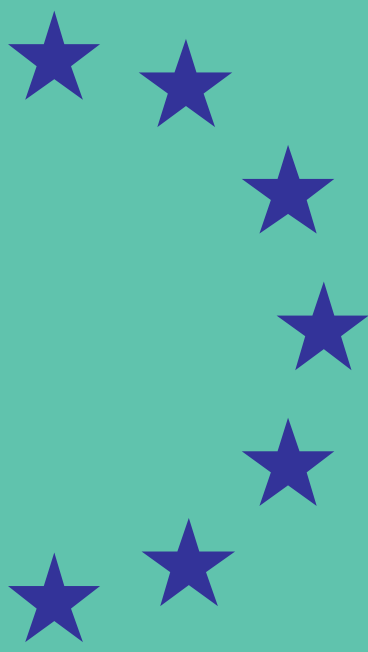




# Slovenia

## Health Care & Long-Term Care Systems



An excerpt from  
the **Joint Report on Health Care  
and Long-Term Care Systems  
& Fiscal Sustainability**,  
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## Slovenia

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### Health care systems

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## 2.25. SLOVENIA

### General context: Expenditure, fiscal sustainability and demographic trends

#### General country statistics: GDP, GDP per capita; population

Slovenia has a population of just above 2 million inhabitants, which is slightly more than 0.4% of the EU population. With a GDP of 39 billion, or 22,600 PPS per capita in 2015 it scores lower than the EU weighted average (29,600). When looking at the unweighted average and at the median level though, respectively 25,200 and 22,100 PPS, Slovenia faces a significantly lower gap, standing at 89.7% of the average, and closely resembling the median. However measured, this gap is mainly due to the economic crisis which since 2008 reduced the national income, whereas in 2008 Slovenia's GDP level in PPS per capita was 91% that of the EU average.

The Slovenian population is projected to decrease from 2.1 million in 2015 to 2 million in 2070, a decrease of 5% in comparison to the EU average increase of 2%.

#### Total and public expenditure on health<sup>(344)</sup> as % of GDP

In 2015 total expenditure on health care amounted to 8.9% of GDP, having slightly increased, though not steadily, during the last decade (8.3% in 2005). This is below the EU average of 10.2%, when looking at weighted average. Looking at the unweighted average and at median EU values however, respectively 8.7% and 8.9%, the level of total health expenditure in Slovenia is slightly higher than the former and at the same level of the latter EU values. The same applies to public expenditure on health care, broadly constant over the last decade (+0.4 pps) and accounting for 6.5%<sup>(345)</sup> of 2015 GDP, which is below the EU<sup>(346)</sup> average of 8% when looking at the weighted figure, but is higher both than the unweighted (6.4%) and than the median (6.2%) values. Also when measured in per capita terms, both total and public health care expenditure are lower than the EU weighted average: 2,002 PPS vs. 3,305 PPS

<sup>(344)</sup> This aggregate includes capital investments.

<sup>(345)</sup> Including public long-term health expenditure (HC.3) and capital investments.

<sup>(346)</sup> This figure refers to the weighted average.

and 1,460 PPS vs. 2,609 PPS respectively (figures for 2015 in €PPS). Comparing these values to unweighted average (2,526 PPS) brings Slovenia closer though not above average, but it places Slovenia at the median (2,002) for the total figure. With an unweighted average value of 1,894 and a median of 1,460, a similar reasoning applies to public health expenditure PPS, with Slovenia at the median level. Looking at health care without long-term care<sup>(347)</sup> reveals a similar picture, with spending below the EU average, but with a smaller gap (5.7% vs 6.8% in 2015).

As a result of declining revenues of compulsory health insurance contributions (and in view of the target that compulsory health insurance should be financed without any further borrowing or increase in the contribution rate), public health expenditure, declined in real terms in 2012 and 2013<sup>(348)</sup>. Since 2014 public health expenditure has been rising in real terms, underpinned particularly by stronger growth in employment and wages and hence higher inflows into the health insurance fund. In 2015 public current public health expenditure reached 6.1% of GDP and total public expenditure, including investments reached 6.5 % of GDP. The share of public expenditure declined from 2010 to 2014, but from 2014 to 2015 it increased up to 72.9%.

Slovenia had already recorded relatively low health expenditure growth before the crisis, but also during the crisis called for strict austerity measures. In the period 2000-2009 health expenditure per capita averaging 4.7% growth per year in real terms in EU28 countries and in Slovenia 4.0%; during the crisis in 2009-2012 it declined to 0.6% in EU28 countries and in Slovenia it fell annually by 0.5% in real terms<sup>(349)</sup>.

#### Expenditure projections and fiscal sustainability

Driven by the change in demographic structure, public spending on health care is projected to

<sup>(347)</sup> To derive this figure, the aggregate HC.3 is subtracted from total health spending.

<sup>(348)</sup> OECD Stat, 2018. Calculations by IMAD (IMAD Development Report 2018, page 120).

<sup>(349)</sup> OECD Health at a glance: Europe 2014 and Institute of Macroeconomic Analysis and Development (2015) Development report 2015. Indicators of Slovenia's Development. Health expenditure.

increase by 18% or 1.0 pp of GDP, more than the 13% average increase in the EU (0.9 pps) according to the "AWG reference scenario" <sup>(350)</sup>. When taking into account the impact of non-demographic drivers on future spending growth ("AWG risk scenario"), health care expenditure is expected to increase by 2 pps of GDP from now until 2070 (EU: 1.6).

Medium fiscal sustainability risks appear over the medium and the long run due, especially for the long-term risk categorisation, to the projected increase in age-related public spending, notably deriving from pensions, healthcare and long-term care <sup>(351)</sup>.

#### Health status

The indicators of health status of the Slovenian population appear similar to those of the EU average. Life expectancy at birth for both women and men was respectively 83.9 years and 77.8 years in 2015, similar to the EU average (83.3 and 77.9 years for men and women respectively). Nevertheless, in 2015 the healthy life years at birth for both sexes were, 57.7 years (women) and 58.5 years (men), substantially lower than the EU-average (63.3 and 62.6 respectively) <sup>(352)</sup>. Infant mortality of 1.6‰ (2015) is well below the EU average of 3.6‰.

Mortality rates <sup>(353)</sup> from both cancer and cardiovascular diseases have dropped over the last 20 years, but they are still above the EU average (and for men they are the highest in Europe). External causes of death are particularly high for men and women because of the high numbers of falls (particularly in old-age) as well as suicides (mortality from suicide was the fourth highest in Slovenia in 2014).

<sup>(350)</sup> The 2018 Ageing Report: [https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070\\_en](https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070_en).

<sup>(351)</sup> European Commission (2018), Fiscal Sustainability Report (2018) [https://ec.europa.eu/info/sites/info/files/economy-finance/ip094\\_en\\_vol\\_2.pdf](https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf).

<sup>(352)</sup> Data on life expectancy and healthy life years is taken from the Eurostat database. Data on life-styles is taken from the Eurostat database and the OECD health data.

<sup>(353)</sup> State of Health in the EU Slovenia Country Health Profile 2017, OECD, Health Observatory and European Commission. [https://ec.europa.eu/health/sites/health/files/state/docs/chp\\_sl\\_english.pdf](https://ec.europa.eu/health/sites/health/files/state/docs/chp_sl_english.pdf).

The lifestyle-related risk factors are in general less prevalent than in the other EU countries. Percentage of regular smokers (18.9% in 2014) was below the EU average in the recorded closest years (20.9% in 2015) and alcohol consumption in 2014 (10.5% litres per capita) was close to the EU average number (10.2 litres per capita in 2015).

#### System characteristics

##### *System financing, revenue collection mechanism, coverage and role of private insurance and out of pocket co-payments*

The Slovenian health system is a Bismarckian system based on statutory health insurance, which is fully regulated by national legislation and administered by the single insurer, Health Insurance Institute of Slovenia (HIIS), an independent public institution. HIIS operates in accordance with the "Stability Pact", whereby HIIS is not allowed to record a loss at the end of the year or go into debt and it cannot itself increase insurance contribution rates <sup>(354)</sup>. The health insurance system is mandatory, providing universal coverage. The extent of rights deriving from compulsory health insurance is specified by the law on health care and health insurance and the regulations on compulsory health insurance, i.e. the act adopted by the assembly of the Health Insurance Institute of Slovenia.

Compulsory health insurance comprises insurance in the case of illness or injury outside work, and insurance in the case of injury at work and occupational diseases. The extent of rights to health care services is defined in percent share of the total service costs. This means that the compulsory health insurance "covers" the majority of health related risks, however, not necessarily all of them and neither in full. The balance is either to be paid by the insured person, or, alternatively and most common, the insured person takes out a complementary insurance policy with a private health insurance company. More than 95 % of the

<sup>(354)</sup> European Observatory on Health System and Policies, World Health Organization and Ministry for Health (2016). Analysis of Health System in Slovenia. Health System Expenditure Review. Final report. [http://www.mz.gov.si/fileadmin/mz.gov.si/pageuploads/Analiza/Report\\_Expenditure\\_review\\_Slovenia\\_FINAL\\_FOR\\_MATTED\\_without\\_cover.pdf](http://www.mz.gov.si/fileadmin/mz.gov.si/pageuploads/Analiza/Report_Expenditure_review_Slovenia_FINAL_FOR_MATTED_without_cover.pdf).

population liable for co-payments is insured by voluntary complementary health insurance <sup>(355)</sup>.

In the 2009–2013 period a series of measures were introduced to balance Health Insurance Institute operations. To generate additional revenues measures included increasing contributions for self-employed and requiring contributions from student employers <sup>(356)</sup>. However, the majority of measures focused on reducing expenditure by reducing the prices of health services, transferring a portion of expenditure on health to complementary health insurance schemes, lowering expenditure on medicines, medical devices, sickness allowances and obligations under international agreements. These measures significantly reduced health care providers' revenue from compulsory health insurance, which had an impact on increasing the losses of these providers, particularly hospitals <sup>(357)</sup>.

Voluntary health insurance (VHI) has two main forms: complementary VHI provides insurance to cover co-payments only, and supplementary VHI provides insurance for a higher standard and a wider scope of benefits than the mandatory insurance. Since co-payments for some health services can represent high financial burden for patients, the share of population holding complementary health insurance is very high and comprises more than 95 % of those who are eligible to pay co-payments <sup>(358)</sup>.

Overall levels of enrolment in complementary health insurance have not changed dramatically during the crisis <sup>(359)</sup>. Total enrolment in 2014 (1,433,484) was at its highest level since 2008 (1,455,828). Since 2009, the government has started to cover co-payments for economically disadvantaged people who meet predetermined

criteria <sup>(360)</sup>. To avoid cream-skimming by insurers and to equalise the variations in risk structure, a risk-equalisation scheme was introduced in 2005. Risk equalisation is retrospective, calculated on the basis of expenditures for health care services and for health care providers <sup>(361)</sup>. Premiums have been community rated since 2005, are similar across the insurers (i.e. premiums currently do not differ across insurers by more than €1 per month). The large premium increase (by more than 16 %) in 2014 was in response to the 2012 "Fiscal Balance Act", which shifted some costs from HIIS to complementary VHI in an effort to keep public expenditure sustainable.

Out-of-pocket payments exist as two main mechanisms: cost sharing and direct payments. Cost sharing takes the form of flat rate co-payments and applies to most types of health care services and to all patients with the exception of some vulnerable social groups (children, unemployed, those with income below a given threshold, chronically ill). However, since a large majority of patients is covered by voluntary insurance covering complementary co-payments, this form hardly exists in the form of direct payments. The latter are used, however, in case of visits to the providers who do not have a contract with the HIIS, to the specialists without a GP's referral and to private dentists. The out-of-pocket payments are also used to avoid waiting times and pay for extra services, not included in the general benefit package of the social insurance system.

Compulsory health insurance contributions constitute the major source of health care financing with 66.5% of current health expenditure (2016) <sup>(362)</sup>. General national and municipal-level taxation represents only 3.8% of current health expenditure, and is mostly devoted to the financing of capital investments in hospitals, specialised health institutions at national and regional levels, national health programmes, medical education and research (Ministry of Health) and public health centres and public pharmacies (municipalities).

<sup>(355)</sup> Health Insurance Institute of Slovenia. Web page: <http://www.zzs.si/zzs/internet/zzseng.nsf/o/87C028D74130DE0AC1256E89004A4C0C>.

<sup>(356)</sup> Health Insurance Institute of Slovenia. Web page: <http://www.zzs.si/zzs/internet/zzseng.nsf/o/87C028D74130DE0AC1256E89004A4C0C>.

<sup>(357)</sup> Institute of Macroeconomic Analysis and Development (2014) Development report 2014. Indicators of Slovenia's Development. Health expenditure.

<sup>(358)</sup> OECD Health Statistics 2015.

<sup>(359)</sup> Overall, the largest decrease in total enrolment was in 2010, when the number of VHI enrollees fell by around 12,000 people (-0.8%); there were smaller decreases in VHI enrollees of around 8,200 and 3,800 in 2009 and 2011, respectively.

<sup>(360)</sup> Health Insurance Institute of Slovenia. Web page: <http://www.zzs.si/zzs/internet/zzseng.nsf/o/87C028D74130DE0AC1256E89004A4C0C>.

<sup>(361)</sup> Health Insurance Institute of Slovenia. Web page: <http://www.zzs.si/zzs/internet/zzseng.nsf/o/87C028D74130DE0AC1256E89004A4C0C>.

<sup>(362)</sup> Statistical Office of the Republic of Slovenia, 2018. Health Expenditure and Sources of Funding 2016.

The share of government budget funding is one of the lowest in the EU and transitioning towards a system that is less reliant on contributions could improve the future stability of health care financing.

Contributions to fund the HIIS are mostly related to earnings from employment. The contribution rate amounts to 13.45% of gross income, out of which 6.36% is paid by the employee and 7.09% by the employer. Both together represented 97% of compulsory insurance revenues in 2016 (including all types of categories of insured persons <sup>(363)</sup>). The other source of HIIS revenues is general taxation with only 3% <sup>(364)</sup>.

Public health expenditure accounted for about 14.9% of the total general government health expenditure in 2016 <sup>(365)</sup>.

*Administrative organisation: levels of government, levels and types of social security settings involved, Ministries involved, other institutions*

The coverage by compulsory health insurance (CHI) is universal. It covers the contributors (employees, pensioners, farmers, self-employed), their dependants (subsidised by the compulsory health insurance), but also unemployed and individuals without income (whose contributions are paid by the National Institute for Employment, central government and municipalities). The benefits package comprises a wide coverage of primary, secondary and tertiary services, pharmaceuticals, medical devices, long sick leave and travel costs. Some services are 100% covered by CHI, while others are only covered up to a certain share of the service's full value. However, the difference to the full value is usually covered by complementary health insurance.

More than 95 % of insured CHI that are liable for co-payments is included also in voluntary complementary health insurance to cover cost-sharing in the social security system.

<sup>(363)</sup> Self-employed, pensioners, farmers, self-payers and other categories.

<sup>(364)</sup> OECD Health at a glance 2017. Sources of health care financing. Page 139.

<sup>(365)</sup> Eurostat Database 2018 (General Government Expenditure by COFOG).

Complementary health insurance guarantees full co-payment coverage for all services covered by compulsory health insurance. This could lead to unnecessary care <sup>(366)</sup>. Introducing a fee for some health services, which could not be covered and reimbursed by complementary insurance, would represent a supplementary tool for cost control for the public health care fund. There is also room to continue to rationalise the public benefit basket by reducing the reimbursement rate or delisting certain less medically necessary services, such as spa treatments, non-emergency ambulance transportation or less clinically-effective medicines <sup>(367)</sup>.

Private sources account for 27.1% of total health expenditure in 2015 and exceed the EU level (21.6% weighted average, 23.6% unweighted average). Private sources consist of two main sources of financing: out-of-pocket payments, representing 12.5% and voluntary health insurance accounting for 14.5% in 2015. Total private expenditure has been increasing over the recent years: its average real yearly growth per capita over the period 2005-2015 has amounted to 2.1% (OECD average: 1.6 %) <sup>(368)</sup>. Out-of-pocket expenditure accounted for 12.5% of total current health expenditure in 2015, compared with 15.9% in the EU-28 (unweighted average 21.8%) <sup>(369)</sup>. During the crisis, a significant share of the shortfall in public funding was compensated for by complementary health insurance schemes, so that out-of-pocket expenditure increased only marginally, however, voluntary health expenditure increased considerably more than out-of-pocket expenditure. Had this not been the case, they would have been significantly affected by lower availability and higher out-of-pocket payments as public funding declined <sup>(370)</sup>.

Slovenian households allocate the largest shares of out-of-pocket expenditure to medical goods (2015: 40%; of which 36% for over-the-counter medicines), therapeutic appliances (20%; of which 16% for glasses), various other health services (physiotherapy) and alternative medicine (11%),

<sup>(366)</sup> OECD (2013). 2013 Economic Survey – Slovenia.

<sup>(367)</sup> OECD (2013). 2013 Economic Survey – Slovenia.

<sup>(368)</sup> OECD Stat 2018.

<sup>(369)</sup> Source Eurostat Database.

<sup>(370)</sup> Institute of Macroeconomic Analysis and Development (2014) Development report 2014. Indicators of Slovenia's Development. Health expenditure.

dental care (8%) and specialist outpatient care (8%). In 2009–2013, increases in out-of-pocket expenditure were recorded by medical goods, long-term institutional care and patient transport), while significant decreases in out-of-pocket expenditure were recorded by dental care, specialist outpatient care, and various other health services (physiotherapy, alternative medicine) <sup>(371)</sup>.

Slovenian households allocate the largest shares of out-of-pocket expenditure to medical goods (2015: 35%; of which 32% for over the counter medicines, therapeutic appliances (21%; of which the most for glasses), various other health services (physiotherapy) and alternative medicine (around 10 %), dental care (8%) and specialist outpatient care (8%) <sup>(372)</sup>.

#### *Types of providers, referral systems and patient choice*

Public primary health care is provided by a mix of public and private providers with concessions. Public providers include health care centres and health stations, institutions established and owned by local communities. Private providers are individual health care professionals working individually or in group practices offering various combinations of services and specialties.

The patients can choose the primary care provider among those who have a contract with the HIIS and have the right to change them after a year. The personal physician plays the role of the gatekeeper since his referral is necessary to proceed to specialist and hospital care. The referral is not required only in case of chronic diseases or long-term treatment when many consecutive contacts with a specialist are necessary. Moreover, patients can select a private physician of their choice, but must cover all costs out-of-pocket.

Specialist outpatient care is provided in hospitals or private health facilities, while ambulatory services are provided in the polyclinics affiliated with hospitals, in community health centres or in private specialists' offices.

<sup>(371)</sup> OECD Stat 2015.

<sup>(33)</sup> OECD Stat 2018 (Based on data by the System of Health Accounts).

<sup>(372)</sup> OECD Stat 2018 (Based on data by the System of Health Accounts).

Specialists can also work part time in private and public health centres, based on civil law contracts. There exist also some private polyclinics, which may or may not have contracts with HIIS and, based on whether or not they hold a contract, paid either in the form of social insurance reimbursement, or as out-of-pocket payments.

Although the number of physicians has been growing more strongly in recent years, Slovenia's gap with the EU remains significant. In the last decade, the number of practising physicians per 100,000 population has been slowly growing from 225 in 2003 to 283 in 2015 (EU average in 2015 was 344) <sup>(373)</sup>. In the 2005–2016 period, the number of practicing physicians in Slovenia grew on average annually by 2.3%, which was faster than in the EU28 average (1.5 %) <sup>(374)</sup>.

Slovenia lags the most regarding the number of general practitioners. Following the adoption of measures <sup>(375)</sup> to strengthen primary health care, in recent years the number of general practitioners has increased reaching 55 per 100 000 inhabitants in 2015, still significantly lower than the EU average (2015: 78) <sup>(376)</sup>. This suggests under provision and problems with access to the primary health care, especially in light of the gatekeeper function exercised by the latter. One of the indicators showing the capacity of the primary level to assume a greater workload is the ratio of general practitioners to specialists. On this indicator too Slovenia lags behind the EU average: the proportion of general practitioners in the total number of physicians stands at 19%, compared with 23% in the EU. In Slovenia, at the primary level, besides general practitioners, there are also paediatricians and gynaecologists who have their own patients.

<sup>(373)</sup> According to national sources, the figure for 2016 is 307 physicians per 100,000 population. [https://podatki.nijz.si/Selection.aspx?px\\_path=NIJZ%20podatkovni%20portal\\_5%20Viri%20v%20zdravstvu\\_1%20Izvajalci%20zdravstvene%20dejavnosti&px\\_tableid=BPI\\_kazalniki.px&px\\_language=sl&px\\_db=NIJZ%20podatkovni%20portal&rxid=f346f106-811d-4b01-89dc-800bcecede2e](https://podatki.nijz.si/Selection.aspx?px_path=NIJZ%20podatkovni%20portal_5%20Viri%20v%20zdravstvu_1%20Izvajalci%20zdravstvene%20dejavnosti&px_tableid=BPI_kazalniki.px&px_language=sl&px_db=NIJZ%20podatkovni%20portal&rxid=f346f106-811d-4b01-89dc-800bcecede2e).

<sup>(374)</sup> Eurostat Database, 2018. Own calculation for EU28 average (unweighted).

<sup>(375)</sup> The introduction of so-called family medicine model practices where registered nurses assume greater responsibilities; and additional funding for the primary level of health care (Ministry of Health, 2012).

<sup>(376)</sup> Eurostat.

The number of nurses, however, is in line with the EU averages (827 per 100 000 in Slovenia vs. 837 in the EU). Therefore, Slovenia has adequate opportunities to introduce changes in the responsibilities of nurses in view of the fact that the number of qualified nurses has been growing in recent years <sup>(377)</sup> as well as in view of the high ratio of practicing physicians to nurses. The large inflow of nurses to the labour market will have to be regulated by additional systemic measures in both health care (a further transfer of certain duties from doctors to registered nurses) and long-term care (faster development of community nursing care) <sup>(378)</sup>.

Due to a lack of providers or long waiting times for some specialised services and surgeries, access to some health care services remains limited. Specific incentives could be developed to promote and encourage staff to work in some specialties currently in shortage. An increase in the supply of primary-care doctors would allow more extensive gatekeeping and cost-effective prevention in the medium term, though this strategy could boost spending in the short term. Nevertheless, and more generally, the human resources strategy needs to tackle staff and population ageing in the future.

To tackle the shortage of doctors at primary level, particularly in demographic areas with an ageing population, an analytical document <sup>(379)</sup> was prepared in 2013, with the objective to reach a proportion of 1.500 patients to one doctor at primary care level over the following 5 years.

To achieve this objective, it was estimated that 1,364 GPs would be required at national level, which required additional 318 GPs in each of the following five years.

Since 2013 the number of places available for general practitioners specialisations was increased so that 66% of available specialisations were allocated to general practitioners. The number of available specialisation for general practitioners

<sup>(377)</sup> In 2008–2012, on average 445 nurses graduated every year, 12% more than on average in the period 2003–2008.

<sup>(378)</sup> Institute of Macroeconomic Analysis and Development (2014) Development report 2014. Indicators of Slovenia's Development. Health Care Resources.

<sup>(379)</sup> "Public network of primary health care in the Republic of Slovenia in the field of general practitioners and paediatricians at the primary level", (2013).

also increased consistently between 2014 and 2018, but many posts were left unfilled due to the low attractiveness of this specialisation.

By reducing the proportion of patients to GPs, this is expected to improve not only the quality and safety of patient care, but also to reduce the cost of patient care, due to the gatekeeping function of primary care.

It is also acknowledged that the existing primary healthcare system needs to be upgraded in order to be able to cope with future challenges. In this view, almost all family practices (a few are left to join in 2018) have evolved into "family medicine model practices". Family medicine model practice is a medical practice, where a family medicine team, in addition to a junior nurse, is supported by a graduate nurse (registered nurse) with additional knowledge, which ensures the transfer of competencies from a doctor to a graduate nurse who treats and manages chronic patients. This is a strengthening of family medicine teams and an improvement in basic public health services, which is a priority policy area. It is expected to result in the improved management of patients with chronic diseases, since part of their care should be taken over by a graduate nurse. A graduate nurse should also cope with some other tasks to be carried out in family practice outpatient clinics, in particular in the area of preventive care and health care in outpatient clinics of the registered population.

In 2018, there were 30 hospitals in Slovenia, and a large majority of them were state owned. Although legal provisions allow for establishment of new private hospitals, privatisation remained limited and there have not been significant private investments in health infrastructure.

The capacity of acute care hospital beds (422 beds per 100 000 inhabitants in 2015) <sup>(380)</sup>, average length of stay (6.8 days) and the number of inpatient discharges (18 per 100 000 inhabitants) are similar to the average figures for the EU (respectively 402 beds, 7.6 days and 16 discharges per 10000 inhabitants) and suggest an efficient utilisation of hospital care. However, the number of hospital beds in acute care could be further lowered, as low occupancy and turnover rates point to excess capacity. In a number of countries

<sup>(380)</sup> EUROSTAT and OECD.



the decline in the number of acute care hospital beds accelerated in 2010–2011 because of the economic crisis and austerity measures in public health care; at first there was no such response to the crisis in Slovenia. Nevertheless, the number of acute care beds declined in 2012, which is probably related to the rationalisation of operations in hospitals. The data about the proportion of surgical procedures conducted as day cases is low compared to EU average (9.7% vs. 32.3% in 2015) and, despite recent progress in increasing the share of surgeries carried out as day cases, more could be done to further develop ambulatory care <sup>(381)</sup>. This suggests that a strategy to increase day case interventions should be then encouraged also to reduce waiting times for surgery.

With regard to the transfer of health care services from hospital inpatient care to ambulatory outpatient care or day care, data have been improving from year to year. According to data for 2016, the proportion of cataract surgeries carried out as day cases was 97.8%, above the EU average of 84.2%. However, the share of inguinal hernia repair and of tonsillectomy performed as day cases are still largely below the average <sup>(382)</sup>. Slovenia is also considering the introduction of more systematic monitoring and making necessary changes to the model of payment of providers of specialist services at the secondary and tertiary levels.

#### *Pricing, purchasing and contracting of healthcare services and remuneration mechanisms*

Within each annual financial plan the HIIS defines a maximum overall amount to be spent on health services in the upcoming year. This annual budget is defined in cooperation with the Ministry of Health and the Ministry of Finance, taking into consideration the macroeconomic situation which affects the expected revenues of the system. The national health budget is determined at the national level, with no further geographical disaggregation (local tax revenue is managed separately by local authorities according to their own criteria).

The first stage consists of partnership negotiations with different groups of health care providers and

other stakeholders over the volume of services to be provided and reimbursed by the HIIS. The second stage involves the individual providers in the negotiations with the HIIS on the type and volume of services that will be provided, the tariffs for these programmes and services, methods of payment, quality requirements, the supervision of the implementation of the contract and the individual rights and responsibilities of the contracting parties. The reimbursements are capped, thus the services provided in excess of the contracted amounts – however, with some exceptions - are not paid for. The same applies to the services which have been contracted but actually not provided.

Voluntary complementary health insurance is provided by one mutual insurance company obliged by law to provide VHI for co-payments and two profit-oriented private insurance companies.

Public expenditure on health administration and health insurance as a percentage of GDP (0.1%) and as a percentage of current health expenditure (2.3%) was slightly below the EU average in 2015 (respectively 0.3% and 3.4%). Over the last decade, major efforts have been done to reduce administrative costs and improve the general management of the sector and, given the system's organisation and regulation, it is important that they be paired with measures to improve quality monitoring.

Payment mechanisms and levels are regulated based on annual contractual arrangements between the HIIS and health care providers as explained before. Each programme has an annual budget at the national level, which is then translated into caps in budgets for individual providers.

Primary care providers are paid through a combined system of capitation and fee-for-service payments. The reimbursable volume of services is outlined in prospectively determined annual contracts. Half of the value of these services is paid per capita for the patients registered with the physician, while the other half is paid on the basis of fee-for-service, according to the number of services provided.

Outpatient specialist care is remunerated on the basis of fee-for-service, according to an HIIS

<sup>(381)</sup> OECD (2013). 2013 Economic Survey – Slovenia.

<sup>(382)</sup> EU26. Figures were taken from Health at a Glance (2018).

classification of services, whereas the volume of services provided is outlined in the contracts. In order to promote preventive services and reduce specialists' referrals, one of the eligibility criteria for HIIS payments is the implementation by the providers of prospectively determined volumes of preventive services.

Different payment mechanisms are valid for certain types of services: for non-acute inpatient care reimbursement is based on prospectively determined number of bed days, for psychiatric care and rehabilitation programme on prospectively determined number of cases, dental services on the fee-for service model.

Since 2003 hospital care has been reimbursed according to a Diagnosis-Related Group (DRG) model. This replaced the per-case payment system, which consisted in payments for complete inpatient episodes and, as such, did not account for the differences in severity of cases. It provided a perverse incentive to increase the number of single inpatient admissions. The DRG model is based on a classification of 653 diagnosis-related groups, which are defined by the clinical diagnosis, procedures undertaken and length of treatment. Payment is based on the volume and value of programmes determined prospectively in the contract. The annual volume of a health care programme reimbursable by the HIIS is limited by the budget, and defined on the basis of the respective programme executed during the previous year, adjusted by the additional annual programmes aiming at improving access to health services and the efficiency of providers. The cost weight used to calculate the value of case-mix is calculated as the relative price of each DRG in comparison to the average DRG price at national level. Since 2005, two procedures, dialysis services and transplantation programme, have been excluded from the prospective DRG model and reimbursed retrospectively on the fee-for-service and per-case basis respectively. In 2013, a new version of the Australian DRG model (v6.0) was imported, but only used for the classification of patients.

The hospitals' employees are salaried under general rules, with some specialists having a special health care contract.

#### *The market for pharmaceutical products*

In 2015 pharmaceutical spending accounted for 0.8% of GDP and 12.7% of public health care expenditure, close to the average figures for the EU (1 % and 12.7% respectively).

Slovenia introduced an external price referencing mechanism for setting maximum prices. The mechanism takes into account the prices of medicinal products in Germany, Austria and France. If due to the size and other characteristics of the Slovenian market, the maximum allowed price does not enable the marketing authorisation holders to supply the market, a higher maximum price can be set as an exception. Internal reference pricing uses the national system of reference prices for mutually interchangeable pharmaceuticals. The system is based on generic substitution of products officially recognised as mutually interchangeable (based on their therapeutic similarity) and listed in a national list of substitutable pharmaceuticals. The lowest drug price in the same group will be used as reference price. Medicinal products financing from public revenues is regulated by the Health Care and Health Insurance Act and falls within the competence of the Health Insurance Institute of Slovenia. Slovenia also has a system defining therapeutic clusters, i.e. groups of pharmaceuticals that have the same therapeutic indication, for which health insurance covers those medicinal products that are comparable in efficacy, safety and cost-effectiveness.

Members of a special committee, formed of experts from various health care fields, decide the levels of reimbursement based on cost-benefit analyses and available financial resources. A positive list details pharmaceuticals that are reimbursable (70% reimbursed by the compulsory insurance and the rest either by complementary insurance either by out-of-pocket payments).

Each physician has a prescribing number in order to control the volume and the type of pharmaceuticals prescribed. Appropriate penalties can be issued by the HIIS to contracted physicians in case of irregularities.

Over the past decade, structural measures were adopted to rationalise expenditure on pharmaceutical products, currently standing at 18.4% as a share of total health expenditure, down

from 21.8% in 2005. Lowering costs through the aforementioned measures – particularly for generics and innovative medical products (with expired patent protection) – facilitated the financing of new innovative medicinal products for which there is no alternative on the market. In order to ensure the entry of new innovative medicinal products on the market, additional systemic measures are being introduced, such as joint public contracts for the purchase of medicinal products in hospitals <sup>(383)</sup>.

#### *Use of Health Technology Assessments and cost-benefit analysis*

Health technology assessment (HTA) is performed at a very basic level. An important step forward has been the launch of a programme for the standardisation of equipment and the introduction of technical guidelines. In 2005, a standard procedure for assessing and implementing new or adapted health care programmes and other new methods of work among the programs of health care was introduced. It was revised then in 2009. In 2010 the Ministry of Health started with activities to set up an HTA network for the organised and systematic assessment of health care technologies (old and new) for all submitted health technologies proposals.

Health technology assessment (HTA), would clearly also be an asset in terms of efficient allocation of resources and could help determine which (new) benefits should be covered by the HIIS. Certain HTA mechanisms are used during regular assessments within the Agency for Medicinal Products and Medical Devices of the Republic of Slovenia, Health Insurance Institute of Slovenia and Health Council, but the NHP does envisage their wider use and the draft government Act on Health Care Quality and Safety envisages the creation of an HTA agency.

#### *E-health and health-system information and reporting mechanisms*

The national eHealth project includes different electronic solutions with a strategic goal to increase the quality and efficiency of the health system, including better planning and management

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<sup>(383)</sup> The Ministry of Health (2014).

of health care organisations and the health system as a whole.

A significant progress in the field of eHealth was made in 2015 and national implementation is continuing in the last years. All hospitals, healthcare centres and pharmacies are connected to the healthcare network that enables secure and reliable communication between them.

The central register of patient data (a solution that enables exchange and shared use of medical documents) currently enables access to over 11 million documents for over 1,69 million patients and thus enables health professionals to save time and make medical decisions based on accurate data (form discharge letters, ambulatory results and patient summaries).

ePrescription was launched nationally in November 2015. More than 92% of prescriptions are already prescribed electronically. The main advantage of the system is a possibility for doctors and pharmacists to check interactions and contraindications of the prescribed medicines.

The national implementation of a central information system for collecting data from all waiting lists was launched at the end of 2015, all healthcare providers are regularly sending data about all patients waiting for the medical service. Enabling eBooking of medical services is already mandatory for all healthcare providers on a secondary and tertiary level. eReferral became obligatory in beginning of 2017 and over 90% of referrals are already written electronically.

A patient portal that enables a patient to see his/her own medical data in eHealth databases, gives or takes consent to medical professionals was published and put in use in 2017.

A "telestroke solution" (i.e. a system that enables a remote consultation and examination of the patient with a suspected brain stroke through a video conference system) is in full use.

Some other, minor solutions that provide valuable data are also in full use (collecting quality indicators of medical care from all family medicine 'model' practices is in place from the beginning of 2015, a portal for safe exchange of radiology picture material is enabled and in use, an

application for doctors for terminologies is in place).

#### *Health promotion and disease prevention policies*

Health promotion and disease prevention is mainly done through State's and HIIS's large scale programmes. Non-governmental organisations play a prominent role in the area of health promotion and disease prevention. Since 2017 there has been a significant increase of NGO funding.

The Slovenian government has launched a number of policies and strategies such as the National Programme on Nutrition and Health Enhancing Physical Activity 2015–25 and the National Cancer Control Programme 2017-2021 to curb the rise in overweight, obesity and hypertension and to reduce incidence of cancer. Beyond the implementation of several EU Directives, new legislation on tobacco control adopted in 2017 includes a ban on all tobacco-and-related-products advertising, promotion and sponsorship, including a display ban (mandatory from march 2018) on tobacco and related products at the points of sale It also includes the implementation of licencing for retailers of tobacco and related products and ban on selling to minors and using e-cigarettes and other tobacco related products in closed public places and workplaces, The new Act also made plain packing mandatory as of 2020 and banned smoking in all vehicles in the presence of minors.

The most recent health promotion campaigns included <sup>(384)</sup>: tackling regional health inequalities, HIV/AIDS prevention, anti-smoking and alcohol policy, food and nutrition, enhancing physical activity, improving mental health and reducing all forms of addiction or dependency. Vaccination rates for diphtheria, tetanus pertussis are high (95%) <sup>(385)</sup>.

Slovenia has in place three national based population cancer screening programmes (cervical cancer, breast and colorectal cancer). The proportion of screening rates for cervical cancer is

quite high (72.1% of the target population in 2015 <sup>(386)</sup>). The same applies to breast cancer screening.

Slovenia has traditionally had a strong network of primary health providers, with health promotion and disease prevention programs being an integral part of service delivery at the primary level. Cardiovascular disease prevention programmes with lifestyle interventions against key risk factors for non-communicable diseases (tobacco use, obesity, high blood pressure, diabetes) have been in place since 2002. From 2011 a system of family medicine model practices has been introduced to strengthen prevention work and to navigate chronic patients through health system.

In 2015, public expenditure on prevention and public health services as a % of GDP (0.2%) and as a percentage of total current health expenditure (2%) was below the EU average for the same year (0.3% and 3.2% respectively).

#### *Recently legislated and/or planned policy reforms*

Improving health care and maintaining its fiscal and financial sustainability are high on the political agenda. Work is ongoing towards the implementation of a reform of the healthcare sector. The economic crisis, rising unemployment, insufficient financial resources and ageing population were main triggers for reforming the health care system. In June 2013 the Ministry of Health opened a public debate on the new legislation proposal on health care.

The combination of compulsory and complementary health insurance, which are the main financial sources for financing health care, is insufficient and not in line with guidelines of social welfare policy. Importantly, the current system is based on sources of financing (contributions) that are subject to cyclical fluctuations, and do not guarantee sustainable financing in the future. Work was put into providing financial projections and scenarios of abolishing complementary health insurance and introducing other/alternative ways of solidarity-based financing schemes.

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<sup>(384)</sup> National Institute of Public Health and Ministry of Health.

<sup>(385)</sup> OECD. health at glance 2015.

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<sup>(386)</sup> Oi Ljubljana, 2015.

One envisaged reform is the broadening of contribution rates to certain new types of revenues with the aim of equalising the financial burden and diminishing large differences in contribution rates among specific groups of insured persons or better balancing the burden on the insured based on the widest possible social consensus. Some steps in this direction were done in 2013 with the adoption of the amendments to the "Health Care and Health Insurance Act". Contribution rates of some groups of the population (self-employed, farmers etc.) were raised, so that partial broadening of contribution bases was introduced.

The findings from the analysis of the health care system undertaken in cooperation with the World Health Organisation and the European Observatory on Health Systems and Policies offered support in the reform process. On the basis of the analysis, the "National Health Care Resolution Plan 2016-2025" was approved by the previous government in December 2015 and was adopted by Parliament in March 2016. In this document <sup>(387)</sup>, the Ministry of Health committed to ensuring an effective planning of human resources in health care, covering the current needs of the population as well as accounting for the changing demographic structure. As a first step, amendments to the Medical Services Act were adopted in July 2017, providing a legal basis for to the Ministry of Health to plan and forecast future needs for different specialisations of physicians in areas of employment that are currently less attractive.

A public discussion on a proposal of the new "Health Care and Health Insurance Act" was concluded in the first quarter of 2017, but the new Health Care and Health Insurance Act with measures for counter-cyclical actions and a more stable financing of the healthcare system was never adopted. In addition, amendments to the Medical Practitioners Act were adopted, where financing of salaries and other costs for internship and specialisation is transferred from HIIS to the general budget.

In September 2017 legislation <sup>(388)</sup> was adopted with the aim to gain additional budgetary funds for

<sup>(387)</sup> The Resolution on National Health Care Plan 2016-2025": Together for a society of health".

<sup>(388)</sup> The Act Determining Intervention Measures to Ensure the Financial Stability of Public Healthcare Institutions Established by the Republic of Slovenia.

public hospitals. Fifteen public hospitals received €135.7 million from budgetary funds to cover accumulated losses and to pay overdue obligations to suppliers. At the same time these are undergoing a process of rationalisation based on individual recovery plans that should be completed by 2021.

In the area of waiting times changes were enforced amending existing legislation <sup>(389)</sup>. With the implementation of the eBooking of medical services a uniform base has been established to manage waiting lists. The purpose of the amendments was to ensure transparency and better management of waiting lists and to regulate a comprehensive supervision of the provision of patients' and obligations.

In addition, the Ministry of Health has launched and/ or designed a number of proposed measures, also in line with the "National Health Care Plan" with a focus on health promotion and disease prevention. The national programme on nutrition and physical activity was adopted in July 2015 and implementation is in progress, in 2017 the comprehensive Action plan has been adopted. In the same direction is the adoption of the "Dementia Strategy". The aim of the strategy is to ensure preventive measures, early diagnosis and appropriate standard of health and social protection and medical care for people with dementia. In 2017 the Government adopted two important documents. First, comprehensive Cancer control plan 2017-2021 with aim to tackle increasing prevalence of cancer diseases and second, National HIV/AIDS strategy until 2025.

The new Pharmacy Practice Act adopted on 15 December 2016 entered into force on 27 January 2017. It introduces new services in order to increase patient safety regarding prescribed therapy, reduce side effects and additional hospitalisation and reduce costs, namely clinical pharmacy and seamless care in hospitals and pharmaceutical care at the primary level. The Act also restricts vertical integration in both directions: producer - wholesaler - pharmacy and vice versa to assure the professional independence of

<sup>(389)</sup> The Act Amending the Patient Rights Act and Rules on the management of waiting lists and waiting times the maximum permissible for individual health services <http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZAKO7379>.

pharmacists. The guiding principle remains public health protection and care for health of individuals.

Further proposals concern pharmacies and their regulation. The proposed legislation aims at ensuring better regulation of pharmacies and the cost-effectiveness of the system. On the hospital level, seamless care and clinical pharmacy are envisaged to optimise the prescription of medicines and to achieve better compliance and safety for patients.

In July 2017, the Ministry of Health designated the coordination and working group for preparing the National cost analysis of the activities, performed by the hospitals. The purpose of the national cost analysis was to eliminate the shortcomings of the Diagnosis-related group – DRG) system-financed acute hospital treatment evaluations, specialist ambulatory service activities and at a later stage presumably other activities, performed by the hospitals.

Amendments to Health Services Act were adopted in the Parliament <sup>(390)</sup>. They deal with criteria for granting concessions for public healthcare services, aiming at improving transparency and accessibility of healthcare services. The amended Act defines the nature of the public healthcare service, defines legally recognised providers (i.e. public institutions and concessionaires) and states that it is carried out under a non-profit regime. Furthermore, the Act includes a comprehensive regulation of the conditions under which health activities can be carried as well a comprehensive regulation of various forms of supervision over providers of healthcare services.

The priorities of the current government focus on efficient management of hospitals and waiting times.

### Challenges

The Slovenian health care system has recently undergone a comprehensive review highlighting critical areas of improvement that should shape planned reforms in the sector. Though a set of efficiency-oriented measures was adopted, Slovenia has not yet solved the main challenges of

the system in terms of fiscal sustainability and stable financing. The main challenges for the health system appear as follows:

- To continue increasing the efficiency of health care spending, promoting quality and integrated care as well as focussing on costs in view of the increasing health care expenditure, which is a challenge to the fiscal sustainability over the coming decades (for instance furthering the efforts in the area of prevention and rationalising hospital care). To this end, to promote public procurement as a means to rationalise expenditure.
- To improve the basis for more sustainable and efficient financing of health care in the future (e.g. considering additional sources of general budget funds), aiming at a better balance between resources and spending, as well as the number of contributors and the number of beneficiaries. This implies tackling the lack of sufficient in-built automatic stabilisers, especially in view of the need to re-consider the role of complementary health insurance as a driver of excess demand and avoidable costs.
- To tackle the excessive use of specialist and hospital care by strengthening the role of the primary care sector and family doctors as gatekeepers and the coordination and integration of care among different health care levels, while ensuring adequate coverage both in urban and in rural areas. To this end to enhance processes and procedures along patients' care pathways. To promote the use of quality indicators and patient oriented measures for health care procedures.
- To further the efforts to contain long waiting lists for some health care services by a more efficient allocation of human and capital resources between sectors and specialisations through active purchasing of services by public health insurance institute and by promoting day cases for surgical procedures. To this end, promote the use of ICT in the gathering, storage, use and exchange of health information.
- To foster the process of modernisation, specialisation and competition among

<sup>(390)</sup> <https://www.uradni-list.si/glasilo-uradni-list-rs/vsebina?urlurid=20173026>.

hospitals, for example by allowing for selective contracting of hospitals by health insurance funds, and extending legal possibilities for quality-based financing of hospital care services. To improve reimbursement mechanisms that create incentives to increase efficiency, including improving the current DRG system to better reflect actual costs. To this end, consider whether remuneration mechanisms of hospital staff and management could be better linked to performance.

- To gradually increase the use of cost-effectiveness information in determining the basket of goods (by using HTA) and the extent of cost-sharing.

Table 2.25.1: Statistical Annex – Slovenia

General context												EU- latest national data			
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
<b>GDP</b>															
GDP, in billion Euro, current prices	29	32	35	38	36	36	37	36	36	38	39	12,451	13,213	13,559	14,447
GDP per capita PPS (thousands)	23.2	23.7	24.3	23.9	20.7	21.2	21.5	21.5	21.2	21.9	22.6	26.8	28.1	28.0	29.6
Real GDP growth (% year-on-year) per capita	3.8	5.3	6.4	3.1	-8.7	0.9	0.5	-2.9	-1.3	2.9	2.2	-4.7	1.5	0.1	2.0
Real total health expenditure growth (% year-on-year) per capita	:	6.0	4.5	3.8	0.9	-2.5	0.7	0.3	-0.2	2.2	-1.9	3.7	0.2	0.2	4.1
<b>Expenditure on health*</b>															
Total as % of GDP	8.3	8.4	8.3	8.3	9.2	8.9	8.9	9.2	9.3	9.2	8.9	10.2	10.1	10.1	10.2
Total current as % of GDP	8.0	8.1	7.9	8.0	7.8	7.5	7.8	8.6	8.6	8.5	8.5	9.3	9.4	9.9	9.9
Total capital investment as % of GDP	0.4	0.3	0.3	0.3	1.4	1.4	1.0	0.6	0.7	0.8	0.4	0.9	0.6	0.2	0.3
Total per capita PPS	1,466	1,588	1,731	1,881	1,961	1,886	1,920	1,935	1,962	2,021	2,002	2,745	2,895	2,975	3,305
Public total as % of GDP	6.1	6.0	5.6	6.1	6.7	6.6	6.5	6.7	6.5	6.3	6.5	8.0	7.8	7.8	8.0
Public current as % of GDP	5.8	5.7	5.3	5.8	6.3	6.3	6.3	6.3	6.2	6.0	6.1	7.7	7.6	7.6	7.8
Public total per capita PPS	1,067	1,130	1,184	1,372	1,426	1,406	1,412	1,403	1,375	1,379	1,460	2,153	2,263	2,324	2,609
Public capital investment as % of GDP	0.26	0.32	0.33	0.29	0.41	0.35	0.29	0.40	0.29	0.28	0.38	0.2	0.2	0.2	0.2
Public as % total expenditure on health	72.8	71.2	68.4	72.9	72.7	74.6	73.5	72.5	70.1	68.2	72.9	78.1	77.5	79.4	78.4
Public expenditure on health in % of total government expenditure	14.7	14.6	15.5	14.8	14.4	14.2	13.8	14.0	11.0	12.8	13.7	14.8	14.8	15.2	15.0
Proportion of the population covered by public or primary private health insurance	99.0	99.0	99.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	99.6	99.1	98.9	98.0
Out-of-pocket expenditure on health as % of total current expenditure on health	13.2	12.5	13.8	12.8	12.7	12.7	12.2	11.9	12.6	13.0	12.5	14.6	14.9	15.9	15.9

Note: \*Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status												2009	2011	2013	2015
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
Population, current (millions)	2.0	2.0	2.0	2.0	2.0	2.0	2.1	2.1	2.1	2.1	2.1	502.1	503.0	505.2	508.5
Life expectancy at birth for females	80.9	82.0	82.0	82.6	82.7	83.1	83.3	83.3	83.6	84.1	83.9	82.6	83.1	83.3	83.3
Life expectancy at birth for males	73.9	74.5	74.6	75.5	75.9	76.4	76.8	77.1	77.2	78.2	77.8	76.6	77.3	77.7	77.9
Healthy life years at birth females	60.1	61.0	62.3	60.9	61.5	64.6	63.8	65.6	65.5	69.6	67.7	62.0	62.1	61.5	63.3
Healthy life years at birth males	56.4	57.7	58.7	59.4	60.6	63.4	64.0	66.5	67.6	67.8	68.5	61.3	61.7	61.4	62.6
Amenable mortality rates per 100 000 inhabitants*	76	68	73	77	82	73	137	134	130	123	128	64	138	131	127
Infant mortality rate per 1 000 live births	4.1	3.4	2.8	2.4	2.4	2.5	2.9	1.6	2.9	1.8	1.6	4.2	3.9	3.7	3.6

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data			
Composition of total current expenditure as % of GDP												2009	2011	2013	2015
Inpatient curative and rehabilitative care	2.3	2.2	2.1	2.3	2.6	2.6	2.6	2.5	2.5	2.4	2.3	2.7	2.6	2.7	2.7
Day cases curative and rehabilitative care	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3
Out-patient curative and rehabilitative care	2.0	2.0	2.0	2.0	2.1	2.1	2.1	2.1	2.1	2.2	2.4	2.5	2.5	2.4	2.4
Pharmaceuticals and other medical non-durables	1.7	1.7	1.5	1.5	1.7	1.8	1.7	1.8	1.8	1.6	1.6	1.2	1.2	1.5	1.4
Therapeutic appliances and other medical durables	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.3	0.3	0.4	0.4
Prevention and public health services	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.3	0.2	0.3	0.3
Health administration and health insurance	0.3	0.4	0.4	0.3	0.4	0.3	0.3	0.3	0.3	0.4	0.3	0.4	0.4	0.4	0.4
Composition of public current expenditure as % of GDP												2009	2011	2013	2015
Inpatient curative and rehabilitative care	2.0	1.9	1.8	2.1	2.3	2.3	2.3	2.2	2.2	2.1	2.0	2.6	2.5	2.5	2.5
Day cases curative and rehabilitative care	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.2	0.1	0.2	0.3	0.3
Out-patient curative and rehabilitative care	1.3	1.3	1.2	1.3	1.4	1.4	1.4	1.4	1.5	1.5	1.7	1.8	1.8	1.7	1.8
Pharmaceuticals and other medical non-durables	1.1	1.0	0.9	0.9	1.0	1.0	1.0	0.9	0.9	0.8	0.8	0.9	0.9	1.0	1.0
Therapeutic appliances and other medical durables	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2
Prevention and public health services	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.2	0.2	0.2	0.1	0.2	0.2	0.2	0.3
Health administration and health insurance	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.3	0.3	0.3	0.3

(1) All the figures under EU-latest national data are computed as weighted averages.

Source: EUROSTAT, OECD and WHO.



Table 2.25.2: Statistical Annex - continued - Slovenia

Composition of total as % of total current health expenditure	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU-latest national data			
	2009	2011	2013	2015											
Inpatient curative and rehabilitative care	28.4%	26.6%	26.0%	29.0%	32.8%	34.4%	33.3%	29.0%	29.0%	28.2%	27.5%	29.1%	27.9%	27.1%	27.0%
Day cases curative and rehabilitative care	2.4%	2.2%	2.2%	2.5%	2.7%	2.8%	2.6%	2.4%	2.1%	1.9%	2.2%	1.7%	1.7%	3.0%	3.1%
Out-patient curative and rehabilitative care	25.5%	25.2%	24.9%	25.2%	26.5%	27.5%	26.2%	24.4%	25.0%	25.9%	27.8%	26.8%	26.3%	23.7%	24.0%
Pharmaceuticals and other medical non-durables	21.8%	20.9%	19.4%	19.3%	22.2%	23.4%	21.9%	20.6%	20.8%	18.6%	18.4%	13.1%	12.8%	14.7%	14.6%
Therapeutic appliances and other medical durables	2.8%	2.6%	2.8%	3.1%	3.8%	4.1%	3.9%	3.4%	3.4%	4.1%	4.1%	3.6%	3.6%	4.1%	4.1%
Prevention and public health services	3.8%	3.7%	3.7%	3.8%	4.1%	4.4%	4.3%	3.9%	3.9%	3.1%	2.6%	2.8%	2.5%	3.0%	3.1%
Health administration and health insurance	3.6%	4.3%	4.8%	4.3%	4.9%	4.0%	3.8%	3.8%	4.0%	4.1%	3.5%	4.5%	4.3%	3.9%	3.8%
<b>Composition of public as % of public current health expenditure</b>															
Inpatient curative and rehabilitative care	34.9%	33.9%	34.2%	35.5%	36.4%	36.5%	37.1%	34.9%	34.7%	34.4%	33.1%	33.9%	33.6%	32.1%	31.9%
Day cases curative and rehabilitative care	3.2%	2.9%	3.1%	3.3%	3.2%	3.1%	3.1%	3.0%	2.8%	2.3%	2.8%	1.9%	2.0%	3.4%	3.5%
Out-patient curative and rehabilitative care	21.6%	23.3%	22.9%	22.9%	22.2%	22.2%	22.7%	22.2%	23.4%	25.4%	27.8%	22.9%	23.5%	22.2%	22.5%
Pharmaceuticals and other medical non-durables	18.2%	18.4%	17.3%	15.9%	15.9%	15.6%	15.4%	14.0%	13.9%	12.6%	12.7%	11.8%	11.9%	12.6%	12.7%
Therapeutic appliances and other medical durables	0.7%	0.7%	0.8%	0.7%	0.6%	0.8%	0.8%	1.0%	0.9%	1.7%	1.8%	1.8%	1.9%	2.0%	2.1%
Prevention and public health services	3.8%	3.9%	3.9%	3.8%	4.0%	4.0%	4.0%	3.9%	3.7%	2.7%	2.0%	2.9%	2.5%	3.2%	3.2%
Health administration and health insurance	3.1%	3.0%	3.2%	2.8%	2.9%	2.9%	2.6%	2.6%	2.6%	2.8%	2.3%	4.1%	4.0%	3.6%	3.4%
<b>Expenditure drivers (technology, life style)</b>															
MRI units per 100 000 inhabitants	:	0.55	0.60	0.69	0.69	0.73	0.83	0.87	0.87	0.87	0.87	1.0	1.4	1.5	1.9
Angiography units per 100 000 inhabitants	0.5	0.5	0.5	0.5	0.6	0.9	0.9	0.8	0.8	0.8	0.8	0.9	0.9	0.9	1.0
CTS per 100 000 inhabitants	1.0	1.1	1.1	1.2	1.2	1.3	1.3	1.3	1.2	1.3	1.3	2.1	1.9	2.1	2.3
PET scanners per 100 000 inhabitants	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2
Proportion of the population that is obese	:	:	16.4	16.8	:	:	:	:	:	18.6	:	15.0	15.1	15.5	15.4
Proportion of the population that is a regular smoker	23.0	18.5	18.9	18.7	:	:	:	:	:	18.9	:	23.2	22.3	21.8	20.9
Alcohol consumption litres per capita	11.1	12.3	11.0	10.9	10.5	10.3	10.6	11.0	9.5	10.5	:	10.4	10.3	10.1	10.2
<b>Providers</b>															
Practising physicians per 100 000 inhabitants	235	236	239	240	241	243	249	254	263	277	283	324	330	338	344
Practising nurses per 100 000 inhabitants	748	760	775	788	803	819	833	816	832	856	878	837	835	825	833
General practitioners per 100 000 inhabitants	38	38	41	41	42	44	45	47	50	52	55	77	78	78	78
Acute hospital beds per 100 000 inhabitants	690	617	608	559	553	546	535	528	523	524	518	416	408	407	402
<b>Outputs</b>															
Doctors consultations per capita	:	6.6	6.7	6.7	6.6	6.4	6.5	6.3	6.5	6.6	6.8	6.2	6.2	6.2	6.3
Hospital inpatient discharges per 100 inhabitants	15	16	16	16	17	16	17	:	:	18	18	17	16	16	16
Day cases discharges per 100 000 inhabitants	2,026	2,142	2,243	2,484	2,566	2,229	1,950	:	:	2,047	1,888	6,362	6,584	7,143	7,635
Acute care bed occupancy rates	70.0	72.0	69.7	71.5	71.2	69.7	68.9	68.8	67.9	68.4	68.8	77.1	76.4	76.5	76.8
Hospital average length of stay	5.8	5.8	6.8	6.9	6.9	6.7	7.3	7.5	6.8	6.9	6.8	8.0	7.8	7.7	7.6
Day cases as % of all hospital discharges	11.7	11.8	12.1	13.3	13.4	12.0	10.5	:	:	10.4	9.7	28.0	29.1	30.9	32.3
<b>Population and Expenditure projections</b>															
<b>Projected public expenditure on healthcare as % of GDP*</b>	2016	2020	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	Change 2016-2070, in pps.		
AWG reference scenario	5.6	5.8	6.1	6.3	6.5	6.7	6.8	6.8	6.8	6.8	6.8	6.7	Slovenia	EU	
AWG risk scenario	5.6	6.0	6.3	6.7	7.1	7.3	7.5	7.6	7.7	7.7	7.7	7.6	1.0	0.9	
													2.0	1.6	
Note: *Excluding expenditure on medical long-term care component.															
<b>Population projections</b>	2016	2020	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	Change 2016-2070, in %		
Population projections until 2070 (millions)	2.1	2.1	2.1	2.1	2.1	2.1	2.1	2.0	2.0	2.0	2.0	2.0	Slovenia	EU	
													-5.2	2.0	

(1) All the figures under EU-latest national data are computed as weighted averages.

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).

## Slovenia

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Long-term care systems

## 3.25. SLOVENIA

### General context: Expenditure, fiscal sustainability and demographic trends

Slovenia has a population of just above 2 million inhabitants, which is slightly more than 0.4% of the EU population in 2016 and is projected to decrease by 5% by 2070. With a GDP of 39 billion, or 22,600 PPS per capita in 2015 it scores lower than the EU weighted average (29,600). When looking at the unweighted average and at the median level though, respectively 25,200 and 22,100 PPS, Slovenia faces a significantly lower gap, standing at 89.7% of the average, and closely resembling the median. Based on the Ageing Report 2018, total public expenditure on long-term care (health and social part) <sup>(571)</sup> is with 0.9% of GDP in 2015 under the EU average in the same year (1.6%).

### Health status

Life expectancy at birth for both women and men was respectively 83.9 years and 77.8 years in 2015, similar to the EU average (83.3 and 77.8 years for men and women respectively). Nevertheless, in 2015 the healthy life years at birth for both sexes were significantly lower than the EU average, with 57.7 years for women and 58.5 years for men (63.3 and 62.6 respectively in 2015). At the same time the percentage of the population having a long-standing illness or health problem was in 2015 slightly lower than in the EU as a whole (33.1% and 34.2% respectively) <sup>(572)</sup>. The percentage of the population indicating a self-perceived long-standing severe limitation in its daily activities has been fluctuating since 2006 (the highest level being 13% in 2011), but despite remaining above the EU-average of 8.1%, the trend seems to have changed in the last years with an overall decrease that reached 9.8 in 2015, only slightly above the 2014 value <sup>(573)</sup>.

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<sup>(571)</sup> Long-term care benefits can be disaggregated into health related long-term care (including both nursing care and personal care services) and social long-term care (relating primarily to assistance with tasks linked with Activities with Daily Living).

<sup>(572)</sup> Source Eurostat, People having a long-standing illness or health problem, by sex, age and labour status [hlth\_silc\_04].

<sup>(573)</sup> According to EU-SILC Survey (Eurostat Database- Population and Social Conditions- Health- Health Status).

### Dependency trends

The number of people depending on others to carry out activities of daily living is projected to increase over the coming 50 years. From 220 thousand residents living with strong limitations due to health problems in 2016, an increase of 18% is envisaged until 2070 to around 260 thousand, which is lower than the EU average of 25% over the same period. According to this scenario, the dependents are becoming a bigger group also as a share of the population and an increase of 25% is projected (from 10.6% to 13.2%), which, conversely, is above the EU-average increase of 21%.

### Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is projected to steadily increase. In the "AWG reference scenario", public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of 0.9 pps, bringing Slovenia from 0.9 <sup>(574)</sup> to 1.8% of GDP spent on long-term care in the period 2016-2070, with a steeper increase than for EU average (93% and 73% respectively) <sup>(575)</sup>. The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 3.5 pps of GDP by 2070. Overall, projected long-term care expenditure increase is expected to add to budgetary pressure on medium and long run. Medium fiscal sustainability risks appear over the medium and the long run due, especially for the long-term risk categorisation, to the projected increase in age-related public

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<sup>(574)</sup> Including public expenditure on LTC (1% of GDP) according to SHA (health and social part) and cash-benefits for economic integration for handicapped from ESSPROS disability function (0.4% of GDP).

<sup>(575)</sup> The 2018 Ageing Report: [https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070\\_en](https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070_en).

spending, notably deriving from long-term care, healthcare and pensions <sup>(576)</sup>.

## System Characteristics

### *Administrative organisation*

Currently, there is no uniform system of long-term care (LTC) in Slovenia. There is no definition of long-term care and therefore no unified entry point or a standard model for assessing care needs for health and social services which could be classified as long-term care services. This creates risks of inefficiencies and makes it more difficult for the user to obtain comparable services for comparable needs and to navigate the system. Different forms of services and benefits which could be classified as LTC services are provided within the health care system, social and parental protection system, pension and disability system and the system of care for the disabled, and are regulated by different acts from these areas. The provision of community based social and healthcare services is not well coordinated between providers of health and social care services and the financing of the system is fragmented. Until now, Slovenia has focused its limited spending on institutional care rather than home care. Over the last fifteen years the government has been preparing a new umbrella regulation, which would bring all the different recipients and benefits under one rule. A new draft legislative proposal aims to establish a fiscally sustainable and accessible LTC system which combines the health and social aspects of care with integrated LTC services, with emphasis on prevention and strengthening the capabilities of the user, with the aim of later transition into higher categories of dependence on the assistance of another person. At the same time it is necessary to strengthen e-care and reduce the administrative burden (with the aim of directing human resources to working with users rather than bureaucracy). The last draft version of the legislation was in public discussion and inter-ministerial coordination in 2017 and awaits the new government which will proceed with the law drafting. However it seems that the revised draft will have to undergo an additional public consultation as currently there is no consensus on

<sup>(576)</sup> European Commission (2018), Fiscal Sustainability Report (2018) [https://ec.europa.eu/info/sites/info/files/economy-finance/ip094\\_en\\_vol\\_2.pdf](https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf).

how the element of financing should be solved. In the spring of 2015, a comprehensive analysis of the Slovenian health care system has started, in the context of which an analysis of long-term care was also carried out. The analysis was completed in December 2015. Key findings are hereby presented <sup>(577)</sup>.

Long-term care expenditure in Slovenia represents only a small component of GDP, and is much lower than health care spending, but is growing much more rapidly. Even on optimistic assumptions about the levels of disability, the effects of demographic change will be to increase expenditure on long-term care by more than 50% by 2035.

There are four main public funding sources for long-term care, but nearly half of the public long-term care spending is by the Health Insurance Institute.

The Health Insurance Institute will see the largest absolute growth in long-term care spending because of its focus on long-term care for older people. The Ministry of Labour will see only a smaller increase given the focus on long-term care for non-elderly people.

Private spending on long-term care is almost all out-of-pocket spending by recipients and this has been growing significantly. On current policy and practice this would increase rapidly (given that the services paid for privately are likely to grow rapidly) and this might not be sustainable.

There is unnecessary complexity in the current public funding of long-term care that leads to confusion about entitlements, difficulty in brokering access to combinations of services needed by users, and this may be a factor in the over reliance on residential care.

Consideration should be given to reducing the complexity of (particularly the public) funding of long-term care. This might be achieved either by shifting responsibility to a single government

<sup>(577)</sup> Analysis of Health Care System in Slovenia. European Observatory for Health Care Systems, WHO and the Ministry of Health of the RS. Available at : [http://www.mz.gov.si/fileadmin/mz.gov.si/pageuploads/Analiza/24\\_11\\_2015/Long\\_Term\\_Care\\_in\\_Slovenia\\_Charles\\_Normand.pdf](http://www.mz.gov.si/fileadmin/mz.gov.si/pageuploads/Analiza/24_11_2015/Long_Term_Care_in_Slovenia_Charles_Normand.pdf).

department and/or agency, or by mechanisms that aim to co-ordinate the spending and entitlements between the different funding organisations.

Consistently with the findings of the Ageing Report, this study shows that long-term care spending is likely to grow rapidly. In addition, the rate of growth will vary hugely between the different public funders of care. With a much longer time scale it would be possible to derive more precise estimates of the changing costs to the different drivers, but the current calculations display clearly the patterns of likely change.

As mentioned above, different forms of services and benefits, which could be classified as LTC services are provided by different systems (healthcare, pension, social and parental protection etc) and are regulated by different acts from these areas.

Long-term care in Slovenia includes cash benefits and benefits in kind (health care and/or social services for institutional care and only social services for home care). Health care services which could be classified as long-term care are not available in home care settings. The provision of community based social and healthcare services is not well coordinated between providers of health and social care services and the financing of the system is fragmented. Until now, Slovenia has focused its limited spending on institutional care rather than home care. Cash benefits and institutional care are organised centrally whereas home care services are provided on a local level.

Funding for long-term care expenditure comes from several sources. Health care benefits in kind (institutional and community services) are financed from the compulsory (99%) and the complementary (1%) health care insurance<sup>(578)</sup>. Currently, the regulation of obligatory social insurances is made in a way that contributions are paid by both employers and employees (including self-employed). Inactive persons are insured either through their active close relatives (children and youngsters in full-time education) or the reduced contributions for them are paid from the state and municipalities' budgets (pensioners, unemployed,

<sup>(578)</sup> Yearly data on national health expenditure prepared in accordance with System of Health Accounts 2011 methodology; also available in OECD Stat 2018.

beneficiaries of minimum income)<sup>(579)</sup>. Cash benefits which are directed to persons with health care needs or with limitation in performing basic activities of daily living (ADL)<sup>(580)</sup>, are financed from the Pension and Disability Fund and partially by the state budget (Ministry of Labour, Family, Social Affairs and Equal Opportunities)<sup>(581)</sup>.

Social services which could be classified as long-term care are partially financed from the state and the municipalities' budgets, and partially paid by the users (recipients). Out-of-pocket payments for social care services depend on the financial situation of a person in need. In case a person has insufficient financial means, the relatives and/or the municipality cover expenses of residential or home care services. Health and social care services which can be classified as long-term care for disabled children and disabled youth in full-time education are entirely (in the case of youngsters in full-time tertiary education only partially) covered by the health care insurance and the state budget.

Providers guaranteeing different services within the scope of institutional forms of assistance integrate health care and social areas, while the assistance has not been integrated in the context of forms provided in the living home environment.

At the beginning of 2016, the National Parliament adopted the Personal Assistance Act, which will be implemented in 2019. The law regulates the right to a personal assistant for active working population with disabilities who need more than 30

<sup>(579)</sup> For example, in Slovenia there are more than 600,000 pensioners, and they do not pay directly any public social insurance contributions (part of compulsory health insurance for them is covered from the state budget) and are nearly 100% included in the voluntary private additional health care insurance.

<sup>(580)</sup> Basic Activities of Daily Living (ADL) include bathing, dressing, eating, getting in and getting into and out of bed or chair, moving around and using the bathroom. Often they are referred to as "personal care" (Colombo et al. 2011). According to the System of Health Accounts methodology (OECD, WHO, Eurostat, 2011) expenditure related to provide help to people with ADL limitations are classified under code HC.3 as LTC health expenditure which means that are included also in health expenditure. However, expenditure for LTC social services (related to IADL limitation – Instrumental Activities of Daily Living) are classified under code HC.R.1. LTC social expenditure are included in total LTC expenditure (HC.3 plus HC.R.1), but excluded from health expenditure.

<sup>(581)</sup> Pension insurance contributions would represent as much as 2.4% of health care financing.

hours of assistance per week (ADL and IADL) and are not treated in the institutional care.

### *Types of care*

For systematic statistics and monitoring of performance and development of long-term care an inter-institutional working group for statistical monitoring of the system was set up in 2012<sup>(582)</sup>. The results of the working group were published in 2014<sup>(583)</sup>. Since then, the Inter-institutional Working Group for statistical monitoring at the Statistical Office of RS has no longer been active, and has been replaced by a newly established inter-institutional working group for the monitoring of long-term care<sup>(584)</sup>. The working group members are representatives of the relevant government departments, representatives of the professions and academics.

Four modes of long-term care provision are included in the current system of long-term care: in-patient care (institutions), day-case care, home care and cash benefits (according to the SHA framework).

Inpatient long-term care (institutional care) is organised by homes for the elderly, special social institutions, centres for training, occupation and care and centres for education of children with special needs. There were 22,415 people altogether residing in these institutions at the end of 2015; mainly in homes for elderly. Inpatient long-term

care was provided for 5.9% of population aged 65 years and over<sup>(585)</sup>.

There were less than 500 users of organised day care, which accounts for 0.1% of population aged 65 years and over. They were mainly included in day care organised by homes for elderly.

Home-based care is organised by community nursing care, home help, family assistant, personal assistance and housing groups. More than 21,600 people received this kind of care at the end of 2015; mostly community nursing care and home help. Home-based care was provided to 5.7% of population aged 65 years and over.

Regarding the total number of cash benefits recipients in 2015 there were almost 42,000 recipients of cash benefits (Attendance and Allowance Supplement based on 6 different acts), of which around 62% were aged 65 years and over and 40% were aged more than 80 years; about 60% were women and 40% men. However, if we are taking into account overlapping between cash benefits and services in kind, there were only 16,570 recipients of cash benefits who only received cash benefit and were not included in any other service classifiable as long-term care. Cash benefits only were received by 4.4% of the population aged 65 years and over.

It is estimated that there were altogether approximately sixty thousand recipients of formal services classifiable as long-term care and cash benefits at the end of 2015; this accounts for 16.1% of population aged 65 years and over. Inpatient care (in institutions) is very well developed and spread in Slovenia. It has a long tradition. Community nursing care is also well spread and developed. On the other hand, home-based social care started to develop approximately twenty years ago and it is still not well developed. Even though the number of people receiving home-based services which can be classified as long-term care is relatively high, the care is not as intensive and comprehensive as in the case of institutional care and services of health and social care are not integrated.

<sup>(582)</sup> Appointed by the Statistical Office of the Republic of Slovenia and led by Social Protection Institute of the Republic of Slovenia. The working group, which is no longer active, included representatives of all main actors providing data on services and benefits which could be classified as LTC services and benefits (in addition to already mentioned institutions, the Institute of Macroeconomic Analysis and Development, the Ministry of Labour, Family Social Affairs and Equal Opportunities, the Ministry of Health, the Slovenian Community of Social Institutions, the National Institute of Public Health, the Pension and Disability Insurance Institute, the Institute for Economic Research and the Health Insurance Institute of Slovenia).

<sup>(583)</sup> Source: Nagode, Mateja, Eva Zver, Stane Marn, Anita Jacovič, Davor Dominkuš. Long-term care – use of international definition in Slovenia. Working paper No. 2/2014 XXIII. Ljubljana: IMAD.

<sup>(584)</sup> Decision of the Minister no. 0241-2 / 2017 from 11.4.2018.

<sup>(585)</sup> Source: Statistical Office of the RS; <https://www.stat.si/StatWeb/en/News/Index/7116>.

### Eligibility criteria

There is no definition of long-term care, no unified entry point nor a model of long-term care needs assessment. The eligibility for a health or social service which could qualify as long-term care is linked to the service in question and is made by a team of professional workers (in the case of institutional care) or by an individual professional worker (in the case of home care). Cash benefits are granted upon application and approval of the expert team (assessing the care needs).

### Co-payments, out of the pocket expenses and private insurance

Benefits in kind are income tested, taking into account recipient, spouse and children.

Out-of-pocket payments depend on the financial ability of a person entitled. In case a person entitled has insufficient financial means, municipalities cover expenses of residential or home care services.

Based on the rules set by the government (Decree on criteria for defining exemptions in the payment of the services, OG RS 110/04,124/04,114/06) the competent local "Centre for Social Work" decides on partial or complete exemption of the user from the payment of the services. The decree defines *the social security threshold*, set as an amount of money that has to remain at disposal of the user after the payment of the services. Further, the decree defines the *ability to pay* as the maximum amount up to which the user is able to participate in the payment of these services. The *payment contribution* is the amount that needs to be paid to the provider of the services and the *exemption from the payment* is defined as the amount which the user of the service is not able to pay according to his/her calculated ability to pay.

The *exemption from the payment* is defined as the difference between the value of the service and user's contribution, whereas the *exemption of the one, who is liable to pay for the services*, is defined as the difference between the amount of the exemption of the payment of the user of the services and the payment contribution. The one being liable for the payment is a physical or legal entity that is not a family member and is obliged to pay the costs of the services. If the contributions of

the user and the liable person do not cover the costs of the services, the difference between the value of the services and both contributions is paid by the local community or the state. In this case the user must ask the competent "Centre for Social Work" for the exempt from payment of all the costs.

Additionally to the criteria defined in the aforementioned decree, the local communities can decide on additional exemptions from payment of the costs of home care services.

If the user of the service who is asking for the exemption from payment of the services is the owner of a real estate property, the issuing of the written order on exemption from payment contains the prohibition from alienation or burdening of this real estate to the credit of the municipality which finances the institutional care of the user. If the user asks for the exemption from the payment of home care services, the prohibition from alienation or burdening is issued only for real estate in the property of the user which is not used as the permanent residence of the user.

A family assistant has a right to the partial coverage of the lost income on the level of the minimal wage or to the proportional coverage of the lost income if he/she stays in a shorter than full time employment. The family assistant has full pension and disability insurance contributions paid as well as contribution for the case of unemployment and parental leave. The time spent for providing the services as family assistant is included into the pensionable period (which is a condition for receiving old age pension after retirement).

Total (public and private) expenditure on long-term care in 2015 amounted to roughly 1.26% of GDP (in 2016 1.24% of GDP) <sup>(586)</sup>. The expenditure for long-term care has been increasing over the years, from 1.08% GDP recorded in 2005. This is mainly due to an increased number of users. In addition, private expenditure has been increasing much faster than public expenditure. Hence, in terms of financing sources, the share of total long-term care accounted for by private expenditure increased in the period 2005-2013

<sup>(586)</sup> Source: Statistical Office of the RS; <https://www.stat.si/StatWeb/en/News/Index/7478>.

(<sup>587</sup>), which has important implications from the social point of view, i.e. affordability of formal care and quality monitoring of informal care (<sup>588</sup>).

### *Role of the private sector*

The providers of services can be public or private entities. Private providers are selected through public tenders and are granted concession with limited duration; they have to fulfil the same conditions as public providers. The standards for provision of services are quite strict (regarding the number of staff, qualifications, procedures, technical equipment and premises) and are defined by the state in the case of social care services (both institutional and home-based care), and by the Health Insurance Institute in the case of health care (institutional and community) services.

Institutional care is organised within the network of institutions for elderly, disabled adults and severely disabled children. Persons staying in residential care are provided with integrated health and social care services. The costs of accommodation are also part of institutional service.

Community nursing and home help are regulated within different regulatory systems. Therefore providers are not the same and operate separately under different regulatory systems. Community health services including services that qualify as long-term care are provided by community nurses who are employed by local health centres or are given a concession. They perform preventive and health education services, health-related services at home and to a certain extent also home help services. They are one of the first professional workers to identify health and social hardship as well as the needs of individual persons and their families for home and long-term care.

Home help is adjusted to the needs of an individual and includes housework assistance (IADL); assistance in essential daily activities (ADL) and

(<sup>587</sup>) From 22.2% to 26.3%, respectively. Source: Statistical office of the RS; <https://www.stat.si/StatWeb/en/News/Index/7478>.

(<sup>588</sup>) Note that at-risk-of-poverty rates among elderly people are over-average and the average monthly pensions are relative low (around €560 in 2015). In this context the increase in the out-of-the-pocket contributions can lead to social problems in the future as it puts affordability of formal care at risk.

assistance in maintaining social contacts. The "Social Protection Institute" carried out a few analysis of the situation of home care in Slovenia. The last analysis (Lebar et al, 2015 (<sup>589</sup>)) showed that home help is provided mainly by public agencies (i.e. centres for social work and homes for older people) and only few were private organisations with concessions.

### *Formal/informal caregiving*

Formal long-term care caregivers (<sup>590</sup>) must meet in relation to education and other working conditions strict rules. Some non-professional providers (family assistant or personal assistant) must already take part in special education programs. Educational programs and their frequency are defined by the "Social Chamber" and approved by the "National Professional Council".

Until a few years ago, Slovenia had no national policy that would deal with informal family carers (<sup>591</sup>) directly. There were some acts, which

(<sup>589</sup>) Lebar, L., Kovač, N., Nagode, M. (2015) Izvajanje pomoči na domu. Analiza stanja za leto 2014. Ljubljana: Inštitut RS za socialno varstvo. Available at: [https://www.irssv.si/upload2/pnd/IRSSV%20Izvajanje%20pomoci%20na%20domu%20%20analiza%20stanja%20v%20letu2014\\_koncno.pdf](https://www.irssv.si/upload2/pnd/IRSSV%20Izvajanje%20pomoci%20na%20domu%20%20analiza%20stanja%20v%20letu2014_koncno.pdf).

(<sup>590</sup>) Carers in inpatient LTC (in institutions): Latest available data of Associations of social institutions of Slovenia indicate that there were 9,943 people employed in homes for elderly and special social institutions in December 2012. Out of these, there were 4,823 people employed in social care and 4,776 people in health care (344 in others). According to the data of Statistical Office of the Republic of Slovenia there were 1,036 carers employed in centres for protection and training – 907 in social services, 61 in health care services and 68 in training services (employment). Carers in home-based LTC: According to the data of Social Protection Institute of the Republic of Slovenia there were 62.4 coordinators of home help at the end of 2012. Home help was carried out by 911 carers, 92.7% of them were regularly employed. In 10.6% local municipalities there was a shortage of carers. According to the data of National Institute of Public Health there were altogether 821 community nurses in Slovenia at the end of 2012 (covering the whole field of community nursing and home care not only LTC). Ministry of Labour, Family, Social Affairs and Equal Opportunities reports that there were 745 family assistants in 2012 and around 800 personal assistants.

(<sup>591</sup>) Informal carers: The results of SHARE survey for 2013 show that in Slovenia around 48,000 people aged 50 or more provided personal care or home help to a person outside their own household (6.5 % of respondents) and around 37,000 people aged 50 and over provided personal care within their own household (6.1% of respondents). Similar share of respondents was for countries in Continental Europe (5-8%), lower in Scandinavian



indirectly concerned informal family carers: Pension and Disability Insurance Act mentions the right to attendance allowance; Health Care and Health Insurance Act the right to compensation for care-giving to a close family member, with whom the insured lives in a common household and Act Amending the Social Security Act that enables family carers as family assistants to get, under specific rules, a financial compensation. Since 2006 several strategic documents were adopted that emphasize the importance of informal carers, mainly to give adequate training and services on the local level (day care, respite care) to the families who care for a disabled elderly family member and to support measures allowing more flexible working arrangements (the right for part-time work without the danger that the carer would lose social security).

#### *Prevention and rehabilitation policies/measures*

In 2011, Slovenia started to develop the network of model practices within the family medicine practice where the preventive activities for the chronically ill or users of long-term care in the home environment are exercised. More than 340 model practices are already operating.

Rehabilitation programs related to long-term care are systematically carried out in the framework of the activities of homes for the elderly and are funded by health insurance institute. There is a lack of such programs in local communities.

#### **Recently legislated and/or planned policy reforms**

Over the last 15 years there were several attempts to prepare the long-term care system reform. Several drafts of the act that would regulate the

whole system of long-term care and the potential (new) compulsory insurance for long-term care were prepared by different stakeholders (Ministry of Labour, Family, Social Affairs and Equal Opportunities, Health Ministry, Association of Providers of Institutional Care, NGO Pensioner's Association). The differences between draft acts prepared by different stakeholders were not so much in the content (arrangements of the system), but mostly in the approach to financing the long-term care system.

The need for long-term care system reform and plans for it also became part of strategic documents, such as the main national development strategy in the area of social protection, the "Resolution on the National Programme of Social Protection for the period 2013-2020" and the strategic document for the health care, the "Resolution on the National Healthcare Plan 2016-2025: Together for the society of health", passed in the parliament in March 2016 and envisaging:

- 1) the integration of health and social services in the area of long-term care;
- 2) strengthening of rehabilitation, reintegration, and prevention for all age groups;
- 3) securing sufficient funds for health and long-term care based on solidarity principles.

Besides the plan for long-term care reform both documents emphasises the development of community based services and unification of health and social home care services. In the draft operational programme for the use of structural EU funds in the new financial perspective, the emphasis is also on de-institutionalisation and support for development of community based services (such as day centres, smaller residential units, etc.).

Since 2012, the long-term care reform is high on the political agenda. A working group for the methodological, statistical and financial issues regarding LTC was established in 2012 <sup>(592)</sup>. At the end of 2013, the government adopted the starting points of the reform of LTC system, including the calendar for the reform. It was agreed that the first step of the reform will be the

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countries (3.5%) and higher in Southern European countries (9-11%). (Nagode, M. in Srakar, A, 2015. Značilnosti starejšega prebivalstva v Sloveniji – prvi rezultati raziskave Share, Institut za ekonomske raziskave, 2015). Research done by Anton Trstenjak Institute of gerontology and intergenerational relations show similar situation that in Slovenia more than 55,000 people aged 50 or more is taking care of their parents and more than 50,000 of their frail partner (Ramovš, J., Lipar, T., Ramovš, M. (2014) Oskrba v onemoglosti. V: Ramovš, Jože (ur) Staranje v Sloveniji – raziskava o potrebah, zmožnostih in stališčih nad 50 let starih prebivalcev Slovenije. Ljubljana: Inštitut Antona Trstenjaka).

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<sup>(592)</sup> See reference 9.

preparation and adoption of new legislation covering the whole LTC system and thus unifying it. A working group for the preparation of the new legislative act was established, composed by representatives of three ministries (covering areas of health, social affairs and finances), associations of users, associations of service providers, the Health Insurance Institute, the Pension Insurance Institute and the Institute of Macroeconomic Analysis and Development.

However, for several reasons (also conflicting interests and lack of political agreement) the health care reform was stopped and is again planned in the coalition agreement to be carried out by the current government. In the spring of 2015, a comprehensive analysis of the health care system has started, in the context of which an analysis of long-term care was carried out. The analysis was completed in December 2015. One of the main conclusions of the analysis of the health care system was that the reform of the health system and the system of long-term care should be prepared in a coordinated manner and that the activities in this regard should be carried out in 2016. Drafting of a new law on long-term care has been one of the priorities of the present government since 2016. Key actors in this area are, in addition to many other stakeholders, the ministry responsible for social affairs and the ministry responsible for health.

With the new legislation, Slovenia plans to introduce solidarity-based financing of long-term care, based on the principles of social-risk insurance. The main aim of the reform is to ensure fiscal sustainability of the long-term care system, on the one hand, and to increase social security and quality of life of persons depending on care and assistance of other people for performing basic and supportive life activities, on the other hand. The new (reformed) system should provide the availability and access to quality services that will enable care and support to individuals in need, especially at home and local community environment.

The reformed long-term care system should also have a positive effect on the reduction of poverty among elderly people (which is above average now). As pensions are relatively low, and the extent of out-of-pocket payments of people in need has been increasing, this currently puts pressure on

the budgets of elderly and their families. With the planned system of long-term care financing, the out-of-pocket contributions would be reduced and even eliminated for the economically disadvantaged.

By the end of the year 2016, the government decided to transfer the responsibility for the preparation of the Long-Term Care Act from the ministry responsible for social affairs to the Ministry of Health, where the Directorate for long-term care was established on 1<sup>st</sup> January 2017. With this transfer, also the coordination of the integrated providers' network development and coordination of pilot projects in the area of long-term care was transferred to the Ministry of Health. The preparation of the Long-term care Act was intensified and submitted into public debate in autumn in 2017, and currently awaits the new government which will proceed with legislative procedure.

The draft act is based on the agreement that the need for long-term care is a new social risk for which the residents of Slovenia have to be insured within the system of public social insurances and on the universal right to long-term care. The new act will also try to ensure that users have the access to quality integrated services, mainly in the local environment (community and home based services) or cash benefits.

The new act will be titled "Act on long-term care and compulsory insurance for long-term care" and will regulate both the provision of services and the financing of the system: with introduction of public compulsory insurance, and additional possibility of voluntary private insurance for non-standard services and accommodation costs in institutional care facilities.

Thus the Act will regulate:

- LTC insurance and financing of activities;
- definition of beneficiaries and rights (services);
- procedure of claiming the rights (including needs assessment);
- provision of LTC services;

- providers of LTC services and public network of providers;
- quality and safety;
- monitoring and information system;
- connection with the health and social care system.

The draft act envisages a single entry point and a uniform procedure for eligibility assessments. The person in need will take part in the assessment procedure and will at the end decide for the type of care and support needed and preferred (services or cash-benefit or personal assistant).

The Social Protection Institute of RS conducted with the partners a pre-pilot project to test and adapt the chosen assessment tool and procedure for the eligibility criteria and the personal planning procedure in 2017.

If the person in need decides for cash-benefits to be used for informal domestic care or for a personal assistant, the user is entitled to 14 days of respite care and the informal carer has the right to appropriate training and advice. Other planned elements of the system are the supervision over the domestic care, the final decision on the threshold of the need of ADL services, the scope and the content of the rights and provisions.

The new system should encourage independent living, user engagement and the use of ICT in long-term care.

Merging of different sources of financing of long-term care system should provide more transparency and effectiveness of financing of this area.

Individual planning, participation of users in the process of preparation of personal care plans and the responsibility of providers for realisation of individual care plans are the planned mechanisms that should also ensure more effective use of funds.

The reorientation from currently prevailing institutional (residential) care to more community based and home based care should as well have

positive financial effects on the budget (less new investments for institutional infrastructure and redirection of funds to new jobs in community and home based services). However this option is at this stage explicitly not among the future intentions of the government, who does not envisage any restriction to institutional care <sup>(593)</sup>. Strengthening of preventive activities (healthy ageing), rehabilitation and the use of ICT should additionally decrease the costs of long-term care.

However, one of the crucial issues related to the reform is still how to separate the costs of long-term care system from the costs of the health care system and how to ensure an additional stable source which would contain the rapid increase in annual household expenditures for long-term care.

The calculation of the financial impact of the proposed solutions in the new Long-Term Care Act aims to also take into account the increase in labour costs due to recent agreement between the government and trade unions presenting the public sector.

As part of preparations for the introduction of the new legislation, the educational curriculum for various profiles at the secondary level was supplemented, in order to integrate the health and social content of the educational programs on the one side and to provide integrated delivery of services at the other side.

## Challenges

Slovenia has a relatively fragmented system of long-term care, with future sustainability concerns, especially in light of high out-of-pocket payments. The main challenges of the system appear to be:

- **Improving the governance framework:** to establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities wrt to the provision of long-term care services; to set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy

<sup>(593)</sup> According to article 5 of the Social Security Act, "rights to services and financial social assistance in Slovenia are exercised on the basis of the principles of equal accessibility and free choice of forms for all beneficiaries under the conditions laid down by law".

to deliver high-performing long-term care services to face the growing demand for LTC services also by adopting and implementing the necessary legislative acts to reform the current long-term care system; to strategically integrate health and social services via such a legal framework; to establish good information platforms for LTC users and providers, setting up a system of records to monitor the existing situation and improve planning; to share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes.

- **Improving financing arrangements:** to foster pre-funding elements, which implies setting aside some funds to pay for future obligations; to define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing.
- **Providing adequate levels of care to those in need of care:** to adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the depth of coverage, that is, setting the extent of user cost-sharing on LTC benefits; and the scope of coverage, that is, setting the types of services included into the coverage; to reduce the risk of impoverishment of recipients and informal carers.
- **Encouraging home care and independent living:** to develop alternatives and improve eligibility to institutional care by e.g. developing new legislative frameworks encouraging home care, cash benefits or financial incentives to encourage home care; developing services in community care which are currently not accessible and would reduce the pressure on institutions; to monitor and evaluate alternative services, to provide effective home care, tele-care and information to recipients, as well as improving home and general living environment design.
- **Ensuring availability of formal carers and support to family carers:** to determine current

and future needs for qualified human resources and facilities for long-term care; to improve recruitment efforts, including through the migration of LTC workers and the extension of recruitment pools of workers; in addition, to continue supporting informal carers, such as through flexible working conditions, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- **Ensuring coordination and continuity of care:** to establish better co-ordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.
- **To facilitate appropriate utilisation across health and long-term care:** to steer LTC users towards appropriate settings.
- **Changing payment incentives for providers:** to consider a new payment model and a focused use of budgets.
- **Improving value for money:** to encourage competition across LTC providers to stimulate productivity enhancements and digitalisation if based on cost-effective solutions; to invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services.
- **Prevention:** to further the efforts in promoting healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.
- **Improving administrative efficiency** including by simplifying the procedures and employing IT solutions based on cost-efficiency considerations.

Table 3.25.1: Statistical Annex – Slovenia

GENERAL CONTEXT															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
<b>GDP and Population</b>															
GDP, in billion euro, current prices	29	32	35	38	36	36	37	36	36	38	39	12,451	13,213	13,559	14,447
GDP per capita, PPS	23.2	23.7	24.3	23.9	20.7	21.2	21.5	21.5	21.2	21.9	22.6	26.8	28.1	28.0	29.6
Population, in millions	2.0	2.0	2.0	2.0	2.0	2.0	2.1	2.1	2.1	2.1	2.1	502	503	505	509
<b>Public expenditure on long-term care (health)</b>															
As % of GDP	0.7	0.6	0.6	0.7	0.7	0.7	0.7	0.9	0.8	0.9	0.8	1.1	1.2	1.2	1.2
Per capita PPS	:	:	:	:	:	:	:	:	:	188.0	189.8	264.1	283.2	352.1	373.6
As % of total government expenditure	1.5	1.4	1.4	1.5	1.5	1.5	1.5	1.8	1.4	1.7	1.7	1.6	1.8	2.5	2.5
Note: Based on OECD, Eurostat - System of Health Accounts															
<b>Health status</b>															
Life expectancy at birth for females	80.9	82.0	82.0	82.6	82.7	83.1	83.3	83.3	83.6	84.1	83.9	82.6	83.1	83.3	83.3
Life expectancy at birth for males	73.9	74.5	74.6	75.5	75.9	76.4	76.8	77.1	77.2	78.2	77.8	76.6	77.3	77.7	77.9
Healthy life years at birth for females	60.1	61.0	62.3	60.9	61.5	54.6	53.8	55.6	59.5	59.6	57.7	62.0	62.1	61.5	63.3
Healthy life years at birth for males	56.4	57.7	58.7	59.4	60.6	53.4	54.0	56.5	57.6	57.8	58.5	61.3	61.7	61.4	62.6
People having a long-standing illness or health problem, in % of pop.	:	36.5	37.7	39.3	30.9	36.1	36.3	35.3	31.6	32.3	33.1	31.3	31.7	32.5	34.2
People having self-perceived severe limitations in daily activities (% of pop.)	:	8.4	7.9	9.7	10.5	12.1	13.0	11.5	9.5	9.3	9.8	8.3	8.3	8.7	8.1
<b>SYSTEM CHARACTERISTICS</b>															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
<b>Coverage (Based on data from Ageing Reports)</b>															
Number of people receiving care in an institution, in thousands	:	:	8	14	19	24	21	21	22	22	22	3,433	3,851	4,183	4,313
Number of people receiving care at home, in thousands	:	:	12	12	13	14	40	38	38	40	41	6,442	7,444	6,700	6,905
% of pop. receiving formal LTC in-kind	:	:	1.0	1.3	1.6	1.9	3.0	2.9	2.9	3.0	3.1	2.0	2.2	2.2	2.2
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients															
<b>Providers</b>															
Number of informal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO.

Table 3.25.2: Statistical Annex - continued – Slovenia

PROJECTIONS									
	2016	2020	2030	2040	2050	2060	2070	MS Change 2016-2070	EU Change 2016-2070
<b>Population</b>									
Population projection in millions	2.1	2.1	2.1	2.1	2.0	2.0	2.0	-5%	2%
<b>Dependency</b>									
Number of dependents in millions	0.22	0.23	0.25	0.27	0.27	0.26	0.26	18%	25%
Share of dependents, in %	10.6	10.9	11.9	12.8	13.1	13.3	13.2	25%	21%
<b>Projected public expenditure on LTC as % of GDP</b>									
AWG reference scenario	0.9	1.0	1.1	1.4	1.7	1.8	1.8	93%	73%
AWG risk scenario	0.9	1.0	1.4	2.1	2.9	3.7	4.4	369%	170%
<b>Coverage</b>									
Number of people receiving care in an institution	35,217	38,050	44,842	54,500	60,976	63,718	64,801	84%	72%
Number of people receiving care at home	34,135	37,014	44,242	54,275	60,730	63,755	64,598	89%	86%
Number of people receiving cash benefits	42,136	45,109	52,122	61,492	68,388	71,524	72,772	73%	52%
% of pop. receiving formal LTC in-kind and/or cash benefits	5.4	5.8	6.8	8.2	9.3	10.0	10.3	92%	61%
% of dependents receiving formal LTC in-kind and/or cash benefits	51.1	53.0	57.1	64.2	70.8	75.1	78.6	54%	33%
<b>Composition of public expenditure and unit costs</b>									
Public spending on formal LTC in-kind ( % of tot. publ. spending LTC)	73.2	74.8	77.9	79.7	81.2	81.5	81.6	12%	5%
Public spending on LTC related cash benefits ( % of tot. publ. spending LTC)	26.8	25.2	22.1	20.3	18.8	18.5	18.4	-31%	-27%
Public spending on institutional care ( % of tot. publ. spending LTC in-kind)	71.2	71.2	70.8	70.7	70.9	70.8	70.8	-1%	0%
Public spending on home care ( % of tot. publ. spending LTC in-kind)	28.8	28.8	29.2	29.3	29.1	29.2	29.2	1%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	28.8	28.2	29.1	30.5	32.3	32.4	31.7	10%	10%
Unit costs of home care per recipient, as % of GDP per capita	12.0	11.8	12.1	12.7	13.3	13.4	13.1	9%	1%
Unit costs of cash benefits per recipient, as % of GDP per capita	12.4	11.3	10.0	9.7	9.4	9.3	9.0	-27%	-14%

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).