European Commission

State of Health in the EU

Slovenia

Country Health Profile 2021

OECD
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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 co-operation 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 Systems Performance Assessment (HSPA).

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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 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in September 2021, based on data available at the end of August 2021.

Demographic and socioeconomic context in Slovenia, 2020

Demographic factors	Slovenia	EU
Population size (mid-year estimates)	2 095 861	447 319 916
Share of population over age 65 (%)	20.2	20.6
Fertility rate[1] (2019)	1.6	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	26 414	29 801
Relative poverty rate[3] (%, 2019)	12.0	16.5
Unemployment rate (%)	5.0	7.1

[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. For EU27, 2020.
[3]Percentage of persons living with less than 60 % of median equivalised disposable income.
Source: Eurostat Database.

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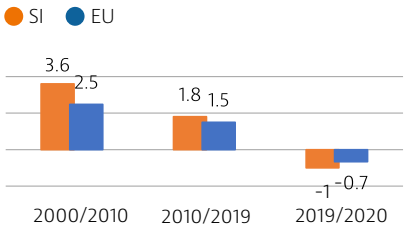
1 Highlights

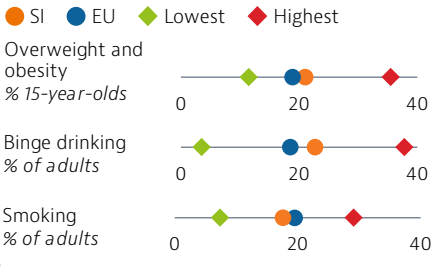
Life expectancy in Slovenia has increased markedly since 2000, but in 2020 the COVID-19 pandemic temporarily erased a year's worth of gains. The Slovenian health system provides near universal coverage and a broad benefits package. Voluntary health insurance plays a large role in covering co-payments levied on services; this also confers a considerable degree of financial protection from out-of-pocket payments. The pandemic exacerbated or laid bare health system weaknesses, including workforce shortages, long waiting times, ageing hospital facilities and fragmented and underfunded long-term care.



Life expectancy gains, years

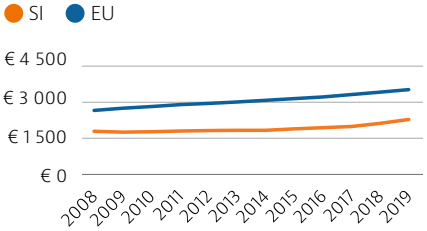
Health Status

Life expectancy in Slovenia had increased by over 5 years between 2000 and 2019. However, in 2020 the COVID-19 pandemic reversed this trend: life expectancy fell from 81.6 years in 2019 to 80.6 in 2020. Stroke, ischaemic heart disease and lung cancer are usually the main causes of mortality, but COVID-19 was responsible for the largest number of deaths in 2020.



Risk factors

More than one fifth of Slovenian adolescents were overweight or obese in 2018. Alcohol intake among both adults and adolescents ranks above the average across EU countries, with binge drinking much more prevalent among male adults. Smoking prevalence has decreased for both adults and adolescents over the last decade, but over one in six adults are still daily smokers. The increasing popularity and use of e-cigarettes is also a concern.



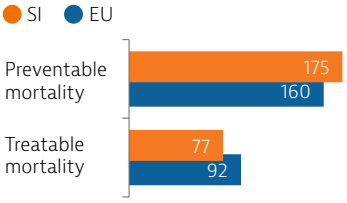
Per capita spending (EUR PPP)

Health system

Health expenditure per capita has risen marginally over the last few years, but it remains well below the rate across the EU as a whole, as does spending as a share of GDP. Public financing of the health system accounted for 73 % of health spending in 2019. Out-of-pocket spending is among the lowest in the EU, however, due mainly to extensive uptake of voluntary health insurance to cover co-payments.

Effectiveness

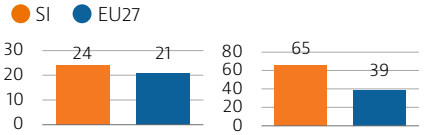
Mortality from preventable causes remains above the EU average. In contrast, mortality from treatable causes is lower than the EU average, indicating that the health care system is generally effective in providing care for people with potentially fatal conditions.



Age-standardised mortality rate per 100 000 population, 2018

Accessibility

Prior to the COVID-19 pandemic, unmet needs for medical care were low, at 2.9 % of the population, with waiting times the primary driver. In 2020, the demand for COVID-19-related care often led to delayed or forgone consultations and treatment for other health issues. Around 24 % of the population reported forgone medical care during the first 12 months of the pandemic.

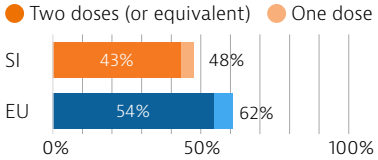


% reporting forgone medical care during first 12 months of pandemic

% using teleconsultation during first 12 months of pandemic

Resilience

The COVID-19 pandemic revealed several resilience challenges, including workforce shortages and underdeveloped long-term care infrastructure prompting plans for more investment. Slovenia accelerated its vaccination campaign in spring 2021, and at the end of August 2021, 43 % of the population had received two vaccine doses (or equivalent).



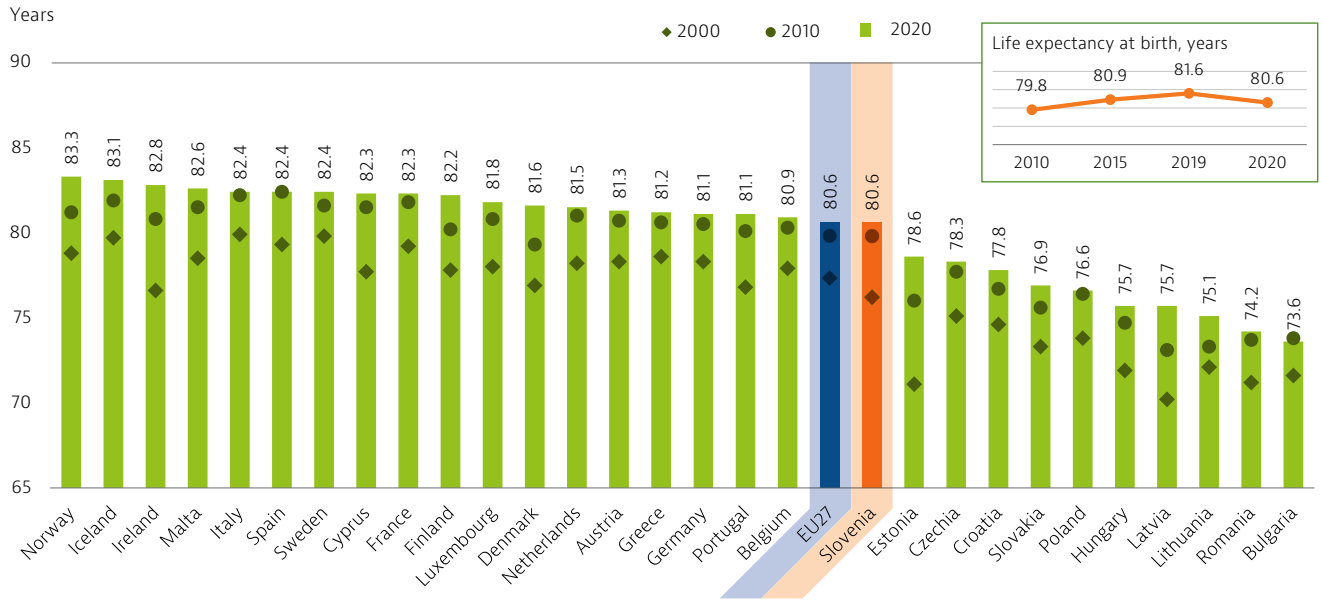
Share of total population vaccinated against COVID-19 up to the end of August 2021

2 Health in Slovenia

After a decade of steady gains, life expectancy fell by a year in 2020

Life expectancy in Slovenia increased overall from 76.2 years in 2000 to 80.6 years in 2020, and is now equal to the average in the EU (Figure 1). After marked increases over the last two decades, there was a temporary and significant drop of 1 year between 2019 and 2020 because of a high death rate due to the COVID-19 pandemic (the average fall in life expectancy across the EU was nearly 8 and a half months). The difference in life expectancy at birth between men and women has been decreasing since 2000. Nevertheless, Slovenian men still live 5.6 years less than women overall (77.8 years compared to 83.4 years), which is equal to the average difference across the EU.

Figure 1. Slovenian life expectancy fell by one year in 2020 and is now equal to the EU average



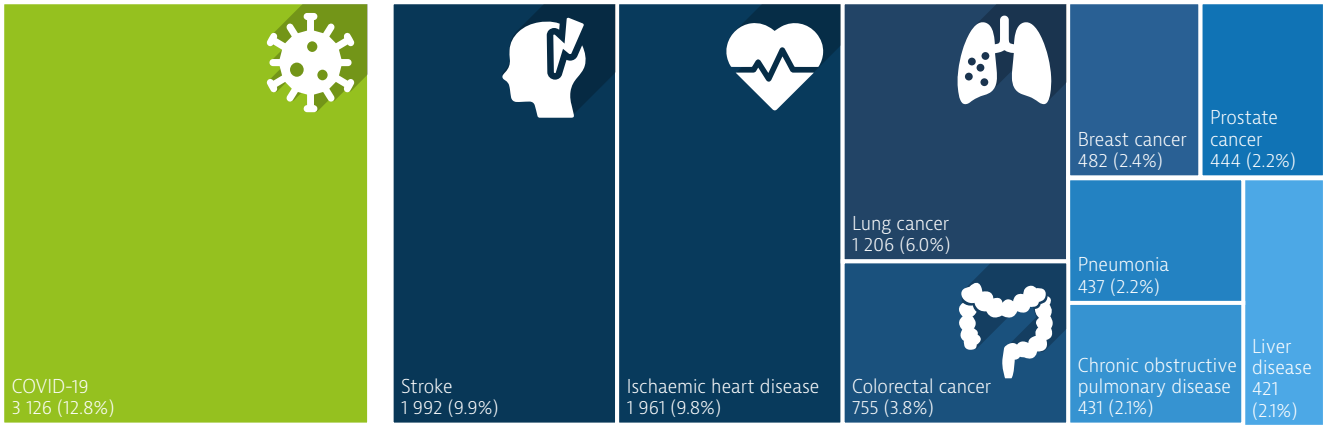
Note: The EU average is weighted. Data for Ireland refer to 2019.
Source: Eurostat Database.

Stroke, ischaemic heart disease and lung cancer were the main causes of death before the pandemic

In 2018, circulatory diseases accounted for 40 % of all deaths in Slovenia, followed by cancer (33 %). More specifically, stroke and ischaemic heart disease were the leading causes of mortality in 2018 (accounting for about 10 % of all deaths each), followed by lung cancer (6 %) (Figure 2).

In 2020, COVID-19 accounted for about 3 130 deaths in Slovenia – nearly 13 % of all deaths. An additional 1 650 were registered by the end of August 2021. Most deaths have been among older people – around 83 % of COVID-19 deaths were in those aged over 75. The mortality rate from COVID-19 up to the end of August 2021 was about 40 % higher in Slovenia than the average across EU countries, at approximately 2 280 per million population compared with about 1 590. The broader indicator of excess mortality, defined as the number of deaths from all causes over what would have been expected based on previous years, suggests that the direct and indirect death toll related to COVID-19 in Slovenia may have been higher in 2020. Overall, excess mortality from March to December 2020 was around 3 940 deaths – about 26 % higher than total reported COVID-19 deaths (3 130).

Figure 2. Stroke and ischaemic heart disease had been the main causes of death, but COVID-19 accounted for the largest share in 2020



Note: The number and share of COVID-19 deaths refer to 2020, while the number and share of other causes refer to 2018. The size of the COVID-19 box is proportional to the size of the other main causes of death in 2018.
Sources: Eurostat (for causes of death in 2018); National Institute of Public Health (for COVID-19 deaths in 2020, up to week 53).

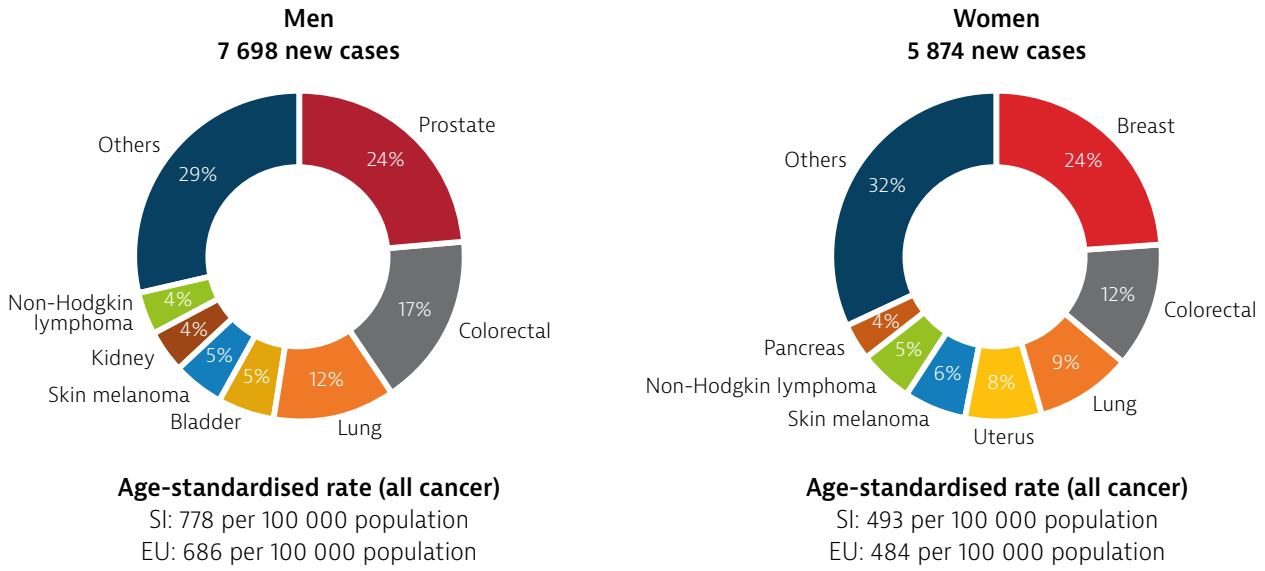
Most Slovenian adults report being in good health, with considerable differences among income groups

In 2019, about two thirds of the population reported being in good health – a proportion slightly lower than that across the EU as a whole (69 %). Women were less likely to report being in good health: 63.8 % of women perceived their health to be good compared to almost 70 % of men. Further, people with higher incomes were more likely to report being in good health: 80 % of the Slovenian population in the highest income quintile reported being in good health, which is slightly above the EU average (79 %). In the lowest quintile, only 50 % of the population reported being in good health, compared to 58 % across the EU.

Lung and other cancers continue to drive mortality

According to estimates from the Joint Research Centre based on incidence trends from previous years, around 13 600 new cases of cancer and about 6 500 deaths from cancer were expected in Slovenia in 2020[1]. Figure 3 shows that the main types of cancer among men are prostate (24 %), colorectal (17 %) and lung (12 %). Among women, the main types are breast cancer (24 %), followed by colorectal (12 %), lung (9 %) and uterine cancer (8 %). Lung cancer accounts for 18 % of all cancer deaths, and has been the most frequent cause of death by cancer since 2000.

Figure 3. The burden of cancer in Slovenia is larger than the EU average for both men and women



Note: Non-melanoma skin cancer is excluded; uterus cancer does not include cancer of the cervix.
Source: ECIS – European Cancer Information System.

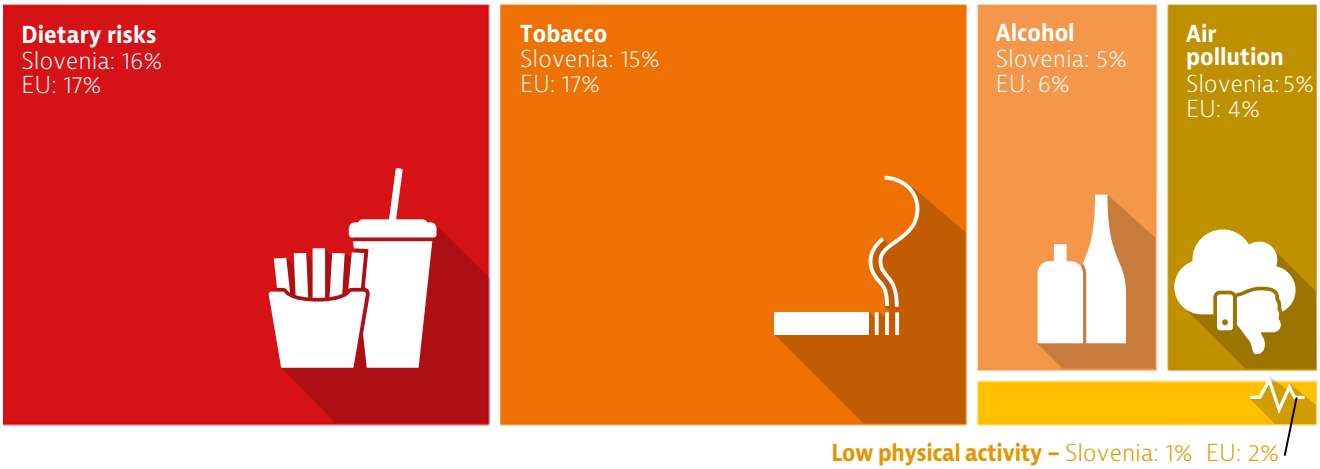
1. *It should be noted that these estimates were made before the COVID-19 pandemic; this may have an effect on both the incidence and mortality rates of cancer during 2020.*

3 Risk factors

More than one third of all deaths are linked to behavioural and environmental risk factors

Over one third of all deaths in Slovenia in 2019 can be attributed to behavioural risk factors, including tobacco smoking, poor diet, alcohol consumption and low physical activity, while environmental issues like air pollution also contribute to a sizeable number of deaths (Figure 4). Dietary risks, including low fruit and vegetable intake, and high sugar and salt consumption, were implicated in 16 % of all deaths in 2019 – which is around the same as the EU average. Tobacco smoking contributed to an estimated 15 % of all deaths in Slovenia, while about 5 % were attributable to alcohol consumption and 1 % to low physical activity. Air pollution, in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure alone, accounted for an estimated 5 % of all deaths in 2019.

Figure 4. Dietary risks and tobacco are the top behavioural risks in Slovenia



Note: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to $PM_{2.5}$ and ozone.
Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Overweight and obesity rates in Slovenia are a public health concern

In 2019, 19 % of adults in Slovenia were obese, which is above the EU average (16 %) (Figure 5). More than one fifth (21 %) of Slovenian 15-year-olds were overweight or obese in 2018[2], which is a higher proportion than in most EU countries. Boys (26 %) are more likely to be overweight than girls (16 %). The government has developed a comprehensive, multi-sectoral National Nutrition and Physical Activity Strategy 2015-25 to improve the nutrition and exercise habits of the population and to tackle obesity.

Poor nutrition is a significant factor driving high rates of overweight and obesity. Although levels have increased since 2014, fewer than one third of 15-year-olds reported eating a piece of fruit (31 %) or portion of vegetables (30 %) every day in 2018. Fruit and vegetable consumption among adults is higher than among adolescents, with over half of adults eating fruit and vegetables daily in 2019. Low physical activity also contributes to overweight and obesity. While Slovenian adults are more physically active than those in most other EU countries, more than one quarter of adults did not meet the WHO recommendation of at least 2.5 hours of moderate-to-vigorous physical activity each week in 2014. Among adolescents, about one in six 15-year-olds reported doing at least 60 minutes of moderate physical activity each day in 2018, with boys (24 %) scoring much higher than girls (11 %).

Smoking among teenagers is now below the EU average

The percentage of adults in Slovenia who smoke daily has dropped since the early 2000s, reaching 18 % in 2019, which is slightly below the EU average. Smoking among 15-year-olds has also decreased: 16 % reported in 2018 that they had smoked in the previous month, compared to 22 % in 2014 – slightly below the EU average. Meanwhile, use of e-cigarettes is an increasingly popular and concerning trend: 10 % of 15- and 16-year-olds in Slovenia reported smoking e-cigarettes in 2019, although this is lower than the EU average (14 %). In 2020, a new law entered into force to mandate plain packaging for tobacco

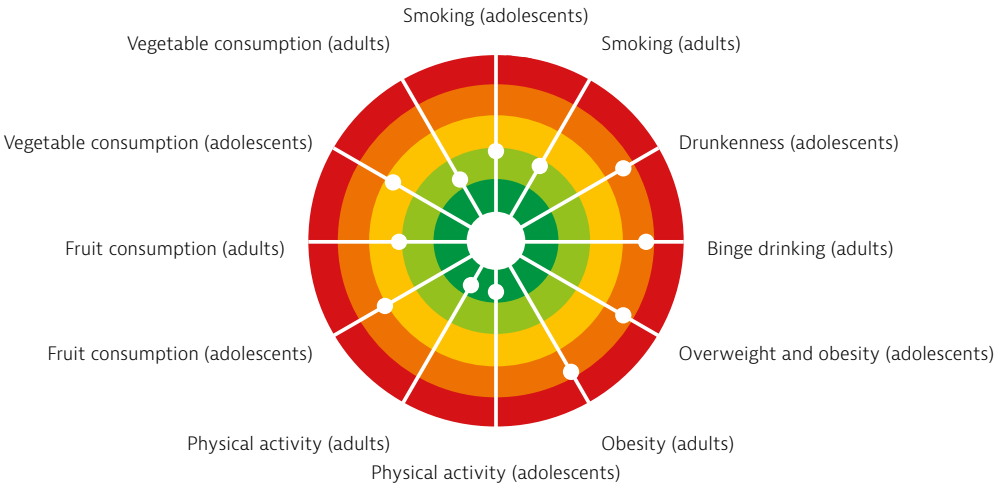
2. According to a national evaluation in 2015, the overweight and obesity rates among children and adolescents had decreased since 2010 (WHO Regional Office for Europe, 2016).Smoking among teenagers is now below the EU average.

products as a means to eliminate indirect advertising and highlight the health risks associated with smoking (see Section 5.1).

Alcohol consumption is high, especially among teenagers and adult men

Although alcohol consumption among adults has remained relatively steady over the last decade, almost one in four (23 %) Slovenian adults reported episodic heavy alcohol consumption (binge drinking[3]) at least once a month in 2019, which is above the EU average (19 %). As with smoking rates, there is a stark gender gap: Slovenian men were twice as likely (31 %) to report heavy episodic alcohol consumption than women (15 %). Even though rates of heavy alcohol consumption have fallen among adolescents in the last two decades, in 2018 over one quarter (27 %) of 15-year-olds reported having been drunk at least twice in their life. This is a higher proportion than in most EU countries (the EU average is 22 %). Although improving, these rates further underline the need for scaled-up promotion of healthy lifestyles among adolescents.

Figure 5. Obesity and excessive alcohol consumption among adolescents remain important risk factors



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.
Sources: OECD calculations based on HBSC survey 2017-18 for adolescents indicators; OECD health statistics, EU-SILC 2017, EHIS 2014 and 2019 for adults indicators.

4 The health system

Social health insurance is provided by a single purchaser

Slovenia has a compulsory social health insurance (SHI) system with a single public insurer – the Health Insurance Institute of Slovenia (HIIS) – that provides near universal coverage. The system is largely financed through SHI contributions, with general taxation at the national and municipal levels providing another modest public source of funding. Three private companies provide voluntary health insurance (VHI), which is used extensively to cover co-payments that are levied on a large range of publicly financed health services.

Hospital care is centralised, while primary care is decentralised

The health system in Slovenia is relatively centralised, which is also reflected in its management of COVID-19 (Box 1). The Ministry of Health is responsible for planning and regulation, and the state owns almost all hospital capacity, the largest share of outpatient specialist care and the entire tertiary care sector. The Health Council advises the Ministry on policy, health technology assessment and the introduction of new therapies and diagnostic procedures. Municipalities are responsible for organisation of primary care. Inpatient hospital care is provided by 30 – mostly public – hospitals. Since 2014, most public health services are provided by the National Institute of Public Health (NIPH) and the National Laboratory for Health, Environment and Food.

3. *Binge drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults.*

Box 1. A new government changed governance arrangements to manage the COVID-19 pandemic

Throughout the pandemic, the response to COVID-19 has been coordinated at the national level. On 12 March 2020, the Slovenian government activated a pre-existing pandemic response plan from 2016. The plan, based on WHO guidelines, did not encompass all the measures needed to respond adequately to the pandemic; however, its activation gave the government the authority to implement new measures daily. The government also formed a special Advisory Commission comprising infectious disease specialists, pulmonologists, microbiologists and public health specialists/epidemiologists. The NIPH also played an advisory role during the crisis.

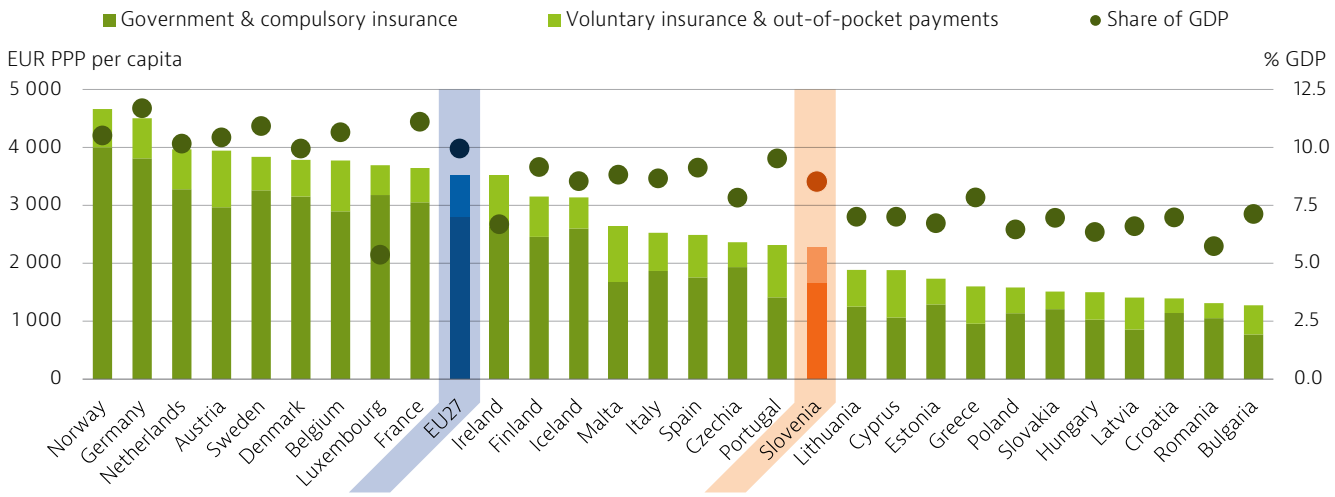
On 13 March 2020, following the resignation of the prime minister, a new government took office, leading to changes in the pandemic plan. A new Advisory Professional Group led by clinicians was formed, which focused mostly on preventing an overload of the hospital system. In the following months, the role of public health experts increased.

Source: COVID-19 Health System Response Monitor.

Even with increasing public expenditure, private spending remains considerable

In line with overall economic growth, health expenditure in Slovenia rose between 2014 and 2019. Per capita health expenditure increased from EUR 1 828 in 2014 to EUR 2 283 in 2019, while total health expenditure as a share of GDP stood at 8.5 % (Figure 6). In 2019, health expenditure, both per capita and as a share of GDP, was higher in Slovenia than in neighbouring Croatia and Hungary, but lower than the average for the EU as a whole.

Figure 6. Health expenditure has increased, but remains below the EU average



Note: The EU average is weighted.
Source: OECD Health Statistics 2021 (data refer to 2019, except for Malta 2018).

The proportion of public spending on health experienced modest growth from 71.1 % of total health expenditure in 2014 to 72.8 % in 2019 (the EU as a whole stood at 79.7 %). Health spending as a share of total government spending also rose, from 12 % in 2014 to 14 % in 2019. During the same period, total private funding for health (including for VHI) decreased somewhat, but at 27.2 % of total health expenditure in 2019, it remains well above the EU average of 20.3 %.

The COVID-19 emergency also prompted additional funding injections in 2020 to support the health and long-term care sectors. The government assumed responsibility for procurement of necessary medical and protective equipment and technologies, as well as medicines for all public health care settings. Moreover, the health budget fully covered all testing and part of subsequent COVID-19-related health interventions (see Section 5.2).

High coverage rates for voluntary health insurance help keep out-of-pocket co-payments down

To help cover high levels of out-of-pocket (OOP) spending on co-payments, more than 95 % of the population liable for co-payments purchase complementary VHI. Subsidies are in place for those who cannot afford the full cost of this insurance. As a result, VHI accounts for more than half of private spending in Slovenia, and accounted for 15.6 % of total health expenditure in 2019. This is the highest in the EU and represents a rapidly growing share of total health expenditure (it was 14 % in 2017).

OOP payments are the other main source of private health financing in Slovenia: at 12 % of total health expenditure in 2019, they are among the lowest in Europe (the EU average is 15 %) and have decreased by one percentage point since 2014 (Section 5.2).

Slovenia's health system provides near universal coverage for a comprehensive list of services

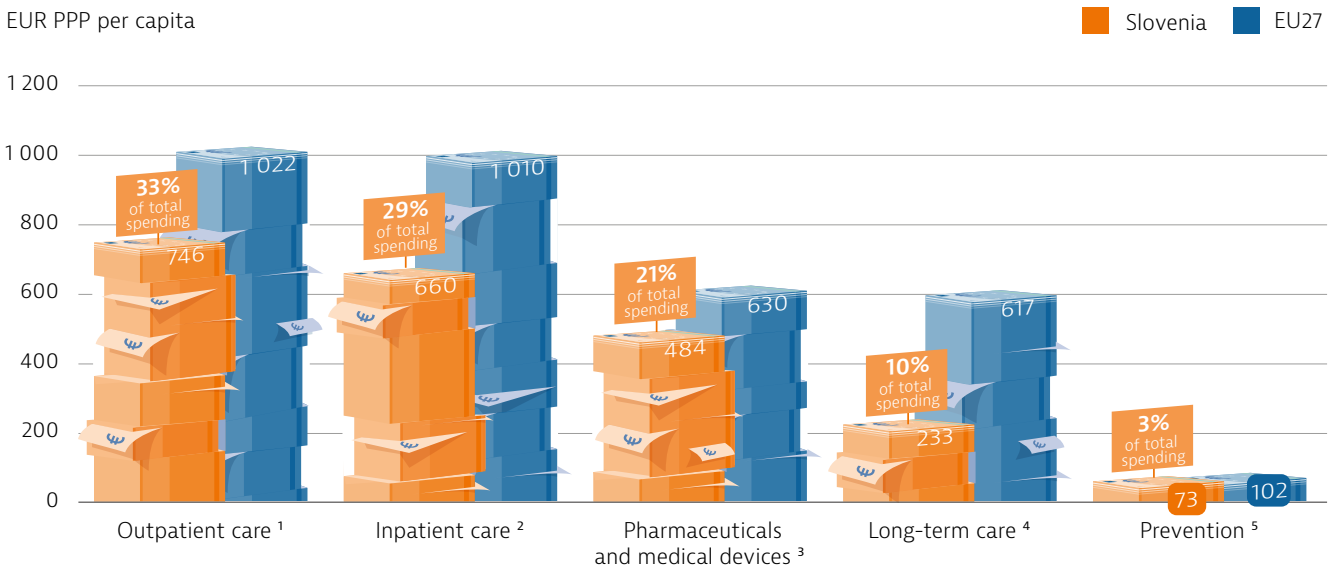
More than 99 % of all permanent residents are covered by the compulsory SHI scheme (see Section 5.2). The benefits package includes primary, secondary and tertiary services, pharmaceuticals, medical devices, sick leave exceeding 30 days and some travel costs to health facilities. Full coverage is offered for a wide list of services, including those related to cancer, infectious diseases, family planning, emergency care, nursing care in inpatient/residential settings (such as residential care homes and other social care institutions) and children/students up to the age of 26. All other services involve cost-sharing, ranging from 10 % to 90 % of the cost, and most of these potential costs are offset by VHI.

Although outpatient care spending has increased, support for broader long-term care services remains limited

The main categories of health expenditure in 2019 were outpatient and inpatient care (Figure 7), comprising almost two thirds of total health expenditure (62 %). Since 2010, financial incentives have encouraged a shift from inpatient to outpatient care; these led to reductions in inpatient care spending of around 3 percentage points and an increase in outpatient care spending of 5.5 percentage points between 2010 and 2019.

The health care component of long-term care (LTC) spending stood at EUR 233 per capita in 2019 (adjusted for differences in purchasing power) or 10.2 % of total health spending, which is considerably less than the rate for the EU as a whole (EUR 617 and 16.3 %). Several cash benefits are available for some categories of LTC, such as home-based assistance with activities of daily living, but in aggregate these are not sufficient to pay for any significant service needed, particularly within home or community-based care settings. The government's new LTC legislation, which sets out eligibility criteria and consolidates the regulation of services, was placed before parliament in 2021. In 2019, Slovenia spent a higher share of total health expenditure on prevention (3.2 %) than the share across the EU as a whole (2.9 %), but less per capita (EUR 73 compared to EUR 102).

Figure 7. Outpatient care accounts for the largest part of health expenditure in Slovenia



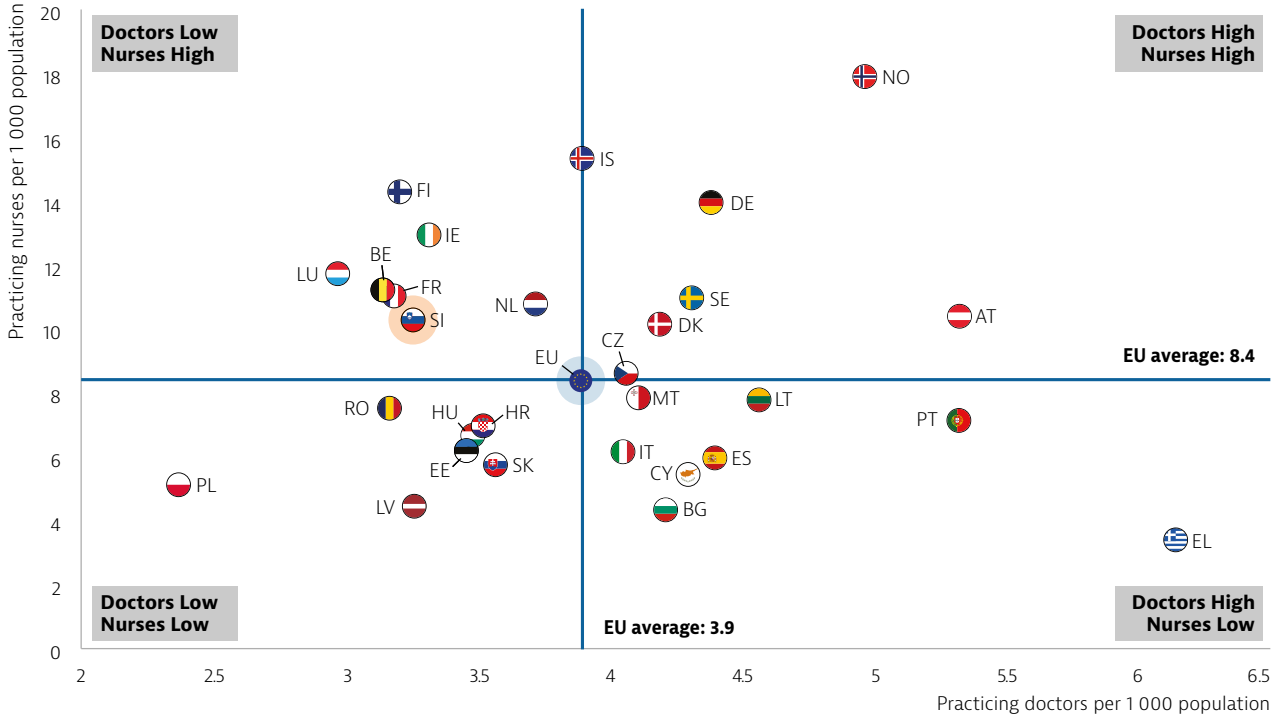
Note: The costs of health administration are not included. 1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes. The EU average is weighted.
Sources: OECD Health Statistics 2021, Eurostat Database (data refer to 2019).

The number of physicians is low, while the role of nurses is being debated

Despite efforts to improve staffing levels, the density of physicians in Slovenia remains below the EU average, at 3.3 physicians per 1 000 population in 2019 (Figure 8), of whom almost one in five is a general practitioner (GP). The number of nursing professionals (10.3 nurses per 1 000 population) is higher than the EU average (8.4 per 1 000 population). However, in Slovenia's case, this number includes both registered nurses (35 % of the total) and vocationally trained "nursing assistants" (65 %).

The composition and role of nursing professionals in Slovenia has become a matter of public debate in recent years. Owing to comparatively low levels of physicians, task-shifting to registered nurses was introduced in 2019, especially in primary care. Further, owing to a low density of these professionals, nursing assistants assumed responsibilities that are formally competencies of registered nurses. The Nursing Chamber of Slovenia therefore advocates training more registered nurses. However, a proposal to enable nursing assistants to obtain a special licence after fulfilling certain criteria was retracted by the Chamber after it faced criticism and opposition from various stakeholders. The low supply of health professionals was a major challenge for Slovenia's response to the COVID-19 pandemic (see Section 5.2).

Figure 8. Slovenia has fewer physicians than the EU average but more nurses



Note: The EU average is unweighted. 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 Greece, the number of nurses is underestimated as it only includes those working in hospitals. For Slovenia, the number includes both registered nurses and vocationally trained nursing assistants.
Source: Eurostat Database (data refer to 2019 or the nearest year).

Primary health care centres serve as a nexus of care coordination

Primary care is mostly provided by a network of community-level primary health care centres, owned and run by the municipalities. Patients choose a primary care physician, who acts as a gatekeeper to specialist care. Outpatient specialist care occurs in public and private hospitals, primary care centres (for some services), private specialist practices and spas. For tertiary care, patients go to clinics and specialised institutes.

Several initiatives have been implemented over the last decade to strengthen care coordination and integration. Since 2011, GP "model practices" (renamed "family medicine practices") introduced new preventive services and coordination of care for patients with stable chronic conditions. To achieve this, registered nurses joined family medicine teams, and tasks were shifted from physicians to nurses. In 2021, more than 90 % of family medicine practices operate under this new model. In addition, new models of health promotion centres implemented since 2017 deliver much more integrated public health interventions and primary health care services in order to improve lifestyle risk factors for chronic non-communicable diseases (see Section 5.1).

5 Performance of the health system

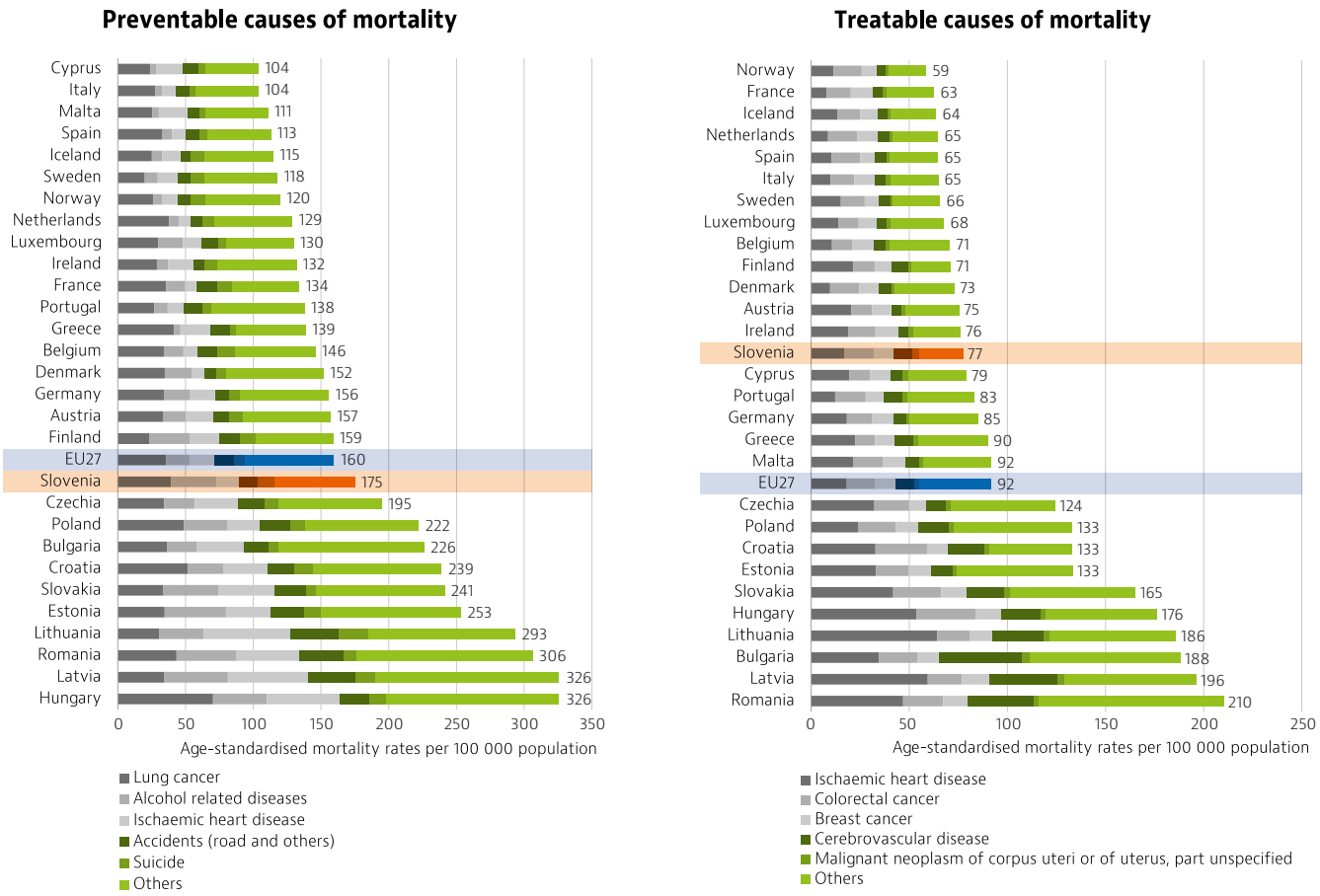
5.1. Effectiveness

Mortality from preventable and treatable causes continue to decrease slowly

Since 2011, the rate of preventable mortality has decreased by around 9 %. Various initiatives addressing issues like smoking, alcohol consumption, nutrition and physical activity have contributed to this positive trend. However, at 175 per 100 000 population, preventable mortality in Slovenia remains higher than the rate for the EU as a whole (Figure 9). Together, lung cancer and alcohol-related diseases are the leading causes, accounting for 45 % of all preventable deaths in 2018. The scale-up of GP family medicine practices and the new health promotion centres is expected to improve screening, counselling, immunisation and increased care coordination. So far, 25 health promotion centres have been launched within the largest primary health centres. Alongside these, 20 community mental health centres (10 for adults and 10 for children) have been established to facilitate a more community-oriented approach to mental health.

Similarly, the rate for treatable causes of mortality has been decreasing steadily since 2011. With a rate of 77 per 100 000 population in 2018, Slovenia continues to be well below the average for the EU as a whole. The leading causes of these deaths that could be avoided mainly through effective health care interventions are ischaemic heart disease (22 %) and colorectal cancer (19 %), along with breast cancer and cerebrovascular disease (stroke) – each accounting for 13 %.

Figure 9. Preventable causes of mortality are above, but treatable causes are below the EU averages



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Half of all deaths for some diseases (e.g. ischaemic heart disease and cerebrovascular disease) are attributed to preventable mortality; the other half are attributed to treatable causes. 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 2018, except for France 2016).

Tobacco control policies include the introduction of plain cigarette packaging in 2020

The leading cause of preventable mortality is lung cancer, which accounts for 22 % of all preventable deaths (see Figure 9). In 2017, the parliament passed comprehensive tobacco control legislation that bans smoking and use of electronic cigarettes in all enclosed public places and workplaces, as well as in all vehicles in the presence of minors. The legislation prohibits all forms of advertising of cigarettes (including e-cigarettes) and other tobacco products, including a ban on all point-of-sale displays. The licensing system for retailers of tobacco and related products, in place since 2018, contains heavy penalties for breaches of the regulations, including withdrawal of the licence in the case of selling products to minors or contravening the advertising ban.

The law also introduced plain packaging for cigarettes and tobacco from 1 January 2020. This measure faced significant pushback from both some members of parliament and the tobacco industry. Nonetheless, proposals to delay implementation of the law were rejected at the committee level of the parliamentary process, based on evidence from the NIPH, anti-tobacco NGOs and public statements from leading WHO experts. The legislation was fully enacted in January 2020.

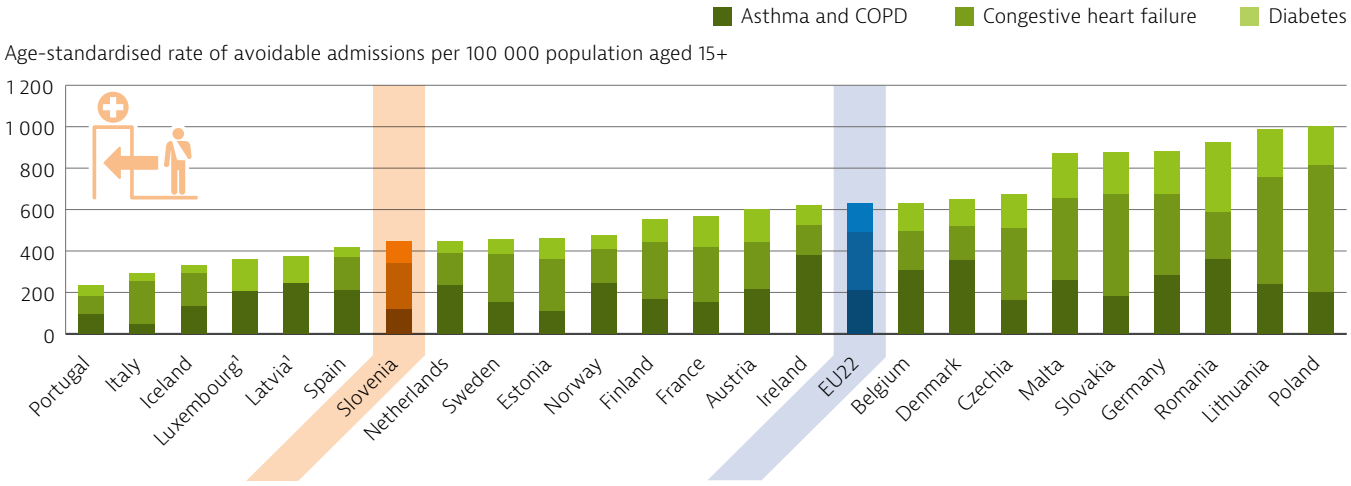
Uptake of influenza vaccinations continues to increase, but remains well below the EU average

The rate of vaccination against influenza among those aged 65 and over has increased slightly since 2016. However, with only 19 % coverage in 2019, Slovenia remains well below the EU average of 42 %. This is due partly to a low perception of risks related to flu among the older population, and partly to the vaccine not being free of charge. Until the 2019/2020 influenza season, the cost of the vaccine for risk groups was covered by the health insurance system, but these patients had to pay for its administration. To increase uptake, since 2020 all costs have been fully reimbursed for these groups. In addition, for the 2020/21 season, the flu vaccination cost was free of charge for all Slovenian citizens to increase coverage further and avoid the confluence of influenza and COVID-19.

Primary care is comparatively effective in preventing avoidable hospital admissions

Hospital admission rates for chronic diseases such as asthma and chronic obstructive pulmonary disease (COPD) in Slovenia have generally been decreasing over the last decade and are among the lowest in the EU (Figure 10). For asthma and COPD, Slovenia had the fourth lowest rate in the EU in 2019 (at 119 admissions per 100 000 population), behind Italy, Portugal and Estonia. This reflects a fairly effective primary care system, where new models such as the family medicine practices provide more coordinated chronic care for target groups, as well as preventive services for the whole population (see Section 4).

Figure 10. Avoidable hospitalisation admissions in Slovenia are below the EU average



Note: 1. Data for congestive heart failure are not available in Latvia and Luxembourg.
Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

The quality of cancer care has been improving

According to CONCORD Programme data, the five-year survival rates for prostate, breast, cervical, colon and lung cancer have gradually improved since 2000-04, and for people diagnosed between 2010 and 2014 they almost all passed or reached the EU averages (Figure 11). This points to improved quality

through more effective therapies and screening. Further support for promoting cancer programmes is available through the Europe's Beating Cancer Plan, launched in February 2021, which focuses on four key action areas: prevention, early detection, diagnosis and treatment, and improving quality of life (European Commission, 2021).

Figure 11. Five-year survival rates for common cancers are above or close to the EU averages

Prostate cancer	Breast cancer	Cervical cancer	Colon cancer	Lung cancer
Slovenia: 85 %	Slovenia: 84 %	Slovenia: 66 %	Slovenia: 62 %	Slovenia: 15 %
EU23: 87 %	EU23: 82 %	EU23: 63 %	EU23: 60 %	EU23: 15 %

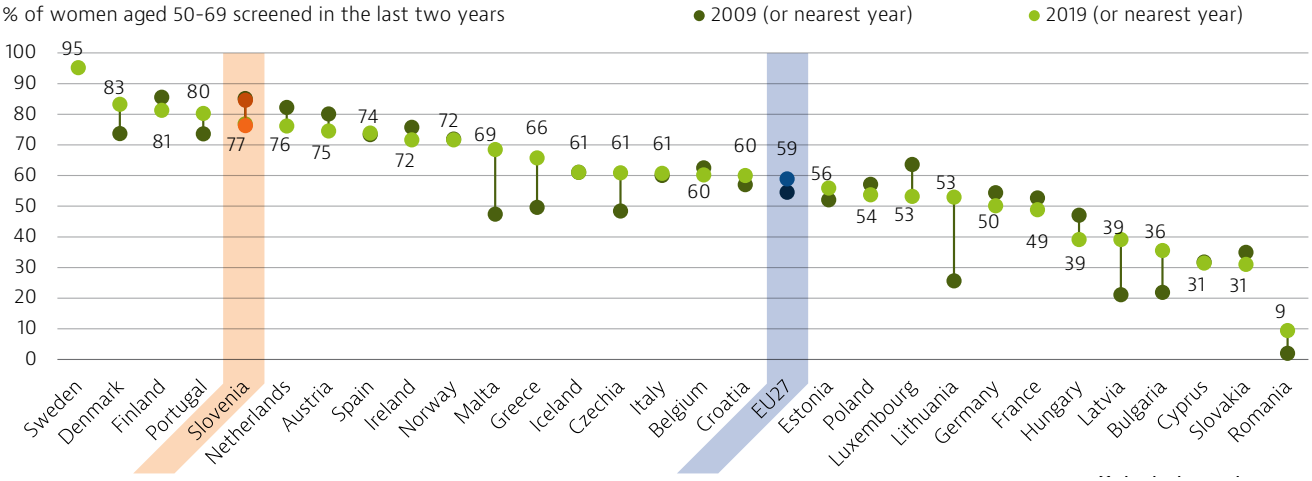
Note: Data refer to people diagnosed between 2010 and 2014. Childhood leukaemia refers to acute lymphoblastic cancer.
Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.

Despite a decrease in the screening rate for breast cancer, Slovenia remained above the EU average before the pandemic

Several screening programmes for cancer have been launched since 2000, including for early detection of cervical cancer in 2001, colon cancer in 2008 and breast cancer (initially as a pilot) in 2008. Since then, breast cancer screening has gradually been introduced region by region, reaching 77 % coverage of women aged 50-69 in 2019.[4] Breast cancer screening rates in Slovenia are now ahead of neighbouring countries like Croatia and Hungary, and above the EU average (Figure 12).

In March 2020, all non-essential ambulatory visits and elective surgery appointments were halted temporarily owing to the COVID-19 outbreak. This meant that all preventive cancer care activities were also suspended, including cancer screening, which resumed in autumn 2020. Although oncology treatment was not halted, an evaluation of the clinical activity in cancer programmes showed a significant drop in the number of oncological referrals in April 2020 and a subsequent steady rise in May 2020 (Zadnik et al., 2020); and recent survey data covering the whole year show that referrals for breast, cervical and colorectal cancer experienced only small declines compared to 2019.

Figure 12. The breast cancer screening programme has a higher participation rate than the EU average



Note: The EU average is unweighted. For most countries, the data are based on screening programmes, not surveys. The data for Slovenia are for single years - 2010 (just one pilot region) and 2019.
Source: OECD Health Statistics 2021 and Eurostat Database

4. *The screening rate for breast cancer was lower in 2019 than 2010 (the base year for Slovenia) because initially more women participated in the pilot programme in the selected region. It took approximately 10 years to reach full regional coverage. When it becomes available, data for 2021 – three years after full regional coverage was achieved – is expected to show higher screening rates.*

5.2 Accessibility

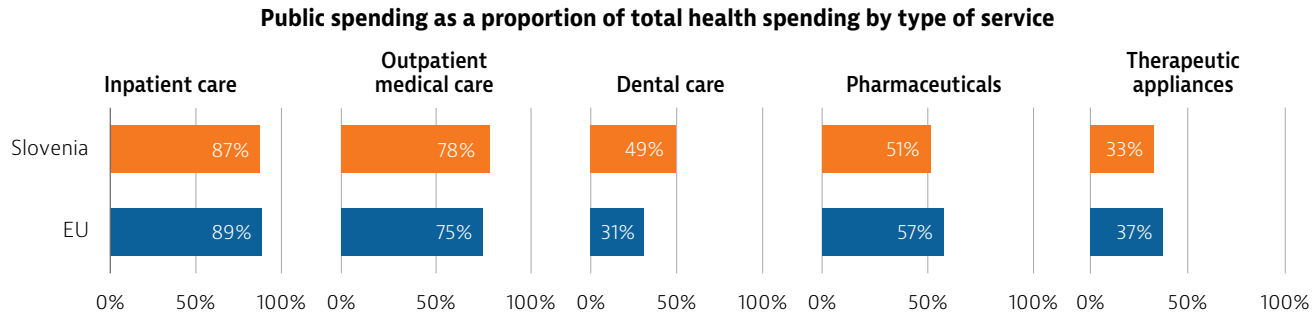
Small gaps in coverage persist for some marginalised population groups

Slovenia has virtually universal population coverage for permanent residents (see Section 4). Less than 1 % of the population are not covered, primarily comprising marginalised groups who cannot meet the formal residency requirements to be eligible for SHI, such as undocumented migrants and ethnic minority groups, including the Roma population. Furthermore, entrepreneurs undergoing bankruptcy are not covered due to inability to pay social contributions. Various efforts have been made to address administrative barriers to access. For example, the government introduced a pathway to permanent residency for people experiencing homelessness; if this is followed, their insurance contributions are covered by the state.

There is significant reliance on complementary insurance to cover high cost-sharing

Slovenia offers a comprehensive benefits package (see Section 4) and provides public financing of services largely on par with the EU average, except for outpatient and dental care, for which SHI provides a greater share of public funding than the EU average (Figure 13). However, the number of services fully financially covered is gradually decreasing, with uncapped cost-sharing varying between 10 % and 90 % of the price of services. As a result, about 95 % of the population who are liable for co-payments purchase complementary VHI, paying a flat-rate premium to cover these cost-sharing arrangements. For poorer households that receive social benefit payments (amounting to approximately 100 000 people) the government subsidises these premiums. The remaining 5 %, for whom the VHI premium is financially out of reach but who also do not qualify for social benefits, are likely to experience higher levels of unmet needs due to cost than the rest of the population.

Figure 13. The share of public financing for outpatient and dental care is higher than the EU average

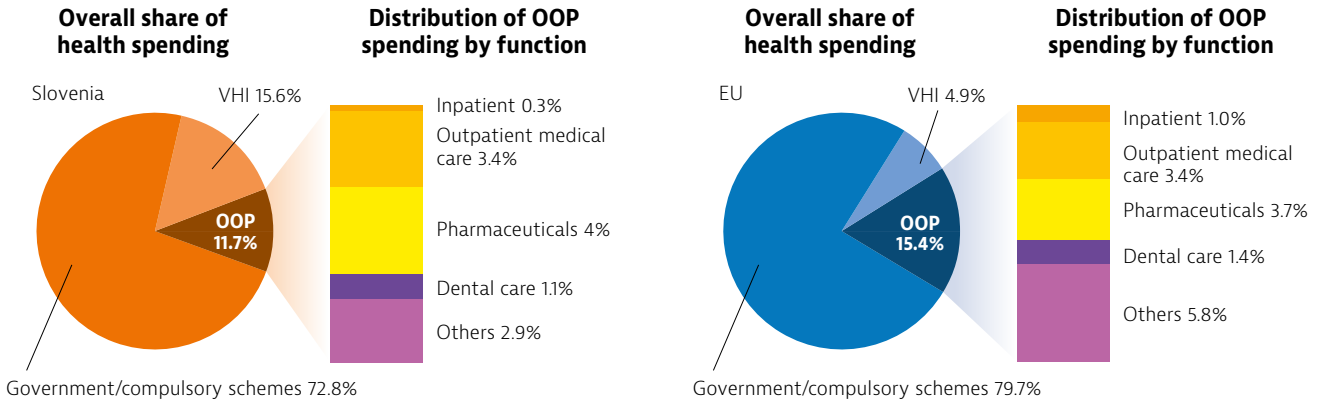


Note: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices.
Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

Out-of-pocket spending is among the lowest in Europe

Since most health services and medicines are covered by compulsory SHI and complementary VHI, Slovenia has the fifth lowest rate of OOP spending on health in the EU – 11.7 % of total health spending compared with 15.4 % across the EU as a whole in 2019 (Figure 14). OOP spending relates to direct payments for services outside the statutory benefits package and cost-sharing for services partly covered by public or private insurance. Informal payments, such as to those providing informal care, also have an impact on households' disposable income. About one third of OOP payments are related to pharmaceuticals (34 % of OOP expenditure in 2019), followed by outpatient care (29 %).

Figure 14. Pharmaceuticals and outpatient care account for three fifths of out-of-pocket spending

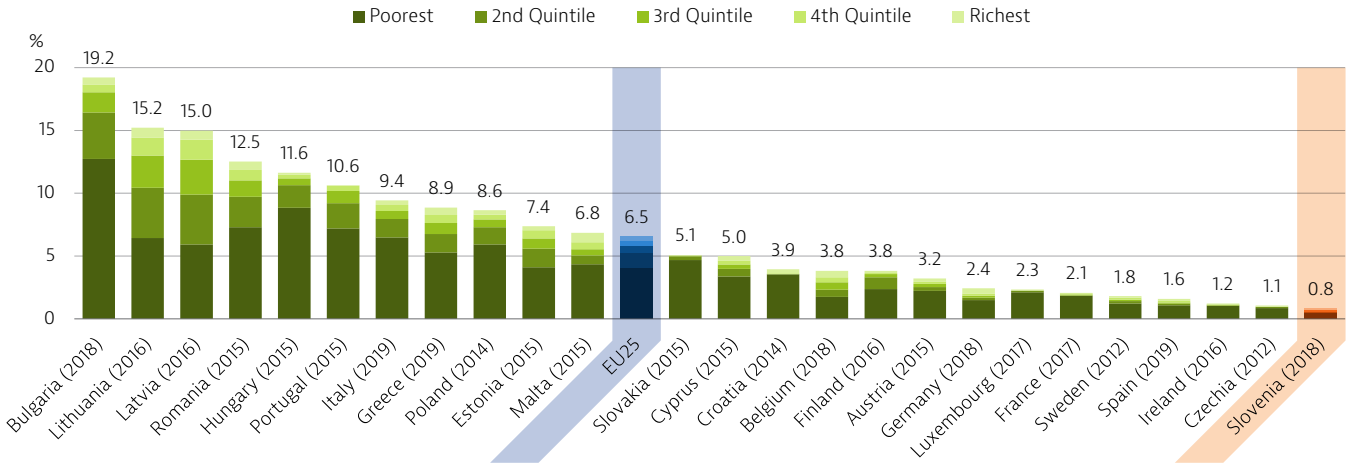


Note: The EU average is weighted. VHI also includes other voluntary prepayment schemes.
Sources: OECD Health Statistics 2021; Eurostat Database (data refer to 2019).

Measures are in place to protect against catastrophic spending

Exemptions are in place for those who cannot cover OOP payments, including state subsidies for pharmaceutical co-payments for war veterans, prisoners and people without income. At 0.8 % in 2018, Slovenia's population experiences the lowest rate of catastrophic expenditure[5] related to health of any European country (Figure 15). Nevertheless, as in other EU countries, over half of this catastrophic spending is concentrated among the poorest households.

Figure 15. Slovenia has the lowest rate of catastrophic health spending in the EU



Note: The EU average is unweighted.
Source: WHO Regional Office for Europe data, 2021.

Self-reported unmet needs for medical and dental care is driven by long waiting times

Prior to the COVID-19 pandemic, in 2019, 2.9 % of the Slovenian population reported unmet needs for medical care due to cost, distance or waiting times, which was above the average for the EU as a whole (1.7 %). However, the difference in unmet needs between income groups is negligible. Consistent with the country's low rates of OOP and catastrophic spending, as well as its dense provider network, long waiting times are the only significant factor driving unmet medical needs.

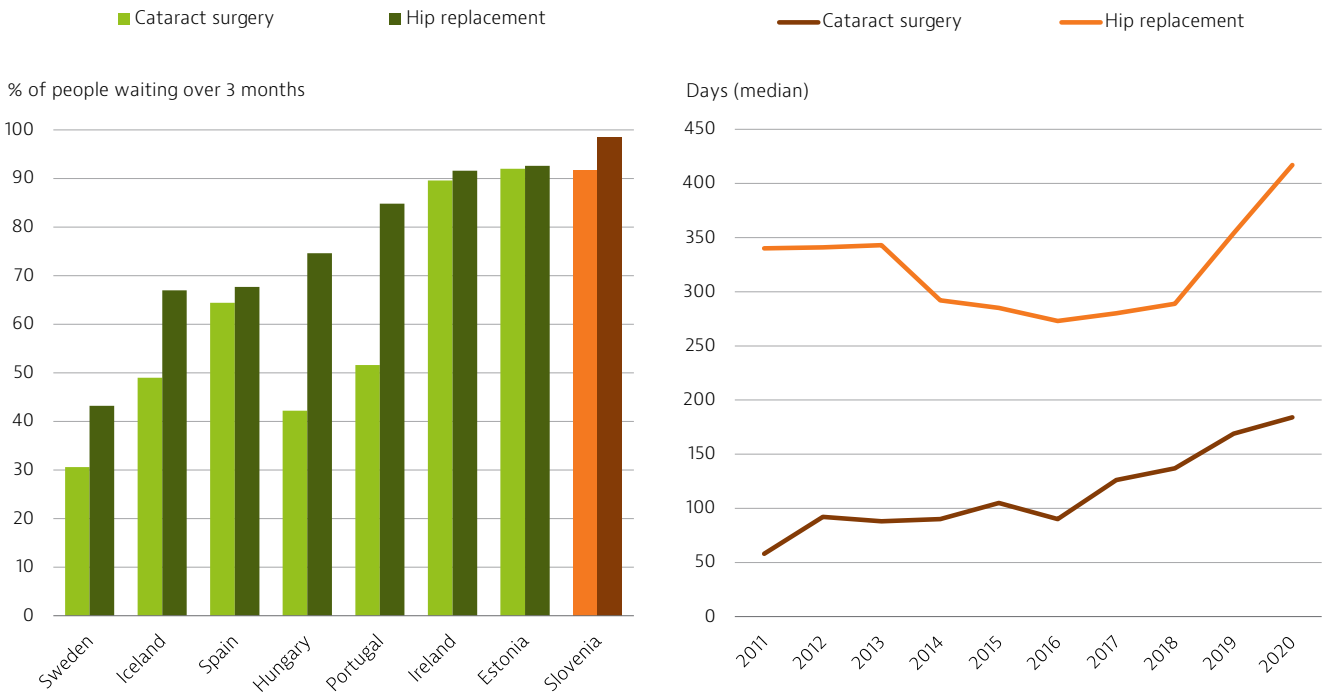
Waiting times for elective (non-urgent) surgery are substantial in Slovenia. In 2020, 92 % of patients on the list for cataract surgery had to wait more than three months for treatment, while 99 % of patients had to wait more than three months for hip replacements (Figure 16). This is a much higher

5. *Catastrophic expenditure is defined as household OOP spending exceeding 40 % of total household spending net of subsistence needs (i.e. food, housing and utilities).*

proportion than in most other EU countries. In 2018, the government targeted long waiting times with additional funding, and plans are in place to provide financial incentives for providers. Unlike most EU countries, the discrepancy in unmet needs between higher and lower income groups is minimal, which is probably because waiting times affect all income levels in a system without many complementary private alternatives (see Section 4).

Levels of unmet needs for dental care are higher than those for medical care, at 3.7 % in 2019 (compared to 2.8 % in the EU), varying between 4.0 % in the lowest income quintile and 3.3 % in the highest. As with medical care, unmet needs for dental care are mainly due to long waiting times, with 3.4 % of Slovenes reporting this as the main reason.

Figure 16. Waiting times for elective surgery in Slovenia are high and continue to grow



Source: OECD Health Statistics 2021

COVID-19 undermined access to care but growing use of online services or teleconsultations helped to bolster availability

All preventive measures, dental services and non-emergency outpatient visits – except oncological and pregnancy-related services – were halted temporarily between March and May 2020 to retain enough capacity to deal with the COVID-19 pandemic. Despite a resumption of services, 24 % of Slovenians reported that they had experienced some unmet needs for health care during the first 12 months of the COVID-19 pandemic (the EU average was 21 %) (Eurofound, 2021).[6] National data from the first seven months of 2020 show that GP consultations decreased by more than 30 %, and the number of planned elective orthopaedic interventions by more than 40 %, with these trends continuing into 2021. The numbers of hospital discharges and outpatient specialist services also fell. Conversely, there was no change in overall service uptake for oncology, dialysis or emergency cardiology in 2020.

At the same time, e-health tools were used to help maintain access to services throughout the pandemic and facilitate continuity of medical services. E-prescriptions are now the prevailing method of filling a prescription in Slovenia (reaching 96 % of all issued prescriptions in 2020). In the first 12 months of the pandemic, some 64 % of Slovenians reported receiving a prescription online or by telephone, and 65 % had a medical consultation via these means (Eurofound, 2021). This is significantly higher than the EU averages of 53 % for prescriptions and 38 % for consultations. Online consultations (for example, by email) are now recognised by the HIIS, which pays physicians for such consultations.

6. *The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.*

Slovenia provides relatively good access to pharmaceuticals

Compulsory SHI covers medicinal products that are on the HIIS's positive and intermediate lists, although only up to a maximum price set by the HIIS. Coverage of products on the positive list is either in full or at 70 %; coverage of products on the intermediate list is only up to 10 % of the price. Patients who have been prescribed a product with a higher price than that set by the HIIS can choose either to pay the difference or to receive a generic product without co-payment. Generic prescribing is an important driver of efficiency, and can improve access to pharmaceuticals for the population. By volume, the share of the generics market in Slovenia grew steadily from 42 % in 2009 to 53 % in 2019, which is above the average for EU countries for which data are available (49 %). Slovenia is also part of the Valletta Declaration, an international collaboration aiming to improve cost–effectiveness and decrease inequalities in access to medicines. The main goals of its pharmaceutical policies are aligned with the new pharmaceutical strategy for Europe adopted in November 2020 (European Commission, 2020).

5.3. Resilience

This section on resilience focuses mainly on the impacts of and responses to the COVID-19 pandemic.[7] As noted in Section 2, the COVID-19 pandemic had a major impact on population health and mortality in Slovenia, with approximately 4 780 COVID-19 deaths recorded between January 2020 and the end of August 2021. Measures taken to contain the pandemic also affected the economy. GDP in Slovenia fell by 6 % in 2020, equal to the EU average.

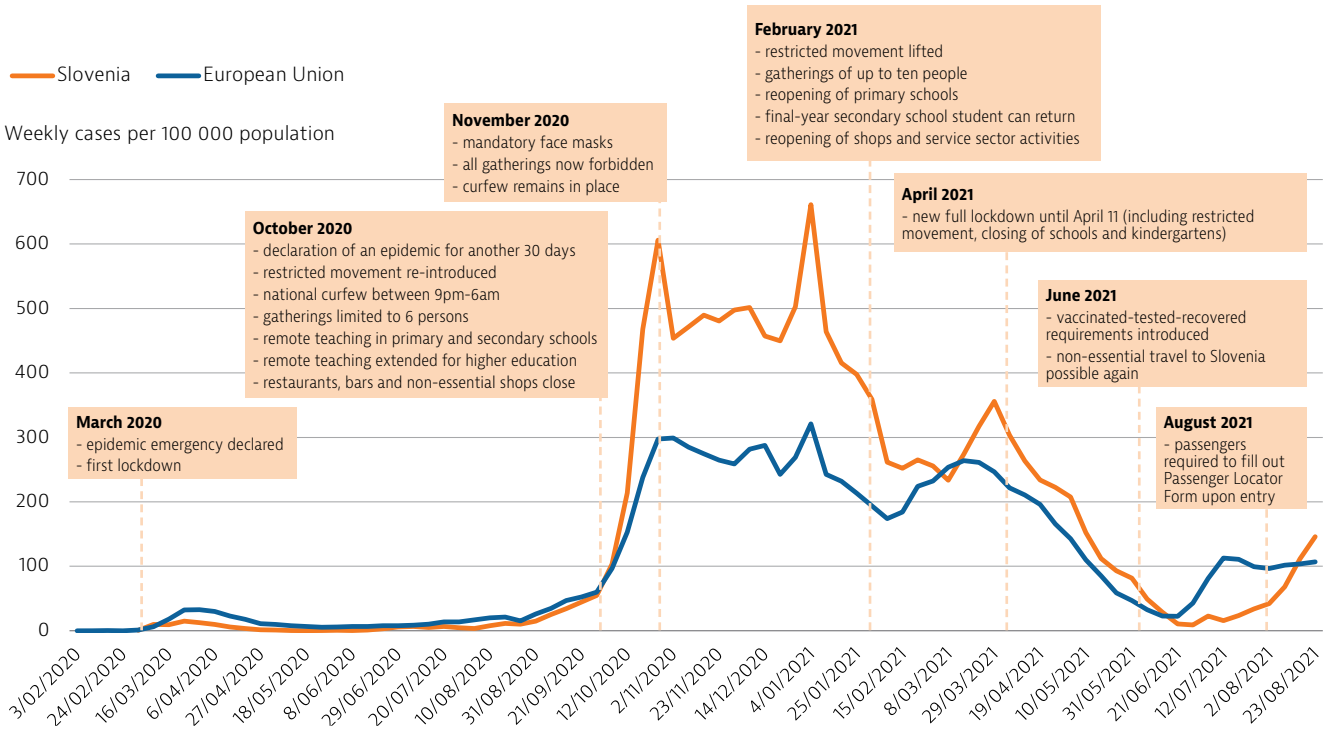
Slovenia took early steps to prevent the spread of COVID-19

The first case of COVID-19 in Slovenia was reported at the beginning of March 2020. Owing to an increase in the number of positive cases, on 12 March the government declared the coronavirus an epidemic, thereby activating a pandemic preparedness plan, followed by several virus mitigation measures. Initially, this included closing kindergartens, schools, universities, all but essential shops, restaurants, hotels, cinemas and hairdressers. At the end of March, the government introduced a new round of measures, including limiting movement within municipality of residence (with exceptions such as travelling to or from work).

Following a reduction in the number of active COVID-19 cases in April 2020, the government gradually phased out the lockdown restrictions, formally declaring an end of the epidemic emergency in mid-May, although wearing a mask in enclosed public spaces continued to be in force. The number of positive cases started to rise slowly and steadily in August, and by October Slovenia was experiencing a second wave of COVID-19 infections, prompting the declaration of another epidemic emergency and a second lockdown (Figure 17). By the end of October 2020, the majority of restrictions from the first lockdown had been reinstated, such as restricted movement, a national curfew and closing of educational facilities and restaurants. At the beginning of 2021 the numbers finally started to decrease, but a spike in daily cases in the end of March 2021 resulted in a third, hard lockdown for two weeks. The lockdown had the intended result, as case numbers started to decrease and restrictions were subsequently lifted, including the opening of schools, kindergartens and restaurants. In June 2021, Slovenia opened up for travellers for the summer holiday season. Safety requirements included mandatory COVID-19 testing, or proof of vaccination or recovery from the virus before arrival.

7. In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessment, 2020).

Figure 17. Slovenia was hit hard by second and third waves of COVID-19

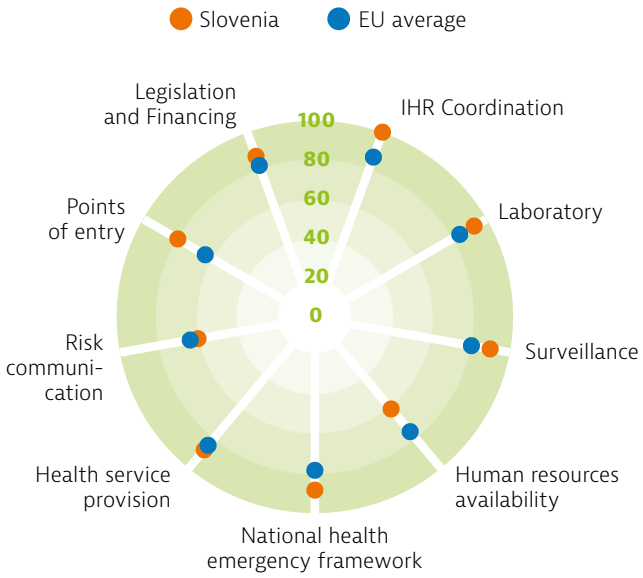


Note: The EU average (calculated by OECD) is unweighted (the number of countries used for the average varies depending on the week).
Sources: ECDC for COVID-19 cases and authors for containment measures.

A pandemic preparedness plan was introduced quickly

Slovenia had an effective initial response to the COVID-19 pandemic. Based on the International Health Regulations (IHR) framework,[8] before the pandemic the country reported above-average scores for many indicators of self-reported capacity to detect and manage public health risks, including legislation and financing, laboratory capacity, surveillance, health emergency framework and points of entry. However, Slovenia scored below the EU average on availability of human resources and risk communication (Figure 18). A pandemic response plan was put in place in March 2020, but it received criticism because it was specific to an influenza epidemic and did not include all the measures needed for the COVID-19 outbreak. More positively, the country's laboratories had been stockpiling reagents before the pandemic started in Slovenia, which meant that there was never a bottleneck in PCR testing.

Figure 18. Slovenia scored above average in many areas of public health emergency capacities



Note: The EU average is unweighted.
Source: WHO IHR (data refer to 2019).

8. *Since 2005, the IHR have provided an overarching legal framework that defines countries' rights and obligations in handling public health events and emergencies. Under the IHR, all member states are required to develop public health capacities to prevent, detect, assess and respond to public health risks. The monitoring process of IHR implementation status involves assessing, through a self-evaluation questionnaire, 13 core capacities.*

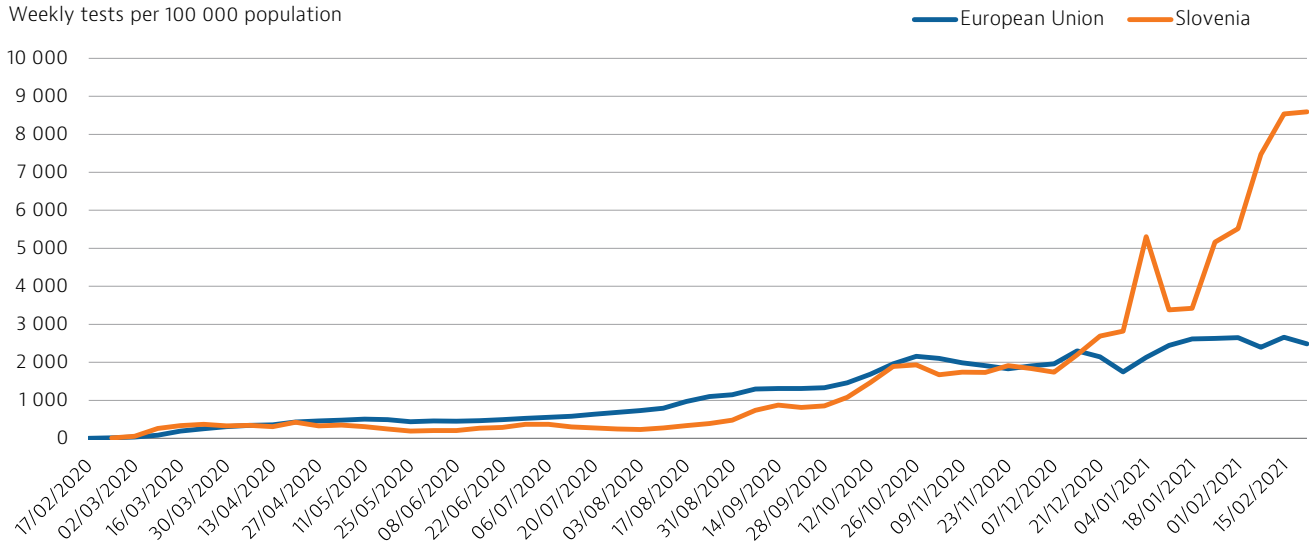
Various policies were used to try to mitigate existing shortages of health care professionals

The numbers of doctors and registered nurses (see Section 4) are low in Slovenia. This was a major challenge during the pandemic, resulting in overburdened medical professionals and at times lower quality of care. As a response, doctors in specialist training were appointed to provide services necessary to manage COVID-19 patients, and medical students were commissioned to work on a dedicated free helpline. In October 2020, a temporary reallocation of medical professionals to more affected areas helped to address higher work pressure due to COVID-19. As compensation, all reallocated health workers were entitled to a 20 % salary top-up. Health care professionals working in particularly risky environments had their hourly rates increased by 65 % during the declared periods of epidemic emergencies (including March to May 2020 and October 2020 to June 2021). Special bonuses were also paid throughout the pandemic to remunerate health workers with additional workloads and those working with COVID-19 patients in hospitals and residential care facilities. Although various initiatives were implemented to mitigate shortages in the health workforce, the crisis highlighted the need for more long-term investment to increase workforce capacity in Slovenia.

A voluntary and free rapid testing campaign started at the end of December 2020

Three national laboratories conduct COVID-19 tests in Slovenia. At the beginning of the pandemic, only those showing symptoms were tested, resulting in relatively high test positivity rates. This strategy changed in mid-March 2020, and three categories of people could get tested: people with symptoms of COVID-19 and in need of hospitalisation, health care professionals and people residing in residential care facilities with signs and/or symptoms of infection. By the end of October 2020, waiting times for appointments for a COVID-19 test had started to increase (Government of Slovenia, 2020a). Moreover, capacity was stretched, and test positivity rates reached over 30 % during this period. In December 2020, in the midst of the second wave, the government initiated a voluntary and free rapid testing campaign, which led to a steep rise in the number of weekly tests (Figure 19).

Figure 19. Slovenia's testing levels accelerated from the second wave of the pandemic in October 2020



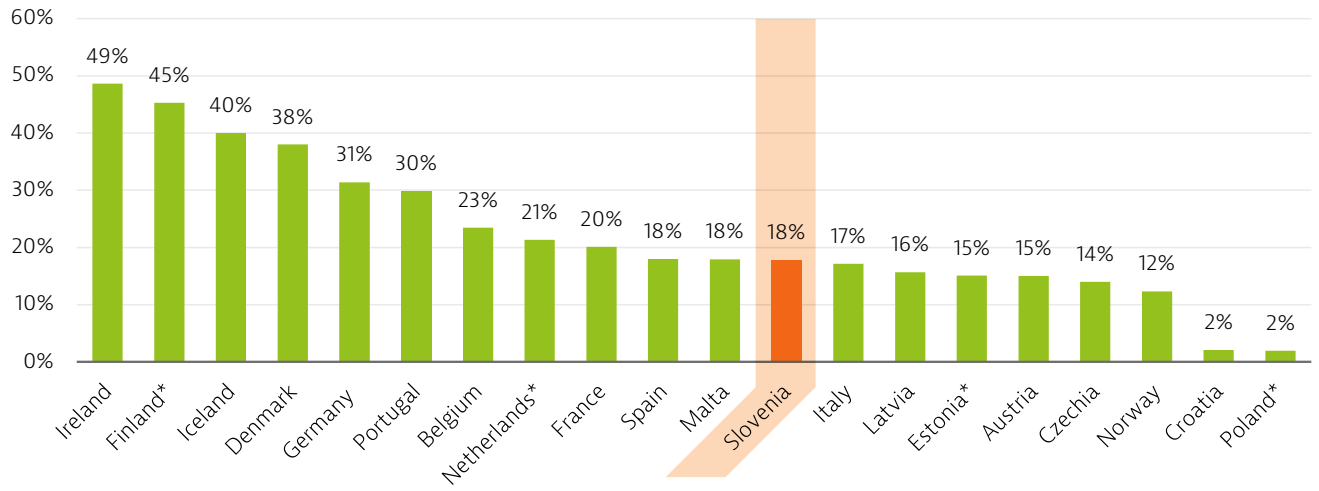
Note: The EU average is weighted (the number of countries included in the average varies depending on the week).
Source: ECDC.

Dissatisfaction with the Slovenian contract tracing application resulted in limited uptake

To prevent further spread of the virus, the government launched a mobile contact tracing app *#OstaniZdrav* (#StayHealthy) in August 2020. It was based on the German-developed, open-source Corona-Warn-App, and was adapted for cross-border data sharing in January 2021. In December 2020, when the government limited movement between municipalities, the contact tracing app was introduced as a condition for crossing municipal borders. This was withdrawn two weeks later, as complaints about the requirement started to emerge. Furthermore, critics pointed out that the app was not working optimally, was not usable on all mobile devices and was not being updated regularly. In particular, the app received bad reviews from Android users, and only 18 % of the population had downloaded it by February 2021 (Figure 20).

Figure 20. Around one in five people downloaded the COVID-19 contact tracing application

% of the population who downloaded the app



*Note: Data as of April 2021. * Data to autumn 2020.*
Source: National data.

COVID-19 patients never occupied more than one third of hospital bed capacity during the first wave

The number of hospital beds in Slovenia is comparatively low (4.4 compared to 5.3 per 1 000 across the EU in 2019). In anticipation of increasing pressure on hospitals during the first wave, the government introduced policies to free up beds and boost surge capacity. For example, certain hospital procedures were halted to free up capacity to treat COVID-19 patients (see Section 5.2), and the army set up field hospitals to create more intensive care unit beds. Since not all the beds could be fitted with adequate ventilators, a rapid tendering procedure was implemented to purchase at least 300 additional ventilators.

When COVID-19 case numbers started to decrease as a result of the lockdown, elective procedures were resumed, but with longer waiting times, worsening an existing problem (see Section 5.2). In the end, the COVID-19 patient hospital bed occupancy rate was never more than one third of total capacity during the first wave of the pandemic. During the second wave, a special coordinator was appointed to manage hospital capacity and provide real-time data.

The COVID-19 pandemic laid bare vulnerabilities in the long-term care system

Several residential care facilities were hotspots during the first wave of the COVID-19 pandemic, most of which were homes for elderly residents. During this period, around 85 % of COVID-19-related deaths were among the population aged over 70, of whom the majority resided in nursing homes. Policies were implemented to protect recipients and providers of LTC from COVID-19, and to maintain continuity of elderly care during the first wave of the pandemic. This included improved access to PPE (through funding or direct distribution), prioritised rapid testing of care home residents and staff, restrictions within facilities (such as restricted visits and isolation measures) and boosting staff numbers (via funding or staff redeployment).

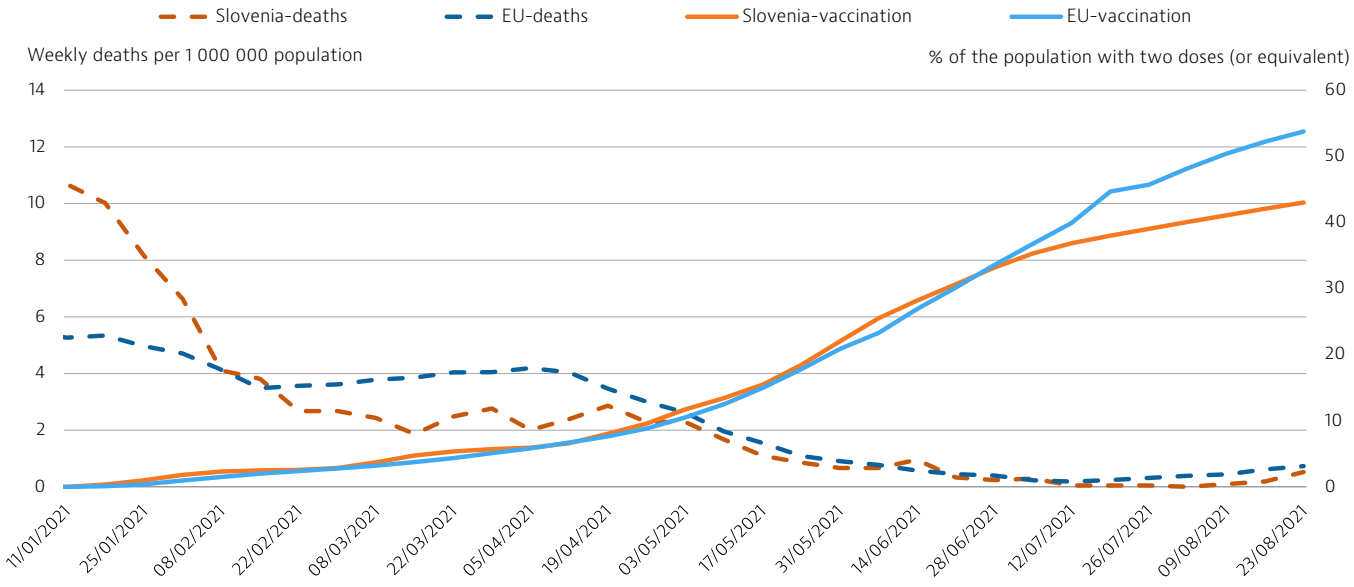
The COVID-19 pandemic showed the need for a more homogenous system of LTC. The current system is highly fragmented, governed by different legal regulations and funded from a variety of sources (European Union, 2021). Other major issues include significant staffing shortages, particularly for the provision of social care, in elderly care homes and limited professional competencies catering for care home patients with complex needs (Government of Slovenia, 2020b).

Slovenia's vaccination campaign picked up pace in spring 2021

A national COVID-19 vaccination strategy was presented by the government at the end of 2020. First-line priority was given to residents and employees of care homes, and front-line and at-risk health professionals. Mobile units from primary health care centres were in charge of carrying out vaccinations in care homes. Second-line priority included patients with a chronic illness or increased risk of severe illness from COVID-19, and those working in critical infrastructure, such as the education, police and transport sectors. Distribution of the vaccines was carried out through a central system, set up and managed by the NIPH

(Government of Slovenia, 2021). By early March 2021, a total of 61 vaccination centres had been established across the country (MMC, 2021), which accelerated progress in vaccinating the population. However, the summer months saw a slowdown, and by the end of August 2021, 43 % of the population had received two vaccine doses (or equivalent), which is below the EU average of 54 % (Figure 21). Vaccination against COVID-19 is provided free of charge to all citizens with permanent or temporary residency.

Figure 21. The vaccination level in Slovenia was on par with the EU average until summer 2021



Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Source: ECDC for COVID-19 deaths and Our World In Data for vaccination rates.

The pandemic highlighted the need for investment in health information systems and infrastructure

The Slovenian health care system had undergone a digital transformation before the COVID-19 outbreak. The e-health Project (2008-15) introduced e-prescriptions, e-appointments (e-referrals and online booking of appointments), several other digital solutions and a system of electronic patient records. Furthermore, in 2017 the government presented a Digital Slovenia 2030 strategy, with specific investments in the health care sector. When the COVID-19 pandemic struck, e-health solutions became an important alternative to delivering health care services face to face. They facilitated an infection risk-free method of communication both between health care professionals and between health care professionals and patients (Stanimirović & Matetić, 2020).

The pandemic also highlighted the need for further investment in health infrastructure. Slovenia's hospitals are relatively old and unsuitable for treating patients with infectious diseases. The government has dedicated over EUR 270 million of its National Recovery and Resilience Plan to investments in the health care sector. In particular, EUR 83 million is dedicated to digital health transformation, including digitalising medical records. A further, EUR 79 million has been set aside for setting up an LTC system that integrates health and social care services. Additionally, EUR 110 million will be put towards increasing the resilience of the health care system, including investment in infrastructure such as new medical facilities and equipment.

6 Key findings

- In 2020, COVID-19 was the main cause of mortality in Slovenia, accounting for about 12 % of deaths. As a result, life expectancy fell temporarily by one year between 2019 and 2020, erasing 20 % of the gains achieved in the previous two decades. At 80.6 years in 2020, average life expectancy among Slovenes is now equal to the EU average.

- In 2018, stroke, ischaemic heart disease and lung cancer were the main causes of mortality. Behavioural and environmental risk factors were associated with more than one third of all deaths. In particular, poor nutrition, tobacco and alcohol are all public health concerns, especially among adolescents.

- Public health policies targeting smoking and alcohol consumption have slowly contributed to decreasing preventable mortality, although it remains higher than the EU average. On the other hand, mortality from treatable causes is below the EU average, indicating that Slovenia provides effective health care interventions. These are evidenced by gradually improving avoidable hospital admissions and five-year cancer survival rates. Cancer screening programmes and new primary care models have also had an impact. Improvements can be encouraged by targeting risk factors and promoting healthy lifestyles, especially among adolescents, which would address some of the drivers of avoidable mortality. Much is expected from the scale-up of general practitioner family medicine practices and health promotion centres, which should improve screening and coordination of public health action across primary care centres.

- The Slovenian health system successfully protects its citizens from high out-of-pocket payments. In the years prior to the COVID-19 pandemic, households experienced low rates of catastrophic spending related to health. At only 12 % of total health expenditure, out-of-pocket spending is among the lowest in Europe, mainly due to the role of widespread voluntary health insurance to cover co-payments and special subsidies for those who cannot afford this insurance.

- Slovenia introduced several measures to overcome health workforce shortages, which are one of the main challenges of the system. These measures include additional funding, task-shifting and new care provision models. The COVID-19 pandemic put extra pressure on the workforce and necessitated several temporary measures to manage the situation. However, the crisis highlighted the need for sustained investment to increase workforce capacity.

- The COVID-19 pandemic challenged access to preventive and other health care services in Slovenia. Uptake of services in primary and preventive care – including general practitioner consultations, cancer screening and planned elective orthopaedic surgery – fell during 2020. Consistent with this trend, the number of hospital discharges and outpatient services also decreased. On the other hand, Slovenia was able to maintain provision of life-saving services, including in oncology, dialysis and emergency cardiology. Increased use of teleconsultations has helped to maintain access to services throughout the pandemic and to facilitate continuity of care.

- The COVID-19 pandemic has highlighted the need for large-scale investment in the health sector and demonstrated the value of having strong digital infrastructure. Hospital and long-term care facilities have largely been neglected over the past decade, resulting in out-of-date buildings and fragmented provision of services across health and long-term care. Slovenia has dedicated over EUR 270 million from its National Recovery and Resilience Plan for investment in the health care sector, including enhancing digitalisation, upgrading of facilities and achieving greater integration between health and social care services.

Key sources

Albreht T et al. (2016), *Slovenia: health system review. Health Systems in Transition*, 18(3):1-207.

OECD/EU (2020), *Health at a Glance: Europe 2020 – State of Health in the EU Cycle*. OECD Publishing, Paris.

References

Eurofound (2021), *Living, working and COVID-19 survey, third round* (February-March 2021).

European Commission (2020), *A pharmaceutical strategy for Europe.*

European Commission (2021), *Europe's Beating Cancer Plan.*

European Union (2021), *2021 Long-term Care Report: Trends, challenges and opportunities in an ageing society.* Country profiles, Volume II.

Government of Slovenia (2020a), *The testing system will be supplemented by rapid tests*, Ljubliana.

Government of Slovenia (2020b), *The first positive signs of stabilisation of the situation at the Hrastnik Care Home*, Ljubliana.

Government of Slovenia (2021), *National vaccination strategy against COVID-19* Version II, 1 March 2021, Ljubliana.

MMC (2021), *In the new vaccination strategy of 61 vaccination centers, the Nigerian strain has also been confirmed in Slovenia*, Ljubliana.

Stanimirović D, Matetić V (2020), Can the COVID-19 pandemic boost the global adoption and usage of eHealth solutions? *Journal of Global Health*, 10(2):0203101.

WHO Regional Office for Europe (2016), *Evaluating implementation of the resolution on the Slovenian food and nutrition action plan 2005–2010: upgraded evaluation, 2016.*

WHO Regional Office for Europe, European Commission, European Observatory on Health Systems and Policies (2021), COVID-19 Health Systems Response Monitor – Slovenia.

Zadnik V et al. (2020), Impact of COVID-19 on cancer diagnosis and management in Slovenia –preliminary results, *Radiology and Oncology,* 54(3):329.

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		

European Commission

State of Health in the EU
Country Health Profile 2021

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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