European Commission









State of Health in the EU

Slovenia

Country Health Profile 2019

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European Observatory on Health Systems and Policies
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The Country Health Profile series

The *State of Health in the EU*'s Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policymakers and influencers with a means for mutual learning and voluntary exchange.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Information.

Contents

1. HIGHLIGHTS 3
2. HEALTH IN SLOVENIA 4
3. RISK FACTORS 7
4. THE HEALTH SYSTEM 8
5. PERFORMANCE OF THE HEALTH SYSTEM 12
   5.1 Effectiveness 12
   5.2 Accessibility 16
   5.3 Resilience 18
6. KEY FINDINGS 22

Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 28 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in August 2019, based on data available in July 2019.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following URL into your Internet browser: http://www.oecd.org/health/Country-Health-Profiles-2019-Slovenia.xls

Demographic and socioeconomic context in Slovenia, 2017

Demographic factors	Slovenia	EU
Population size (mid-year estimates)	2 066 000	511 876 000
Share of population over age 65 (%)	18.9	19.4
Fertility rate[1]	1.6	1.6
Socioeconomic factors		
GDP per capita (EUR PPP[2])	25 500	30 000
Relative poverty rate[3] (%)	13.3	16.9
Unemployment rate (%)	6.6	7.6

1. Number of children born per woman aged 15-49. 2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. 3. Percentage of persons living with less than 60 % of median equivalised disposable income.
Source: Eurostat Database.

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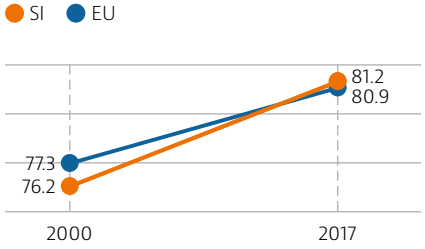
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1 Highlights

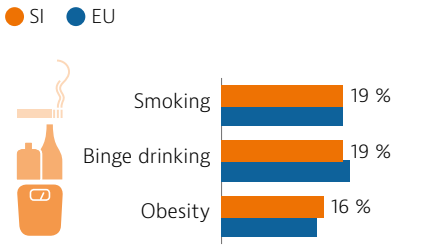
Average life expectancy in Slovenia has increased rapidly in the last decade, but morbidity and mortality due to behavioural risk factors are on the rise. Social Health Insurance is compulsory with a single payer system and covers virtually all permanent residents. Slovenia is taking steps to prepare its health system to address the needs of a fast-ageing population and growing numbers of people with chronic conditions by improving health promotion and care coordination. Creating a strong primary care system has been a major focus for health policy reforms.



Life expectancy at birth, years

Health status

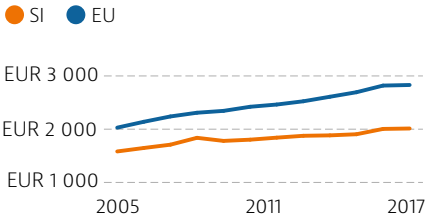
Life expectancy at birth was 81.2 years in 2017, up from 76.2 years in 2000. Slovenia has reached important milestones, including substantial reductions in mortality from major causes, especially ischaemic heart disease and stroke. The growing burden of lung cancer in women and the comparatively lower proportion of healthy life years for older people are still of concern, as more than half of the years lived after age 65 are impacted by disability.



% of adults

Risk factors

In 2014, 19 % of adults smoked every day, the same as the EU average. Binge drinking among adults was below the EU average in 2014, but considerably more adolescents reported excessive episodic drinking than in other EU countries. In Slovenia, addressing overweight and obesity is considered a priority. In 2017, 16 % of adults were obese. Most risk factors in Slovenia are more common among individuals with only primary education, contributing to inequalities in health.



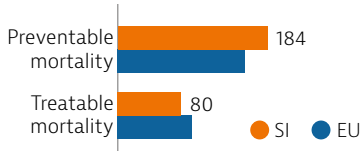
Per capita spending (EUR PPP)

Health system

Health spending has slowly increased since 2006, although it remains below the EU average. In 2017, Slovenia spent EUR 2 060 per capita on health, compared to an EU average of EUR 2 884. While the public share of health spending is below the EU average of 79.4 %, it has gradually grown since 2014 and reached 72.2 % in 2017. The majority of the population also purchases complementary Voluntary Health Insurance, mainly to cover co-payments. Slovenia has one of the lowest rates of out-of-pocket spending in the EU, at just 12.3 % of current health expenditure.

Effectiveness

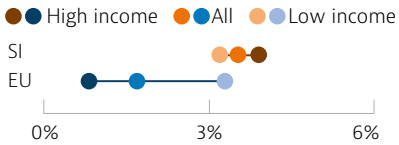
Concerted efforts on intersectoral policies and preventive measures have contributed to declines in preventable mortality, although it remains above the EU average. The rate of avoidable hospital admissions is below the EU average, pointing to an effective primary care system.



Age-standardised mortality rate per 100 000 population, 2016

Accessibility

Among the efforts to address long waiting times, which is the main challenge in accessing health care services, plans are underway to tackle the shortfall of health care professionals, especially general practitioners. Notably, the reported difference in access to medical services across income groups is one of the smallest in the EU.



% reporting unmet medical needs, 2017

Resilience

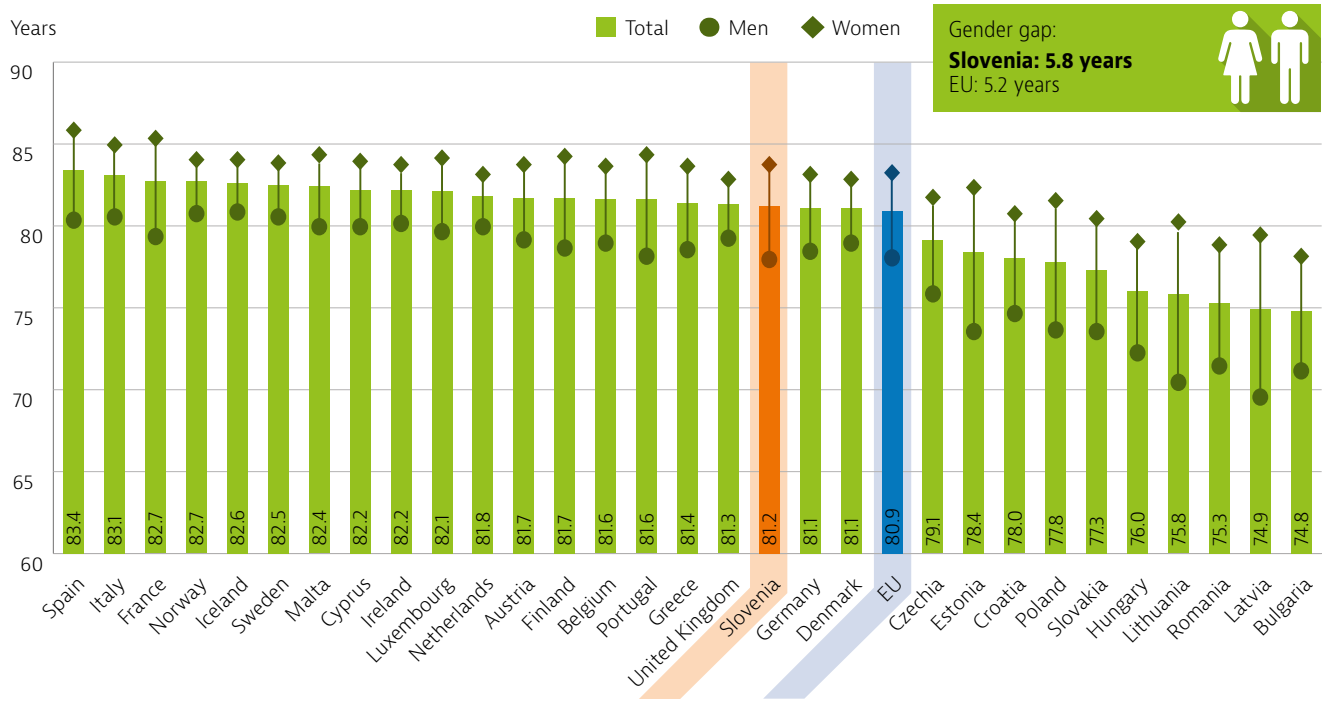
Securing long-term fiscal sustainability of the health system continues to be a priority, particularly considering population ageing. Slovenia also lacks key legislation for long-term care and integration of services.

2 Health in Slovenia

The life expectancy of Slovenians has risen remarkably since 2000

The population of Slovenia has experienced considerable and continuous health gains since 2000. Life expectancy at birth increased by five years between 2000 and 2017 (from 76.2 years to 81.2 years), one of the highest increases in the EU during that period. As a result, life expectancy in Slovenia is slightly higher than the EU average (Figure 1). Although the gender gap in life expectancy at birth has decreased by 1.9 years since 2000, Slovenian men live about 6 years less than women (78.2 compared to 84 years).

Figure 1. Life expectancy has overtaken the EU average but a considerable gender gap persists



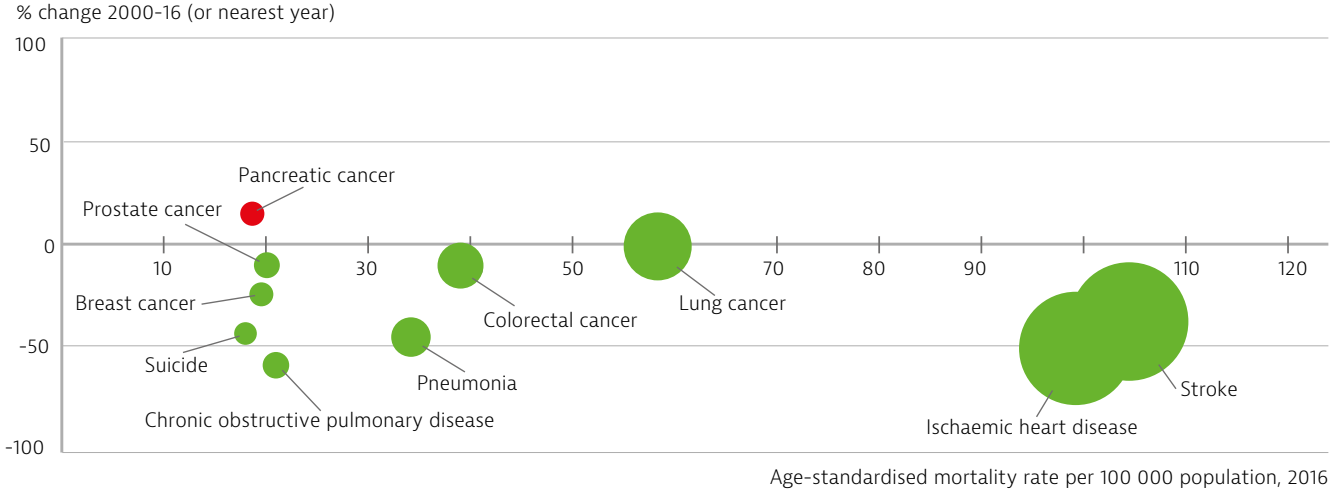
Source: Eurostat Database.

Ischaemic heart disease and stroke are the two leading causes of mortality

Cardiovascular diseases remain the main causes of death in Slovenia, despite steep reductions in mortality rates since 2000. In 2016, ischaemic heart disease was responsible for one in ten deaths, with a similar mortality rate reported for stroke (Figure 2). Although only mortality from pancreatic cancer increased in the period 2000-16 among the ten leading causes of death, lung cancer mortality is increasing among women and lung cancer remains the most frequent cause of death by cancer among Slovenians.

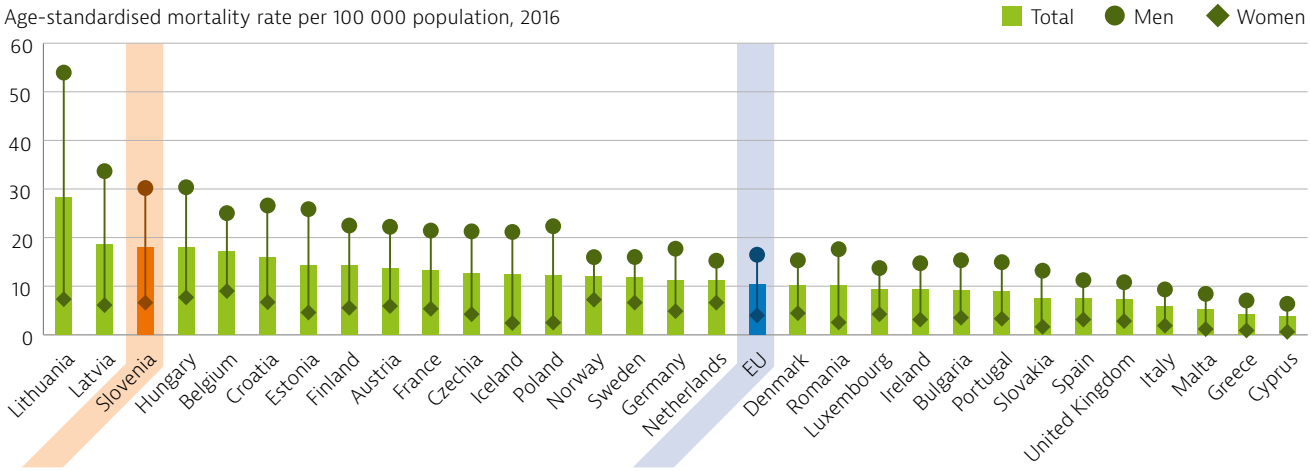
Progress has been achieved in reducing mortality rates due to suicide, which decreased by more than 40 % between 2000 and 2016. The most pronounced drop was after 2006, when a comprehensive community programme for early detection and treatment of depression was introduced. Yet, in 2016 the suicide rate in Slovenia was the third highest in the EU (18.1 per 100 000 population, compared to the EU average of 10.3 per 100 000) (Figure 3). The importance of the issue is recognised by the health authorities, and a comprehensive suicide prevention programme is in place (Section 5.1).

Figure 2. Mortality from all leading causes has fallen – only pancreatic cancer continues to rise



Note: The size of the bubbles is proportional to the mortality rates in 2016.
Source: Eurostat Database

Figure 3. Despite improvements, the suicide rate is still high, particularly among men



Source: Eurostat Database (data refer to 2016 or the nearest years).

Inequalities in self-reported health status across income groups are substantial

In 2017, almost two thirds (65.3 %) of adults in Slovenia reported being in good health, slightly below the EU average (69.7 %) (Figure 4). However, as in most other countries, the proportion of people who report being in good health varies substantially across income groups. Only 51.4 % of people in the lowest income quintile considered themselves to be in good health, compared to 77.1 % in the highest income quintile. Both proportions are below the respective EU averages (61.2 % and 80.4 %).

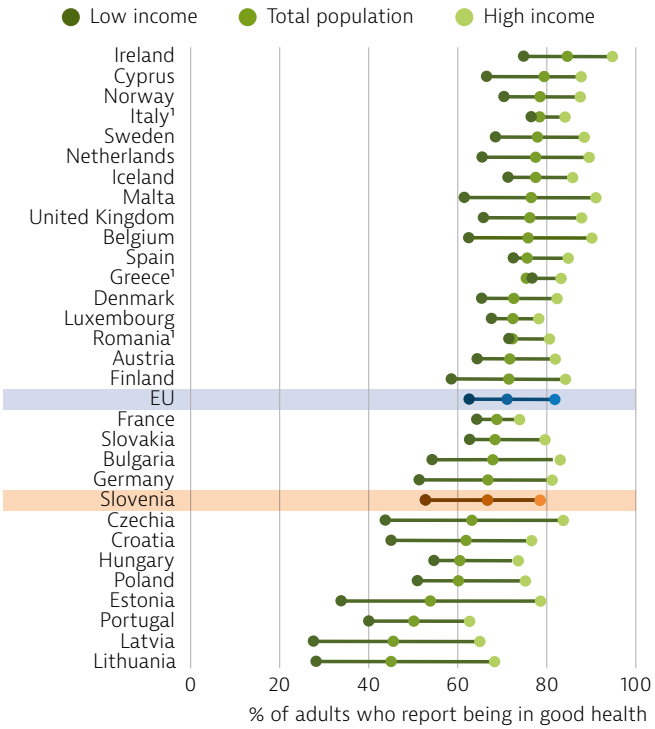
Women over 65 years of age spend more years living with disabilities

Despite the rapid increase in life expectancy in recent years in Slovenia, there are challenges in preserving good health in those additional years of life gained. In 2017, Slovenians aged 65 could expect to live an additional 19.8 years (Figure 5), similar to the EU as a whole, and up from 16.9 years in 2000. However, more than 12 of these years are lived with disabilities. The gender gap in life expectancy at age 65 is still considerable, as men's life expectancy at that age is almost four years lower than women's. Yet, there is no difference between men and women in the number of healthy life years[1], as women live a greater part of their lives with some disabilities.

1: 'Healthy life years' measures the number of years that people can expect to live free of disability at different ages.

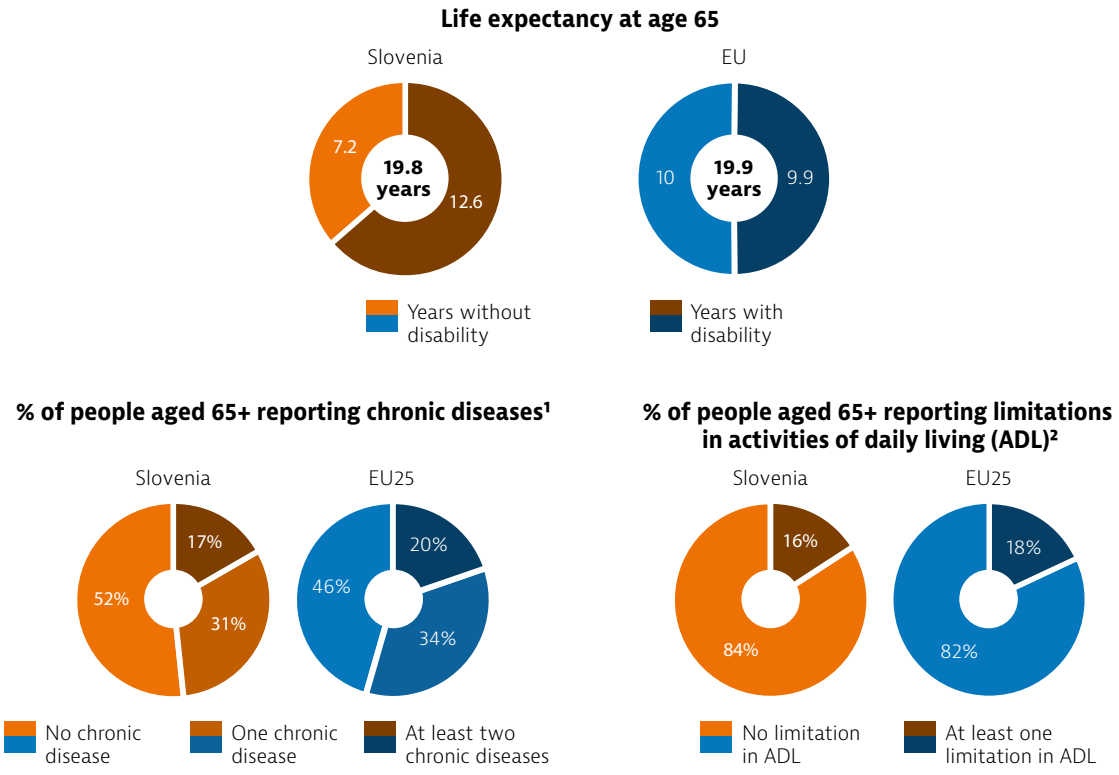
Overall, just over half of people aged 65 and over reported that they had no chronic diseases, which is higher than in the EU as a whole (46 %). Of those who do, around 17 % reported having two or more. Most people are able to continue to live independently in old age, but one in six people report some limitations in basic activities of daily living, such as dressing and showering, that may require long-term care. This proportion is nearly the same as in other EU countries.

Figure 4. The proportion of Slovenians reporting to be in good health is lower than the EU average



Note: 1. The shares for the total population and the population on low incomes are roughly the same.
Source: Eurostat Database, based on EU-SILC (data refer to 2017).

Figure 5. More than half of life lived after 65 is spent with health issues disabilities



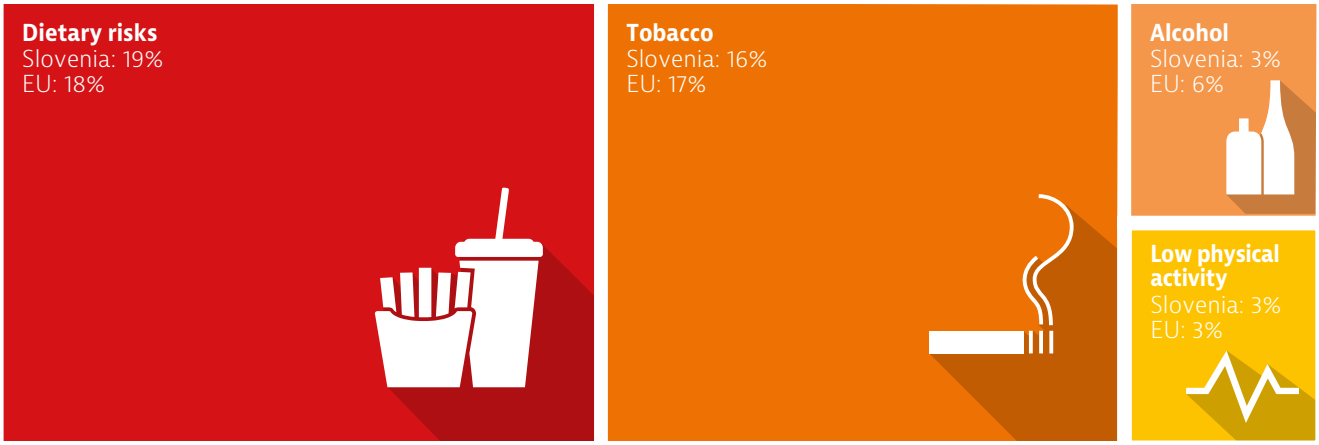
Notes: 1. Chronic diseases include heart attack, stroke, diabetes, Parkinson disease, Alzheimer's disease, rheumatoid arthritis and osteoarthritis. 2. Basic activities of daily living include dressing, walking across a room, bathing or showering, eating, getting in or out of bed and using the toilet.
Source: Eurostat Database for life expectancy and healthy life years (data refer to 2017); SHARE survey for other indicators (data refer to 2017).

3 Risk factors

More than one third of all deaths are related to behavioural risk factors

Estimates show that around 37 % of all deaths in Slovenia can be attributed to behavioural risk factors (Figure 6), similar to the EU average of 39 %. About 19 % of all deaths in 2017 were connected to dietary risks such as low fruit and vegetable intake, as well as high sugar and salt consumption. Tobacco (including direct and second-hand smoking) was responsible for an estimated 16 % of all deaths, while alcohol and low physical activity each contributed to about 3 % of all deaths.

Figure 6. Dietary risk factors lead the burden of mortality from behavioural risks



Note: The overall number of deaths related to these risk factors (7 500) is lower than the sum of each one taken individually (8 000), because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable consumption and high sugar-sweetened beverages consumption.
Source: IHME (2018), Global Health Data Exchange (estimates refer to 2017).

Overweight and obesity rates are higher in Slovenia than in most EU countries

In 2017, 16 % of adults in Slovenia were obese, which is above the EU average (15 %) (Figure 7). One fifth of Slovenian 15-year-olds were overweight or obese in 2013-14, a substantial increase since 2001–02. However, according to a national evaluation in 2015, the growing trend in overweight and obesity rates among children and adolescents has reversed since 2010 (WHO, 2016). The government has developed a comprehensive, multisectoral National Nutrition and Physical Activity Strategy 2015-25 to improve the nutrition and exercise habits of the population and to tackle growing obesity levels (Section 5.1). Physical activity and consumption of fruit and vegetables among adults is relatively high. The proportion of physically inactive adults is highest among those with lower education, while the reverse is true for adults with higher educational attainment (Ministry of Health, 2015).

Smoking among teenagers is higher than the EU average

In 2014, nearly one in five Slovenian adults reported smoking daily. The percentage of adults who smoke on a daily basis has dropped since the early 2000s, and is now on par with the EU average (19 %). Smoking among adolescents, and in particular among girls, is also higher than in many other EU countries. In 2015, one quarter of 15- to 16-year-old girls reported they had smoked in the past month, a much greater proportion than boys (19 %). In response, a stronger tobacco control law was passed in 2017, which also regulated the sale of e-cigarettes, especially important given the increasing popularity among teenagers (Section 5.1).

Excessive alcohol consumption, especially among teenagers, is an important public health issue

In 2014, almost one in five Slovenian adults reported episodic heavy alcohol consumption (binge drinking)[2] at least once a month, which is just below the EU average. As is the case with many other risk factors, there is a stark difference between rates reported

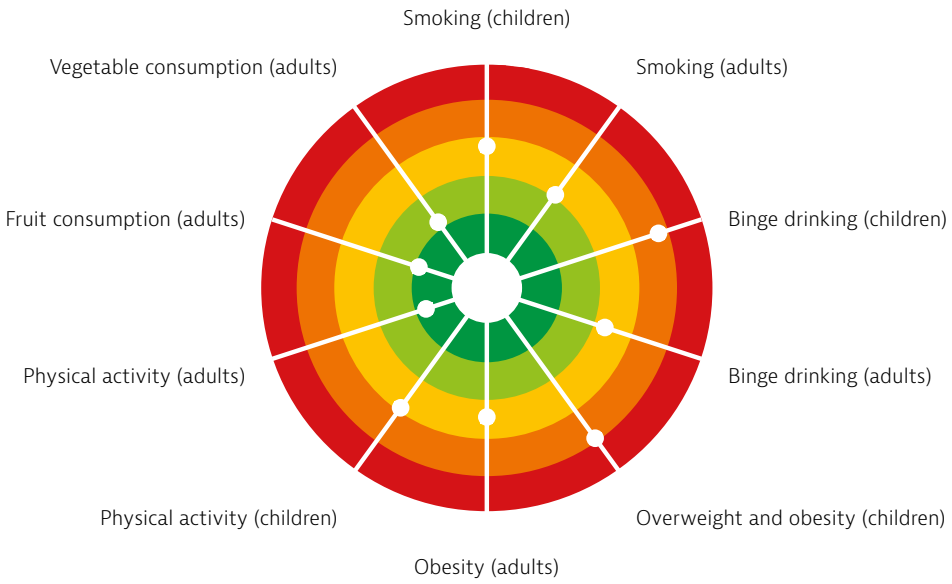
2: Binge drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults and five or more alcohol drinks for children.

by men and women (29 % for men but 10 % for women). Binge drinking among teenagers is even more concerning. More than two fifths of adolescents in Slovenia reported at least one episode of binge drinking during the past month in 2015, a higher frequency than in most other EU countries. Binge drinking remains an important issue considering the increased risk of accidents and injuries related to heavy alcohol consumption.

Slovenia is taking steps to address socioeconomic inequalities in health risks

Many behavioural risk factors in Slovenia are more common among people with lower education or income. In 2014, one in six adults (17 %) who had not completed their secondary education smoked daily, compared to 12 % among those with a tertiary education. Similarly, in 2017 about 21 % of people without a secondary education were obese, compared to only 10 % among those with a higher education. This higher prevalence of risk factors among socially disadvantaged groups contributes to inequalities in health and life expectancy in most European countries. Slovenia is attempting to reduce this inequality gap by using European structural and investment funds for the modernisation and development of comprehensive, equity-based community health and social care.

Figure 7. Smoking, excessive alcohol consumption and obesity are leading risk factors in Slovenia



Note: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white 'target area' as there is room for progress in all countries in all areas.
Source: OECD calculations based on ESPAD survey 2015 and HBSC survey 2013–14 for children indicators; and EU-SILC 2017, EHIS 2014 and OECD Health Statistics 2019 for adults indicators.

4 The health system

Shifting demographics emphasise the need for structural reforms

Slovenia has mandatory Social Health Insurance (SHI) operated by a single purchaser, the Health Insurance Institute of Slovenia (HIIS). Virtually every resident is covered under the single compulsory insurance scheme. About 95 % of the population also purchases complementary Voluntary Health Insurance (VHI), mainly to cover co-payments, which is the highest share in the EU. There is an ongoing debate on the long-term fiscal sustainability of the health system, given that Slovenia relies almost exclusively on payroll contributions to fund its system, but has one of the fastest ageing populations in the EU (European Commission, 2019a and Box 1).[3]

3: *Although it is acknowledged that increasing health system funding does not, per se, ensure future fiscal sustainability.*

Box 1. Proposed reforms to tackle fiscal sustainability and long-term care are stalling

Given the susceptibility of health sector revenues to labour market fluctuations, the draft Health Care and Health Insurance Act proposed measures to diversify funding streams, such as replacing the current form of supplementary health insurance with a compulsory income-dependent contribution. Drafted in 2016 and submitted for consultation in 2017, progress came to a halt following general elections in June 2018 and the establishment of a new government in September 2018. In 2019, the government discussed the proposed changes of the Health Care and Health Insurance Act, which would abolish complementary health insurance. At the time of writing, the final proposal has not been submitted or approved. Similarly, the issue of future fiscal sustainability is still unresolved.

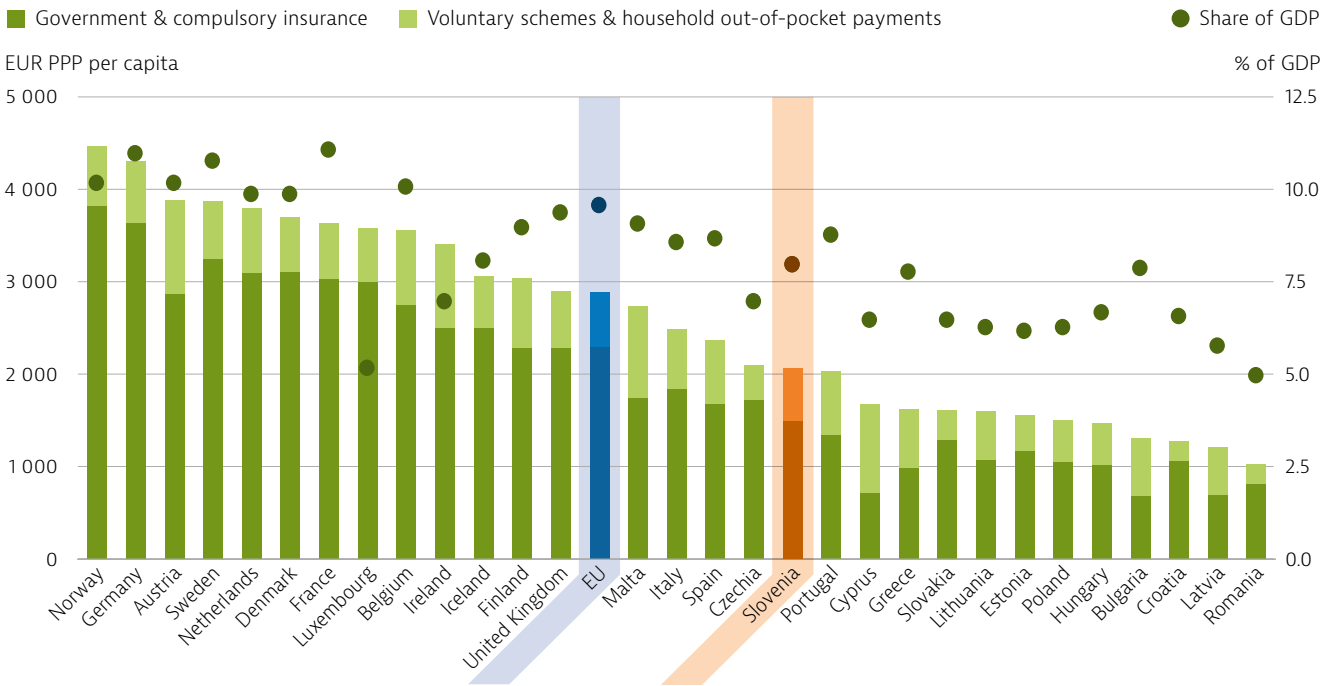
At present, there is no single overarching regulation on long-term care and its financing. First drafted in October 2017, work on a Long-term Care Act is still in progress. While a two-year pilot project was initiated in 2018, the government plans to deal with legislation on long-term care only after the adoption of a new Health Care Act. Therefore, a legislative proposal on long-term care is expected in 2020. These delays are a setback in implementing reforms in health and long-term care that ensure quality, accessibility and long-term fiscal sustainability (Council of the European Union, 2019).

The health system is relatively centralised, and the Ministry of Health is responsible for health legislation, planning, implementation, and regulation. Municipalities are in charge of organisation and provision of primary care, but they play a limited role in decision making in the health system. The state owns almost the entire hospital capacity, most of the outpatient specialist care sector and the entire sector of tertiary care.

The share of public spending has grown, nevertheless private spending is high

In line with overall economic growth, health expenditure has slowly increased in Slovenia. At EUR 2 060, health expenditure per capita in 2017 was about 25 % less than the EU average. Health spending as a share of GDP was 8.2 %, also below the EU average (9.8 %, Figure 8). Nevertheless, health expenditure as a share of GDP as well as per capita was higher in Slovenia than most of the Member States that joined the EU in 2004 and after, including neighbouring countries Croatia and Hungary.

Figure 8. Health expenditure in Slovenia is the third highest among the newer Member States



Source: OECD Health Statistics 2019 (data refer to 2017).

Increasing the share of public financing for health care is a top priority on the new government's agenda. Although the public share of health spending has slowly grown since 2014, reaching 72.2 % in 2017, it is below the EU average (79.3 %). Private sources of health care financing accounted for 27.8 % of total health spending compared to 20.7 % in the EU. However, about half of private spending comes from VHI, which accounts for 14.3 % of current health expenditure, the highest share in the EU. Other private spending comes almost entirely from out-of-pocket expenditure (12.3 %), which is one of the lowest in Europe.

Slovenia has virtually universal coverage and a comprehensive benefit package

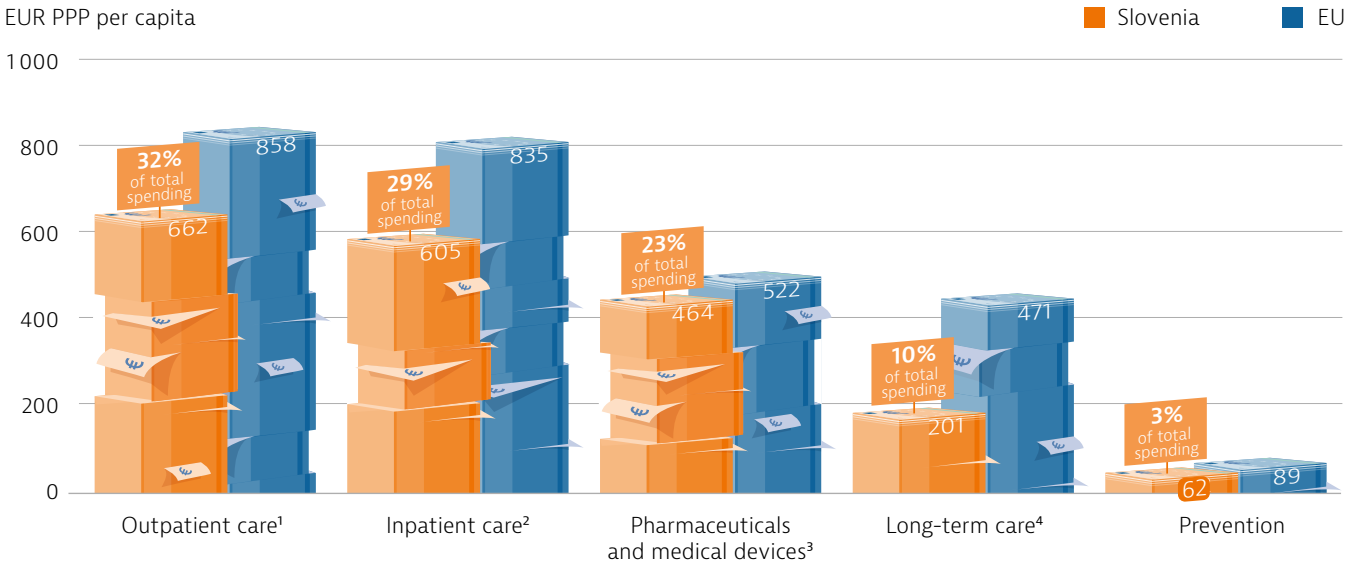
Practically every permanent resident in Slovenia is covered under the single compulsory insurance scheme, and opting out is not allowed. According to the Annual Business Report of the HIIS, at the end of December 2018, 3 430 people were uninsured (0.17 %), mostly due to unclear residence status or unpaid health insurance for more than two months (Section 5.2) (Health Insurance Institute of Slovenia, 2019). The insured population is entitled to a benefit package that includes primary, secondary and tertiary services, pharmaceuticals, medical devices, sick leave exceeding 30 days, and costs of travel to the closest health facilities for their conditions.

Slovenia is among the few EU countries to have shifted spending to outpatient care

The main categories of health spending in 2017 were outpatient and inpatient care (Figure 9). Since 2010, financial incentives (such as case-based payments for surgical procedures delivered in ambulatory care) have been in place to encourage a shift away from inpatient care to day surgery or ambulatory care. Accordingly, inpatient care as a share of current expenditure in health decreased by almost 3 percentage points in 2017 compared to 2010, while outpatient care increased by almost 5 percentage points during the same period, resulting in shares (29.4 % for inpatient and 32.1% for outpatient) that are similar to the EU averages (28.9 % and 29.7 %).

Although in absolute terms Slovenia spent less on prevention per capita than the EU average (EUR 62 and EUR 89, respectively) in 2017, this accounted for 3.0 % of total health expenditure, which is in line with the EU average (3.1 %). However, spending on long-term care, which is especially important when facing a rapidly ageing population, still accounts for a limited share (9.8 %), and is less than half of EU average spending (Figure 9). Spending on long-term care is financed primarily out of pocket by users, and such outlays are growing.

Figure 9. Spending on long-term care is less than half the EU average



Note: Administration costs are not included. 1. Includes home care; 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the outpatient market; 4. Includes only the health component.
Sources: OECD Health Statistics 2019, Eurostat Database (data refer to 2017).

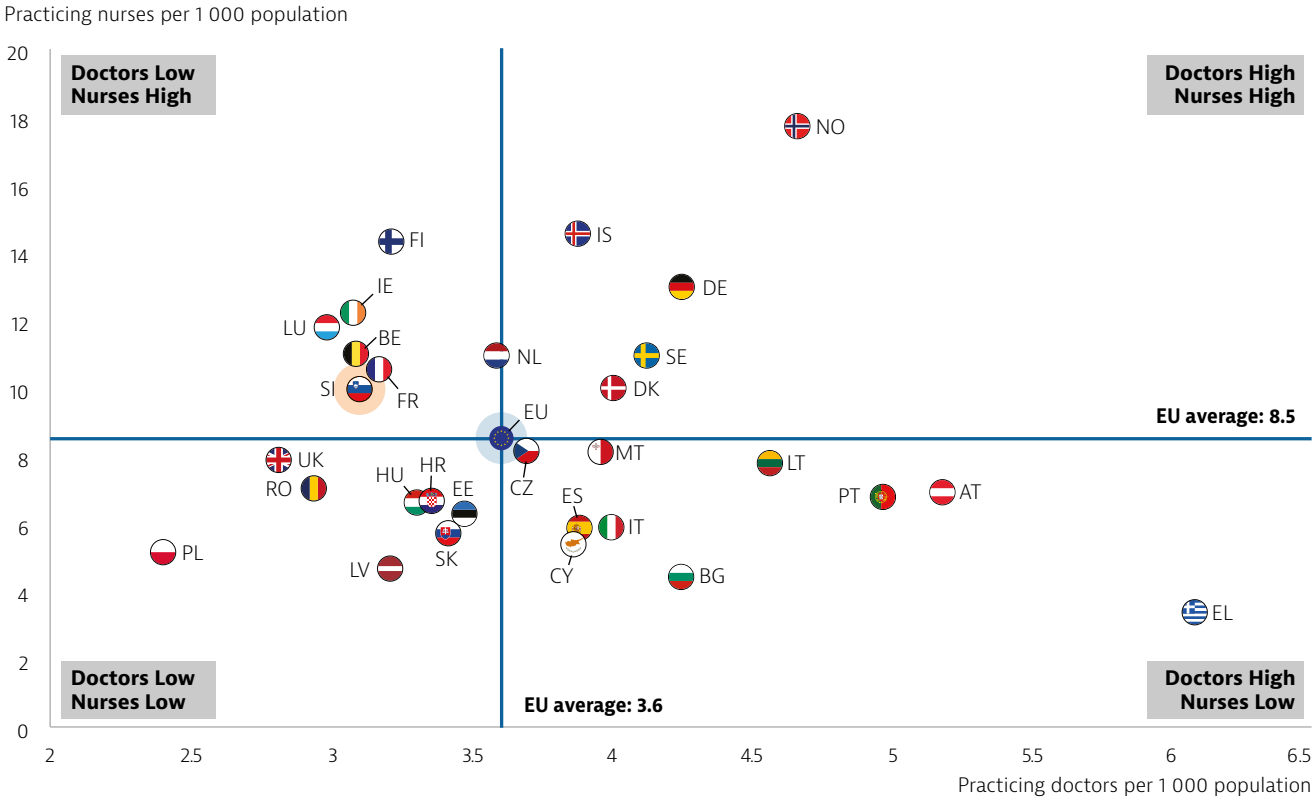
The majority of Slovenians invest in complementary Voluntary Health Insurance

The health system provides near universal coverage, but there are relatively high levels of cost-sharing. Primarily in order to cover co-payments, the majority of the population pays for VHI, and there are arrangements in place for individuals who cannot afford the cost. Given the high enrolment in VHI, direct out-of-pocket (OOP) payments are comparatively low (12.3 % of current health expenditure compared to 15.8 % EU average in 2017) (Section 5.2).

Plans to address the shortage of doctors are under way

The number of doctors in Slovenia (3.1 per 1 000 population) is well below the EU average (Figure 10). Patients report difficulties registering with a general practitioner (GP), even in dense urban areas. These issues escalated after an agreement with the Ministry of Health to adopt a lower workload per GP, which unmasked a deficit of almost 400 GPs (one third of the total workforce). As an immediate solution was lacking, several GPs threatened to resign from their posts. Activities are under way to try to prevent this from happening. The GP specialty was not a popular choice due to a previous remuneration scheme for salaries and pensions being linked to years in training (four years for GPs as opposed to six years for other specialties). This compensation issue has now been addressed and more GPs are currently being trained. In contrast, Slovenia can rely on a higher number of nurses (9.9 per 1 000) than the EU average (8.5). However, this figure should be interpreted carefully as it also includes the number of vocationally trained nurses and their share is around two thirds of all staff in nursing care. The number of registered nurses, compliant with the Directive on regulated health professions, remains at around 3.4 per 1 000 population.

Figure 10. The number of nurses is higher than EU average, while the number of doctors trails behind



Note: In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30% in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital. In Slovenia as in some other countries, the number of nurses includes nursing staff who have completed only vocational training and are not compliant with the Directive on regulated health professions.
Source: Eurostat Database (data refer to 2017 or the nearest year).

Long waiting lists for certain services in the public health care network are still problematic

Long waiting lists represent a persistent issue in the Slovenian health system. Despite the Ministry of Health's attempts to reduce them by pressing the HIIS to allocate additional money, especially for diagnostic services, effective incentives in the public system are currently missing, which threatens system sustainability (see Section 5.3). Further, a rise in the number of patients with chronic conditions is creating an increased workload for the already low number of GPs, which in turn results in more specialist referrals and longer waiting times. As GPs act as gatekeepers for accessing specialised care, an increase in the supply of GPs would also ensure an improved control of specialist referrals (European Commission, 2019c).

Health education centres further strengthen primary health care

Health education centres (HECs) have been operating since 2002 and use a context-specific, multidisciplinary approach to health promotion and disease prevention programmes in community settings. While initially HECs focused on providing lifestyle interventions for patients at risk for non-communicable diseases (NCDs), the programme evolved to strengthen the focus on inequalities, and extended its scope to include the healthy population. There are plans to scale up HECs, transform them into Health Promotion Centres (HPCs) and extend the new model for health promotion and disease prevention to all primary health care centres with support from the European Structural and Investment Funds (WHO Regional Office for Europe, 2018) (see Section 5.3). Other initiatives to improve coordination and integration of care include the GP model practice (see Box 3), which also allowed for the establishment of protocols for patients' management, chronic patient registers, and the development of indicators for quality monitoring.

5 Performance of the health system

5.1 Effectiveness

Current reorientation towards prevention can further decrease preventable mortality

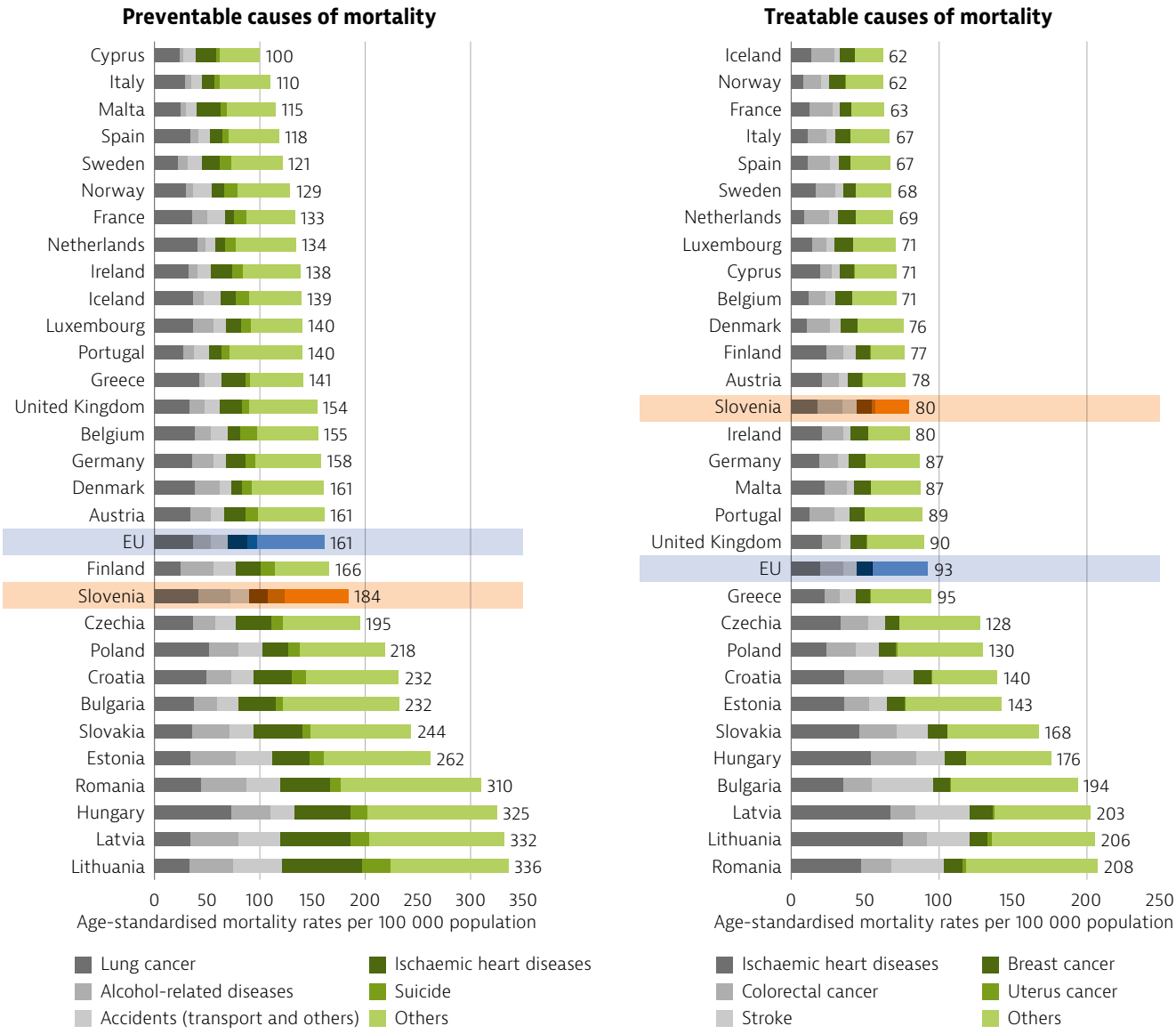
In 2016, the rate of preventable mortality that could have been averted through public health and primary prevention interventions was higher in Slovenia than the EU average (Figure 11), but has reduced by about 12 % since 2011. While this signals progress, there is further scope for improvement. Much is expected from the introduction of GP model practices (see Section 5.3) and health promotion centres, which should boost prevention efforts through improved screening, counselling, immunisation and increased care coordination (European Commission, 2019b). The substantial differences in preventable mortality between men and women is particularly striking, as men report systematically higher rates of ischaemic heart disease, lung cancer, accidents, alcohol-related disorders, and suicide.

Advocacy and intersectoral cooperation have contributed to the policy response on tobacco control and alcohol regulation, despite lobbying from interest groups. Smoking levels have declined, although lung cancer is still a top cause of preventable mortality. Alcohol consumption remains high, and the rate of preventable deaths due to alcohol-related diseases is almost double the EU average. Although Slovenia has introduced several measures to limit alcohol misuse, it still lacks excise duty on wine, and recently, after an 18-year ban, a proposal was passed that allowed beer and wine to be sold at sports events.

Mortality from treatable causes has declined and is now well below the EU average

In Slovenia, rates of avoidable deaths from treatable causes (that is, causes of deaths that can be avoided through timely and effective care) have been steadily decreasing, and in 2016 were below the EU average, suggesting relatively effective health care. Ischaemic heart disease and colorectal cancer accounted for the largest share of these deaths, followed by stroke and breast cancer (Figure 11).

Figure 11. Preventable mortality rates are higher than the EU average while mortality from treatable causes is lower



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Mortality from treatable (or amenable) causes is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.
Source: Eurostat Database (data refer to 2016).

Despite suicide prevention programmes, suicide rates are still double the EU average

Suicide rates in Slovenia have been declining but are still double the EU average (Figure 3). Rates are also about four times higher for men than women. There are also differences in suicide rates among regions, with the central-eastern part of the country reporting higher suicide rates. In response, a number of suicide prevention campaigns and interventions with a multi-level approach have been implemented. In particular, a programme launched in 2006 focused on training GPs to improve their capacity to identify early signs of depression (since GPs have a gatekeeping role and can refer to a psychiatrist if needed). De-stigmatisation of mental health was also aided by improved quality of treatment.

The Slovenian government has taken action on nutrition and physical activity

In an effort to tackle the growing burden of chronic disease and obesity, the parliament adopted the National Programme on Nutrition and Physical Activity for Health 2015–20, based on a life-course approach to promote healthy lifestyles (Ministry of Health, 2015). However, adequate mechanisms to measure the effectiveness of programme implementation are

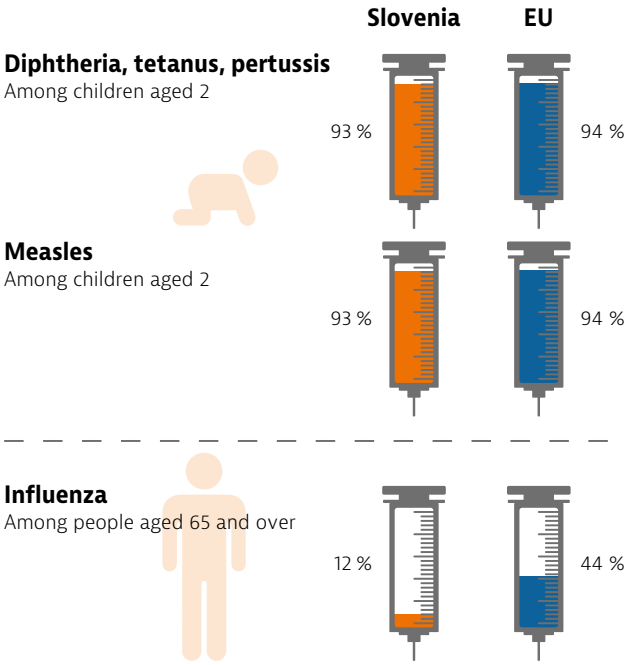
not fully in place. A main focus of the Programme addresses socioeconomic disparities through measures to provide equitable health opportunities to the population in these areas. There are also national programmes and projects in schools all over Slovenia promoting healthy eating (e.g. hot meals in all primary and secondary schools with a focus on equity) and physical activity (e.g. SLOfit surveillance system). The urgency of the chronic disease and obesity problem has led to negotiations with the food and beverage industry. From 2015, the industry has voluntarily agreed to restrict soft drink advertising in school settings as well as in magazines and cinemas for children under the age of 12 (OECD, 2017).

Vaccination rates against influenza among older adults are well below the EU average

Slovenia has one of the lowest rates of vaccination against influenza among those aged 65 and over, with only 12 % coverage compared to 44 % on average in the EU (Figure 12), and even further from the WHO target of 75 %. Low perception of risks affects vaccination coverage among older people, and the vaccination is not free of charge (the vaccine itself is covered, but individuals have to pay for its application, which in the season 2017/18 cost EUR 7 for this age group).

Mandatory childhood vaccinations are fully covered by national funding. Child vaccination rates against diphtheria, tetanus and pertussis are relatively high, although measles coverage is two percentage points lower than the 95 % target defined by WHO. The measles vaccine is mandatory and free of charge for children and students. However, several factors hinder improvements in vaccination coverage, including vaccine hesitancy and relative lack of disease knowledge, both among general population and health care professionals (Rechel, Richardson & McKee, 2018).

Figure 12. Immunisation rates for influenza are very low at only 12%, compared to the EU average of 44%

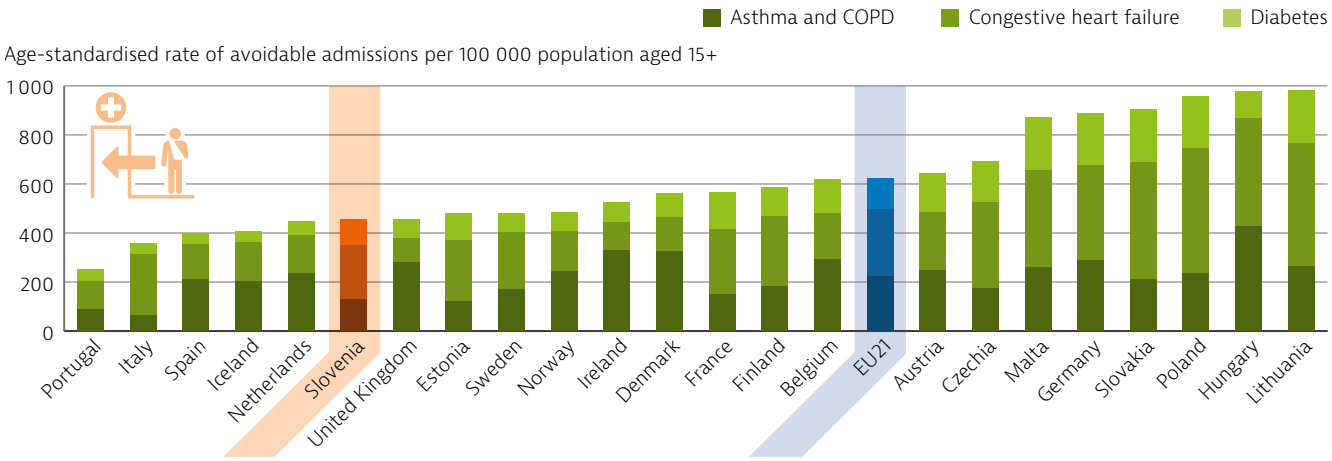


Notes: Data refer to the third dose for diphtheria, tetanus and pertussis, and the first dose for measles.
Source: WHO/UNICEF Global Health Observatory Data Repository for children (data refer to 2018); OECD Health Statistics 2019 and Eurostat Database for people aged 65 and over (data refer to 2017 or nearest year).

Comparatively low rates of hospitalisation reflect a strong primary care system

Slovenia performs well in terms of avoidable hospitalisations for asthma and chronic obstructive pulmonary disease (COPD), diabetes, and congestive heart failure (Figure 13). The rate of avoidable hospital admissions for these conditions is below EU average, which points to a relatively effective primary care sector.

Figure 13. Avoidable hospital admissions have declined and are now below EU average



Source: OECD Health Statistics 2019 (data refer to 2017 or nearest year).

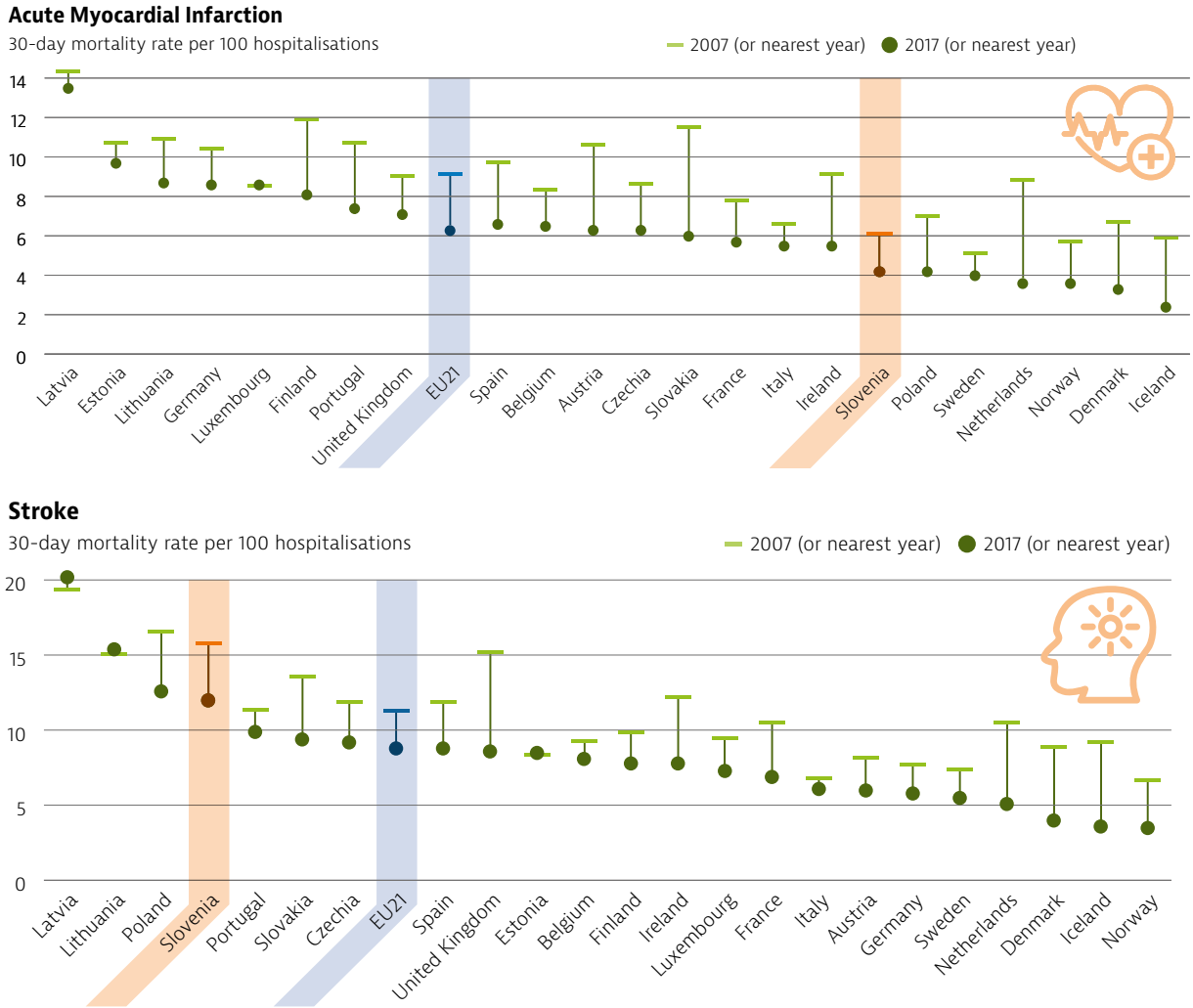
Cancer care is improving, also due to effective screening

There has been a steady improvement in five-year survival rates for lung, breast, colorectal and prostate cancer, and between 2010 and 2014 rates reached levels comparable to the EU average. Higher survival rates signal better quality of cancer care (i.e. more effective therapies), and also partly result from population-based screening programmes, which have an indirect impact on mortality by reducing the incidence of late stage cancers in a population. The screening programmes for cervical and breast cancer have higher participation rates than the EU averages. The national colorectal cancer screening programme started in 2009 and maintains a high participation rate, reaching 64.6 % in 2018 (National Institute of Public Health of Slovenia, 2019). Historically, colorectal cancer incidence and mortality were high, but data from the cancer registry for Slovenia shows a decrease in the incidence rate since 2011.

Mortality after stroke continues to be above the EU average

The 30-day mortality rates after hospital admission for heart attack and stroke provide an indication of hospital care quality and the effectiveness of medical interventions. In line with the reduction in treatable mortality from ischaemic heart disease, the death rate within 30 days of admission to hospital for acute myocardial infarction (AMI) in Slovenia is below many other EU countries. In contrast, the death rate within 30 days of hospitalisation for stroke is higher than the EU average (Figure 14). The "Telestroke" (*Telekap*) programme, in place since 2015, consists of early detection of signs of stroke and early administration of effective therapies, and should contribute to reducing this excess mortality.

Figure 14: Mortality rates following hospital admission for stroke show room for improvement



Note: Figures are based on admission data and have been age-sex standardised to the 2010 OECD population aged 45+ admitted to hospital for AMI and ischaemic stroke.
Source: OECD Health Statistics 2019.

Progress on implementing quality assurance is slow

Currently, there are no national standards set for health care quality. The Agency for Health Quality and Safety, proposed as part of the National Health Plan, has not yet been established. However, hospitals as well as some other health care providers, are accredited according to international standards (e.g. by the International Organization for Standardization). With technical support from the European Commission's Structural Reform Support Service, Slovenia has put in place some structures for monitoring the quality and safety of health care services (European Commission, 2019b). These include the annual collection and analysis of 78 quality indicators for hospitals, which have become a benchmarking tool for the convergence of quality in hospitals. With the introduction of GP model practices in 2011, a set of 35 quality indicators was developed to monitor quality in primary care.

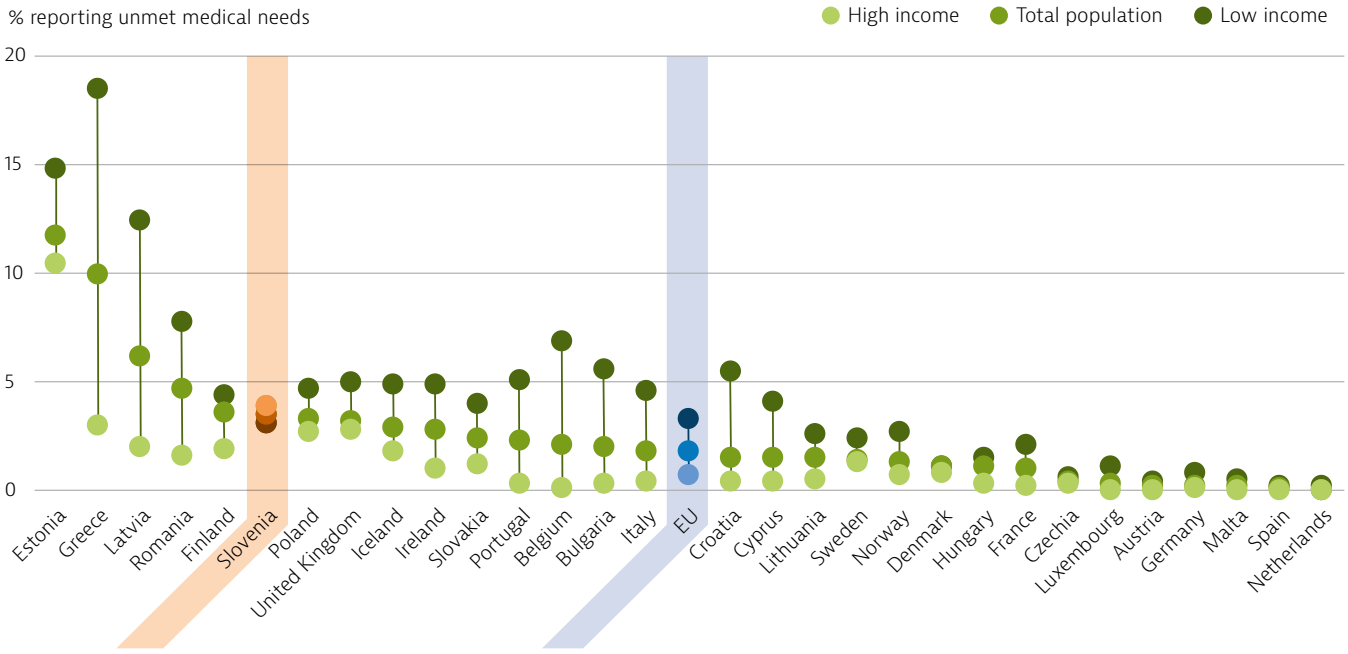
5.2 Accessibility

Long waiting times are the main driver of unmet medical and dental needs

In 2017, 3.5 % of the population reported some unmet needs for medical care due to financial reasons, distance or waiting times (Figure 15). This total is almost double the EU average (1.7 %). This jump from very low unmet medical needs observed in previous years (e.g. 0.4 % in 2016) is most likely linked to ambiguity in survey questions, which were corrected in 2016. Long waiting times were reported by 3.3 % of the population in 2017 as the main factor influencing unmet needs.

Notably, access to care shows only minimal variation among income groups. The most likely reason is that waiting times affect lower and higher incomes equitably in a system without many alternative private options. Evidence on the use of fully private health insurance or OOP payments to skip waiting lists is mainly anecdotal. Unmet dental needs are at a similar level, at 3.8 % in 2017, and were also driven by excessive waiting times. However, more people are willing to pay privately for dental care, and around 15 % of all dentists work exclusively for direct payment or private supplementary insurance schemes.

Figure 15. Unmet needs for medical care are very similar across income groups



Note: Data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used. In Slovenia, unmet needs for high income groups are greater than those reported by low income groups.
Source: Eurostat Database, based on EU-SILC (data refer to 2017).

The benefit package is broad but subject to cost-sharing

As mentioned in Section 4, Slovenia has virtually universal population coverage, with under 1 % of the population not covered by SHI. Marginalised groups who find it difficult to meet formal residency requirements are those mainly affected (Box 2). For the vast majority of people covered by health insurance, some services (such as family planning, prevention, screening, and long-term nursing care) and services for certain population groups (pregnant women, children, and students until the age of 26) are fully covered by compulsory health insurance. However, other services may require substantial co-payments, which are uncapped and vary between 10 % and 90 % of the price of services. For example, the basic benefit package includes most dental services for children and teenagers without co-payment. For adults, dental services require co-payments in all cases apart from rare emergencies. Given the high co-payments, about 95 % of the population purchases VHI. All insured people pay a unified flat premium, and the government subsidises premiums for poorer households receiving social benefit payments (in total around 100 000 people). For the remaining 5%, the lack of VHI is a major obstacle in accessing health services.

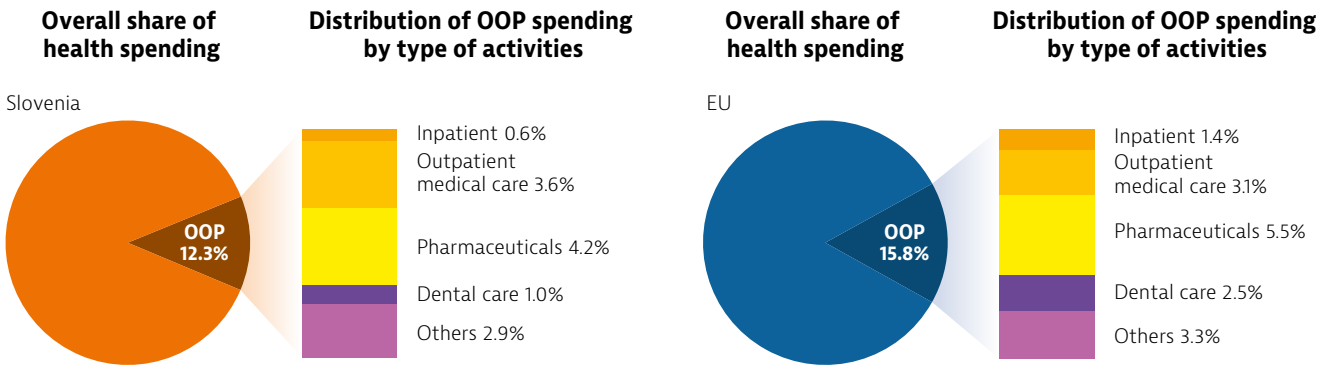
Out-of-pocket spending is low and measures are in place to guarantee financial protection

Despite expenses for VHI, Slovenia has one of the lowest rates of OOP spending on health in the EU. OOP spending amounted to 12.3 % of total health spending in 2017, compared with 15.8 % on average in the EU (Figure 16). The largest share of OOP spending was for outpatient pharmaceutical expenditure, followed by outpatient medical care. As most health services and medicines are covered by compulsory and complementary health insurance schemes, the share of OOP spending is low, which suggests that Slovenian households are largely protected against catastrophic health expenditure.[4] At the same time, exemption measures are also in place to guarantee financial protection: for example, the state covers pharmaceutical co-payments for war veterans, prisoners and people without income.

Box 2. Gaps in population coverage mainly affect marginal groups

Certain marginalised populations (ethnic minorities such as Roma, undocumented migrants, and homeless people) often lack health insurance. Unclear residence status is a main challenge, as the eligibility criteria for compulsory health insurance include permanent residency. Some initiatives are in place to address this – for example, homeless people can register for permanent residence at specific institutions (e.g. Centre for Social Work) and thus acquire the right to compulsory health insurance. Their insurance contributions are then covered from municipal budgets. Other efforts in social and health services include training staff who come into contact with these groups on specific cultural competencies, as well as outreach activities to tackle prejudices and hostility in the community.

Figure 16. Out-of-pocket spending is lower than EU average and mainly related to pharmaceuticals



Source: OECD Health Statistics 2019 (data refer to 2017).

4: *Catastrophic expenditure is defined as household out-of-pocket spending exceeding 40% of total household spending net of subsistence needs (i.e. food, housing and utilities)*

Strategies are being implemented to target regional disparities in access to health

The shortage of health care workers in some areas of the country, especially in rural areas and less developed parts of the country, is an important barrier to access. Slovenia's approach to addressing health workforce and geographical bottlenecks includes the implementation of the 'GP model practices' nationwide (see Box 3), as well as increasing medical training capacity, in particular for GPs. In addition, the planned health promotion centres (see Section 4) have a specific focus on narrowing the equity gap through improving access to care and preventive counselling in underserved areas.

5.3 Resilience[5]

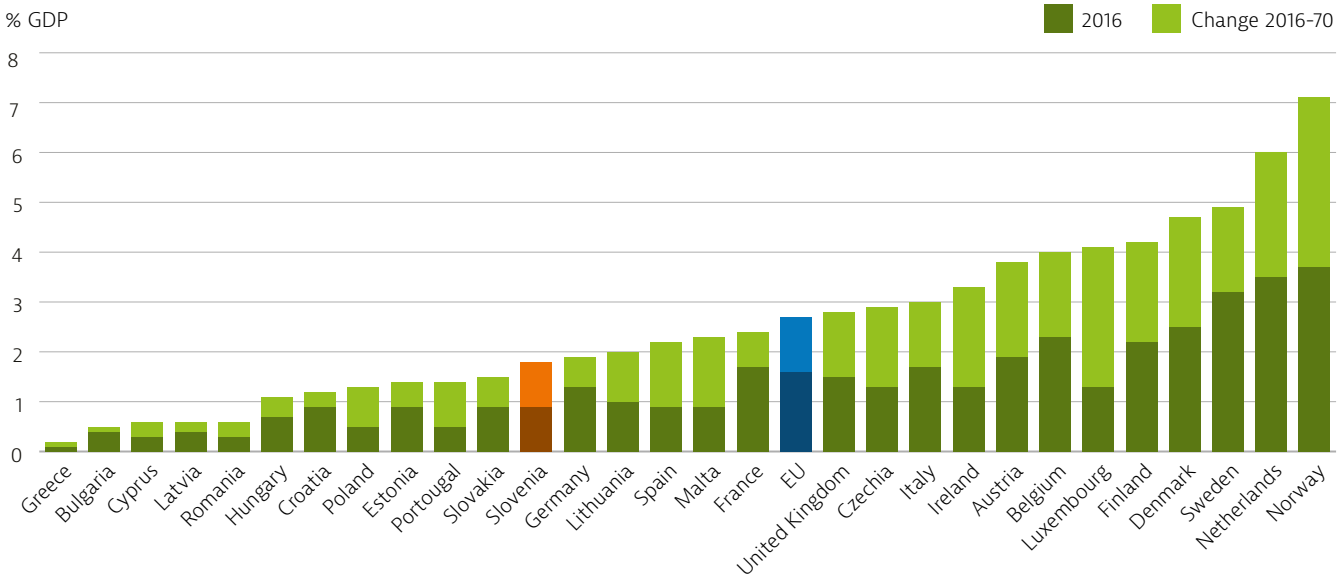
Securing long-term fiscal sustainability of the health system remains a priority

Health care funding in Slovenia is highly cyclical as it relies almost exclusively on health insurance contributions paid to the HIIS. A shift towards a system that is less dependent on contributions from individuals' wages would allow for more stable health care financing, as well as prepare for future challenges, as the current system will be inadequate to fund the projected increases in health care costs (European Commission, 2019a). There have been various attempts to reform and broaden the funding sources for the health system. At the beginning of 2017, the draft Health Care and Health Insurance Act proposed abolishing the VHI scheme and replacing it with income-dependent levies but the legislative proposal has not yet been put before parliament (see Box 1).

The ageing population will add pressure to health and long-term care budgets and entail changes to care models

Demographic changes and the ensuing reduction of working-age inhabitants challenge the fiscal sustainability of the pension, health care and long-term care systems. In the scenario shown in Figure 17, a projected increase in public spending on long-term care would double the share of GDP spent on it in the period 2016-70 (European Commission-EPC, 2018). In addition to these financing needs, care models will also change, but Slovenia still lacks legislation on long-term care and integration of services, with plans for the new law to be adopted by the Parliament in 2020 (see Box 1). Currently, long-term care is provided within different social protection systems and within the framework of different legislations. Health care spending is projected to increase by one percentage point of GDP over the same period. The projected increase contributes to the identification of sustainability risks in the medium and in the long term (European Commission-EPC, 2018).

Figure 17. Public spending on long-term care as a percentage of GDP is projected to double from 2016 to 2070



Note: The EU28 total is weighted by GDP.
Source: European Commission-EPC, 2018.

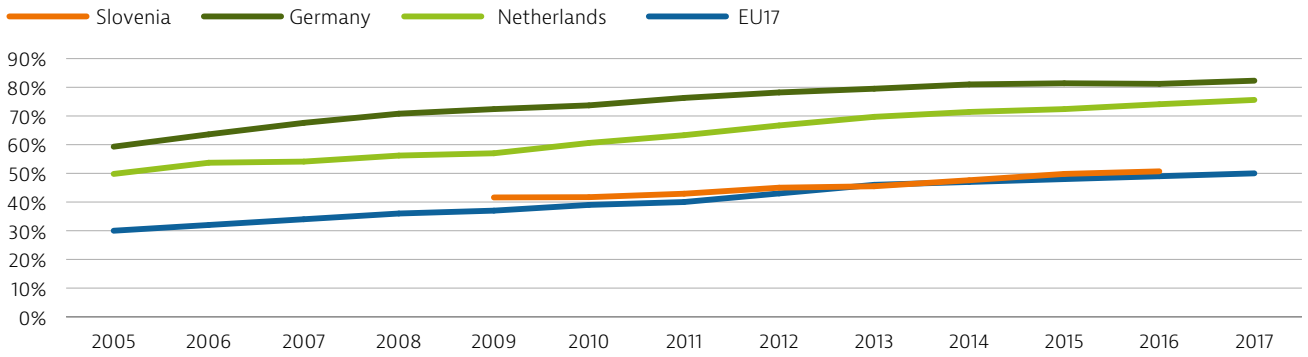
5: Resilience refers to health systems' capacity to adapt effectively to changing environments, sudden shocks or crises.

Slovenia has implemented measures to optimise pharmaceutical spending

After outpatient and inpatient care, spending for pharmaceuticals and medical devices is the third largest category of health expenditure in Slovenia (Section 4), as well as a main component of OOP spending. Maximising the potential take-up of generics may lead to substantial savings and lower OOP spending. Even though the share of the generics market by volume in Slovenia is similar to the EU average, there is room for improvement as several countries (e.g. the Netherlands and Germany) have substantially higher rates of generic penetration (Figure 18).

It is common for pharmaceutical manufacturers to grant voluntary discounts on medicines for hospitals, and although this is also the case in Slovenia, the rebates may be relatively low, ranging anywhere between 1 % and 10 % (Vogler et al., 2010). Plans to introduce a central public tendering process resulted in three tenders for medicines in hospitals since 2015. The most recent, in 2017 (which expired in summer 2019), selected two suppliers with the lowest prices. However, savings were minimal (less than 1%) and as of mid-2019, hospitals will return to individual tenders. The intent to run a central public tendering process remains, but it will require more preparatory work.

Figure 18. There is scope to increase the use of generic medicines



Note: Data refer to the share of generics in volume.
Source: OECD Health Statistics 2019.

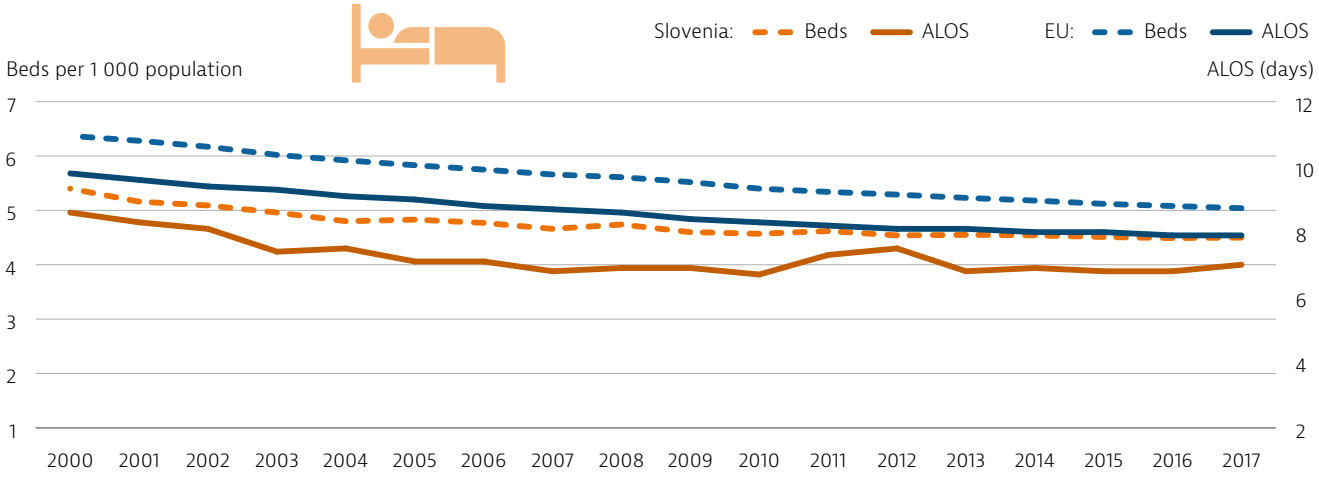
Some elements of health technology assessment are in place to guide decision making

There is no dedicated health technology assessment (HTA) agency or national regulatory HTA framework for introducing new health technologies into the system of public financing in Slovenia. However, elements of HTA are included in the pricing and reimbursement procedures for pharmaceuticals. The Ministry of Health collaborates with the European scientific/technical cooperation on HTA, the EUnetHTA Joint Action, and intends to establish a national HTA agency. International cooperation has been an important catalyst to support the development of activities to complete this implementation. In this context, Slovenia is an active member of the Pricing and Reimbursement Information network which gathers competent authorities across Europe and beyond. The National Health Plan foresees a broader use of HTA mechanisms, and the draft government Act on Health Care Quality and Safety envisages the creation of an HTA agency (European Commission-EPC, 2018).

Further switching to day surgery can boost hospital efficiency

There has been some progress in improving hospital efficiency. The total number of beds per population has decreased by almost 20 % since 2000 and is below the EU average. Similarly, the average length of stay in hospitals has also been reduced to seven days (2017), about one day below the EU average (Figure 19). However, low occupancy rates (69.5 % compared to 77.1 % in the EU) and high turnover of patients suggest that the number of hospital beds in acute care could be further reduced. The rate of hospital discharges (183 per 1 000 population) is marginally higher than in the EU as a whole – 172) and has increased by almost 10 % since 2000, although this figure is most likely to have been impacted by the introduction of diagnosis-related groups (DRGs). However, the increasing population share aged over 65 will require a comprehensive plan to address higher demand for hospitalisation.

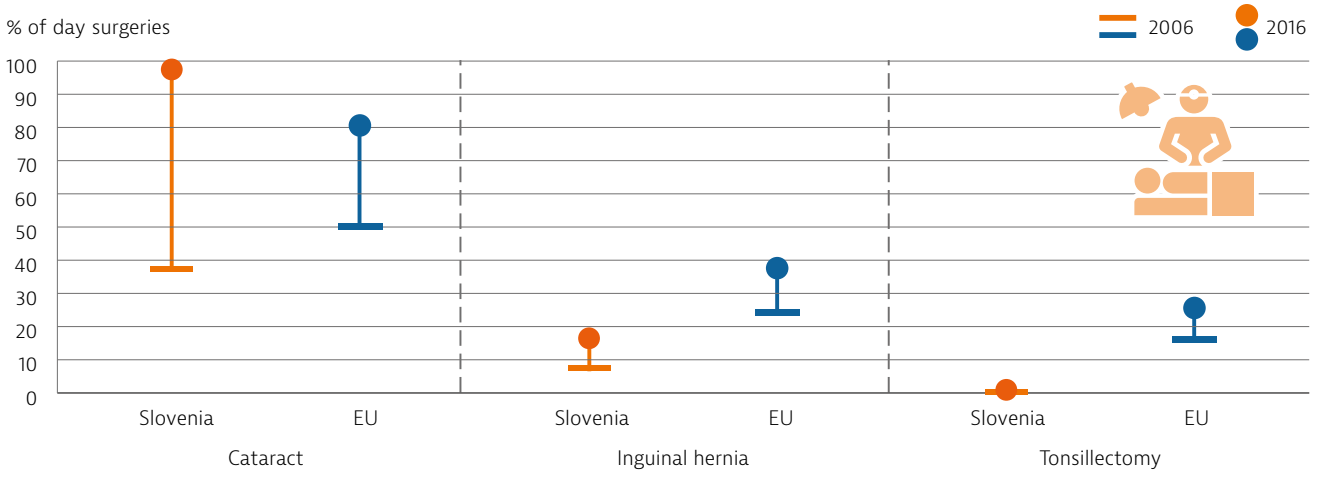
Figure 19. Hospital beds and average length of stay have been reduced and are consistently below the EU average



Source: Eurostat Database.

Enabling a greater use of day surgery could also help achieve substantial savings in hospital expenditure as the diffusion of day surgery in Slovenia is still limited for some procedures. For example, while there has been a rapid increase in cataract surgeries performed as outpatient procedures, reaching an even higher rate than the EU average (98 % and 84 % respectively) in 2016, in the same year no tonsillectomies were performed as day surgery, compared to 29 % in the EU (Figure 20).

Figure 20. Day surgery is limited for some procedures but very high for cataract surgery



Source: OECD Health Statistics 2018; Eurostat Database (data refer to 2006 and 2016, or the nearest years).

The focus on person-centred care is increasing, facilitated by innovations in skill mix

In Slovenia, a new paradigm for primary care is characterised by a shift towards integrating prevention and coordination, in place of acute and chronic care. Echoed by the implementation of GP model practices (Box 3) and reforms under the Slovenia National Health Care Plan (2016-25), strategies include the integration of health promotion centres within primary care centres, starting with 25 centres by 2020 and subsequently to include all primary health care centres by 2025.

Significant progress has been made in implementing eHealth infrastructures

The implementation of eHealth infrastructures is one of the main long-term goals of the Slovenian public sector and plays an important role in the strengthening of primary care. Slovenia's eHealth project consists of 20 solutions, with ePrescription being one of the most widely implemented. Since its national rollout in early 2016, the quality of its operations has been constantly improving, and the number of users now stands at 90 % of all health care providers. The eAppointment service is based on electronic referral and schedules appointments from the primary health care level to the secondary/tertiary health care level, providing an overview of waiting periods. Despite some technical problems since its introduction in 2016, eAppointment has seen recent improvements and is currently one of the country's main eHealth priorities, since it has significant implications for monitoring and managing waiting times.

Box 3. Skill mix innovations are occurring in GP practices

In 2011 the Ministry of Health piloted a new approach for the management of chronic conditions and disease prevention at the primary care level through the 'GP model practices' (*referenčne ambulante*). The main innovation is adding a 0.5 full-time equivalent (FTE) qualified nurse with specific training in NCD prevention. This nurse is responsible for assessing the condition of stable chronic patients and coordinating care, carrying out preventive counselling and screening for risk factors to the core team (which traditionally included a GP and a nurse). Nurse training is funded by the HIIS and consists of eight modules (focusing on prevention and chronic diseases) for carrying out protocols in the follow-up of chronic patients. These nurses collaborate closely with GPs, easing their workload and promoting a multidisciplinary approach to care. The full conversion of GP practices was expected by 2018, but budgetary constraints postponed the deadline to mid-2020. In 2017, 75 % of all GP practices nationwide employed an additional 0.5 FTE nurse.



6 Key findings

- The health of the Slovenian population continues to improve, although gaps in life expectancy by gender and socioeconomic groups persist. The considerable increase in life expectancy partly results from declining cardiovascular mortality. However, ischaemic heart disease and stroke lead as the main causes of death, followed by lung cancer. High suicide rates are also prevalent despite a reduction in overall numbers. Behavioural risk factors, in particular dietary risks, are an important public health concern, especially with regard to children, adolescents, and disadvantaged populations.

- Although there has been gradual progress in reducing mortality due to cardiovascular disease, differences between genders remain marked. The five-year survival rates for lung, breast, colorectal and prostate cancers have also improved. Lower mortality rates and improved survival reflect more effective therapies, but also partly result from population-based screening programmes and a higher focus on prevention.

- An important development in recent years has been the reorientation of the health system towards prevention and public health activities, particularly aimed at non-communicable diseases and risk factors, through health promotion centres, model practices, counselling and screening in primary health care. These services also aim to tackle geographic barriers to health care and increase equity of access and outcomes for underserved populations.

- The compulsory health insurance system provides universal coverage to all permanent residents, yet private spending is relatively high. About 95 % of the population purchases complementary voluntary health insurance, mainly to cover co-payments. Given the high uptake of voluntary insurance, out-of-pocket spending is low, which indicates that households are mostly protected against catastrophic expenditure.

- Long waiting times have been an enduring challenge, despite efforts to address them, for example through occasional added funding. Survey results show that waiting times are the main reason for self-reported unmet medical and dental needs. On a positive note, little variation in levels of unmet needs among income groups indicates that access to care is generally equitable.

- The shortage of doctors is a major health system challenge in Slovenia. In particular, the low numbers of general practitioners negatively influence waiting times. More doctors are currently being trained, and salaries have been corrected to reduce the wage gap in comparison to hospital specialists.

- Slovenia is one of the most rapidly ageing countries in the EU, and health spending as a share of GDP is forecast to increase in the coming years. The country also faces a major challenge with the projected growth of long-term care expenditure and the need for a shift in care models. These are projected to pose fiscal sustainability risks in the medium to long term. Given that the current system is heavily dependent on payroll contributions, there are proposals to diversify the health system's funding sources. There are plans to reform both health care and long-term care financing, but legislation has been postponed to mid-2020 at the earliest.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT	United Kingdom	UK

European Commission

State of Health in the EU
Country Health Profile 2019

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, in cooperation with the European Commission.

The concise, policy-relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

- health status in the country
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

The Commission is complementing the key findings of these country profiles with a Companion Report.

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Please cite this publication as: OECD/European Observatory on Health Systems and Policies (2019), *Slovenia: Country Health Profile 2019, State of Health in the EU*, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

ISBN 9789264676220 (PDF)
Series: State of Health in the EU
SSN 25227041 (online)

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