This Health System Summary is based on the Health System Review (HiT) published in 2021 and relevant reform updates highlighted by the Health Systems and Policies Monitor (HSPM) (www.hspm.org). For this edition, key data have been updated to those available in March 2022 to keep information as current as possible. Health System Summaries use a concise format to communicate central features of country health systems and analyse available evidence on the organization, financing and delivery of health care. They also provide insights into key reforms and the varied challenges testing the performance of the health system.


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How is the health system organized?

ORGANIZATION

Slovenia has a universally accessible, mostly publicly owned health care system underpinned by the core values of universality, solidarity, equality, equity of funding, accessibility, quality and safety. It is based on a statutory, employment-based social health insurance (SHI) system, with a single payer, the Health Insurance Institute of Slovenia (Zavod za zdravstveno zavarovanje Slovenije – ZZZS). Voluntary Health Insurance (VHI), provided by three companies, also plays a significant role, providing complementary coverage for co-insurance (called co-payments in Slovenia) of services within the benefits package; the supplementary insurance market is small.

The National Parliament determines policy and approves relevant budgets annually. The Ministry of Health (MoH) has a stewardship role, implementing policy, developing, and supervising the system to ensure that public health and health care services are provided in line with national legislation and regulations. The National Institute of Public Health (Nacionalni inštitut za javno zdravje – NIJZ) is responsible for essential public health functions and provides support for the health system and health care governance (Box 1).

PLANNING

The MoH is responsible for strategic planning. A national health care plan that must be approved by Parliament is the principal instrument. The current plan spans 2016–2025 and defines the goals and activities to be undertaken. Infrastructure planning, such as of secondary and tertiary health care facilities, distribution of large-scale medical equipment and capital investment in hospitals, is based on health needs assessment and is overseen by the MoH. Municipalities are responsible for capital investment planning in primary health care.

BOX 1 | ASSESSING INSTITUTIONAL CAPACITY FOR POLICY DEVELOPMENT AND IMPLEMENTATION

Health policy-making in Slovenia frequently suffers from insufficient capacity for policy development and implementation. This has been obvious, for example, in the case of the long-awaited reform of long-term care (LTC) and in the preparation of planning and strategic documents, which can take a long time. Further, the implementation of these instruments is often uncertain due to a lack of adequate resources, both human and financial. Frequent political changes in Slovenia also impact implementation efficiency.

A notable exception is the public health system, which enjoys strong institutional capacity through the Public Health Directorate at the MoH and the NIJZ. The close collaboration of these entities ensures strong scientific support for the development of public health policies and facilitates programme implementation. Such strong institutional capacity is also more resilient to frequent political changes.

PROVIDERS

Providers can be individual or institutional. Individual providers in primary and secondary care practice work: 1) as salaried employees of a public provider; 2) based on concessions (i.e. as a private provider within the publicly financed network, where payment is determined by a contract with ZZZS); or 3) as private providers
outside the public system (receiving direct payments from patients or their supplementary VHI).

Municipality-owned, multi-professional, community-based primary health care centres (CPHCs) mainly deliver primary care and employ 76% of primary care physicians. The vast majority of hospitals providing specialized secondary and tertiary care are state owned.

How much is spent on health services?

FUNDING MECHANISMS

Revenue flows to the health care system through public and private sources. The main public sources are employee-employer SHI contributions and to a much smaller degree, general taxation. Both national and municipal level taxation provides revenue for capital investments, national public health programmes, and to ensure financial resources for socially vulnerable groups. Premiums for VHI and household out-of-pocket (OOP) payments drive private spending.

The national health budget is determined by the ZZZS, the MoH and the Ministry of Finance (MoF) every year; the Government gives final approval. The budget allocates resources based on historical data to care areas with no further allocation by geography or need. In parallel, the ZZZS and MoF define a yearly cap on total public expenditure for SHI, which is operationalized in the health insurance fund’s contracts with providers.

HEALTH EXPENDITURE

FIG. 1 TRENDS IN HEALTH EXPENDITURE, 2000–2019

Note: GDP: gross domestic product; PPP: purchasing power parity.

Health expenditure rose from around 7.8% of gross domestic product (GDP) in 2000 to 8.5% in 2019 (Fig. 1). Among countries with an SHI system, Slovenia spent more per capita (US$ PPP 3,629) than Slovakia and Czechia, but less than the Netherlands, Austria and Germany (Fig. 2).

Public spending on health was 72.8% – government (3.4%) and SHI (69.4%) – of total spending in 2019, which is below the EU average (79.7%). This accounts for 6.2% of GDP but is projected to be confirmed as 7.3% of GDP in 2020. Private health expenditure, driven by VHI and OOP payments, reached 27.2% of total spending in 2019 (EU average: 20.3%). In 2018, 73% of the Slovene population (around 95% of those liable) had complementary VHI to help cover co-payments, a key feature of the SHI system. Consequently, VHI accounts for more than half of private health expenditure, which is the highest in the EU.

FIG. 2  CURRENT HEALTH EXPENDITURE (US$ PPP) PER CAPITA IN WHO EUROPEAN REGION COUNTRIES, 2019

Notes: CHE: current health expenditure; PPP: purchasing power parity.
Data for Albania are from 2018.
Source: Global Health Expenditure Database, December 2021.
OUT-OF-POCKET PAYMENTS

At 11.7% of total health spending in 2019, OOP payments were far below the EU average of 15.4% (Fig. 3). They are driven by cost-sharing (via co-payments) and direct payments. However, since most services are covered by compulsory SHI and complementary VHI, OOP spending mainly relates to direct payments for services outside the statutory benefits package and cost-sharing for services partly covered by public or private insurance. Information on the division of OOP payments according to cost-sharing and direct payments is not available. However, a review of the allocations by health system function showed that in 2019 payments went to: inpatient care (2.2%), ambulatory services (29.2%), pharmaceuticals (34.1%), dental care (9.4%), and other (25.1%). Informal payments, such as for informal care, also have an impact on households’ disposable income.

FIG. 3  COMPOSITION OF OUT-OF-POCKET PAYMENTS, 2019

Note: OOP: out-of-pocket.

Source: OECD Health Statistics, 2021; Eurostat Database, 2021 (data refer to 2019).

COVERAGE

More than 99% of all permanent residents are covered by Slovenia’s SHI scheme (Box 2). The statutory benefits package is comprehensive, offering 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, and for children/students up to the age of 26. All other services involve cost-sharing, ranging from 10% to 90% of the price of services and goods.
Primary health care services are paid for via several mechanisms (Fig. 4). Services provided in CPHCs by personal physicians (e.g. family medicine specialists, primary-level paediatricians, and gynaecologists) are financed through a combination of capitation and fee-for-service (FFS); mental health and health promotion services are paid a flat rate; and dentistry, physiotherapy and community nursing services are paid exclusively FFS. Outpatient secondary-level specialist services provided by hospitals are remunerated on an FFS basis; inpatient care uses a payment model based on diagnosis-related groups (DRGs).
What resources are available for the health system?

HEALTH PROFESSIONALS

The ratio of physicians to population (328 per 100,000) is lower than the EU27 average (382) (Fig. 5). Meanwhile, the density of practising nurses (1,033 per 100,000 population) is above the EU average (915 per 100,000 population). This number includes vocationally trained nursing technicians (about 63% of total nurses) and registered nurses (around 37%).

Personnel shortages are acute in primary health care (specialists in family medicine, paediatricians, gynaecologists, community nurses) and for nursing professionals in hospitals. Rural areas experience challenges in primary care and outpatient specialist care, which are mainly concentrated in larger towns. Several measures have been introduced to overcome shortages, including additional funding, task-shifting and new care provision models.

Notes: EU27: European Union 27 countries; WHO EURO: WHO European Region.

HEALTH INFRASTRUCTURE

In 2019, there were 413 beds in acute hospitals per 100,000 in Slovenia, which is more than the EU average (Fig. 6). Since 1990, acute care beds have decreased by 37% (representing 79% of all hospital beds). A total of 30 public and private hospitals provide inpatient care in Slovenia, of which 27 are state owned.

The number of magnetic resonance imaging (MRI) units and computed tomography (CT) scanners is low compared with the EU average (1.24 and 1.82 per 100,000 versus 1.64 and 2.0 per 100,000) (Fig. 7). There is no national needs assessment or plan for investment in such equipment; rather it is the responsibility of health care facility owners.

FIG. 6  BEDS IN ACUTE HOSPITALS PER 100 000 POPULATION IN SLOVENIA AND SELECTED COUNTRIES, 2000–2019

FIG. 7  MAGNETIC RESONANCE IMAGING (MRI) AND COMPUTED TOMOGRAPHY (CT) SCANNERS IN SLOVENIA, 2019


Note: Data for MRI and CT scanner units include those in ambulatory facilities and acute hospitals.

DISTRIBUTION OF HEALTH RESOURCES

The location of hospitals in Slovenia is historical; many were founded in the 19th century in the same places they are today. Both Ljubljana and Maribor, the two largest cities, have a university clinic; the Institute of Oncology, the Rehabilitation Institute and the main psychiatric clinic are in Ljubljana; and there are 10 general hospitals located in regional centres.

CPHCs and concessionaires working in primary care are the first point of entry to health care and are relatively fairly distributed across Slovenia. CPHCs follow a territorial logic and are situated to serve 35,000 residents on average (ranging from 328,000 in Ljubljana to 4,200 in the small town of Radeče).

How are health services delivered?

PRIMARY AND AMBULATORY CARE

Most primary care is delivered by a network of 63 CPHCs, owned by municipalities. They follow a community-oriented care model and offer a wide range of preventive, diagnostic, curative, rehabilitative, palliative and health promotion services (Box 3). Patients can choose their personal physician (family medicine specialists, paediatricians, gynaecologists, dentists), who act as gatekeepers to secondary and tertiary care via referrals.

CPHCs also provide a range of support functions and services, such as laboratory and diagnostic services, physiotherapy and occupational therapy, mental health services, community nursing and health promotion programmes. Individual or group concessionaries may also provide publicly financed care.

Specialist outpatient activities at the secondary care level are performed in public and private hospitals, private specialist practices and spas. Certain bigger CPHCs also offer selected specialized secondary-level ambulatory services. This is especially true of cities and towns without a general hospital nearby. Finally, individual or group practices of private specialists also provide care; these may have a concession or not. Access to specialized secondary-level ambulatory care is typically by referral, which is mandatory for reimbursement by the ZZZS. Despite significant past efforts, long waiting times, especially for secondary-level specialist ambulatory services, persist.

BOX 3 | WHAT ARE THE KEY STRENGTHS AND WEAKNESSES OF PRIMARY CARE?

The organization of CPHCs enables a unique integration of preventive and curative services, with emphasis on outreach to vulnerable individuals/populations and providing services tailored to their specific health needs. Moreover, primary care in Slovenia is well distributed geographically.

Starting in the 1990s, reforms worked to ensure financial protection for patients and improve effectiveness, especially in the context of the country’s chronic disease burden. Measures help those who cannot cover OOP payments, including state subsidies for pharmaceutical co-payments for war veterans, prisoners and people without income. Nevertheless, other access challenges persist, such as rising shortages due to geography and a population need for different types of primary care providers. Additionally, insufficient cooperation of primary care with the secondary care level hampers care coordination and rational monitoring of complex chronic patients. Ongoing reforms, such as Family Medicine Practices and Health Promotion Centres, aim to strengthen care coordination and prevention in primary care.
**HOSPITAL CARE**

Hospital care is accessible through a referral by a specialist or primary care physician or emergency services. Once referred, patients may freely choose their specialist providers, who are mainly located in regional centres near hospitals. Nearly all inpatient services and most secondary-level outpatient services are provided in hospital; tertiary care is provided by university medical centres (Ljubljana and Maribor) and other specialized institutions.

Slovenia’s 27 public hospitals represent more than 90% of all inpatient capacity. Efforts have been made since the 2000s to shift care provision from inpatient to outpatient settings. Consequently, the number of acute hospital beds and the average length of hospital stay have decreased, and the share of 1-day surgical procedures has increased.

**PHARMACEUTICAL CARE**

Slovenia spent 17.4% of total spending on pharmaceuticals in 2019 (EU27 average: 13.9%). There are 342 pharmacy units (242 public, 98 private, 2 hospital-based) accessible to outpatients in 2020. Municipalities are responsible for capital investment for public pharmacies within their territories. SHI covers medicines on a positive list (0–30% co-payment) and an intermediate list (90% co-payment), though only up to a maximum attributed value set by the NIJZ. The NIJZ monitors drug consumption.

**LONG-TERM CARE**

Long-term care (LTC) is the joint responsibility of the MoH and the Ministry of Labour, Family, Social Affairs and Equal Opportunities and, as such, is regulated under distinct legislation. With no overarching regulation, the rights and services for the elderly, chronically ill, disabled and other individuals with special long-term needs are provided through different routes across the health, social care and pension and disability sectors, with different procedures for assessing financial support. Consequently, some people in need benefit more from current arrangements than others, whose needs might remain unrecognized altogether.

The need for a universal systemic solution for LTC was highlighted by the COVID-19 pandemic, and, after a prolonged legislative process, a new Long-term Care Act was adopted by Parliament in late 2021. Additionally, reform measures for (health related) LTC provision will be addressed in the framework of Slovenia’s National Recovery and Resilience Plan.

**BOX 4 | ARE EFFORTS TO IMPROVE INTEGRATION OF CARE WORKING?**

Public health and primary care services are quite well integrated in Slovenia under the multi-professional, community-based, person-centred primary health care model. Several reforms to community-based primary health care centres (CPHCs) in the last 10 years have also looked to strengthen management of chronic care within these settings. However, lack of cooperation between the primary and secondary care levels has not improved substantially. Interaction between the two takes place mostly through referrals and exchange of patient records. This may change in the future with new e-solutions for patient records and prescriptions, among other things. Meanwhile, there are good examples of coordination with health and social care, mostly for patient who need institutionalization or at-home nursing care.
DENTAL CARE

Dental care is organized principally at the primary care level. Primary care dentists are one of the categories considered as personal physicians. As with health care, dental services are supplied by three types of providers: 1) dentists in the public network, primarily employed by CPHCs and funded through ZZZS; 2) concessionaires; and 3) private dentists working for private patients. Although dental care is historically part of the basic benefits package in Slovenia, and public financing for dental care is generally larger in Slovenia than across the EU (49% versus 31%), a significant share of active dentists is purely private (15%); 40% are concessionaires.

What reforms are being pursued?

In the last 5 years, Slovenia has implemented an e-Health programme to improve service quality, integrate existing health information systems and optimize health data. Recent applications include a Central Registry of Patient Data (CRPD), a patient portal (zVEM), e-prescriptions, e-appointments and e-referrals, e-triage, teleradiology and remote monitoring for stroke patients. These were critical for continuity of service provision during the COVID-19 pandemic.

Strengthening primary care has been a long-standing priority. In 2019, the WHO Regional Office for Europe and the NIJZ conducted an analysis of the root causes of the challenges to primary health care intended to inform a new strategy due in 2022. There have also been several organizational reforms to CPHCs, focusing on further care integration (Box 4). A network of 28 health promotion centres (HPCs),

| BOX 5 | KEY HEALTH SYSTEM REFORMS OVER THE LAST 10 YEARS |
| --- |
| • Pilot project for integrated prevention and management of lifestyle related chronic diseases in primary health care (2014–2016; 2018): with an emphasis on vulnerable populations, to introduce health promotion centres; reinforce collaboration between public health and primary health care; and strengthen community-engagement-for-health approaches, including engagement of civil society (implemented). |
| • National Programme on Nutrition and Physical Activity for Health 2015–2025 (2015): to define 10 strategic goals and actions for improving nutrition and enhancing regular physical activity in the population throughout the life-course (under implementation). |
| • National Health Care Plan 2016–2025 “Together for a society of health” (2016): to set the vision and objectives for the development of the health system from 2016 to 2025 (under implementation). |
| • Long-term care (LTC) reforms (2016; 2017): to establish a new directorate for LTC at the MoH (2016; implemented); to draft a LTC Act in 2017 to introduce a systemic regulation of LTC (passed in 2021, though mandatory insurance part of the LTC Act is to be defined in 2024). |
| • Nationwide “family medicine practices” roll-out (2018): first introduced in 2011 to improve care of chronic patients and introduce preventive services, “model practices” were scaled up nationally and recognized as standard for family medicine teams (implemented). |
first piloted in 2014, is gradually being introduced. A national scale-up of Family Medicine Practices, first piloted in 2011, began in 2018. These comprise a 0.5 full-time equivalent of registered staff nurses dedicated to improving prevention and care coordination for patients with stable chronic diseases.

Meanwhile, the financing and organization of LTC has been a persistent issue of national debate. In 2016, a new directorate was established at MoH to develop and implement new LTC legislation, which was adopted in 2021 after a prolonged legislative process. It introduces systemic regulation of LTC, though the financing of this system are not detailed (Box 5).

Future reform activity is likely to focus on the above as well as on health workforce planning; waiting times in secondary-level specialist care; diversification of health system revenue; and health system performance assessment (HSPA).

**How is the health system performing?**

**HEALTH SYSTEM PERFORMANCE MONITORING AND INFORMATION SYSTEMS**

Health system performance has improved in the last 30 years, primarily in inpatient care. The information generated clearly influences national health policy goals. However, performance assessment is lacking in primary health care. In 2017, the MoH asked the NIJZ to establish HSPA frameworks and capacities in the Slovene health system; while performance indicators were defined for all levels of health care, they have not yet been integrated into the system.

Over the past two decades, Slovenia’s health data collection, which is mostly centralized, has been modernized. Efforts to develop a standardized health information system have leveraged e-Health solutions and standard classification sets, leading to new streamlined data collection systems. A national e-Health (e-Zdravje) project (2010–2015) implemented new applications to improve service quality and capture and optimize the use of enhanced data.

**ACCESSIBILITY AND FINANCIAL PROTECTION**

Due to almost universal population coverage for a broad range of services, accessibility of services is good. Despite this, some more vulnerable populations, though small in number, face difficulties in obtaining insurance, and physician shortages make it hard to ensure patient access to services, particularly in primary care and rural areas.

In 2018, Slovenia experienced the lowest rate of catastrophic spending in Europe (0.8% of the population). More than half was for dental services that were not publicly financed. Although the rate of catastrophic spending is low, as in other EU countries, catastrophic spending is concentrated among the poorest households.

Meanwhile, in 2020, 2.7% of the population reported unmet needs for medical care due to cost, distance or waiting times, which is above the EU average (1.8%). However, the differences in unmet need among income groups is negligible (Fig. 8). Consistent with low OOP payments and catastrophic spending and a solid provider network, waiting times are the only significant factor driving unmet medical need. These are likely to disproportionately impact poorer households.
FIG. 8  UNMET NEEDS FOR A MEDICAL EXAMINATION (DUE TO COST, WAITING TIME, OR TRAVEL DISTANCE), BY INCOME QUINTILE, EU/EEA COUNTRIES, 2020


HEALTH CARE QUALITY

The National Health Plan 2016–2025 sets out several objectives related to improving quality and safety, including increased capacity and financial resources; strengthened training in quality, safety, and patient communication; and updating the set of quality indicators currently collected (Government of the Republic of Slovenia, 2016) (Box 6).

The indicator of avoidable admissions to hospitals – especially related to chronic conditions – is often used to gauge the strength and quality of primary care. By this measure, Slovenia compares relatively well to other European countries. In 2019, hospital admission rates for select conditions were among the lowest in the EU at 491 per 100 000 population (Fig. 9). However, the quality of hospital care in Slovenia varies depending on the condition or indicator considered. The standardized 30-day hospital mortality rate for acute myocardial infarction (AMI) is the second lowest in Europe at 4.2 per 100 patients, after the Netherlands and Sweden (3.5 each) (Fig. 10), but the rate of 30-day mortality following ischaemic and haemorrhagic stroke is concerning. Although these rates have improved, Slovenia still has in-hospital case-fatality rates that are above the European average for both conditions (Fig. 10).
BOX 6 | WHAT DO PATIENTS THINK OF THE CARE THEY RECEIVE?

While there are structures in place to monitor quality indicators, including patient experience, they are not yet integrated into national priority-setting, capacity planning or health service purchasing mechanisms.

Nationally, patients’ experiences in acute care and mental health are primarily surveyed. In 2013, (last published survey) services received an overall average score of 90.4 out of 100. However, concerns have been raised about the reliability of these results. In 2017, a national system for patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs) was established for specialist outpatient services and acute (hospital) care; in 2019, the average assessment of patient experiences was 9.25 out of 10.

Meanwhile, the most recent Eurobarometer survey (2014) on patient safety and quality of care reported that 73% of respondents considered the overall quality of health care in Slovenia to be very good or fairly good, compared with an EU28 average of 71% (European Commission, 2014).

FIG. 9 AVOIDABLE HOSPITAL ADMISSION RATES FOR ASTHMA AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CONGESTIVE HEART FAILURE AND DIABETES, 2019

Notes: COPD: chronic obstructive pulmonary disease.
Data for congestive heart failure are not available in Latvia and Luxembourg. Data for diabetes for Luxembourg is from 2015.
Source: OECD Health Statistics, 2021 (data refer to 2019 or nearest year).
Slovenia has made important gains across several health-system sensitive indicators, with scope for further improvement. Between 2000 and 2019, amenable mortality rates decreased, from 163.2 per 100 000 population to 73.7, lower than the EU average (Fig. 11). Preventable mortality, however, remains just above the EU average, despite significant efforts to address wider determinants of health and dedicated public health interventions – but this rate too has been reduced from 100.8 per 100 000 population in 2000 to 57.5 in 2019 (see also Box 7).

The standardized death rates per 100 000 population for the main causes of mortality – circulatory diseases and malignant neoplasms – have improved but remain comparatively high. Further, a first-ever HSPA report, assessing survival rates for colorectal, breast, lung, prostate, and cervical cancer, saw that while most of these indicators were modestly improving, survival rates were still worse than the EU average, except for cervical cancer.

**BOX 7 | ARE PUBLIC HEALTH INTERVENTIONS MAKING A DIFFERENCE?**

**Accessibility**

All public health interventions are fully financed by the ZZZS. This translates to an even distribution of activities across the country and equal access to all insured. Given the nature of financing, however, valid health insurance is a condition for accessing these programmes, which is a barrier for the small proportion of the population without insurance.

**Effectiveness**

Targeted anti-tobacco and alcohol interventions have seen a significant impact on health behaviours in Slovenia. Further, in the past 20 years, three major public health interventions in secondary prevention have made a tangible difference, though their roll-out has been protracted. These include:

- a programme for early detection of risk factors for cardiovascular diseases;
- a programme for early detection of depression and treatment; and
- cancer screening programmes for cervical (2002), breast (2008) and colorectal cancer (2009), which have helped reduce the incidence of cervical and colorectal cancer, decrease mortality due to cervical and colorectal cancer, and increase relative survival rates for breast cancer.
FIG. 11 AMENABLE AND PREVENTABLE MORTALITY PER 100,000 POPULATION IN SLOVENIA AND EU COUNTRIES, 2000 AND 2019

Notes: EU27: European Union 27 countries. Age-standardized death rates for all persons calculated by European Observatory for Health Systems and Policies. Source: Mortality and population data from WHO detailed mortality files (released June 2021); amenable causes as per list by Nolte and McKee (2004); preventable causes: lung cancer, chronic liver disease, road traffic.
HEALTH SYSTEM EFFICIENCY

Regarding the efficient use of health system resources, no country spends less on health with lower rates of amenable mortality than Slovenia (Fig. 12). Some spend significantly more and have correspondingly lower amenable mortality, suggesting that investing slightly more resources in the right areas could generate improvements to timely and appropriate treatment.

For hospital care, the average length of stay in a hospital (for acute care) in 2018 was 6.7 days, which is shorter than in Italy but longer than in Austria and Czechia. Meanwhile, several policies have targeted pharmaceutical spending and prescription practices (Box 8). In particular, the share of the generics market in Slovenia is steadily growing, from 35.2% in 2005 to an estimated 53.2% in 2019. Although this rate is above the regional average (49%), there is still room to scale-up generic penetration.

The Slovene health system in 2019 allocated most expenditure to outpatient (32.7%) and inpatient care (28.9%). Inpatient care spending was lower than the EU27 average (EU27 average 29.1%); outpatient care spending was higher (the EU27 average is 29.5%), reflecting the policy priority to shift from inpatient to outpatient care where this is clinically appropriate. However, many elements that could improve efficiency, such as a clear methodology for budget allocation based on population health needs, strategic purchasing, or the formal use of health technology assessment (HTA) to support coverage decisions, are still missing.

**FIG. 12 AMENABLE MORTALITY PER 100 000 POPULATION VERSUS HEALTH EXPENDITURE PER CAPITA, SLOVENIA AND SELECTED COUNTRIES, 2019**

Notes: PPP: purchasing power parity.
The consumption of medicines in Slovenia is steadily increasing. SHI covers medicinal products that are on the ZZZS’s positive and intermediate lists, but only up to a maximum price. Products on the positive list are covered in full or require 30% co-insurance. Products on the intermediate list require 90% co-insurance. Patients who have been prescribed a product with a higher price than set by the ZZZS can either pay the difference or receive a generic product without co-insurance.

Cost-control measures are an important policy area for Slovenia and can have a long-term impact on the supply of medicines. Special attention is also paid to the rational prescribing of drugs and in preventing the accumulation of already dispensed, but unused, medicines in the home environment. Several interventions promote more rational use of medicines in Slovenia: the classification of new drugs on the drug lists, which occurs on a regular basis; a multidisciplinary national body to coordinate policies on medicine use has been established; there is a national essential medicines list; falsified medicines are prevented from entering the legal market; there is continuing medical education; clinical guidelines, supervision, and proper patient information are used; and the public are educated about medicines.

Summing up

Among statutory health insurance countries, Slovenia is rather unique in that it relies almost exclusively on payroll contributions to fund its system, making health sector revenues vulnerable to economic and labour market fluctuations, and population ageing. Important organizational changes are underway or have been implemented, especially in prevention, primary, emergency and long-term care. Access to services is generally good, given the wide coverage of statutory health insurance. Further, Slovenia has some of the lowest rates of OOP and catastrophic spending in the EU, due to extensive uptake of complementary VHI. Yet long waiting times for some services are a persistent issue. Population health has improved in the last decades, albeit health inequalities due to gender, social and economic determinants and geography remain an important challenge.

Recently, the Slovene health care system was overwhelmed by the demand for COVID-19-related care. The pandemic’s longer-term effects are still unknown, but it has significantly impacted on life expectancy in the short-term and resulted in delayed or forgone consultations and treatments for other health issues, and longer waiting times. Additional challenges that need to be addressed to ensure long-term sustainability, strengthen resiliency and improve the capacity for service delivery and quality of care include: 1) health workforce planning; 2) outdated facilities; 3) health system performance assessment; and 4) implementation of current LTC reform.
## POPULATION HEALTH CONTEXT
### KEY MORTALITY AND HEALTH INDICATORS

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**Notes:** SDR: standardized death rate; TB: tuberculosis.

*Age-adjusted rates with the European standard population 2010.

**Source:** Eurostat, 2021; World Bank, 2022 for maternal mortality.

### REFERENCES

The European Observatory on Health Systems and Policies is a partnership that supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health systems in the European Region. It brings together a wide range of policy-makers, academics and practitioners to analyse trends in health reform, drawing on experience from across Europe to illuminate policy issues. The Observatory’s products are available on its web site (http://www.healthobservatory.eu).