Slovenia

Health Care & Long-Term Care Systems

An excerpt from

the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability,

published in October 2016
as Institutional Paper 37
Volume 2 - Country Documents

Economic and Financial Affairs
Economic Policy Committee

Slovenia

Health care systems

1.25. SLOVENIA

General context: Expenditure, fiscal sustainability and demographic trends

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

The gap between Slovenian (21,000 PPS in 2013) and average EU GDP per capita (27,900 PPS) has remained somewhat stable since 2009 (21100 vs 26800 PPS in 2009), although slightly increasing. Indeed, the negative impact of the economic and financial crisis on the Slovenian economy has been very strong (GDP growth ([267]) slowdown from 6.9% in 2007 to 3.3% in 2008 and -7.8% in 2009). After years of low or negative growth 2012 and 2013 recorded, respectively, -2.7 and -1.1, the economy picked-up during 2014 with 3.0%. The positive trend continued through 2015([268]) (2.9%) and is projected positive until 2017 (2.3% projected, with a slightly lower level in 2016). ([269])

The Slovenian population is projected to decrease from 2.1 million in 2013 to 2 million in 2060. Life expectancy is projected to increase by 7.1 years for men and 5.9 for women, i.e. somewhat faster than in the EU on average. Slovenia is expected to be strongly affected by the ageing process. From already high starting levels, the share of the old population (65+) is expected to almost double (from 17.3% to 29.4%) and the share of the very old (80+) to increase almost threefold (from 4.6% to 12.4%).

Total and public expenditure on health([270]) as % of GDP

In 2013 total expenditure on health care amounted to 9.2% of GDP, having slightly increased, though not steadily, during the last decade (8.7% in 2003). This is below the EU average of 10.1%, 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 both EU values. The same applies to public expenditure on health care, broadly constant over the last decade (+0.4%) and accounting for 6.6% ([271]) of 2013 GDP, which is below the EU ([272]) average of 7.8% when looking at the weighted figure, but is higher both than the unweighted and (6.4%) and than the median (6.1%) values. Also when measured in per capita terms, both total and public health care expenditure are lower than the EU weighted average: 1901 PPS vs. 2988 PPS and 1361 PPS vs. 2208 PPS respectively (figures for 2013 in PPS EUR). Comparing these values to unweighted average (2,399 PPS) and median (2,085) does not bring Slovenia above average, but it considerably reduces the gap, placing Slovenia very close to the median level for total health expenditure PPS. With an unweighted average value of 1,696 and a median of 1,398, an entirely similar reasoning applies to public health expenditure PPS, in which Slovenia almost matches the median level.

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 for four consecutive years in real terms, having declined by as much as -3.6% over the entire 2010–2013 period. ([273]) In 2013 public health expenditure as a share of GDP was thus 6.6%. At the same time, there was a change in the ratio of public to private expenditure on health. The share of public expenditure declined; it stood at 71.8% in 2013, which is lower than EU average.

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

([267]) Source: http://pxweb.stat.si/pxweb/Dialog/Saveshow.asp.
([268]) Source: http://www.stat.si/StatWeb/en/show-news?id=5796&idp=1&headerbar=10.
([269]) European Commission (2016), European Economic Forecast Winter 2016.
([270]) This aggregate includes capital investments.
([271]) Including public long-term health expenditure (HC.3) and capital investments.
([272]) This figure refers to the weighted average.
([273]) SURS, 2015: http://www.stat.si/StatWeb/en/show-news?id=5306&idp=10&headerbar=15 and IMAD calculation. According to international recommendations, the GDP implicit price deflator was used to calculate real growth (SURS, 2015: http://www.stat.si/StatWeb/en/show-news?id=5404&idp=1&headerbar=10.

Slovenia it fell annually by 0.5% in real terms. ([274])

Expenditure projections and fiscal sustainability

Driven by the change in demographic structure, public spending on health care is projected to increase by 21% or 1.2 pps of GDP, more than 13% average increase in the EU (0.9 pps) according to the "AWG reference scenario". ([275]) 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 1.9 pps of GDP from now until 2060 (EU: 1.6). Such a large projected growth in public health care spending, together with considerable expected increase in the other age-related items of public expenditure (e.g. pensions, long-term care, education) ([276]) and the unfavourable current budgetary stance, results in high risk for both the medium and the long-term sustainability of the Slovenian public finances.

Slovenia faces high sustainability risks over the medium and the long term due to the high initial debt-to-GDP ratio, the unfavourable initial budgetary position and the strong projected impact of age-related public spending (notably pensions, healthcare and long-term care). ([277])

Health status

The indicators of health status of the Slovenian population appear similar to those of the EU average. Life expectancy, both of women (83.6 years) and of men (77.2 years) is about the same than in the other EU countries (respective averages of 83.3 and 77.8 years) and is consistent with Slovenia's economic development level, while healthy life expectancy stands below the EU average for women (59.5 vs 61.5 years) and is slightly lower for men (57.6 vs. 61.4 years) ([278]). Infant mortality of 2.9‰ (2013) is well below the EU average of 3.9‰.

Over the last decade the main non-communicable diseases accounted for about 80% of all deaths in Slovenia; external causes for 9%; and communicable diseases for less than 1%. In total, 38.5% of all deaths were caused by diseases of the circulatory system, followed by neoplasms (29.1%), ischaemic heart disease (10%), injuries and poisoning (9.8%) and cerebrovascular diseases (7.9%). ([279]) Mortality by age and sex shows a pattern similar to the European averages.

The lifestyle-related risk factors are in general less prevalent than in the other EU countries. Percentage of regular smokers (20.5% in 2012) is below the EU average in the recorded closest years (22.4% in 2011 and 22% in 2013 and alcohol consumption (9.5% litres per capita in 2013) is close to the EU average number (9.8 litres per capita).

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 ([280]). The health insurance system is mandatory, providing universal coverage. The extent of rights deriving

([274]) 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.

([275]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

([276]) SI has the second highest projected growth of pensions expenditures in EU (3.5 pp of GDP until 2060), the second highest growth of education expenditure (0.8 pp of GDP until 2060) and LTC expenditure are also expected to grow faster that on average in EU (1.5 p.p. of GDP).

([277]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf

([278]) 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.

([279]) WHO Country Cooperation Strategy at a glance http://www.who.int/countryfocus/cooperation_strategy/ccsbriefs_svn_en.pdf.

([280]) 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_FORMATTED_without_cover.pdf

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 population liable for co-payments is insured by voluntary complementary health insurance. ([281])

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. ([282]) 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. ([283])

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 public entities have gradually reduced health financing over the nineties, the share of the population holding voluntary complementary health insurances has increased a lot and 72% of the whole population in 2012 were covered, however, when excluding children and students by the age of 26 who are fully covered by compulsory health insurance, 95 % of population liable for co-payments is holding complementary VHI. ([284])

Overall levels of enrolment in complementary health insurance have not changed dramatically during the crisis. ([285]) Total enrolment in 2014 (1,485,697) was at its highest level since 2008 (1,492,330). Since 2009, the government has started to cover co-payments for economically disadvantaged people who meet predetermined criteria. ([286]) 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. ([287]) Premiums have been community rated since 2006, are similar across the insurers (i.e. premiums currently do not differ across insurers by more than EUR 1 per month) and do not generally increase drastically over time. 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 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

([281]) Health Insurance Institute of Slovenia. Web page: http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/87C028D74130DE0AC1256E89004A4C0C.

([282]) Health Insurance Institute of Slovenia. Web page: http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/87C028D74130DE0AC1256E89004A4C0C.

([283]) Institute of Macroeconomic Analysis and Development (2014) Development report 2014. Indicators of Slovenia's Development. Health expenditure.

([284]) OECD Health Statistics 2015.

([285]) Overall, the largest decrease in total enrolment was in 2010, when the number of VHI enrolees fell by around 12,000 people (-0.8%); there were smaller decreases in VHI enrolees of around 8,200 and 3,800 in 2009 and 2011, respectively.

([286]) Health Insurance Institute of Slovenia. Web page: http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/87C028D74130DE0AC1256E89004A4C0C.

([287]) Health Insurance Institute of Slovenia. Web page: http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/87C028D74130DE0AC1256E89004A4C0C.

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 65.2% of total expenditure (2013). ([288]) General national and municipal-level taxation represents 6.6% of total expenditure (only 3.2% of current 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). 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. They represent the major source of public funding. The other public source of finance is general taxation. This non-earmarked revenue allocated for health is estimated annually and accounted for about 14% of the total general government health expenditure in 2012. ([289])

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's costs. Some services are 100% covered by CHI, while others are only covered up to a certain % 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. Complementary health insurance guarantees full co-payment coverage for all services covered by compulsory health insurance. This could lead to unnecessary care. ([290]) 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 purse. 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. ([291])

Private sources account for 28.2% of total health expenditure in 2013 and exceed the EU level (22.6% weighted average, 26.5% unweighted average). Private sources consist of two main sources of financing: out-of-pocket payments, representing around 12.1% in 2013 and voluntary health insurance accounting for 14.6% in 2013. Total private expenditure has been increasing considerably over the recent years: its average real yearly growth over the period 2000-2013 has amounted to 3.2% (OECD average: 3.5 %). ([292]) However, out-of-pocket payments are still relatively low as most health services and medicines are covered by compulsory and complementary health insurance schemes. Out-of-pocket expenditure accounted for only 12.1% of total health expenditure in 2013, compared with

([288]) Statistical Office of the Republic of Slovenia 2015. Health Expenditure and Sources of Funding.
([289]) OECD Fiscal Sustainability of Health Systems, 2015, page 35.

([290]) OECD (2013). 2013 Economic Survey - Slovenia
([291]) OECD (2013). 2013 Economic Survey - Slovenia
([292]) OECD Stat 2015.

20.6% in the EU-28 (unweighted average); per capita, this is EUR 216 in PPS terms in Slovenia and EUR 385 in PPS terms in the EU. ([293]) 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. 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. ([294])

Slovenian households allocate the largest shares of out-of-pocket expenditure to medical goods (2013: 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%), 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). ([295])

There is scope to increase out-of-pocket health expenditure in Slovenia as its burden amounts to slightly above 2% of final household consumption, and is one percentage point lower than the OECD average (OECD, 2011e). Concerns over rising inequalities in access to care could be addressed by differentiating co-payments according to income levels while ensuring full co-payment coverage for chronically ill people. ([296])

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.

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 263 in 2013 (EU average in 2013 was 344). In the 2000–2012 period, the number of physicians in Slovenia grew on average annually by 1.7%, which is the same as the EU average. ([297])

Slovenia lags the most regarding the number of general practitioners. After Slovenia took certain measures ([298]) to strengthen primary health care, in

([293]) Source Eurostat Database.
([294]) Institute of Macroeconomic Analysis and Development (2014) Development report 2014. Indicators of Slovenia's Development. Health expenditure.
([295]) OECD Stat 2015.
([296]) OECD (2013). 2013 Economic Survey - Slovenia
([297]) Institute of Macroeconomic Analysis and Development (2014) Development report 2014. Indicators of Slovenia's Development. Health Care Resources.
([298]) In 2010 and 2011 Slovenia took certain measures to strengthen primary health care: (i) the introduction of new teaching outpatient clinics where physicians specialising in general practice can register their patients; (ii) the introduction of so-called reference outpatient clinics where registered nurses assume greater responsibilities; and (iii)

recent years the number of general practitioners has increased reaching 50 per 100000 inhabitants in 2013, still significantly lower than the EU average (2013: 78.3). ([299]) 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 22.5% in the EU. In Slovenia, at the primary level, besides general practitioners, there are also paediatricians and gynaecologists who have their own patients.

The number of nurses, however, is in line with the EU averages (827 per 100000 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 ([300]) 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). Given the restrictions on hiring in the public sector, qualified nurses may otherwise have difficulty finding a job. ([301])

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 specialities 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 ([302]) was prepared in 2013. The medium-term objective of this document in the next 5 years is to reach a proportion of 1.500 patients to one doctor at primary care level.

To achieve this objective, it is estimated that 1,364 GPs would be required at national level, which requires additional 318 GPs in the next five years.

Since 2013 the Ministry has increased the number of places available for general practitioners specialisations, in a way, that 66% of available specialisations were intended for general practitioners. The number of available specialisation for general practitioners also increased in 2014 and 2015.

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.

The Ministry of Health is aware also that the existing primary healthcare system, though well organised, urgently needs to be upgraded in order to be able to cope with future challenges. In this context, one of the most important projects is the establishment of “model practices” that will, by upgrading the work of family medicine teams, show the path of development in this area in terms of their organisational structures, services and, not least of all, financial resources. ([303])

Reference outpatient clinics are family medicine outpatient clinics that are, in addition to a junior nurse, reinforced 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 reinforcement of family

additional funding for the primary level of health care (Ministry of Health, 2012).

([299]) Eurostat.

([300]) In 2008–2012, on average 445 nurses graduated every year, 12% more than on average in the period2003–2008.

([301]) Institute of Macroeconomic Analysis and Development (2014) Development report 2014. Indicators of Slovenia's Development. Health Care Resources.

([302]) "Public network of primary health care in the Republic of Slovenia in the field of general practitioners and paediatricians at the primary level", (2013).

([303]) Ministry of Health (2014).

medicine teams and thus represents basic public health services, which is a priority of health policy. It should 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.

The aim is to convert the majority of family practice outpatient clinics into reference outpatient clinics in a period of 5 to 7 years. From 2011 until 2015, 587 reference outpatient clinics have been set up. The Ministry of health is planning that all general practices would become model practices by 2017.

The organisation of the healthcare network at the primary level and simulations taking into consideration the structure of the population and the number of required healthcare staff (for the purposes of planning human resources) is underway. ([304])

There were 27 hospitals in Slovenia in 2013 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 hospitals beds (359 beds per 100 000 inhabitants in 2013) ([305]), average length of stay (6.3 days) and the number of inpatient discharges (16.6 per 100 000 inhabitants) are similar to the average figures for the EU (respectively 356 beds, 6.3 days and 16.5 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 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 (10.5% vs. 28.7% in 2011) and, despite recent progress in increasing the share of surgeries carried out as day cases, more could be done to further develop ambulatory care. ([306]) This suggests that a strategy to increase day case interventions should be then encouraged also to reduce waiting times for surgery.

In the scope of health care services, the transfer of programmes from acute hospital care to day hospital care or specialist outpatient care is in progress. For this purpose, standards and a diagnosis-related group system are gradually being introduced for treatment in day hospital care.

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 in Slovenia. According to data for 2013, the proportion of cataract surgeries carried out as day cases was 89%. For example, 86.1% of carpal canal treatments were carried out as day cases during the same year. ([307]) Considered is also 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).

([304]) Ministry of Health (2014)
([305]) National Institute for Public Health, 2015.
([306]) OECD (2013). 2013 Economic Survey - Slovenia
([307]) Health Insurance Institute of Slovenia. Annual Report for the Year 2015. (2016). http://www.zzzs.si/ZZZS/info/egradiva.nsf/o/817E8F5609C531D2C1257F7600499948?OpenDocument

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 (0.16%) and as a percentage of current health expenditure (2.6%) is slightly below the EU average in 2013 (respectively 0.27% and 3.5%). 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 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.

Hospital care is reimbursed according to a Diagnosis-Related Group (DRG) model, which replaced in 2003 the per-case payment system, which consisted in payments for complete inpatient episodes, and as such did not accounted 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.

The diagnosis-related group system was updated on 1 January 2013 by introducing the Australian modification to the International Classification of

Diseases ICD-10-AM and the Classification of Diagnostic and Therapeutic Procedures. ([308])

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

The market for pharmaceutical products

In 2013 pharmaceutical spending accounted for 1.34% of GDP and 21.7% of public health care expenditure, slightly above the average figures for the EU (1.5% and 17.1% respectively).

An international pricing system determines ex-factory prices with respect to the level in comparable EU Member States, while 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 essential similarity) and listed in a national list of substitutable pharmaceuticals. The lowest drug price in the same group will be used as reference price.

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 (75% 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.

The impact of systemic measures on the cost control of medicinal products since 2006 is as follows: the proportion of costs for medicinal products with respect to overall health care expenditure in 2006 was 21.7% (the proportion accounted for by compulsory health insurance was 15.9%); in 2011, this figure fell to 20.1% (of which compulsory health insurance accounted for 13.2%) with respect to overall health care expenditure. 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 specific medicinal products in hospitals, therapeutic equivalents for non-hospital treatment with medicinal products and the introduction of compulsory discounts for certain groups of medicinal products financed from public funds.([309])

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.

eHealth 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 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 2016. An important amendment to the legislation that deals with the databases containing medical data was adopted in 2015,

([308]) The Ministry of Health (2014).

([309]) The Ministry of Health (2014).

which was key for implementation of deliverables of the national eHealth project.

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 1.3 million documents for over 400.000 patients and thus enables health professionals to save time and make medical decisions based on accurate data (mainly discharge letters and ambulatory results). Legal and technical basis for patient summary that was defined according to the (EU) eHealth network guidelines was established in 2015. The collection of patient summaries will start in the second half of 2016.

ePrescription was launched nationally in November 2015. More than 70% 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, more than 75% of healthcare providers already sent 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 and mandatory eBooking of medical service made by the family doctor (or nurse) will start in the first half of 2016.

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) and a patient portal that will enable a patient to see his/her own medical data will be published in 2016.

Health promotion and disease prevention policies

Health promotion and disease prevention is mainly done through State's and HIIS's large scale programmes, GPs and nurses thanks to a strong emphasis given on health promotion and disease prevention during education and employers for occupational diseases. In 2013, public expenditure on prevention and public health services as a % of GDP (0.23%) and as a percentage of total current health expenditure (3.7%) is above the EU average (0.19% and 2.5% respectively). The most recent health promotion campaigns included ([310]); 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%). ([311]) The proportion of screening rates for cervical cancer is also quite high (72.1% of the target population in 2015. ([312])

Recently legislated and/or planned policy reforms

Improving health care and maintaining its financial sustainability is high on 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. At the same time the proposal of the new public health services development strategy was launched for the public debate.

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

([310]) National Institute of Public Health and Ministry of Health.
([311]) OECD. health at glance 2015.
([312]) Oi Ljubljana, 2015.

(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..

Changes are envisaged also in the field of health care provider network (mainly hospitals), their management, organisational structure and accountability.

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 Law". 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 will shape the reform. On the basis of the analysis, the "National Health Care Resolution Plan 2016-2025" was approved by the government in December 2015 and was adopted by Parliament in March 2016. In the "Resolution on National Health Care Plan 2016-2025": Together for a society of health" it is anticipated that the Ministry of Health will ensure an appropriate way of planning human resources in health care, that would in addition to the needs of the population also take into account the changing demographic structure. Special attention will be dedicated to the balance of health care professionals, by transferring certain competences and responsibilities between occupational groups and introducing new content in line with developments in medicine and other health professions. Therefore the following measures are currently planned:

- Action 1: To establish a system for monitoring human resources in the health care system and national register of health professionals.
- Action 2: To adopt a national plan for the development and management of human resources in the health sector and the relevant legislation.
- Action 3: In cooperation with local communities to introduce incentives for work in the areas of employment less attractive.

Based on the resolution, it is expected that the "Health Care and Health Insurance Ac"t will be in public discussion in autumn 2016 and adopted in 2017.This will focus on the issues of financing and sustainability of the healthcare system, on improving payment and purchasing practices with focus on efficiency and quality and on re-organising the system of long-term care.

In 2015, the Ministry of Health started a pilot project in the area of waiting times. The project is ongoing and it is anticipated that it will last until June 2016. Emerging results from the pilot will be translated into system changes and incorporated into legislation. Further planned changes concern the "Patient Rights Act and Rules" on the management of waiting lists and on maximum allowed waiting times by health service. The implementation of the eBooking of medical services a uniform base will be established to manage waiting lists.

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 the same direction is the recent 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.

A system of "family medicine model practices" was launched at the primary healthcare level in 2011, and expected to cover all practices by end 2018, is currently being implemented to strengthen preventive approaches in primary care and lower the pressure at a secondary healthcare level.

With the objective to reduce lifestyle-related non-communicable diseases, the project "Towards better health and reducing inequalities in health" was launched to strengthen the public health role of primary healthcare centres. All age groups are included with the special focus on vulnerable groups and pilot testing has already started. To the same end, to tackle the above average economic burden of tobacco use, the Ministry of Health put a proposal of the new "Restriction of the Use of Tobacco and related Products Act" under public discussion.

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.

Challenges

The analysis above shows that a wide range of promising reforms has been implemented in recent years to strengthen the efficiency of care provision and cost control. In addition, the Slovenian health care system has recently undergone a comprehensive review highlighting critical areas of improvement that should shape planned reforms in the sector. Based, amongst others, on emerging results, the main challenges for the health system emerge 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). 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 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, for instance with the implementation of pay-for-performance (P4P) schemes.

- 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 1.25.1: **Statistical Annex – Slovenia**

General context												EU- latest national data		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	26	28	29	32	35	38	36	36	37	36	36	9289	9800	9934
GDP per capita PPS (thousands)	21.1	22.1	22.8	23.4	24.0	23.7	20.5	21.1	21.3	21.3	21.0	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	2.9	4.4	3.8	5.5	6.4	3.2	-8.8	0.9	0.5	-2.7	-1.2	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	3.5	0.8	3.9	4.5	1.0	9.6	0.8	-2.7	0.0	2.9	-3.4	3.2	-0.2	-0.4

Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	8.7	8.4	8.4	8.3	7.9	8.4	9.2	8.9	8.9	9.4	9.2	10.4	10.1	10.1
Total current as % of GDP	8.1	8.0	8.0	7.8	7.5	7.9	8.6	8.6	8.6	8.7	8.7	9.8	9.6	9.7
Total capital investment as % of GDP	0.5	0.4	0.4	0.5	0.4	0.5	0.6	0.3	0.3	0.6	0.5	0.6	0.5	0.5
Total per capita PPS	1323	1377	1455	1552	1635	1875	1954	1875	1897	1952	1901	2828	2911	2995
Public as % of GDP	6.2	6.1	6.1	6.0	5.7	6.2	6.8	6.6	6.5	:	6.6	8.1	7.8	7.8
Public current as % of GDP	5.9	5.8	5.8	5.7	5.3	5.8	6.3	6.3	6.3	6.3	6.2	7.9	7.7	7.7
Public per capita PPS	882	941	995	1044	1089	1271	1300	1293	1398	:	1361	2079	2218	2208
Public capital investment as % of GDP	0.3	0.3	0.3	0.3	0.3	0.4	0.5	0.3	0.3	:	0.4	0.2	0.2	0.1
Public as % total expenditure on health	71.6	73.1	72.6	72.3	71.9	73.9	73.7	74.0	73.7	:	71.6	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	14.1	14.0	14.0	14.2	13.9	14.1	14.6	14.0	13.8	14.6	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	99.0	99.0	99.0	99.0	99.0	100.0	100.0	100.0	100.0	100.0	100.0	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	12.7	12.3	13.2	12.5	13.8	12.8	12.7	12.7	12.2	11.9	12.1	14.1	14.4	14.1

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

Population and health status												**2009**	**2011**	**2013**
Population, current (millions)	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.1	2.1	2.1	502.1	504.5	506.6
Life expectancy at birth for females	80.3	80.8	80.9	82.0	82.0	82.6	82.7	83.1	83.3	83.3	83.6	82.6	83.1	83.3
Life expectancy at birth for males	72.5	73.5	73.9	74.5	74.6	75.5	75.9	76.4	76.8	77.1	77.2	76.6	77.3	77.8
Healthy life years at birth females	:	:	60.1	61.0	62.3	60.9	61.5	54.6	53.8	55.6	59.5	:	62.1	61.5
Healthy life years at birth males	:	:	56.4	57.7	58.7	59.4	60.6	53.4	54.0	56.5	57.6	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	93	85	76	68	73	77	82	73	160	158	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	4.0	3.7	4.1	3.4	2.8	2.4	2.4	2.5	2.9	1.6	2.9	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	2.34	2.31	2.27	2.15	2.06	2.31	2.56	2.58	2.61	:	2.47	3.13	2.99	3.01
Day cases curative and rehabilitative care	0.18	0.18	0.19	0.17	0.17	0.20	0.21	0.21	0.21	0.20	0.18	0.18	0.18	0.19
Out-patient curative and rehabilitative care	2.04	2.00	2.04	2.04	1.97	2.01	2.07	2.06	2.06	:	2.13	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	1.76	1.73	1.74	1.69	1.54	1.54	1.73	1.75	1.72	:	:	1.60	1.55	1.44
Therapeutic appliances and other medical durables	0.24	0.22	0.22	0.20	0.22	0.25	0.30	0.31	0.30	0.29	0.29	0.31	0.31	0.32
Prevention and public health services	0.29	0.30	0.30	0.30	0.29	0.30	0.32	0.33	0.34	:	0.33	0.25	0.25	0.24
Health administration and health insurance	0.42	0.35	0.29	0.35	0.38	0.34	0.38	0.30	0.30	0.17	0.34	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	2.12	2.10	2.03	1.92	1.82	2.05	2.28	2.29	2.32	:	2.14	2.73	2.61	2.62
Day cases curative and rehabilitative care	0.17	0.16	0.18	0.17	0.16	0.19	0.20	0.20	0.19	0.19	0.17	0.16	0.16	0.18
Out-patient curative and rehabilitative care	1.26	1.23	1.26	1.32	1.22	1.32	1.39	1.39	1.42	:	1.49	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	1.07	1.06	1.06	1.04	0.92	0.92	1.00	0.98	0.96	1.37	1.34	0.79	1.07	0.96
Therapeutic appliances and other medical durables	0.05	0.04	0.04	0.04	0.04	0.04	0.04	0.05	0.05	0.06	0.06	0.13	0.12	0.13
Prevention and public health services	0.23	0.23	0.22	0.22	0.21	0.22	0.25	0.25	0.25	0.24	0.23	0.25	0.20	0.19
Health administration and health insurance	0.23	0.20	0.18	0.17	0.16	0.16	0.18	0.17	0.16	:	0.16	0.11	0.27	0.27

(1) All the figures under EU-latest national data are computed as weighted averages. Source: EUROSTAT, OECD and WHO

Table 1.25.2: **Statistical Annex - continued – Slovenia**

Composition of total as % of total current health expenditure	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	28.9%	29.0%	28.5%	27.6%	27.5%	29.3%	29.8%	30.1%	30.5%	:	28.3%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	2.2%	2.2%	2.4%	2.2%	2.3%	2.6%	2.5%	2.4%	2.4%	2.3%	2.1%	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	25.2%	25.1%	25.6%	26.2%	26.3%	25.5%	24.1%	24.0%	24.1%	:	24.5%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	21.7%	21.7%	21.9%	21.7%	20.6%	19.5%	20.1%	20.4%	20.1%	:	:	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	3.0%	2.7%	2.7%	2.6%	2.9%	3.2%	3.5%	3.6%	3.6%	3.4%	3.4%	3.2%	3.3%	3.3%
Prevention and public health services	3.6%	3.8%	3.8%	3.9%	3.9%	3.8%	3.7%	3.8%	4.0%	:	3.8%	2.6%	2.6%	2.5%
Health administration and health insurance	5.2%	4.4%	3.6%	4.5%	5.1%	4.3%	4.4%	3.5%	3.5%	1.9%	3.9%	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	36.1%	36.1%	34.9%	33.9%	34.2%	35.5%	36.4%	36.5%	37.1%	:	34.7%	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	2.8%	2.8%	3.2%	2.9%	3.1%	3.3%	3.2%	3.1%	3.1%	3.0%	2.8%	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	21.4%	21.2%	21.6%	23.3%	22.9%	22.9%	22.2%	22.2%	22.7%	:	24.0%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	18.2%	18.2%	18.2%	18.4%	17.3%	15.9%	15.9%	15.6%	15.4%	21.9%	21.7%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	0.8%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%	0.8%	0.8%	1.0%	0.9%	1.6%	1.6%	1.6%
Prevention and public health services	3.9%	4.0%	3.8%	3.9%	3.9%	3.8%	4.0%	4.0%	4.0%	3.9%	3.7%	3.2%	2.7%	2.5%
Health administration and health insurance	3.9%	3.4%	3.1%	3.0%	3.1%	2.8%	2.8%	2.8%	2.6%	:	2.6%	1.4%	3.5%	3.5%

												EU- latest national data		
Expenditure drivers (technology, life style)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
MRI units per 100 000 inhabitants	:	:	:	0.55	0.60	0.69	0.69	0.73	0.83	0.88	0.87	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	:	0.4	0.5	0.5	0.5	0.5	0.6	0.9	0.9	0.8	0.8	0.9	0.9	0.8
CTS per 100 000 inhabitants	:	0.9	1.0	1.0	1.1	1.2	1.2	1.3	1.3	1.3	1.2	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	:	0.1	0.1	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Proportion of the population that is obese	:	:	:	:	16.4	16.8	:	:	:	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	:	:	23.0	18.5	18.9	18.7	:	:	:	20.5	:	23.2	22.4	22.0
Alcohol consumption litres per capita	11.5	12.3	13.5	12.3	11.0	10.9	10.5	10.3	10.6	11.0	9.5	10.3	10.0	9.8

Providers	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Practising physicians per 100 000 inhabitants	225	230	235	236	239	240	241	243	249	254	263	329	335	344
Practising nurses per 100 000 inhabitants	735	740	748	760	775	788	803	819	833	816	827	840	812	837
General practitioners per 100 000 inhabitants	:	:	38	38	41	41	42	44	45	47	50	:	78	78.3
Acute hospital beds per 100 000 inhabitants	401	385	388	384	378	383	371	368	369	362	359	373	360	356

Outputs	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Doctors consultations per capita	6.9	:	:	6.6	6.7	6.7	6.6	6.4	6.5	6.3	6.5	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	:	15.5	15.4	16.0	16.2	16.2	16.6	16.3	16.6	:	:	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	:	1,665	2,026	2,142	2,243	2,484	2,566	2,229	1,950	:	:	6368	6530	7031
Acute care bed occupancy rates	68.0	73.0	70.0	72.0	70.0	71.5	71.2	69.7	68.9	68.8	67.9	72.0	73.1	70.2
Hospital curative average length of stay	6.1	6.2	5.8	5.8	5.5	5.7	5.6	5.5	6.8	7.0	6.3	6.5	6.3	6.3
Day cases as % of all hospital discharges	:	9.7	11.7	11.8	12.1	13.3	13.4	12.0	10.5	:	:	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060**	**EU Change 2013 - 2060**
AWG reference scenario	5.7	5.9	6.4	6.8	6.9	6.8	1.2	0.9
AWG risk scenario	5.7	6.1	6.8	7.3	7.5	7.5	1.9	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060, in %**	**EU - Change 2013 - 2060, in %**
Population projections until 2060 (millions)	2.1	2.1	2.1	2.1	2.1	2.0	-1.0	3.1

(1) All the figures under EU-latest national data are computed as weighted averages. Source: EUROSTAT, OECD and WHO

Slovenia

Long-term care systems

2.25. SLOVENIA

General context: Expenditure, fiscal sustainability and demographic trends

Slovenia, member of the European Union since 2004, has a population of just above 2 million inhabitants, which is slightly less than 0.4% of the EU population. With a GDP of 38.5 billion ([439]), or 22,600 PPS per capita in 2014 it scores lower than the EU weighted average (27,900). 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. Total public expenditure on long-term care is with 1% of GDP in 2013 ([440]) slightly under the EU average in the previous years (1.0%).

Health status

Life expectancy at birth for both men and women was respectively 77.2 years (78.0 in 2014) and 83.6 years (83.7 in 2014) in 2013 and is similar to the EU average (77.8 and 83.3 years for men and women respectively). Nevertheless, in 2013 the healthy life years at birth for both sexes were, 59.5 years (women) and 57.6 years (men), substantially lower than the EU-average (61.5 and 61.4 respectively). At the same time the percentage of the population having a long-standing illness or health problem was in 2013 slightly lower than in the EU as a whole (31.6% and 32.5% respectively). ([441]) The percentage of the population indicating a self-perceived long-standing severe limitation in its daily activities has been slightly increasing since 2005 (from 9.5% in 2005 to 13% in 2011), but despite remaining above the EU-average of 8.7%, the trend seems to have changed in the last years (11.5% in 2012 and 9.5% in 2013) ([442]).

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 230 residents living with strong limitations due to health problems in 2013, an increase of 30% is envisaged until 2060 to around 300 thousand. This applies to the "demographic scenario" of the 2015 Ageing Report, which assumes that the dependent population evolves in line with the total elderly population and all gains in life expectancy are spent in bad health. That is less steep an increase than in the EU as a whole (40%). In a less pessimistic scenario, and assuming that half of the projected gains in life expectancy are spent without disability (AWG reference scenario), the number of the dependent population reaches 282 thousands, i.e. a 21.5%. Also as a share of the population, the dependents are becoming a bigger group and an increase of 31% is projected (from 11.3% to 14.8%), below the EU-average increase of 36%.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. 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 1.5 pp, bringing Slovenia from 1.4 ([443]) to 2.9% of GDP spent on long-term care in the period 2013-2060 of GDP by 2060. ([444]) 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,

([439]) Statistical Office of the Republic of Slovenia (SURS) first estimate, February 2016

([440]) Total long-term care expenditure http://www.oecd-ilibrary.org/social-issues-migration-health/data/oecd-health-statistics/system-of-health-accounts-health-expenditure-by-function_data-00349-en?isPartOf=/content/datacollection/health_e_f-data-en, SURS: http://www.stat.si/StatWeb/en/show-news?id=5306&idp=10&headerbar=15

([441]) Source Eurostat, People having a long-standing illness or health problem, by sex, age and labour status [hlth_silc_04], Last update 23.03.15, Extracted February 2016 .

([442]) According to EU-SILC Survey 2013 (Eurostat Database-Population and Social Conditions- Health- Health Status)..

([443]) 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).

([444]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

projects an increase in spending of 2.8 pps of GDP by 2060 (expenditure projected to increase to 4.2% GDP). Overall, projected long-term care expenditure increase is expected to add to budgetary pressure on medium and long run. Sustainability risks appear over the medium and the long run due to the projected increase in age-related public spending, notably deriving from long-term care, healthcare and pensions). ([445])

System Characteristics

Administrative organisation

Currently, there is no uniform system of long-term care (LTC) in Slovenia. Different forms of LTC services and benefits 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. Over the last ten years the government has been preparing a new umbrella regulation, which would bring all the different recipients and benefits under one rule. The last draft version of the legislation was in public discussion in 2010. Adoption was postponed, also due to lack of insight in the financial/fiscal implications. Preparations of the law have again intensified in the autumn of 2013 aiming to prepare financial projections in order to support the legislation, as financial sustainability is one of the critical issues of this legislation. 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. ([446])

– LTC 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 LTC by more than 50% by 2035.

– There are four main public funding sources for LTC, but nearly half of the public LTC spending is by the Health Insurance Institute.

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

– Private spending on LTC 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 LTC 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 LTC. This might be achieved either by shifting responsibility to a single government department and/or agency, or by mechanisms that aim to co-ordinate the spending and entitlements between the different funding organisations.

– This report shows that LTC spending is likely to grow rapidly, and that 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.

Long-term care in Slovenia includes benefits in kind (health care and/or social services in a form of institutional or home care) and cash benefits. Currently, LTC is regulated by several acts in the field of social security, such as health care and health insurance, pension and disability insurance

([445]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf.

([446]) 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.

and social assistance. Cash benefits and institutional care are organised centrally whereas home care services and community are provided on a local level.

Funding for LTC 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. 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, the unemployed, beneficiaries of minimum income)([447]). Cash-benefits which are directed to persons with limitation in performing basic activities of daily living (ADL) ([448]), are financed from the Pension and Disability Fund and partially by the state budget (Ministry of Labour, Family, Social Affairs and Equal Opportunities).

Social LTC services are partially financed from the state and the municipalities' budgets, and partially paid by the users (recipients). Out-of-pocket payments for social care LTC 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 LTC services 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.

Types of care

For systematic statistics and monitoring of performance and development of LTC an inter-institutional working group for statistical monitoring of LTC was set up in 2012([449]). The first LTC report prepared by working group was issued in 2014 ([450]).

Four modes of LTC provision are carried out in the current system of LTC (by following SHA framework): in-patient care (institutions), day-case care, home care and cash benefits.

Inpatient LTC (institutional care) is organised by homes for elderly, special social institutions, centres for training, occupation and care and centres for education of children with special needs. There were 21 902 people altogether residing in these institutions at the end of 2013; mainly in homes for elderly. Inpatient LTC was provided for 4.9% of population aged 65 years and over. ([451])

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

([447]) For example, in Slovenia there are more than 400,000 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.

([448]) 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.

([449]) Appointed by Statistical Office of the Republic of Slovenia and led by Social Protection Institute of the Republic of Slovenia. The working group includes representatives of all main actors providing data on long-term care (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 an Disability Insurance Institute, the Institute for Economic Research and the Health Insurance Institute of Slovenia).

([450]) Source: Nagode, Mateja, Eva Zver, Stane Marn, Anita Jacović, Davor Dominkuš. Long-term care – use of international definition in Slovenia. Working paper No. 2/2014 XXIII. Ljubljana: IMAD.

([451]) Source: Statistical Office of the RS (2015). Available at: http://www.stat.si/StatWeb/en/show-news?id=4933&idp=21&headerbar=17.

Home-based LTC is organised by community nursing care, home help, family assistant, personal assistance and housing groups. More than 20 700 people received home–based LTC services at the end of 2013; mostly community nursing care and home help. Home-based care was provided to 4.5% of population aged 65 years and over.

Regarding the total number of cash benefits recipients in 2013 there were more than 40.000 recipients of cash benefits (Attendance and Allowance Supplement based on 6 different acts), of which around 60% were aged 65 years and over and 35% 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 17.181 recipients of cash benefits who only received cash benefit and were not included in any other LTC service. Cash benefits only were received by 1.9% of the population aged 65 years and over.

It is estimated that there were altogether 60 312 recipients of formal LTC services and cash benefits at the end of 2013; this accounts for 11.4% of population aged 65 years and over. Inpatient LTC (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 LTC started to develop approx. 20 years ago and it is still not well developed. Even though the number of people receiving home-based LTC 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.

Eligibility criteria

There is no unified entry point or a model of LTC needs assessment. The eligibility for a service is linked to the service in question and is made by an expert team (in the case of institutional care) or by an individual expert (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 young adult (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 exempt of the user from the payment of the services. The decree defines *the border of social security*, set as an amount of money that has to remain at disposal of the user of the service after the payment of the LTC services. Further on, the decree defines the *ability to pay* as the maximum amount up to which the user is able to participate in the payment of the LTC service. The *payment contribution* is the amount that needs to be paid to the provider of the LTC service and the *exempt 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 *exempt from the payment* is defined as the difference between the value of the service and user's contribution, whereas the *exempt of the one, who is liable to pay for the services*, is defined as the difference between the amount of the exempt 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 LTC 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 LTC 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 LTC in 2013 amounted to roughly 1.3% of GDP. ([452]) The expenditure for LTC is 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 LTC accounted for by private expenditure increased in the period 2005-2013([453]), which has important implications from the social point of view, i.e. affordability of formal care and quality monitoring of informal care.([454])

Role of the private sector

The providers of LTC 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 LTC 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 ([455]). Persons staying in residential care are provided with integrated health and social care services. The costs of accommodation are also part of institutional LTC 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 LTC services are provided by community nurses who are employed by local health centres or are given 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 assistance in maintaining social contacts. The "Social Protection Institute" carried out a few analysis of the situation of home care in Slovenia.

([452]) 1.31% of GDP in 2013 (2012: 1.33%), of which public expenditure was 0.95% and private expenditure 0.36% of GDP. Data are based on the OECD, Eurostat, WHO System of Health Accounts methodology. Source: Statistical Office of the RS (2015) http://www.stat.si/StatWeb/en/show-news?id=5306&idp=10&headerbar=15

([453]) From 22.2% to 27.5%, respectively. Source: Statistical office of RS – Expenditure on health 2003-2013, July 2015. Note: Data are based on the OECD, Eurostat, WHO System of Health Accounts methodology.

([454]) Note that at-risk-of-poverty rates among elderly people are over-average and the average monthly pensions are relative low (EUR 565 in 2013). 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. In the situation of a lasting economic crisis the problem of out-of-the-pocket payments already became visible in decreasing scope of formal LTC, especially institutional (decreasing number of people in old-people care institutions: 3% in 2013 returned to their homes).

([455]) At the end of 2012 there were 20.077 available places in 99 institutions for elderly and adults (people over 18). These institutions comprise 55 public institutions for elderly, 39 private institutions for elderly and 5 special institutions.

The last analysis (Lebar et al, 2015([456]) 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 LTC caregivers ([457]) 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 few years ago, Slovenia had no national policy that would deal with informal family carers ([458]) directly. There were some acts, which 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 emphasise 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

The area of prevention and rehabilitation in the context of long-term care in Slovenia has not yet been systematically regulated. Prevention projects/activities are primarily funded by the ministry responsible for social welfare and, some local communities. For several years the "Institute Anton Trstenjaka" is successfully conducting a special program designed to prevent falls of the elderly in local communities. Within the framework of activities of the "Institute Emonicum" a similar program for nursing homes started in 2014. The ministry in collaboration with some local communities promotes various prevention programs in relation to the treatment of persons with dementia.

In 2011, Slovenia started to develop the network reference dispensaries within which the preventive activities for the chronically ill or users of long term care in the home environment are exercised. More than 340 reference dispensaries are already operating.

([456]) 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.

([457]) Carers in inpatient LTC (in institutions): Data of Associations of social institutions of Slovenia indicate that there were 9943 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 4776 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.

([458]) 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 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 hat 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 partner458. (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).

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 10 years there were several attempts to prepare the LTC system reform. Several drafts of the act that would regulate the whole system of LTC and the potential (new) insurance for LTC were prepared by different stakeholders (Ministry of Labour, Family, Social Affairs and Equal Opportunities, Association of Providers of Institutional Care, NGO Pensioner's Association). The differences between different 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 LTC system.

The need for LTC 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" (passed in the parliament in April 2013). Besides the plan for LTC reform it 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 LTC reform is high on the political agenda again. A working group for the methodological, statistical and financial issues regarding LTC was established in 2012. ([459]) 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 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), different associations of users, different associations of service providers, the Health Insurance Institute, the Pension Insurance Institut and, the Institute of Macroeconomic Analysis and Development.

However, for different reasons (also collision of 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 LTC 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 is one of the important tasks of the national government in the year 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 will introduce solidarity-based financing of LTC, based on the principles of social-risk insurance. The main aim of the LTC reform is to ensure fiscal sustainability of the LTC 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 access to and availability of quality services of LTC that will enable care and support to individuals in need, especially in home and local community environment.

The reformed LTC 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-the-pocket payments of people in need has been increasing, this currently means a strong pressure on the budgets of elderly and their families. With the planned system of financing the LTC, the out-of-the-pocket contributions will be reduced

([459]) See reference 8.

significantly and for some categories of users will not be necessary any more.

The draft act is based on the agreement that the need for LTC is a new social risk for which the residents of Slovenia have to be insured within the system of public social insurances. The new act will also deal with new arrangements of LTC provision in a way that the users will have the access to quality integrated services, mainly in the local environment (community and home based services) or cash benefits or a combination of both.

The new act will be titled "Act on long-term care" and will regulate both the LTC content (services) and stable financing of the system: with introduction of public compulsory insurance, and additional possibility of voluntary private insurance for non-standard LTC 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, and;
- providers of LTC insurance and providers of LTC services.

The draft act envisages a single entry point and a uniform expert procedure for LTC needs assessment. The person in need will take part in the needs assessment procedure and will at the end decide for the type of care and support needed and preferred (services or cash-benefit or a combination of both or technical aid including the possibility of adaptation of the place of residence). If the person in need decides for cash-benefits to be used for informal domestic care, 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, These will be decided after the findings of a project based on a micro-simulation model carried out by the Institute for Economic Research are available.

The new system should encourage more responsible health behaviour of individuals (through differentiated insurance payments), and enable introduction of systematic prevention, development of rehabilitation services and the use of ICT in the LTC.

Merging of different sources of financing of LTC 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). More systematic preventive activities (healthy ageing), rehabilitation and the use of ICT should additionally decrease the costs of LTC.

However, one of the crucial issues related to the reform of LTC is still how to separate the costs of LTC system from the costs of the health care system and how to ensure additional, stable source which would slow down rapidly increasing annual household expenditures for long-term care.

Challenges

Slovenia has a relatively fragmented system of LTC, with future sustainability concerns, especially in light of high out-of-pocket payments. The main challenges of the system in 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 to deliver high-performing long-term care services to face the growing demand for LTC services; to strategically integrate medical and social services via such a legal framework; 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; to establish good information platforms for LTC users and providers; 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.

- **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 to institutional care by e.g. developing new legislative frameworks encouraging home care and regulation controlling admissions to institutional care or the establishment of additional payments, cash benefits or financial incentives to encourage home care; to monitor and evaluate alternative services, including incentives for use of alternative settings; 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 focused use of budgets negotiated ex-ante or based on a pre-fixed share of high-need users.

- **Improving value for money:** to encourage competition across LTC providers to stimulate productivity enhancements. 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.**

Table 2.25.1: **Statistical Annex – Slovenia**

GENERAL CONTEXT

GDP and Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
GDP, in billion euro, current prices	26	28	29	32	35	38	36	36	37	36	36	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	21.1	22.1	22.8	23.4	24.0	23.7	20.5	21.1	21.3	21.3	21.0	26.8	27.6	28.0	28.1	27.9
Population, in millions	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.1	2.1	2.1	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	0.8	0.8	0.9	0.8	0.8	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	:
Per capita PPS	134.7	149.2	167.2	168.5	176.3	193.8	191.3	198.5	207.2	:	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	1.8	2.0	1.9	1.9	2.0	2.0	2.0	2.0	:	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	80.3	80.8	80.9	82.0	82.0	82.6	82.7	83.1	83.3	83.3	83.6	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	72.5	73.5	73.9	74.5	74.6	75.5	75.9	76.4	76.8	77.1	77.2	76.6	76.9	77.3	77.4	77.8
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	:	62.6	62.1	62.1	61.5
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	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	:	30.7	36.5	37.7	39.3	30.9	36.1	36.3	35.3	31.6	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	:	9.6	8.4	7.9	9.7	10.5	12.1	13.0	11.5	9.5	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
Number of people receiving care in an institution, in thousands	:	:	:	:	8	14	19	24	21	21	22	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	12	12	13	14	40	38	38	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	1.0	1.3	1.6	1.9	3.0	2.9	2.9	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.25.2: **Statistical Annex - continued – Slovenia**

PROJECTIONS

Population	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**MS Change 2013-2060**	**EU Change 2013-2060**
Population projection in millions	2.1	2.1	2.1	2.1	2.1	2.0	-1%	3%
Dependency								
Number of dependents in millions	0.23	0.25	0.28	0.29	0.30	0.30	30%	40%
Share of dependents, in %	11.3	12.1	13.2	14.2	14.6	14.8	31%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	1.4	1.7	1.9	2.4	2.7	2.9	103%	40%
AWG risk scenario	1.4	1.7	2.2	2.9	3.6	4.2	190%	149%
Coverage								
Number of people receiving care in an institution	21,902	24,722	29,383	36,239	41,040	43,292	98%	79%
Number of people receiving care at home	38,410	44,467	50,743	58,739	63,705	65,890	72%	78%
Number of people receiving cash benefits	46,851	55,494	65,594	78,845	92,761	99,637	113%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	5.2	6.0	7.0	8.4	9.5	10.2	97%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	46.2	49.5	52.9	58.9	65.5	69.3	50%	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	64.5	63.6	62.9	63.2	61.4	60.0	-7%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	35.5	36.4	37.1	36.8	38.6	40.0	13%	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	66.8	67.4	68.2	69.5	70.0	70.3	5%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	33.2	32.6	31.8	30.5	30.0	29.7	-10%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	58.2	60.2	59.4	60.3	59.5	57.8	-1%	-2%
Unit costs of home care per recipient, as % of GDP per capita	16.5	16.2	16.0	16.3	16.4	16.1	-2%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	22.4	22.8	23.0	23.2	23.6	23.9	7%	-2%

(1) Projected public expenditure as % GDP includes public expenditure on long-term care based on SHA (1.0%) and also a component from ESSPROS (economic integratoin of the handicapped, 0.4%).