery): EQ-5D[25] instrument was used to evaluate the patients' health states before and after the procedure, following the carefully prepared instructions. The data were analysed using regression model and EQ-5D value set for Slovenia. The analysis found that there are significant differences among health care providers in the share of the patients who reported positive changes in health care status as well as statistical significant differences among health care providers in average improvement in patient reported outcomes in all four programmes (Prevolnik Rupel, Ogorevc, 2013).

[24] To measure improvement in patient safety DNV (Det Norske Veritas) has developed the National Integrated Accreditation for Healthcare Organizations℠program (NIAHO℠) which blends ISO 9001 quality management with Medicare's Conditions of Participation for Hospitals. The result is a more streamlined accreditation process which captures "best practices" and turns them into standard practices across the organisation, leading to sustainable, continual improvement. Health care providers implementing NIAHO℠ have begun to realise significant measurable improvement in patient safety, health outcomes and financial performance. Joint Commission International (JCI) measures patient safety and quality improvement in the global community. Created in 1994 by The Joint Commission, JCI has a presence in more than 90 countries today. JCI works with health care organisations, governments, and international advocates to promote rigorous standards of care and provides solutions for achieving peak performance. World Health Organization (WHO) partnered with JCI and The Joint Commission to establish the first WHO Collaborating Centre for Patient Safety Solutions.

[25] EQ-5D™ is a standardised instrument for use as a measure of health outcome. It is applicable to a wide range of health conditions and treatments, it provides a simple descriptive profile and a single index value for health status. EQ-5D is primarily designed for self-completion by respondents and is ideally suited for use in postal surveys, in clinics and face-to-face interviews. It is cognitively simple, taking only a few minutes to complete. EQ-5D™ is a trade mark of the EuroQol Group. EQ-5D instrument is built of 5 dimensions: mobility, self-care, usual activities, pain/discomfort and depression/anxiety. Each dimension is divided into three (or five in EQ-5D-5L) levels. These are a no-problems-level, a level, where patient has some problems and a level with extreme problems. For each dimension the patient chooses a level and consequently we get a 5 digit patient profile, e.g. 12312 (patient has no problems with mobility, has some problems with taking care of self, has extreme problems with usual activities, has no pain or discomfort and has some problems with depression/anxiety). There are 243 possible patient profiles in EQ-5D-3L definition of health states and for each health state the value is calculated. The values are calculated in a separate study using one of the possible techniques for preference elicitation (TTO, SG, VAS or DCE). Slovenian value scale was calculated on VAS basis in 2011.

3.2.4 Sustainability

Planning of health workforce has long been a center of debates, due to unclarities, bad planning, clash of various interests and lack of vision. For years the education possibilities for health workforce have been limited due to ”numerus clausus”, the number of faculties and high schools was small. The number of physicians in Slovenia was in ex-Yugoslavia resolved by importing physicians from other ex-yugoslav countries, however, after the independence Slovenia was left with a deficit of doctors. For the last 20 years, there was no strategic document prepared on the future development of health care in Slovenia. In 2002-2005 projections on the number of nurses and doctors and future demand were prepared leading to opening of new medical faculty and new nursing schools as well as higher entry allowed into existing health care and medical schools. The number of physicians in hospitals has increased by 17.4% in the past 9 years and in primary health care by 8.7%. Primary health care that is put as a priority and gate keeper of Slovenian health care system was left far behind. The number of nurses increased by 34% in the same period and Slovenia has enough nurses to satisfy its demand. Health workforce planning as a strategic policy that would settle these issues has not yet been prepared nor accepted.

Financial sustainability became a big issue after 2008, when the outcome of HIIS raised dramatically. This was mostly a consequence of new wage system in public sector, which increased wages and payments for night shifts for health care workforce. At the same time the incomes started to decrease due to economic crises and increase in unemployment rates. The finances of HIIS would demand taking loans, however, measures for sustainable compulsory health care were taken. In 2012, the measures saved 442 million EUR. However, in 2011 and 2012 HIIS had to transfer a part of its payment obligations into the next year. In 2011 these amounted to 41 million, in 2012 to 64 million EUR. The main measures taken to assure financial sustainability were (HIIS Annual Report, 2013):

a) lowering drug prices in the process of negotiations with suppliers (16 mio EUR in 2012),

b) lowering prices of health care services for 3% (30 mio EUR in 2012),

c) lowering % (share) of health care services covered from compulsory health care insurance – increasing share of services covered from complementary health insurance (25 mio in 2012),

d) defining therapeutic drugs groups (10 mio EUR),

e) lowering absenteesm compensations (8 mio EUR), and

f) other measures (8 mio EUR).

Health care providers found themselves in a bad situation as well. 12 hospitals had a negative balance in 2012 and 14 had a positive balance, altogether amounting to a negative result of 13.2 mio EUR. 15 primary health care centers out of 57 had a negative result, but still all health care centers together had a positive result of 3.03 mio EUR.

3.2.5 Summary

In 2010 and 2011, health care policy was following priorities set in the Europe 2020 agenda as well as those in the WHO health care strategy. The approach was systematic with the overview of the area (financing, inequalities, quality, human resources) and the strategic direction were set. The main goal as defined in the Health Strategy by 2020 is setting up a flexible health care system that will through quality and safe health care services efficiently satisfy the needs of the Slovenian population. Although some goals were achieved, the whole reform was not enacted leaving basic problems that need to be tackled in health care still open. In 2012 and 2013, the health care policy consisted mostly of ad-hoc reactions to make the health care system financially sustainable by trying to increase/establish new contributions or lowering outcomes as described. No systematic attempt towards achieving sustainable health care system in long term was noticed.

The strength of the system which has traditionally had strong primary care level, strong prevention, screening and health promotion are starting to lose its way as they are not sufficiently supported in the development. Nicely set system of voluntary complementary health insurance that played a major role in fund collection in the times of abundance proved to be highly inefficient and questionable in the time of economic crises – it resulted in high profits of private insurance companies by transferring savings from austerity measures out of the public system. The response that would change such a solution has not yet been prepared. The system is nowadays facing a high level of unstability in financial, accessibility and resources sense that have not been yet addressed properly.

Reforms still needed are:

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

3.3 Reform debates

There were no major reform proposals by political actors since the Upgrade of health care system by 2020, which was prepared in Februar 2011, only months before the government left. Since then two governments changed but no new reform was proposed by any political party. The debate mainly evolved around austerity measures that touched single and separate issues within the health care system like therapeutic groups of drugs, increase in contribution rates for self employed, lowering prices for health care services, change of share of health care services covered by compulsory health insurance, but did not tackle the health care services or health care insurance as a system. The measures therefore also had perverse effects on accessibility, assurance of rights for citizens and equality.

Civil initiatives were formed mostly on the side of medical physicians: a group of medical doctors claimed they want transparent and efficient public system of health care which would transform the Slovenian health care system into a competitive, high quality and financially sustainable system. Their basic lines of thoughts rely on health care insurance, which was in line with Upgrade Health Care System by 2020 document, on health care system, which was equally based on this document and went into the direction of ensuring autonomy of providers, specialisation and decentralisation of health care services as well as their integration across levels and regionally. Such solution would rationalise the system on providers' side and make it financially sustainable. Together with the reform of health care insurance (abolishment of complementary health care insurance and introduction of new health care levy that would be payable from net incomes in order to cover newly defined BBP from public sources) and reform of the payment system for drugs, medical devices and services would make the system sustainable. The other stakeholders such as the movement for public health care, trade unions as well as the union of primary health care physicians supported the initiative of physicians, who presented their ideas at organised protests against the current health care policy.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

In Slovenia long-term care has not been yet systematically regulated; its regulation is scattered among various system of social care for different groups of recipients and for different benefits that are received within the system.

The Act on long-term care which is going to bring all the different recipients and benefits and financial sources under one umbrella has been discussed in Slovenia since 2004, the last draft version of the legislation was in public discussion in 2010.

The work on legislation preparation has intensified in September 2013 again aiming to prepare financial projections in order to support the legislation – financial unsustainability was one of the major reasons why the law has not been adopted.

4.1.2 System characteristics

On January 1, 2013, there were 20,077 available places in 99 institutions on 122 locations for institutional care, and 6,583 receipients of home care in Slovenia. The number of receipients has been increasing from 2006 (5,328 receipients) to 2011 (6,624 recipients) and declined for the first time in 2012. The goal according to the national programme (resolution on national programme of social care 2006-2010) is to provide home care for at least 3% of population aged 65+ in 2010. For Slovenia this goal has been reached only in one region (Goriška) and in Slovenia in total home care is assured for 1.7% of the population aged 65+. The goal in this area according to the new resolution (2013-2020) is to provide home care to 3.5% of elderly aged 65+ by 2020 (IRSSV, 2013).

Regarding number of cash benefits recipients, the last data are available for June 2013 when there were 29.738 receipients of cash benefits (Attendance and Allowance Supplement). From January 2013, there are three different amounts of benefit for recipients, depending on their level of disability: the lowest amounts to 146.06 EUR (18,192 receipients), medium to 282.11 EUR (10,398 receipients) and the highest to 418.88 EUR (524 receipients).

The separate form of taking care of eldery is day care for persons aged 65+ who are not capable of living independently. Currently there are 350 places available in day care. The goal in the new resolution is to increase this number to 3,000 places for elderly 65+ by 2020.

Short-term institutional care for elderly 65+ and paliative care is underdeveloped; the goal in the resolution is to assure 1,100 places for elderly 65+ and 300 places for paliative care in specialised institutions.

Flaker et al. (2011) estimate that half of the population in long-term care (56%) live at home, 39% live in institutions and only 5% are situated in mixed forms of care. The majority of those who live at home do not receive in kind benefits but mostly cash benefits – home care as benefit in kind is only received by 20% of those elderly living at home.

The total expenditure for long-term care amounted to 1.26% of GDP. Out of that public expenditures amounted to 0.94% of GDP and private - to 0.32% of GDP. In spite of austerity measures the real growth of public expenditures for long-term care amounted to 4.8% in 2010. Even higher was the growth of private LTC expenditures (8.6%).

4.1.3 Details on recent reforms in the past 2-3 years

There were no recent reforms in the past 2-3 years and the system of long-term care has not been set up yet as a separate system of social protection.

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

There have been no analyses performed regarding regional disparities, interlinks between poverty and the need of long-term care or coordination of care. The new draft Act introduces coordinators of care who is going to prepare an individual plan for each care receiver that will include the most suitable mix of various forms of care. Regarding regional disparities data exist on the number of places, care receivers and demand for care for institutional and home care. However, no analysis is made regarding poverty and need for long-term care.

4.2.2 Quality and performance indicators

In Slovenia there is no national quality management strategy and the field is legally not settled. In general, quality indicators in long term care are not defined on a national level and they are only being introduced via E-Qalin model[26]. Regarding health care provision in long-term care, quality assurance is regulated through the National Strategy on Quality and Patient Safety, through clinical pathways and quality indicators (PATH). In the field of informal care no quality indicators and quality monitoring is going on.

E-Qalin in institutional care in Slovenia was initiated in 2004: in year 2005 it was introduced in 6 homes for elderly, in 2006 in 3, 2007 in 5, 2008 in 4, 2009 in 2 and in 2010 in 5: altogether it was introduced in 25 homes for elderly. Out of those 19 are still included in the E-Qalin system, whereas 6 are not actively involved in the model, mostly due to the management, which sees E-Qalin application as additional workload of little added value and are not willing to cooperate further in the process.

Regarding quality vision in long-term care the new legislation under preparation brings some changes. The Act plans the introduction of a National Professional Council which will monitor the long-term care policy and give suggestions and initiatives to the development directions of long-term care. Among other tasks the Council will suggest professional and

[26] E-Qalin partnership developed model for quality management. It is a bottom up model, intended to develop voluntary standards of quality and exchange of experiences. The aim of the partnership is to develop standards and methodologies for quality management in social care. The development of E-Qalin model was initiated in 2004 in 5 countries: Austria, Germany, Italy, Luxembourg and Slovenia. It first applied only to institutional care (homes for elderly in Slovenia). The model was later on further developed, in Slovenia an application of the model for centres for social work that organize home care started in 2009. E-Qalin model consists of two pillars: the first one is called "structures and processes" and the second one is called "results". The area of structures and processes includes all the procedures, instruments and values in the organisation. The second area includes consequence of the first process. Both areas are equally important and in the final estimation each represents 50% of the final score. There are always more opinions and views on whether processes and structures are well developed and coordinated inside the institutions. For this reason, there are 5 viewpoints that are taken into account in the organisation: elderly, employees, management, environment and learning organisation. The area of results is equally judged from 5 viewpoints: elderly, employees, management, social impact and orientation into the future. Estimating quality according to E-Qalin is based on PDCA methodology (Plan, Do, Check, Act) and the phases follow each other in circles. The defined quality indicators get a certain amount of points that are later on summed up. For estimating an institution according to EQalin model special software was developed, that automatically transfers individual values and calculates the final result, helps in other calculations and graphical presentations, in managing documentation and analysis of data.

organisational measures to enhance the quality of work of providers and will prepare suggestions for higher effectiveness and efficiency in carrying out long-term care. It will also initiate the introduction of new technologies and approaches in LTC, suggest quality indicators and safety standards and monitor and give incentives to enhance the quality of long-term care services.

Monitoring and quality assurance is not legally settled. Currently, the main mechanism to assess quality of care in the field of long-term care is still the inspection. The Ministry of Labour, Family and Social Affairs is responsible for social inspection and the Ministry of Health is responsible for health inspection.

Considering informal care, there are not many mechanisms for assuring and monitoring the quality of care. One of the mechanisms that enabled some insight into the area of informal care was the introduction of the institute of family helpers in 2004. Family helpers are financed through the municipal budget and are under the Law on Social Care which demands from the regional Centres for Social Work to monitor whether the family helper provides proper care to the person he/she takes care of. In a case when the Centre for Social care finds evidences of improper care, it is obliged to hand over all documentation to a special Committee that issues further opinion on retaining the status of family helper. Moreover, Centre for Social Care must issue an annual report on the work of family helpers that include the opinion of the person being taken care of. The family helper is obliged to report on her/his work at least once a year to the Centre for Social Work. He/she must take part in the educational programmes defined by the Social Chamber. Social inspection - a body that works under the Inspectorate for Work of Republic of Slovenia - can always carry out supervision over the work of a family helper. This work mostly includes supervision and monitoring, however, no quality guidelines or indicators are developed and demanded in the field of informal care.

4.2.3 Sustainability

As long-term care is not yet defined as a separate field there are no policies enacted that would strategically discuss and assure its financial or workforce sustainability. Due to its inclusion in health care and austerity measures taken, the public funds for long-term care have decreased in the past years as described. According to the demographic projections (e. g. EC EPC Ageing Working Group - AWG) it is assumed that the area is not going to be financially or workforce sustainable in the long run. This is why possible solutions in the reform are discussed regarding both issues including private insurance, restructuring non-formal carers into formal etc. As no final solutions are taken it is still difficult to discuss the long-term sustainability of the system.

4.2.4 Summary

The reform to ensure sustainable, flexible, high quality and accessible long-term care system has been underway since 2004. The official draft Act has not been yet in public debate as the prepared draft still lacks financial estimates and projections according to expenditure on long-term care and number of care receivers. In this moment, the system is still oriented towards institutional care, home care is increasing but still takes up only around 23% of all LTC expenditures. The resources for assuring long-term care are scattered among health care, pension care and social transfers systems. Not being a separate system of social protection no analysis on needs, regional/gender disparities have been conducted. Regarding strategic documents resolution on national programme of social care for 2013-2020 was prepared by the Minitsry of Labour, Family, Social Affairs and Equal Opportunities that addresses also

long-term care and sets it as one of priority areas, where new financial and human workforce sources will be needed.

4.3 Reform debates

Reform debates have been lively in the past few months. Three versions of long-term care legislation have been prepared, the first one by the Ministry of Labour, Family, Social Affairs and Equal Opportunities, the second by the Association of societies of pensioners and the third one by the Society of Social Institutions of Slovenia. They are not public, but the fact of the existing three versions expresses the pressure and need for systematic legislation in the field of long-term care. The reform debates untill recently have been concentrated appeals for passing new legislation. Only in September 2013 some details from the legislation became publicly debated in media. The debates are typically concentrated on financial side of the long-term care assurance, especially on transferring long-term care services and funds from pension and health care insurance as well as on the introduction of the so-called compulsory contractual insurance from net income that would be carried out by private insurance companies. Although some main issues of the new legislation are already popping up in the media (criteria for care receivers, rights, long-term care insurance, coordinator of care) the details are still largely unclear so there are no further detailed debates on the long-term care issues. The working group has been formed at the Ministry for the preparation of data, long-term care models and projections that is going to prepare the first draft of the legislation and sustainability of long-term care system by the end of January 2014.

5 References

ACT ON BALANCING PUBLIC FINANCE (2012), OG RS 40/2012, retrieved on October 10, 2013 at http://zakonodaja.gov.si/rpsi/r08/predpis_ZAKO6388.html

ACT ON HEALTH CARE AND HEALTH CARE INSURANCE (1992), retrieved on October 7, 2013 at http://zakonodaja.gov.si/rpsi/r03/predpis_ZAKO213.html

ACT ON HEALTH CARE SERVICES (1992), retrieved on October 7, 2013 at http://zakonodaja.gov.si/rpsi/r04/predpis_ZAKO214.html

ALBREHT T ET AL (2009), Slovenia Health System Review, Health Systems in Transition, 11(3), European Observatory on health Systems and Policies, Copenhagen, 2009.

ASSOCIATION OF SOCIAL INSTITUTIONS OF SLOVENIA (2013), retrieved on September 15, 2013 at http://www.ssz-slo.si/splosno-o-domovih-in-posebnih-zavodih.

FERLIČ ŽGAJNAR, B, DNEVNIK O (2013): ZZZS uvaja prvo terapevtsko skupino zdravil – HIIS introduces teh first therapeutic group of drugs, Ljubljana, 30.09.2013

BUZETI ET AL (2011), Health Inequalities in Slovenia, January 2011.

COMMISSION STAFF WORKING DOCUMENT ON LONG-TERM CARE IN AGEING SOCIETIES 2013 (2013), retrieved on September 3, 2013 at http://ec.europa.eu/social/BlobServlet?docId=9769&langId=en

ČOK M, MAJCEN B (2010), The estimate of consequences of transferring complementary health care insurance into compulsory health care insurance, Institute for Economic Research, Ljubljana, June 2010.

ECFIN Paper on long-term care (2012), retrieved on September 10, 2013 at http://ec.europa.eu/economy_finance/publications/economic_paper/2012/pdf/ecp469_en.pdf

EUROPEAN COMMISSION IN ECONOMIC POLICY COMMITTEE (2012), 2012 Ageing Report, retrieved on September 10, 2013 at http://ec.europa.eu/economy_finance/publications/european_economy/2012/pdf/ee-2012-2_en.pdf

FLAKER V, NAGODE M, RAFAELIČ A, UDOVIČ N (2011), Nastajanje dolgotrajne oskrbe: ljudje in procesi – ekperimenti in sistem – Establishing long term care: people and processes – experiments and system, Faculty for Social Work, Ljubljana, 2012.

HEALTH INSURANCE INSTITUTE OF SLOVENIA (2013), HIIS Annual Report for year 2012, retrieved on October 10, 2013 at http://www.zzzs.si/ZZZS/info/egradiva.nsf/o/B65EB118EAC3DF54C1257B1D003281DE?OpenDocument

INICIATIVA ZDRAVNIKOV ZA VZPOSTAVITEV TRANSPARENTNEGA IN STROKOVNEGA JAVNEGA ZDRAVSTVA V REPUBLIKI SLOVENIJI, Ljubljana, 2013, retrieved on October 10, 2013 at http://iniciativa-zdravnikov.si/dokumenti-iniciative/

INSTITUTE FOR MACROECONOMIC ANALYSIS AND DEVELOPMENT (2013), Development Report, Ljubljana, retireved on October 8, 2013 at http://www.umar.gov.si/fileadmin/user_upload/publikacije/pr/2013/POR_2013s.pdf

INSTITUTE FOR PUBLIC HEALTH (2013), Monthly report on waiting lists, January 1, 2013, retirieved on October 10, 2013 at http://www.ivz.si/cakalne_dobe_porocila

MAJCEN B, ČOK M, SAMBT J, TURK T, STROPNIK N, DEKKERS G, PREVOLNIK RUPEL V, LAVRAČ V, KUMP N, OGOREVC M (2012), Izgradnja kombiniranega mikrosimulacijskega modela in modela generacijskih računov, Inštitut za ekonomska raziskovanja, Ljubljana.

MALNAR B, HAFNER-FINK M (2013): Thirty years of gender differences in self-assessed health: the case of Slovenia, Ljubljana, Zdrav Var 2013; 52:99-107.

MINISTRY OF HEALTH (2010), National Strategy on Quality nad Safety in health Care, Ljubljana, retrieved on October 10, 2013 at http://www.mz.gov.si/fileadmin/mz.gov.si/pageuploads/kakovost/nacionalna_strategija_kakov_in_varn_2010-2015/Nacionalna_strategija_kakovosti_in_varnosti_v_zdravstvu_2010-2015.pdf

MINISTRY OF HEALTH (2011), Quality and Accreditation Management. retrieved on October 10, 2013 at http://www.mz.gov.si/si/delovna_podrocja/zdravstveno_varstvo/kakovost_in_varnost_sistema_zdravstvenega_varstva/vodenje_kakovosti_in_akreditacije/

MINISTRY OF HEALTH (2011), Tax for assuring funds for compulsory health insurance ia a case of abolishment of complementray health insurance, Ljubljana, 2011.

MINISTRY OF HEALTH (2011), Upgrade of Health Care System by year 2020, Ljubljana, 2011.

NAGODE M, LEBAR L (2013), Home care – situation analysis for 2012, IRSSV - Social Protection Institute of Republic of Slovenia, Ljubljana, May 2013.

NAGODE M, MARN S, JACOVIĆ A, ZVER E (2012), Managing database for services and expenditures for long term care. IRSSV - Social Protection Institute of Republic of Slovenia, Ljubljana, 2013.

OECD report on quality in long-term care 2013 (2013), retrieved on September 3, 2013 at http://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=1920&furtherNews=yes

PREVOLNIK RUPEL V, OGOREVC M (2013): Kako bolniki ocenjujejo zdravstvene storitve v Sloveniji – How the patients value health care services in Slovenia, Ljubljana, Medicina danes, 31.5.2013.

RESOLUTION ON NATIONAL PROGRAM OF SOCIAL CARE FOR 2013-2020 (2013) , OG RS 39/2013, Ljubljana, Retrieved on October 10, 2013 at http:// www.uradni-list.si/1/content?id=113130.

ROK SIMON M, TOMŠIČ S, ŠELB ŠEMERL J, NADRAG P, MIHEVC PONIKVAR B, LAVTAR D, KOROŠEC A, KOFOL BRIC T (2013), Inequalities in women's mortality by education, Ljubljana, Zdrav Var 2013; 52: 77-86.

VZAJEMNA (2013), Revised Annual Report for year 2012, retrieved on October 10, 2013 at http://www.vzajemna.si/media/revidirano.letno.porocilo.2012.pdf

ZVER E, NAGODE M, MARN S, JACOVIĆ A (2013), Dolgotrajna oskrba – uporaba mednarodne definicije v Sloveniji – Long term care – use of international definition in Slovenia. Working paper no. 5/2013 (XXII).

Annex – Key publications

[Pensions]

MAJCEN B., ČOK M., SAMBT J., TURK T., STROPNIK N., DEKKERS G., PREVOLNIK-RUPEL V., LAVRAČ V., KUMP N., OGOREVC M. (2012), Izgradnja kombiniranega mikrosimulacijskega modela in modela generacijskih računov, Inštitut za ekonomska raziskovanja, Ljubljana.

"The development of a combined mikrosimulation model and model of generational accounts"

This study, which is in fact a research report, presents the work done in the synthesis of the two models, the development of programme modules (the demographic module, the economic module, the pension module. In particular, it presents some results of the application of the pension module.

BELOPAVLOVIČ, Nataša (2012), »Pokojninska reforma – kdaj in zakaj«, Pravna praksa 31(13)

"The Pension reform – when and why"

Nataša Belopavlovič, a distinguished legal expert on labour relations and pension issues, argues why it is necessary to pass the pension reform. Her arguments are based on statistical data. She cites the decreasing ratio between active insured persons and pensioners, increased longevity and decreasing ratio between average pensions and average wages which show the large financial inbalances and social unsustainability of the pension system. She also cites the study (described in ANR 2012) by the Institute for Economic Research on the socioeconomic position of pensioners and the elderly population, which shows a gradual deterioration of the economic and social position of pensioner households.

[Health care]

ROK Simon M, TOMŠIČ S, ŠELB ŠEMERL J, NADRAG P, MIHEVC PONIKVAR B, LAVTAR D, KOROŠEC A, KOFOL BRIC T: Inequalities in women's mortality by education; Zdrav Var 2013; 52: 77-86). Retrieved from: http://www.degruyter.com/view/j/sjph.2013.52.issue-2/sjph-2013-0010/sjph-2013-0010.xml?format=INT

Background: Researchers have found that mortality is decreasing in all socioeconomic population groups but the relative differences in mortality between lower and higher social classes remain unchanged or have even increased. In Slovenia this has not yet been studied.

Methods: The analysis included all women in Slovenia who died in the 2005-2010 period and were recorded in the Registry of deaths. Cause of death data was linked to data on the educational attainment of the deceased person, which was applied successfully in 98.8% of cases. The rate ratios (RR) for age-standardised death rates were calculated for women with a low and high educational attainment.

Results: The calculated gap in life expectancy at age 30 between women with low and high educational attainment stood at 5.5 years. Women aged 0-84 with a low educational attainment had a statistically significant higher risk of death than women with a high educational attainment (RR=1.65; 95% CI: 1.57-1.73). Inequalities in premature mortality

were even greater (1.78; 1.65-1.93). Educational inequalities in premature mortality were revealed in the majority of causes of death, e.g. cervical cancer (1.99; 1.22-3.67), lung cancer (1.70; 1.30-2.26), cardiovascular diseases (3.02; 2.41-3.91), causes directly attributable to alcohol (7.34; 4.96-12.27), motor vehicle accidents (2.23; 1.21-4.45) and suicide (1.68; 1.19-2.41).

Conclusions: Significant socioeconomic gaps in women's mortality in Slovenia obligate us to more systematic monitoring of health inequalities in the future. Further research is required in order to clarify specific reasons for the major gaps in mortality from specific causes of death.

PREVOLNIK Rupel V, OGOREVC M (2013): Kako bolniki ocenjujejo zdravstvene storitve v Sloveniji –, Ljubljana, Medicina danes, 31.5.2013. Retrieved from: http://www.finance.si/poisci?act=yes&avtor=Dr.+Valentina+Prevolnik+Rupel

"How the patients value health care services in Slovenia"

Objectives: The main objective of the article is to explore in Slovenia for the first time the use of patient evaluation of the health states in determining the quality of health care programmes provision among health care providers. The other goals are to explore the impact of different variables on the patient reported outcomes.

Methods: EQ-5D instrument was used in four health care programmes (hip replacement, hernia surgery, carpal tunnel release and veins surgery) to evaluate the patients' health states before and after the procedure, following a carefully prepared instructions. The data were analysed using regression model and EQ-5D value set for Slovenia, calculated on the basis of spatial econometric methods.

Results: There are significant differences among health care providers in the share of the patients who reported positive changes in health care status as well as statistical significant differences among health care providers in average improvement in patient reported outcomes in all four programmes. Optimal allocation of patients would significantly increase patient reported outcomes.

Conclusions: The analysis exposed some differences in average health state valuations across four health care programmes among providers. Further data on patient reported outcomes for more than a single year should be collected. On the basis of trend data further analysis to determine reasons for differences should be conducted. .The possibility to use this approach for measuring health care providers' performance and its use in contracting should also be explored.

MALNAR B, HAFNER-FINK M (2013): Thirty years of gender differences in self-assessed health: the case of Slovenia, Ljubljana, Zdrav Var 2013; 52:99-107. Retrieved from: http://www.degruyter.com/view/j/sjph.2013.52.issue-2/sjph-2013-0012/sjph-2013-0012.xml?format=INT

Background: This article explores gender trends in self-rated health in Slovenia over the period of thirty years. The main research goals are to examine the associations between gender, social class and health, establish the extent that the patterns of subjective health converge with those in other countries and identify the most vulnerable health groups.

Methods: The study is based on six waves of the Slovenian Public Opinion survey carried out between 1981 and 2012 on representative samples of the adult Slovenian population. The main dependent variables are the respondent's self-assessed health and three indicators of psychosomatic health - experiences of insomnia, irregular heartbeat and anxiety. The main

independent variables are gender and socio-economic status. The relationship between them was examined using Chi-square tests.

Results: The 30 year trend is consistent with prior studies, which found that women report poorer self-assessed health than men. In Slovenia, this gender gap was observed in both social classes, but was more pronounced for women in the lower educated category. The higher prevalence of stress symptoms among women supports the theory of chronic exhaustion resulting from the dual-role strain.

Conclusions: In Slovenia the welfare state was able to buffer the adverse effects of increased economic stresses to a significant extent after 1991, resulting in favourable health outcomes for both genders. Dismantling these arrangements may result in short-term financial gains but is likely to trigger long-lasting negative consequences for public health, especially in the case of vulnerable groups such as women.

MINISTRY OF HEALTH (2011), Upgrade of Health Care System by year 2020, Ljubljana, 2011. Retrieved from: http://www.vlada.si/fileadmin/dokumenti/si/projekti/2011/zdravstvena/NADGRADNJA_ZDRAVSTVENEGA_SISTEMA_DO_LETA_2020_pdf_160211.pdf

The vision of the Upgrade document was changing and upgrading the health care system to guarantee positive health among the Slovenian population. Strategic goal was the establishment of a flexible health care system that will effectively fulfil the citizens' needs by offering them quality and safe health care services.

Fundamental principles of the health care system upgrade:

1. Ensuring the geographical accessibility of health care services by decentralising and strengthening regionalisation and, at the same time, ensure the professional development as well as the transfer and linking of knowledge among different levels;

2. Ensuring qualitative accessibility by providing safe and quality services in health care;

3. Ensuring financial accessibility through strategically ensuring services to different categories of population after having defined the basic benefit package in accordance with the principles of clinical efficiency, cost effectiveness as well as that of health insurance system changes.

[Long term care]

ZVER E, NAGODE M, MARN S, JACOVIĆ A (2013), Dolgotrajna oskrba – uporaba mednarodne definicije v Sloveniji – Long term care – use of international definition in Slovenia. Working paper no. 5/2013 (XXII).

In Slovenia, long-term care system is not regulated under single legislation, but is provided under various laws or through separate systems of social protection. The law regulating this area has been in preparation for a number of years, the last draft was in the public debate in 2010. In addition to settle the field contextually, it is also necessary to statistically support and monitor the field through data. There is a need for an organised, coordinated and systematic collection of such data through an uniform approach.

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