



State of Health in the EU Slovenia

Country Health Profile 2023

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 policy makers and influencers with a means for mutual learning and voluntary exchange. For the first time since the series began, the 2023 edition of the Country Health Profiles introduces a special section dedicated to mental health.

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).

Contents

1. HIGHLIGHTS	3
2. HEALTH IN SLOVENIA	4
3. RISK FACTORS	7
4. THE HEALTH SYSTEM	9
5. PERFORMANCE OF THE HEALTH SYSTEM	11
5.1 Effectiveness	11
5.2 Accessibility	14
5.3 Resilience	16
6. SPOTLIGHT ON MENTAL HEALTH	20
7. KEY FINDINGS	22

Data and information sources

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

and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was finalised in September 2023, based on data that were accessible as of the first half of September 2023.

Demographic and socioeconomic context in Slovenia, 2022

Demographic factors

	Slovenia	EU
Population size	2 107 180	446 735 291
Share of population over age 65 (%)	21.1	21.1
Fertility rate ¹ (2021)	1.6	1.5

Socioeconomic factors

GDP per capita (EUR PPP ²)	32 546	35 219
Relative poverty rate ³ (%)	12.1	16.5
Unemployment rate (%)	4.0	6.2

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

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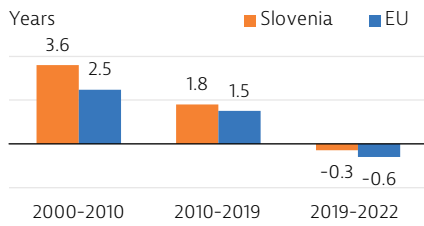
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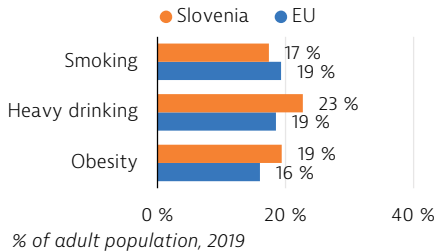
1 Highlights



Changes in life expectancy at birth

Health Status

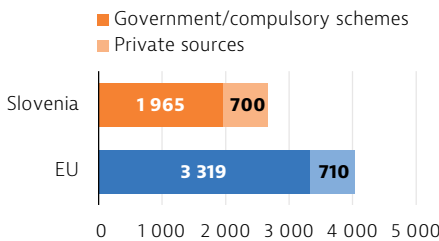
Half of the gains in life expectancy made in the previous decade in Slovenia were reversed during the first two years of the pandemic but rebounded strongly in 2022. Overall, Slovenia's life expectancy declined by 0.3 years during the pandemic period. At 81.3 years in 2022, life expectancy was above the EU average. Considerable inequalities in life expectancy by gender persist.



% of adult population, 2019

Risk Factors

Poor diet and tobacco consumption are responsible for around 31 % of deaths, and alcohol consumption for another 5 %. Although smoking rates have declined, alternative smoking products like electronic cigarettes pose new challenges, especially among adolescents. Prevalence of heavy drinking and overweight and obesity among adults and adolescents have increased.



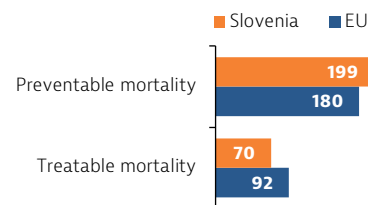
EUR PPP per capita, 2021

Health System

Slovenia's health expenditure – at EUR 2 665 per capita – is about two thirds of the EU average. Health expenditure has increased, driven by injections from Slovenia's pandemic response. Public spending on health reached 73.7 % of total health expenditure in 2021. Private spending is mostly by voluntary health insurance, while out-of-pocket payments are comparatively low.

Effectiveness

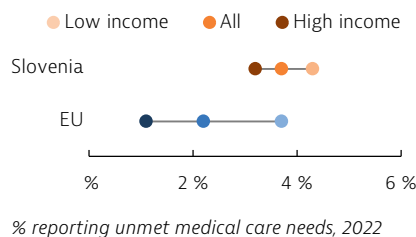
Driven by lung cancer, alcohol-related diseases and COVID-19 deaths, preventable mortality in Slovenia in 2020 was higher than the EU average. Treatable mortality rates have decreased by one third since 2011 to below the EU average. Ischaemic heart disease and colorectal cancer account for over two fifths of treatable causes of death.



Age-standardised mortality rate per 100 000 population, 2020

Accessibility

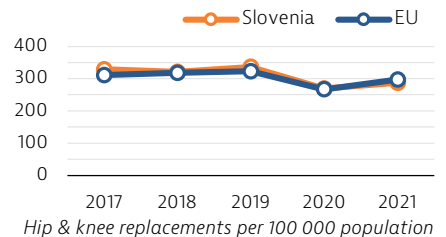
According to EU-SILC data, reported unmet medical needs decreased to 3.7 % in 2022, and the gaps with the EU average (2.2 %) and between income groups were reduced compared to the previous two years during the pandemic. Waiting times for specialist care are a key barrier to timely access to care.



% reporting unmet medical care needs, 2022

Resilience

The disruption to Slovenia's health services during the COVID-19 pandemic was on a par with that across the EU. Combined, hip and knee replacements fell by 15 % between 2019 and 2021. Waiting times for these procedures are consistently higher than the EU averages, but they experienced smaller increases than comparator countries.



Hip & knee replacements per 100 000 population

Mental Health

In 2019, 7.9 % of Slovenian adults reported having depression. As across the EU, women and individuals on lower incomes report depression more frequently. COVID-19 reinforced the links between mental health and socioeconomic status, and increased the mental health burden in Slovenia. The government responded by accelerating the establishment of mental health centres. These were originally required by the National Mental Health Programme 2018-28 – one of several measures introduced to improve prevention and strengthen community-based, integrated mental healthcare delivery.

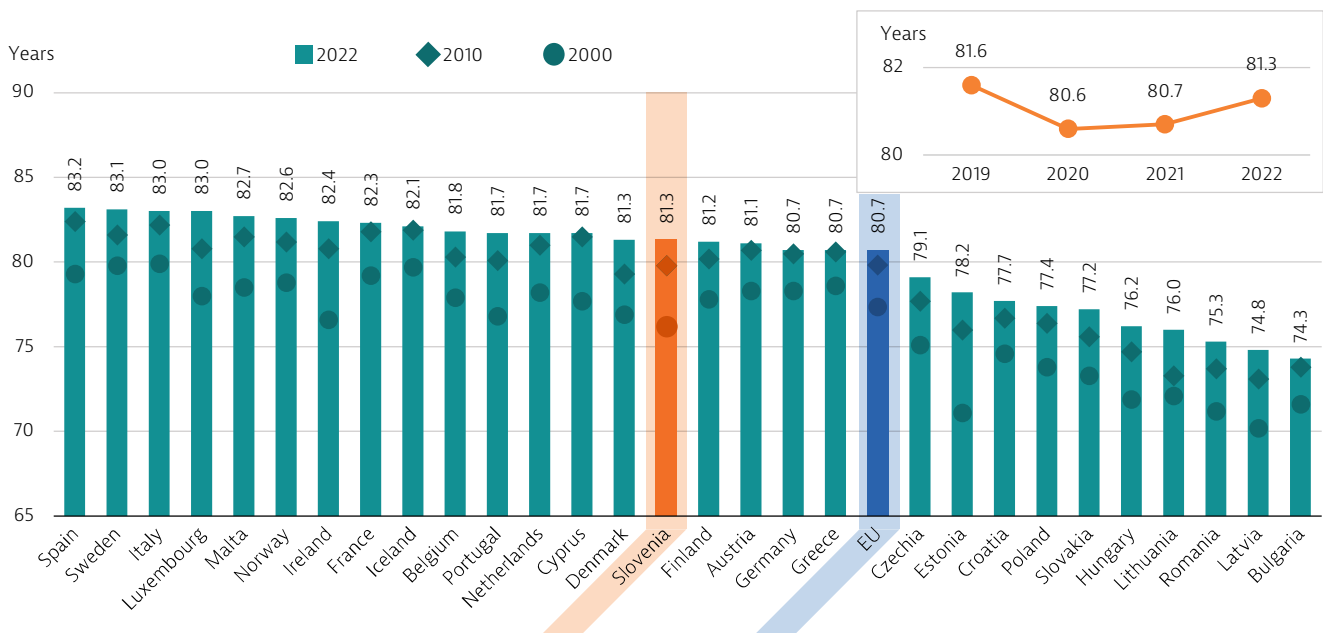
2 Health in Slovenia

Life expectancy at birth in 2022 is still lower than pre-pandemic levels

In 2022, life expectancy at birth in Slovenia was 81.3 years. While lower than pre-pandemic levels, it was slightly higher than the EU average and the level in countries with much higher health spending per capita such as Germany, Austria and Finland (Figure 1). In the 15 years before the pandemic, life expectancy increased steadily and surpassed the EU average in 2012 but, as in many

other EU countries, fell by 1 year in 2020 due to the impact of the COVID-19 pandemic. In 2021, life expectancy at birth rebounded slightly, in contrast to a further decline across the EU. The increase continued more strongly in 2022, recording a gain of 0.6 years. There are significant disparities by gender: in 2022, men were on average expected to die 5.5 years earlier than women, partly due to greater exposure to smoking, obesity and heavy drinking (see Section 3).

Figure 1. Despite the pandemic, Slovenia's life expectancy at birth remains higher than the EU average



Notes: The EU average is weighted. The 2022 data are provisional estimates from Eurostat that may be different from national data and may be subject to revision. Data for Ireland refer to 2021.

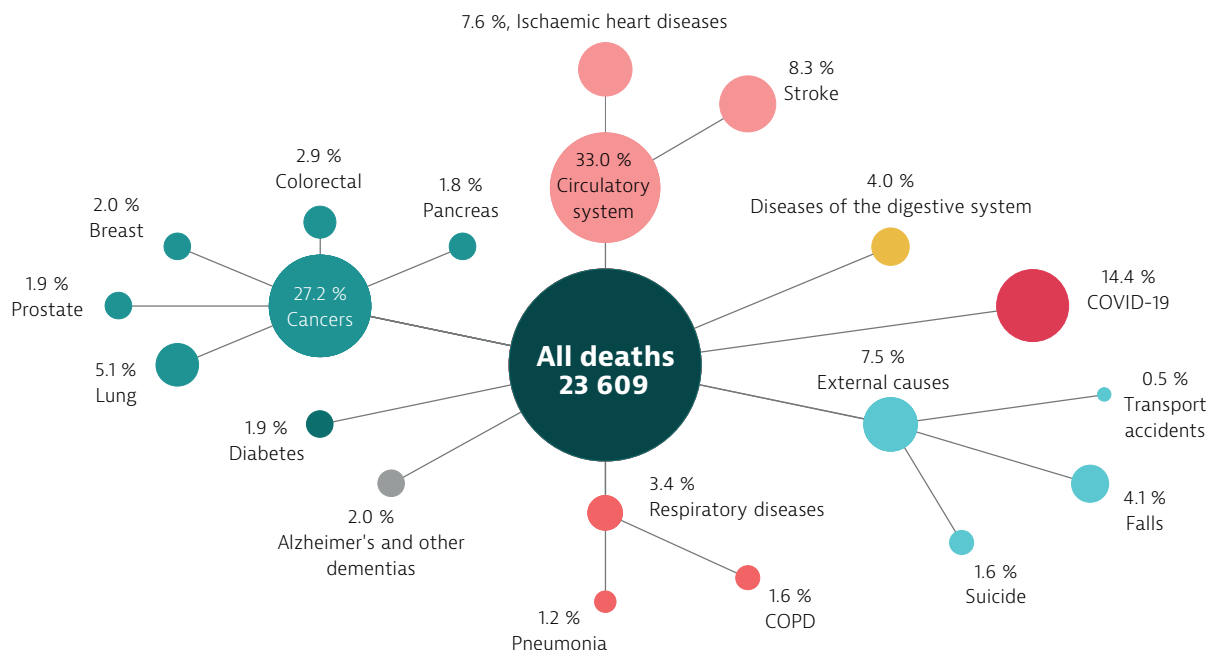
Source: Eurostat Database.

COVID-19 was one of the leading causes of death in Slovenia in 2020

Circulatory diseases and cancer account for around 60 % of all deaths. Circulatory diseases such as stroke and ischaemic heart disease remain the leading causes of death in Slovenia, accounting for one third of all deaths in 2020 – a share in line with the EU average. Cancers accounted for 27.2 % of all deaths in Slovenia, and lung cancer remains the most common cause of cancer death (Figure 2). COVID-19 was the third main recorded cause of mortality in 2020, accounting for about 3 400 deaths (14.4 % of all deaths), a majority of which (52 %) occurred among individuals aged 85 and over, which is above the EU average (43 %).

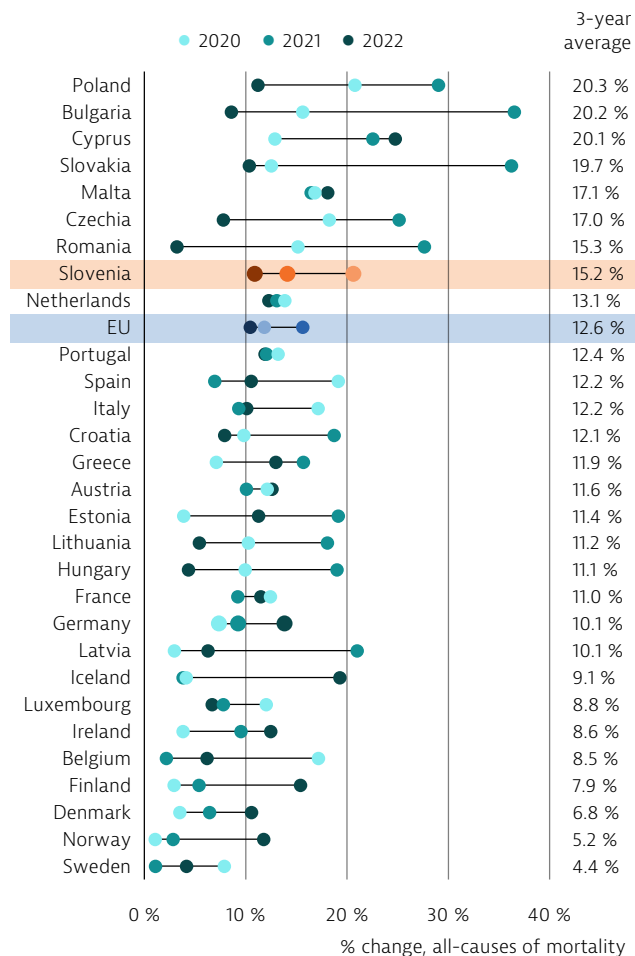
Excess mortality, defined as deaths that occurred (regardless of their cause) above a baseline derived from pre-pandemic levels, provides a more comprehensive account of the mortality impact of the pandemic. In Slovenia, over 9 000 excess deaths occurred in 2020-22, accounting on average for 15.2 % of deaths above their historic baseline, which is greater than the 12.6 % EU average (Figure 3). Excess mortality reached a peak in 2020 at 20.6 %, largely due to the severe COVID-19 surge near the end of the year, before the vaccine rollout. Slovenia's excess mortality was 14.1 % in 2021 and 10.9 % in 2022 – both rates close to the EU averages.

Figure 2. COVID-19 was the third main cause of mortality in 2020



Note: COPD refers to chronic obstructive pulmonary disease.
Source: Eurostat Database (data refer to 2020).

Figure 3. Excess mortality in Slovenia between 2020 and 2022 was above the EU average



Notes: Excess mortality is defined as the number of deaths from all causes exceeding the average annual number of deaths in the five years preceding the pandemic (2015-19).
Source: OECD Health Statistics based on Eurostat mortality data.

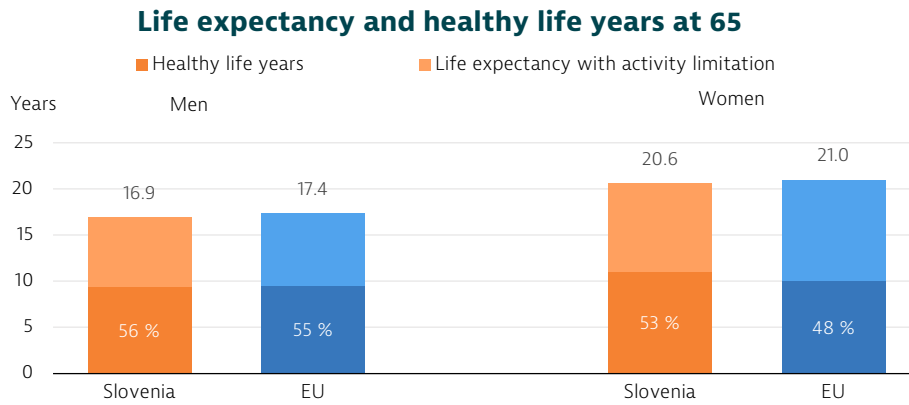
Reductions in excess mortality were due in part to Slovenia's COVID-19 vaccination programme, which contributed to lowering the fatality rate of large COVID-19 waves in late 2021 and early 2022; however, slow vaccine uptake has constrained further progress.

Older people in Slovenia have lower levels of co-morbidity

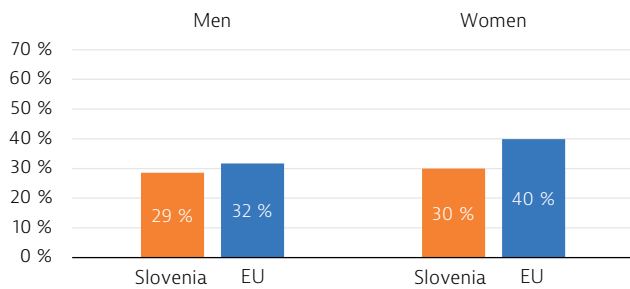
The share of the population in Slovenia aged 65 and over grew from 13.9 % in 2000 to 20.2 % in 2020, and is projected to increase to 31 % by 2050. In 2020, 65-year-old women in Slovenia could expect to live a further 20.6 years, while men could expect to live a further 16.9 years (slightly below the EU averages) (Figure 4). Older people enjoy almost half a year more of healthy life (defined as disability-free life expectancy) in Slovenia (10.2 years) than the EU average (9.8 years).¹ A similar share of those aged 65 and over in Slovenia experience activity limitations to the EU averages, with women reporting disabilities more frequently (29 %) than men (23 %). Meanwhile, fewer older women in Slovenia reported having multiple chronic conditions than the EU average.

¹ Although possible cultural differences in population perceptions of health and disability in later years may not be captured in the survey, with implications for data comparability.

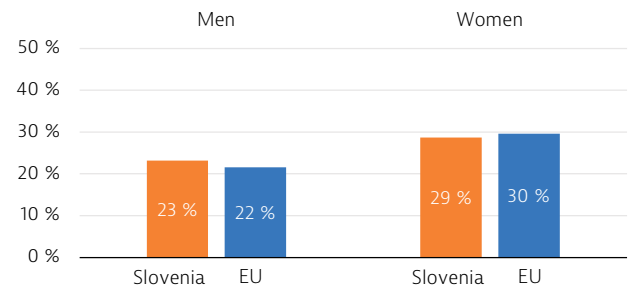
Figure 4. Fewer people aged 65 and over live with multiple morbidities in Slovenia than across the EU



Proportion of people aged 65 and over with multiple chronic conditions



Limitations in daily activities among people aged 65 and over



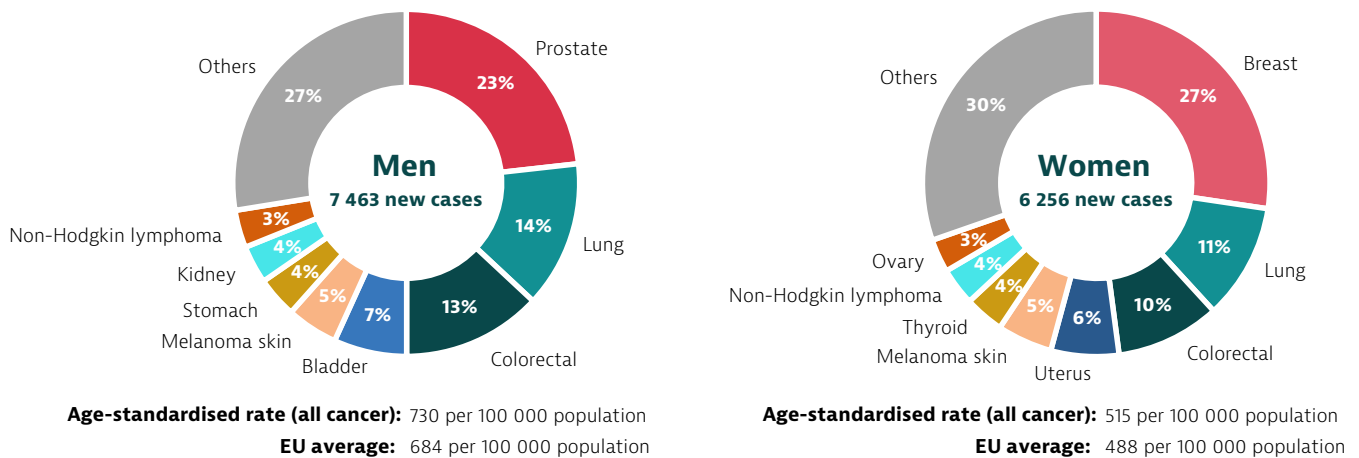
Sources: Eurostat Database (for life expectancy and healthy life years) and SHARE survey wave 8 (for multiple chronic conditions and limitations in daily activities). Data refer to 2020.

The burden of cancer is above the EU average

According to estimates from the Joint Research Centre based on incidence trends from previous years, just over 13 700 new cases of cancer were expected to be diagnosed in Slovenia in 2022. Cancer incidence rates were expected to be higher

than the EU averages for both men and women. Figure 5 shows that the main cancer sites among men were expected to be prostate, lung and colorectal cancer, while for women they were breast, lung and colorectal cancer.

Figure 5. Cancer incidence in Slovenia is higher for men than women



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

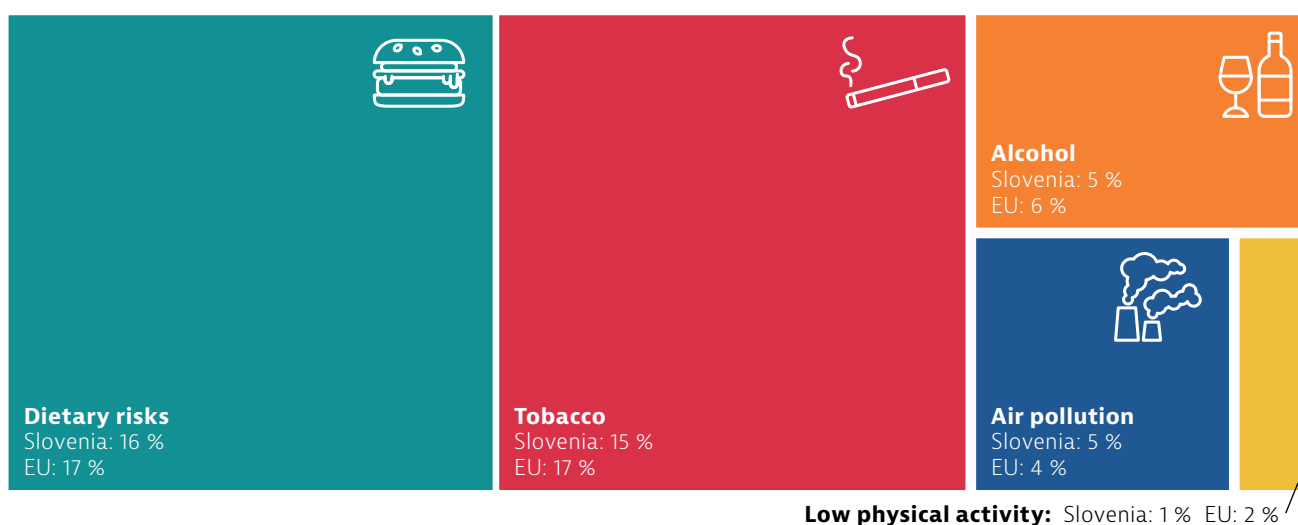
3 Risk factors

Behavioural and environmental risk factors account for over one third of all deaths

Over one third (35 %) of all deaths in Slovenia in 2019 could be attributed to behavioural risk factors, including tobacco smoking, poor diet, alcohol consumption and low physical activity – a lower proportion than the EU average (39 %). Poor diet, including low fruit and vegetable intake and high sugar and salt consumption, accounted for

16 % of all deaths in 2019; tobacco consumption contributed to an estimated 15 %, alcohol consumption to about 5 % and low physical activity to about 1 % (Figure 6). While these are slightly below the EU averages, air pollution – in the form of fine particulate matter (PM_{2.5}) and ozone exposure – involved an estimated 5 % of all deaths in 2019, which is above the EU average of 4 %.

Figure 6. Poor diet and tobacco use are the main behavioural health risks in Slovenia



Notes: 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 fine particulate matter (PM_{2.5}) and ozone.
Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Obesity is a major public health concern

Slovenia's obesity rates have been increasing, and are higher than the EU averages. Nearly one in five (19.4 %) adults identified as obese in 2019. While above the EU average (16.0 %), Slovenia's rates are increasing more slowly: the rates in 2014 were 18.6 % in Slovenia and 14.9 % across the EU. Poor dietary and physical activity habits can underpin the risk of overweight and obesity. In 2019, only 5.3 % of adults reported consuming at least five servings of fruit and vegetables per day, which is below the EU average (12.4 %) and a reduction from 2014 levels (7.5 %). Meanwhile, nearly a third of adults reported engaging in at least 2.5 hours of weekly physical activity, which – although in line with the EU average – has decreased since 2014.

Overweight (including obesity) is also a concern among adolescents in Slovenia: 24.3 % of 15-year-olds were overweight in 2022, which is above the 21.2 % EU average and represents a

steady increase since 2002, when the rate was 13.0 %. In contrast to adults, dietary habits among adolescents have improved: the share of 15-year-olds consuming vegetables daily was 30.0 % in 2018. This represents an increase from 24.0 % in 2014, although it then remained stable in 2022, and remained below the EU average (34.0 %). Meanwhile, the proportion of 15-year-olds reporting at least some moderate physical activity every day reached 18.0 % in 2018 to decrease slightly in 2022 (17.0 %), which is above the EU average (15.0 %). Additionally, during the pandemic, the physical fitness of children aged 6-15 fell sharply to the lowest recorded level – by about 13 % in June 2020 compared to 2019 (OECD/EU, 2022).

To improve the nutrition and exercise habits of the population and tackle obesity, the government has introduced several policies, including the multi-sectoral National Nutrition and Physical Activity Strategy 2015-25, and encouraged the

renewal of food and nutrition guidelines that should support both health and climate goals. More resources will be important to bolster efforts, particularly among children, and to recover from further impacts of COVID-19.

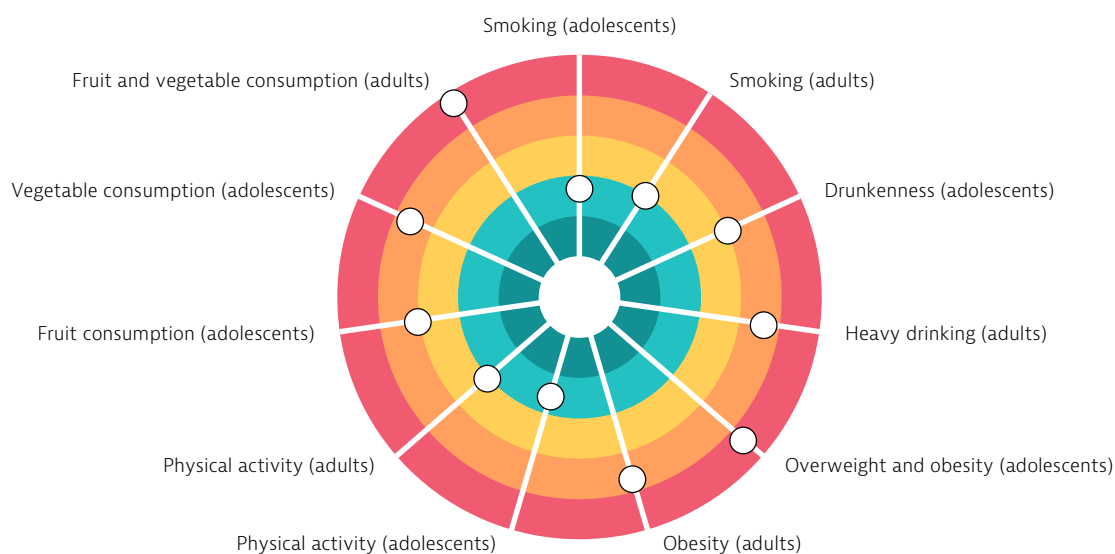
Among teenagers, smoking rates are below the EU average, but alcohol consumption remains high

The prevalence of daily smoking in Slovenia has declined. Some 17.4 % of adults in 2019 were daily smokers – below the current EU average of 19.3 % – compared to 18.9 % in 2014 (Figure 7). As in many countries, men were more likely to be smokers (19.3 %) than women (15.6 %) in 2019, and individuals on lower incomes are more frequently smokers (18.3 %) than those on higher incomes (15.0 %). Smoking has also decreased to below-EU average levels among 15-year-olds – from 22.0 % having smoked in the previous month in 2014 to 14 % in 2022, compared to 17 % on average in the EU. Nonetheless, alternative smoking products like

electronic cigarettes are increasing in popularity, posing a new public health and regulatory challenge: one in ten 15- and 16-year-olds reported using electronic cigarettes in 2019, although this is lower than the EU average of one in seven.

Alcohol consumption has fluctuated over the past two decades in Slovenia. The average amount of alcohol consumed annually by Slovenians aged over 15 was 10.6 litres per capita in 2021. However, unlike EU trends, the prevalence of heavy drinking² has increased, from 19.0 % in 2014 to 22.7 % in 2019, which is well above the EU average (18.5 %). Heavy drinking is more prevalent among men, although the gender gap has narrowed somewhat. Among adolescents, heavy drinking rates have fallen in the last two decades, but almost one quarter (23.0 %) of 15-year-olds in Slovenia still reported having been drunk at least twice in their lives in 2022 – a high proportion compared to the EU average of 18 %.

Figure 7. Rates of obesity and alcohol consumption are higher than the EU averages, while rates of fruit and vegetable consumption are lower



Notes: 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 2022 for adolescents indicators; and EHIS 2019 for adults indicators.

² Heavy drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults.

4 The health system

The social health insurance system provides near universal coverage via a single payer

Slovenia's health system is relatively centralised, and statutory employment-based social health insurance (SHI) covers more than 99 % of permanent residents. Those not covered include people who are temporarily uninsured due to unclear or changing insurance status and vulnerable populations facing longer-term challenges because they cannot fulfil the formal residency requirements (see Section 5.2). The Health Insurance Institute of Slovenia is the single purchaser of services, and a reform of its legal status and management is under consideration.

Additionally, complementary health insurance (CoHI) covers about 95 % of the population eligible for SHI, primarily to cover copayments. For those who receive social benefit payments, CoHI premiums are covered by the state. The supplementary insurance market – primarily to cover outpatient specialist visits and obtain second opinions – is small but growing. Triggered by a large increase in premiums by one CoHI insurer, CoHI was abolished in July 2023 and will be replaced from January 2024 by a fixed compulsory contribution.

Primary care is mainly delivered by municipal community health centres and hospital care mostly by state-owned facilities

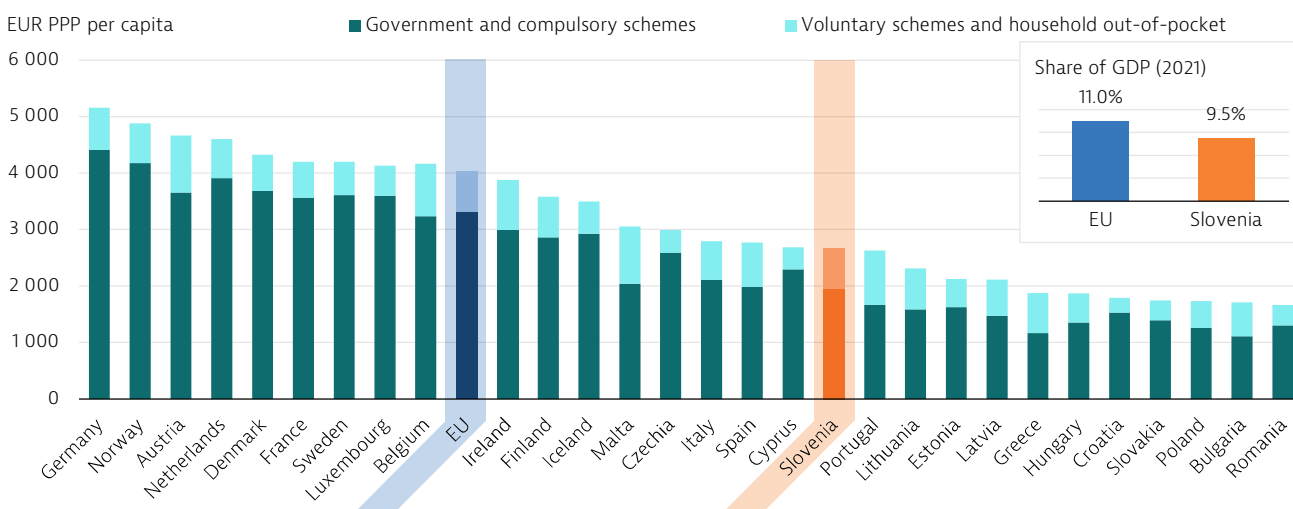
Primary care is mainly delivered by municipal multidisciplinary community-based primary healthcare centres (CPHCs). Primary care physicians act as gatekeepers to secondary and tertiary care. Private providers may deliver care within the public system under contract with the Health Insurance Institute of Slovenia or directly via supplementary voluntary health insurance or out-of-pocket (OOP) payments.

Most outpatient secondary care and inpatient services are provided by state-owned hospitals, although some secondary services are delivered in CPHCs and independent outpatient clinics. Two university medical centres (in Ljubljana and Maribor) and other state-owned specialised institutions deliver tertiary specialised care.

Health expenditure remains comparatively low despite record growth in 2021

Health expenditure grew to 9.5 % of GDP in 2021, which is lower than the EU average (11.0 %). Per capita health expenditure also increased, driven by injections from Slovenia's pandemic response, reaching EUR 2 665 (adjusted for differences in purchasing power) in 2021. Slovenia's health spending is about two thirds of the EU average (EUR 4 028 per capita in 2021) (Figure 8).

Figure 8. Slovenia's health spending is lower than the EU average but higher than in other small countries



Note: The EU average is weighted.

Source: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

Out-of-pocket payments are among the lowest in the EU

Public sources accounted for 73.7 % of current health expenditure in 2021, which is below the EU average (81.1 %). Private sources represented the remaining 26.3 % of current health expenditure, of which voluntary health insurance schemes – driven by CoHI – comprised more than half (13.4 %). This was the highest proportion in the EU. At 12.9 % of current health expenditure, OOP payments were lower than the EU average (14.5 %), partly due to CoHI usage, which averts direct OOP spending. OOP payments apply primarily to direct payments for services outside the statutory benefits package (see Section 5.2).

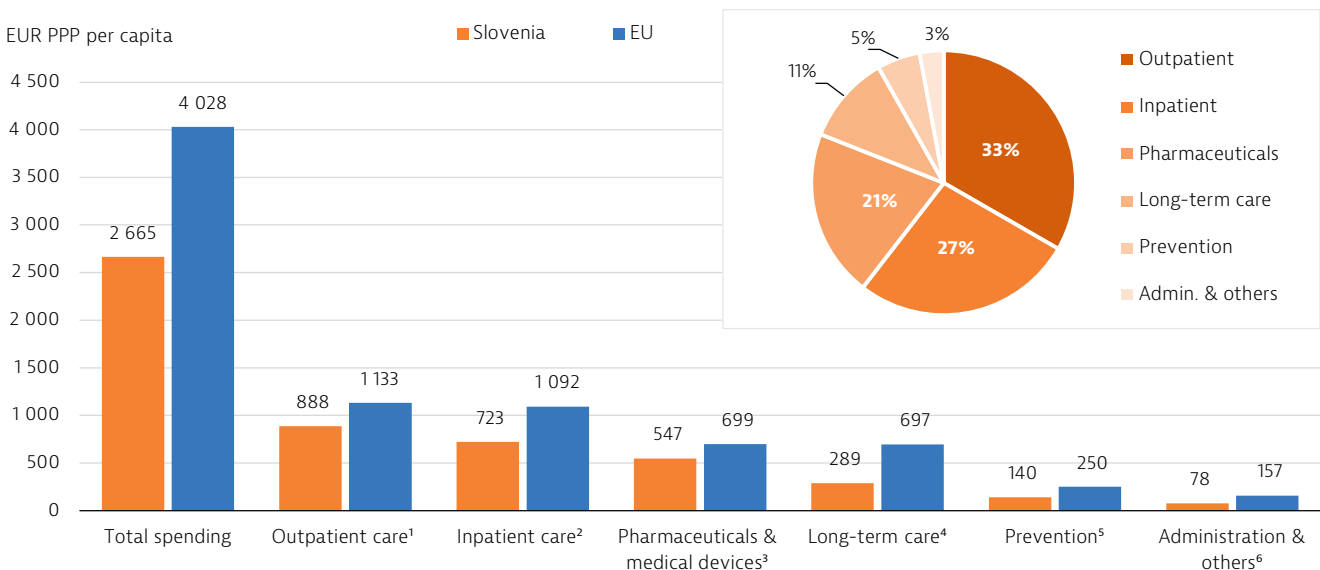
Care has shifted from inpatient to outpatient settings, while long-term care remains underfunded

Per capita spending on all health functions was lower than the EU averages in 2021 (Figure 9). As a share of current health expenditure, however, Slovenia spent more on outpatient care (33 %) than the EU average (29 %), while inpatient care

spending (27 %) was slightly below the EU average (28 %). This ratio contrasts with EU-wide trends, and is the result of financial incentives since 2010 encouraging a shift from inpatient to outpatient settings. This move is also reflected in hospital capacity metrics, including hospital bed numbers, which decreased from 5.4 per 1 000 population in 2010 to 4.3 per 1 000 in 2021 (the EU average is 4.8 per 1 000).

In other sectors, spending on prevention was 5.3 % in 2021, which is on a par with the EU average (6.0 %), and outpatient pharmaceutical spending (21 %) was above the EU average (18 %), due in part to a small market and relatively lower use of generics. During the COVID-19 pandemic, the healthcare component of long-term care spending increased, reaching 10.9 % of current health expenditure in 2021, but it trails the EU average (16.1 %). The Long-Term Care Act, which entered into force in December 2021 and then expired in August 2023, was replaced directly by a new Act. This legislation will be implemented in phases from January 2024 until full implementation by December 2025.

Figure 9. Outpatient care receives the largest share of health spending



Notes: 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; 6. Includes health system governance and administration and other spending. The EU average is weighted.

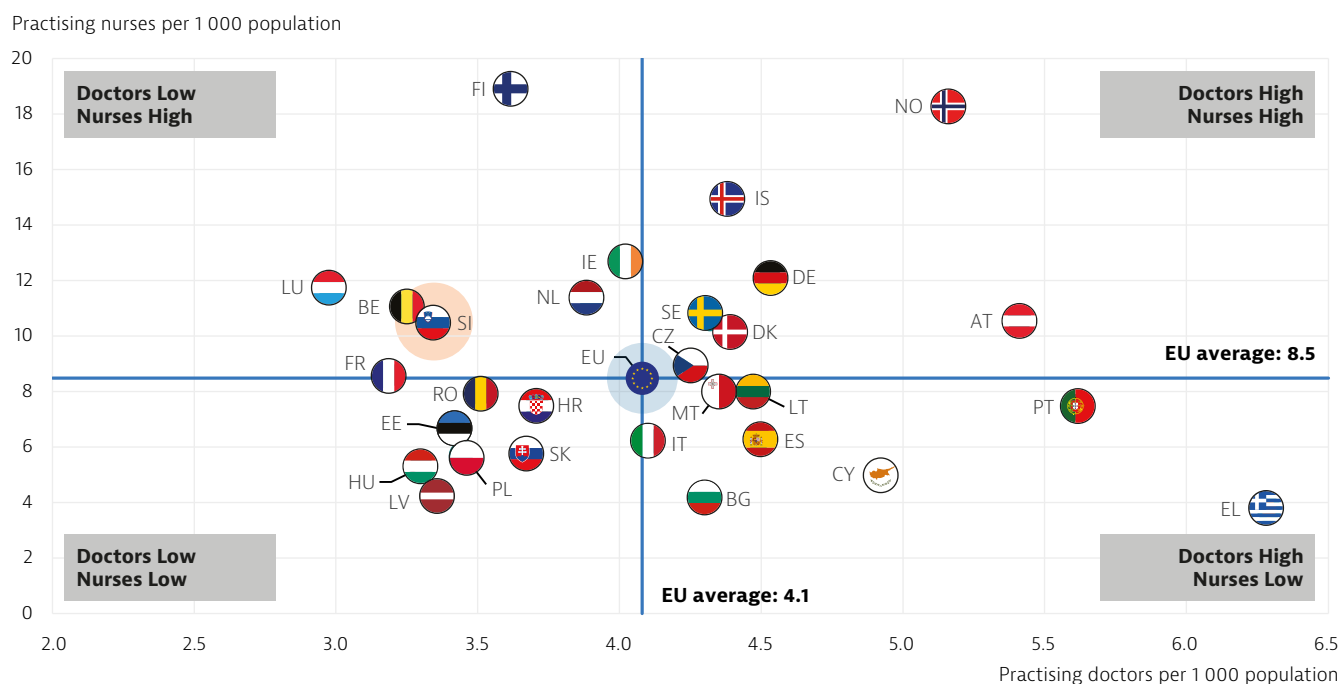
Source: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

Workforce shortages persist, particularly among primary care physicians and hospital nurses

At 3.3 practising doctors per 1 000 population, Slovenia's physician density in 2021 was below the EU average of 4.1 per 1 000 (Figure 10), with particularly acute shortages in primary care. Fewer than one in five physicians in Slovenia is a generalist (18.6 %) – a lower rate than the EU

average (20.4 %). In contrast, nurse density levels were high, with 10.5 practising nurses per 1 000 population compared to the EU average of 8.5 per 1 000. For Slovenia, this number includes vocationally trained nursing assistants (around 13 000) and registered nurses (around 9 000). Despite these high levels, however, nursing shortages persist in hospitals, primarily due to salary imbalances.

Figure 10. Slovenia has fewer physicians and more nurses than the EU averages



Notes: The EU average is unweighted. The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). 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. Source: OECD Health Statistics 2023 (data refer to 2021 or the nearest available year).

5 Performance of the health system

5.1 Effectiveness

COVID-19 was the third leading cause of preventable death in 2020

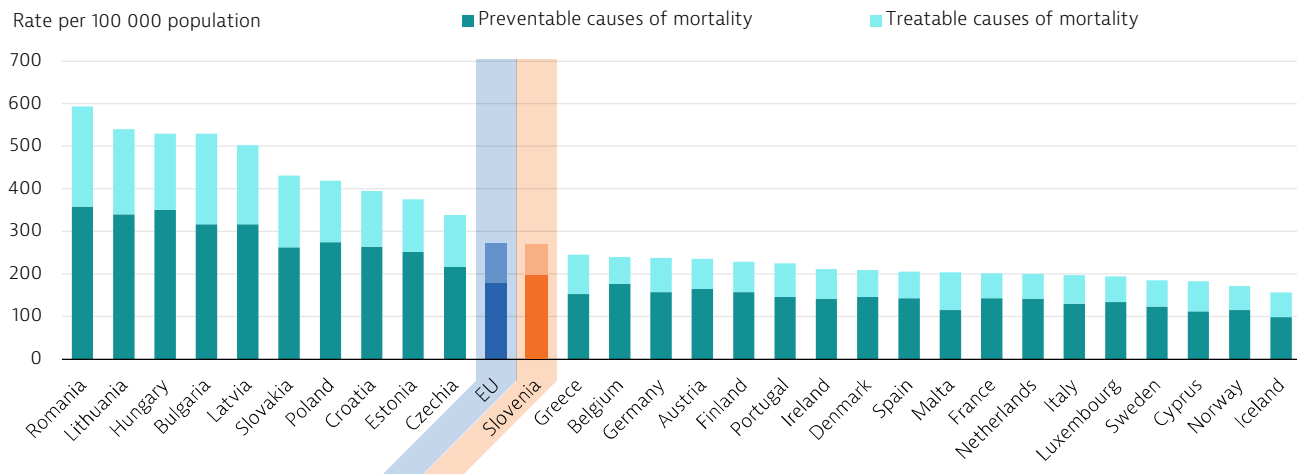
Slovenia's preventable mortality rate decreased from 209 per 100 000 population in 2011 to 173 per 100 000 in 2019, but remained above the EU average of 154 per 100 000 that year. As in other countries, rates rose in 2020 to 199 per 100 000, partly due to the classification of COVID-19 as a preventable cause of death (Figure 11), and remained above the EU average (180 per 100 000). In 2020, the main causes of preventable mortality were lung cancer (18 %), alcohol-related diseases (16 %) and COVID-19 (15 %), which together constituted almost half (49 %) of all preventable deaths. Meanwhile, mortality from treatable causes has decreased steadily since 2011, reaching 70 per 100 000 population in 2020, which is below the EU average of 92 per 100 000. The leading causes of treatable mortality were ischaemic heart disease (23 %), colorectal (20 %) and breast cancers (14 %), and stroke (11 %).

Several programmes have been scaled up to address preventable and treatable mortality, especially through strengthening health promotion and primary care, with an emphasis on chronic conditions and vulnerable populations. New family medicine model practices, for example, dedicate an extra 0.5 full-time equivalent registered nurse role to screening and coordination of chronic care, while health promotion centres aim to improve prevention, early detection, counselling and care coordination for chronic care. Implementation progress slowed, however, during the pandemic, with disruptions in both curative and preventive care delivery due to suspended and delayed care, patients avoiding care, personnel redistribution and workforce exits.

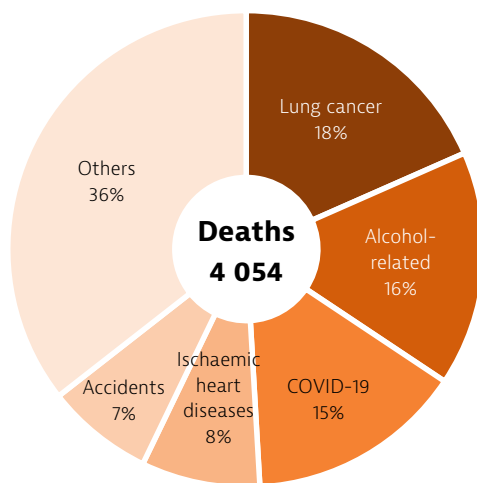
Prevention measures for smoking and alcohol-related diseases have had mixed results

Given their contribution to preventable mortality, lung cancer and alcohol-related conditions are public health priorities. Behavioural risk factors contribute significantly to these rates, and several policies to reduce smoking and alcohol

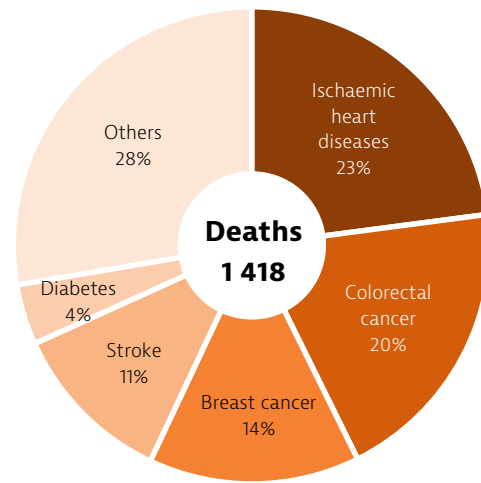
Figure 11. Preventable mortality rates remain above the EU average, but treatable mortality rates are below it



Preventable causes of mortality



Treatable causes of mortality



Slovenia

Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through healthcare interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths from some diseases (e.g. ischaemic heart disease, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death. Source: Eurostat Database (data refer to 2020).

consumption have been introduced in the last 10 years. The former include bans on smoking and use of electronic cigarettes in enclosed public places and workplaces, bans on advertising tobacco products, and a licensing system for retailers of tobacco and related products. To reduce alcohol-related disease incidence, the Law on Restricting Access to Alcohol (2004) was updated in 2017; cardiovascular disease risk factor screening programmes (2014-16) were expanded to include alcohol-related behaviour; and designated registered nurses in family medicine model practices supported alcohol cessation programmes.

Progress has been uneven, suggesting that there is opportunity to increase policy effectiveness through campaigns targeting specific populations, and improved detection, diagnosis and

management of conditions. While smoking rates decreased overall and among both sexes between 2014 and 2019, progress was greater among men than women. The proportion of men aged over 15 who were daily smokers fell from 21.8 % to 19.3 %, while the proportion among women decreased from 16.0 % to 15.6 %. Notably, lung cancer became the leading cause of preventable death among women in 2020, overtaking breast cancer. Additionally, some drinking behaviours have decreased in Slovenia (Perko et al., 2019), but alcohol-related diseases remained the second leading cause of preventable mortality in 2020, while they are only the fourth leading cause of death in the EU. The average share of preventable deaths attributed to alcohol-related diseases in the EU (10.0 %) is lower than that in Slovenia (18.0 %).

Changes to fee reimbursements during the pandemic improved uptake of influenza vaccinations among older people

The rate of childhood immunisation for diphtheria, tetanus and pertussis in Slovenia has been roughly on a par with the EU average since 2017, reaching 95 % in 2020. Meanwhile, following the average trend across the EU, human papillomavirus vaccination rates among teenage girls rose between 2017 (38 %) and 2022 (44 %), although without reaching the EU average (63.4 %).

Vaccination rates against seasonal influenza among the population aged 65 and over have historically been below the EU averages – in part due to low risk perception of flu and mandatory administration fees. The influenza vaccination rate was highest in 2000 (35.0 %), dropped steeply to 9.8 % in 2016, and increased to 27.0 % in 2020. While well below the EU average (43.8 %), the rate has increased by about 40 % from 2019 levels, and is more than double the 2017 level. Increases are partly attributable to the introduction of full fee reimbursement during the 2020/21 flu season and fear of illness during the COVID-19 pandemic. However, the vaccination rate fell to 24.5 % in 2021, and growing vaccine hesitancy may pose a future challenge.

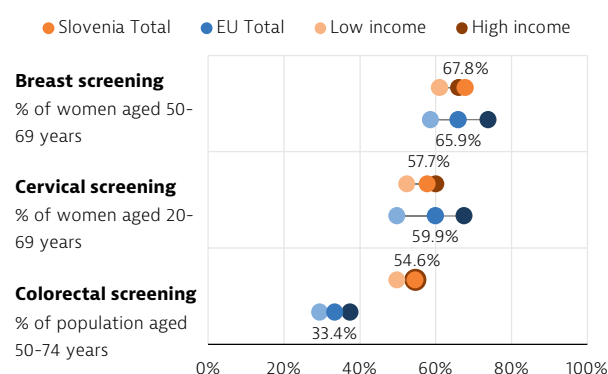
Cancer screening rates have improved, but limited resources and disparities by income and location hamper progress

Since 2000, screening programmes fully covered by SHI have been launched for cervical (2001), colon (2008) and breast (2008) cancers. Based on survey data, in 2019, the breast cancer screening rate among women aged 50-69 who had been screened in the last two years was slightly above the EU average, while the colorectal cancer screening rate among the target population aged 50-74 was far above the average. Meanwhile, the cervical cancer screening rate among women aged 20-69 was slightly below the EU average (Figure 12). There are, however, differences by geography, age and income, although these are narrower than the gaps across the EU. For example, the north-eastern regions of Slovenia are underrepresented in screening rates. Additionally, women in the highest income quintile reported higher cancer screening rates than those in the lowest quintile for all cancer types. Breast cancer screening rates had the smallest disparity by income, and cervical cancer screening rates the largest.

Slovenia has reinforced its commitment to cancer detection and treatment through several policy measures. The National Cancer Control Programme

was first introduced in 2010 and is now in its third iteration. The third Programme has three goals: to slow down increasing cancer incidence; to increase cancer survival rates; and to improve the quality of life of patients with cancer through comprehensive survivorship approaches and palliative care. Additionally, two new cancer screening pilots are in preparation, and a *Helicobacter pylori* infection screening programme is being tested through several EU-funded projects. Despite these efforts, shortages in cancer-related resources, including oncology specialists and advanced high-cost treatment equipment (such as proton therapy), may undermine potential effectiveness.

Figure 12. Disparities in cancer screening by income exist, although they are narrower than the EU averages



Notes: Low income is defined as the population in the lowest income quintile, whereas high income is defined as the population in the highest income quintile. The proportions refer to people who report having undergone a test in the two years preceding the survey.

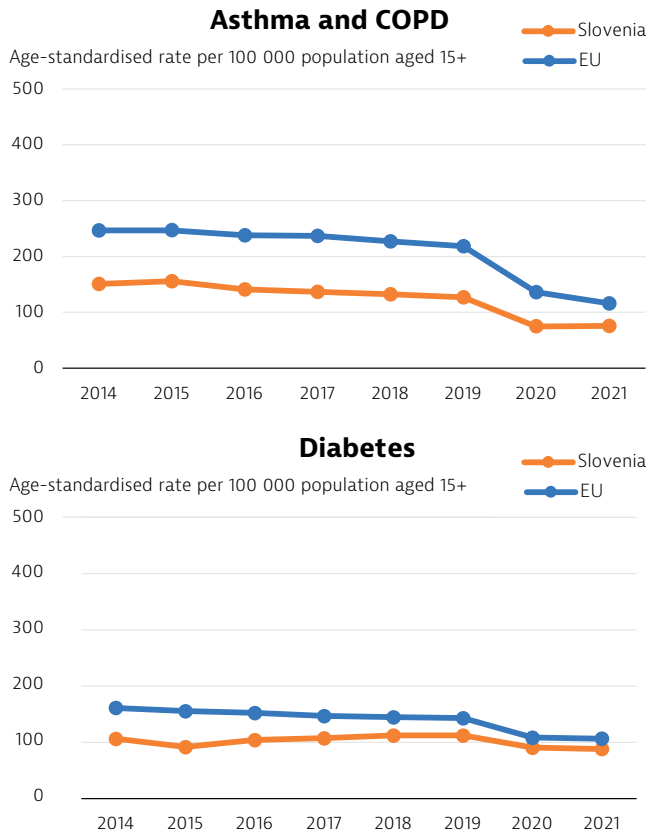
Source: Eurostat Database (based on EHIS 2019).

Avoidable hospital admissions are low in Slovenia

The indicator of avoidable admissions to hospitals for chronic conditions is used to gauge the strength, access and quality of primary care. By this measure, Slovenia compares well to other EU countries. In 2021, Slovenia's rates of avoidable hospital admissions related to selected chronic conditions were among the lowest in the EU (Figure 13). At 75.8 per 100 000 population, admission rates for asthma and chronic obstructive pulmonary disease (COPD) together were far below the EU average of 116.1 per 100 000 in 2021, and had halved since 2014. At 88.4 per 100 000 in 2021, diabetes-related avoidable hospital admissions were also lower than the EU average (106.6 per 100 000). This may be attributable in part to the dynamic between increasing obesity rates in Slovenia (see Section 3) and the effectiveness of outpatient care to manage this condition. In 2020 and 2021 these avoidable hospital admissions were

significantly lower than in pre-pandemic years, which should be interpreted in the context of the pandemic. Increased healthcare needs severely affected hospitals' capacity to provide acute care, and the disruption caused by COVID-19 modified patients' healthcare-seeking behaviour.

Figure 13. During the COVID-19 pandemic, rates of avoidable hospital admissions for selected chronic conditions dropped



Note: Admission rates are not adjusted for differences in disease prevalence across countries.

Source: OECD Health Statistics 2023.

5.2 Accessibility

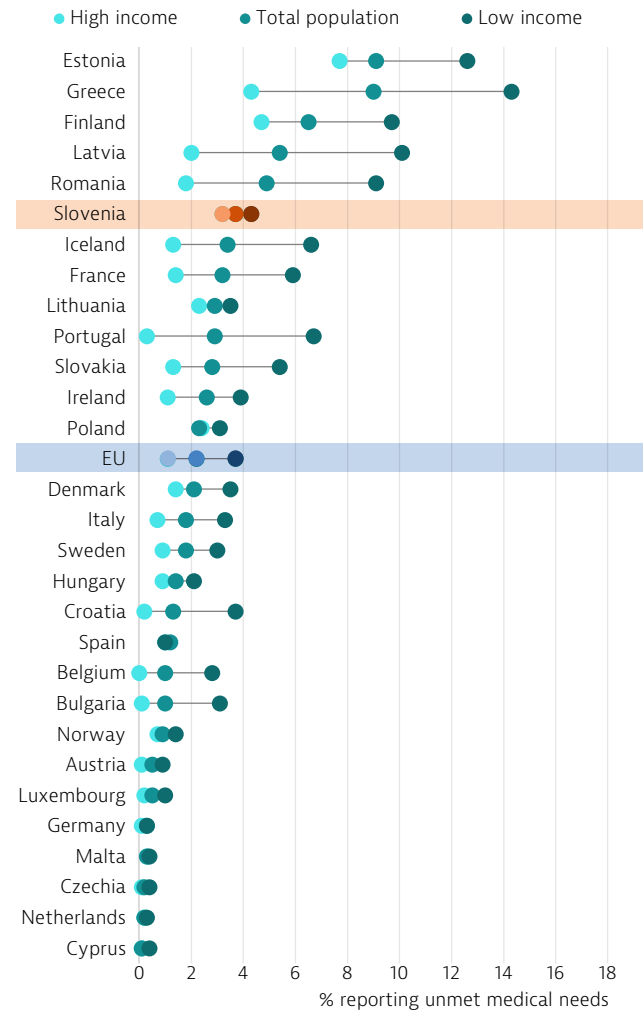
Self-reported unmet needs for medical care are increasing due to waiting times

Unmet medical needs due to overall cost were negligible, testifying to Slovenia's low OOP spending and robust protection from catastrophic spending. Waiting times, which have been a persistent challenge for decades – and which, as elsewhere, were exacerbated by the pandemic – are the main driver of unmet needs. In 2021, according to data from the EU-SILC survey, 4.8 % of the Slovenian population reported unmet needs for medical care due to costs, distance to travel or waiting times. This was more than double the EU average of 2.0 %. It also represented a significant rise from pre-pandemic levels of 2.9 % in 2019. Disparities

between income groups had also increased: in 2021, unmet medical needs were reported by 6.6 % of the population in the lowest income quintile compared to 4.4 % in the highest, while in 2019, they were reported by 2.9 % in the lowest income quintile and 2.4 % in the highest. However, in 2022, the rate of reported unmet needs decreased to 3.7 %, and the gaps with the EU average (2.2 %) and between income groups were reduced (Figure 14).

Over the last five years, Slovenia has introduced several initiatives to reduce waiting times, including financial incentives and improvements in the reporting system. In addition, the Ministry of Health invested around EUR 100 million in additional financing to hospitals and incentives within primary healthcare to reduce waiting lists. Despite these efforts, waiting times remain a persistent challenge for the Slovenian health system.

Figure 14. Slovenia's rate of unmet medical needs is well above the EU average



Notes: Data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.

Source: Eurostat Database, based on EU-SILC (data refer to 2022, except Norway (2020) and Iceland (2018)).

The number of services fully financially covered by social health insurance is decreasing

The public benefits package includes comprehensive primary, secondary and tertiary services and pharmaceuticals and medical devices, as well as basic dental care, with fewer differences across categories of insured people. Copayments of between 10 % and 90 % apply to most services and goods in the basic benefits package, except for specific conditions and individuals. These include health services for children up to age 26, family planning services, infectious disease prevention and care, emergency care and treatment of malignant diseases. However, the list of fully financially covered services is gradually decreasing, as the funds collected are not sufficient to cover the broad scope of services.

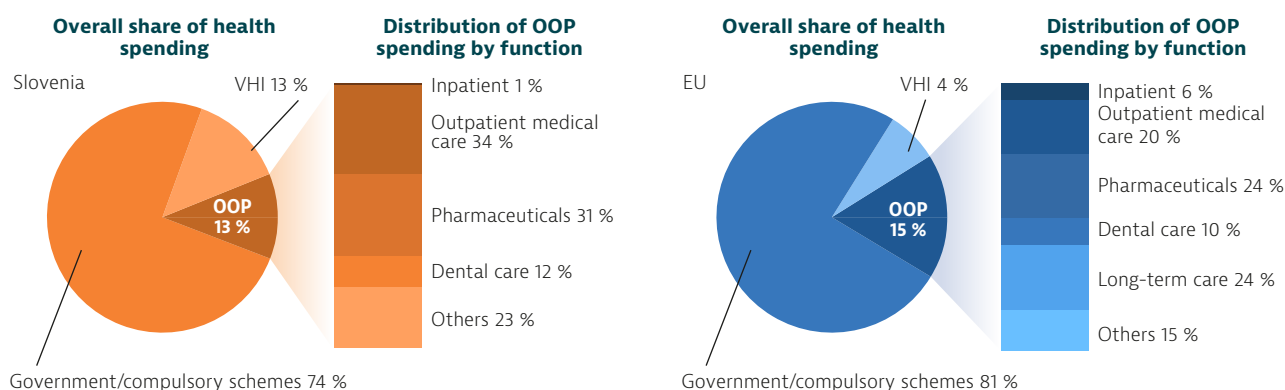
In 2021, public spending on inpatient care in Slovenia (90 %) was below the EU average of 91 %, as was spending on outpatient care (75 % compared to 79 % across the EU), pharmaceuticals (52 %

compared to 59 % across the EU) and therapeutic appliances (32 % compared to 38 % across the EU). Public spending on dental care was far above the EU average, at 44 % compared to 34 %.

Low out-of-pocket spending contributes to the low rate of catastrophic spending on healthcare

The share of OOP payments has been largely constant since 2005. At about 13 % of total health expenditure in 2021, OOP spending in Slovenia was below the EU average of 15 % (Figure 15). Low OOP spending can be attributed in part to wide service coverage by SHI and the mitigation of high cost-sharing by extensive utilisation of CoHI (see Section 4). The outpatient spending share constitutes the largest share of OOP, and is much higher in Slovenia (34 %) than across the EU (20 %). Pharmaceuticals also constitute a large share of OOP expenditure (31 %, which is also higher than that across the EU (24 %).

Figure 15. Pharmaceuticals and outpatient care account for nearly two thirds of out-of-pocket spending



Notes: VHI refers to voluntary health insurance, which also includes other voluntary prepayment schemes. The EU average is weighted.
Sources: OECD Health Statistics 2023; Eurostat Database (data refer to 2021).

CoHI and low OOP spending have helped to protect insured people from catastrophic health spending.³ Only 0.8 % of Slovenia's population experienced catastrophic expenditure related to health in 2018 (the latest year for which data are available). This makes Slovenian catastrophic spending the lowest in the EU that year, with almost two thirds concentrated among the poorest households. Measures in place to protect the population – especially those on low incomes – against catastrophic health spending include exemptions for those who cannot cover OOP payments and state subsidies for pharmaceutical copayments for war veterans, prisoners and people without income.

Uptake of teleconsultations during the pandemic built on previous advances in digital health

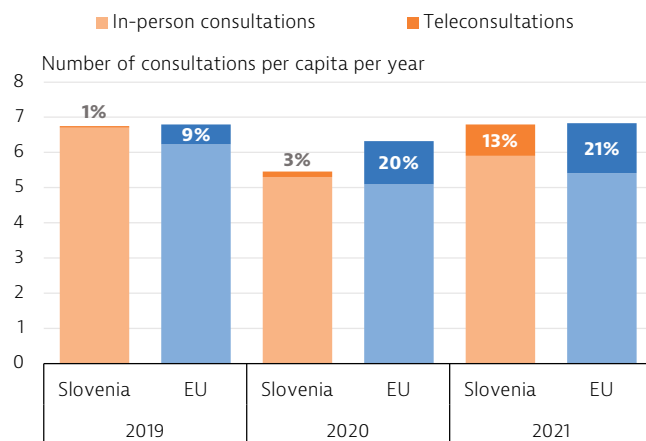
National and Eurostat data show that the number of teleconsultations per capita per year expanded minimally between 2019 and 2020, from 1 % to 3 %, which is far below the available EU average on that same period (Figure 16). However, remote consultations increased during the COVID-19 pandemic, reaching 13 % in 2021. Separate survey data from Eurofound also point to an expansion in the use of teleconsultations in Slovenia: the share of people reporting that they had received a medical consultation online or by telephone since

³ Catastrophic expenditure is defined as household OOP spending exceeding 40% of total household spending net of subsistence needs (i.e. food, housing and utilities).

the beginning of the pandemic rose from 45 % in June/July 2020 to 65 % in February/March 2021 (Eurofound, 2021).⁴

Uptake was supported by the inclusion of telemedicine in several new services in the public benefits package and advances made in the context of the digital health programme launched in 2015, including new infrastructure, new digital tools, a patient portal and telemonitoring for stroke patients. However, physician capacity to handle increased demand for telemedicine services is limited, hampering the full potential of such tools.

Figure 16. Remote consultations occur less frequently in Slovenia than across the EU



Source: OECD Health Statistics 2023.

Important health workforce shortages can be explained by challenging working conditions and decreases in the number of junior physicians

The health workforce shortages faced by Slovenia, especially for primary care providers and nurses in hospitals (see Section 4), can be explained in part by working conditions, including salary and work-life balance concerns. Further, the rate of medical graduates per 100 000 is below the EU average. Meanwhile, the outlook is even more worrying for family physician shortages, as a large cohort of current doctors will retire soon, and there is an observed decline in the number of junior physicians entering the family medicine speciality, with ramifications for system sustainability and resilience. The consequences are already visible, as family physician shortages have significantly affected population coverage and access across Slovenia, including in the capital Ljubljana. In February 2023, Slovenia estimated that 136 000

individuals were not currently registered with a family doctor, despite the key gatekeeping role of primary care physicians (HSPM, 2023).

In late 2022 and early 2023, the Ministry of Health instigated measures to tackle these acute coverage challenges, increasing funding to the primary healthcare sector and establishing new practices in CPHCs specifically for non-registered individuals. A total of 64.2 additional team equivalents are already available across 94 CPHCs. However, as they are mostly staffed by doctors and nurses in family medicine teams working overtime and financed from a central budget, it is unclear how this parallel service delivery model will affect the sustainability of the primary healthcare system over time.

5.3 Resilience

The COVID-19 pandemic has proved to be the most significant disruption to health systems in recent decades. It has shed light on the vulnerabilities and challenges within countries' emergency preparedness strategies and on their ability to provide healthcare services to their populations. In response to the enduring effects of the pandemic – as well as other recent crises such as cost-of-living pressures and the impact of conflicts like the war against Ukraine – countries are implementing policies to mitigate the ongoing impacts on service delivery, invest in health system recovery and resilience,⁵ improve critical areas of the health sector, and fortify their preparedness for future shocks.

Slovenia has fewer hospital beds and lower bed occupancy rates than the EU average

Hospital bed numbers in Slovenia have been decreasing gradually since 2005, reaching 4.3 per 1 000 population in 2021, which is slightly below the EU average of 4.8 per 1 000. Before the pandemic, bed occupancy and hospital discharge rates were also decreasing gradually, but they fell abruptly in 2019-20. Both rates increased again in 2021, with occupancy rates (60.7 %) now below the EU average (64.7 %), and the hospital discharge rate going back up to 15 100 per 100 000, which is on a par with the average across the EU (Figure 17).

Decreases in inpatient capacity and usage are partly attributable to the early implementation of pandemic contingency measures, through which elective and non-urgent procedures were postponed to free up beds and boost surge capacity

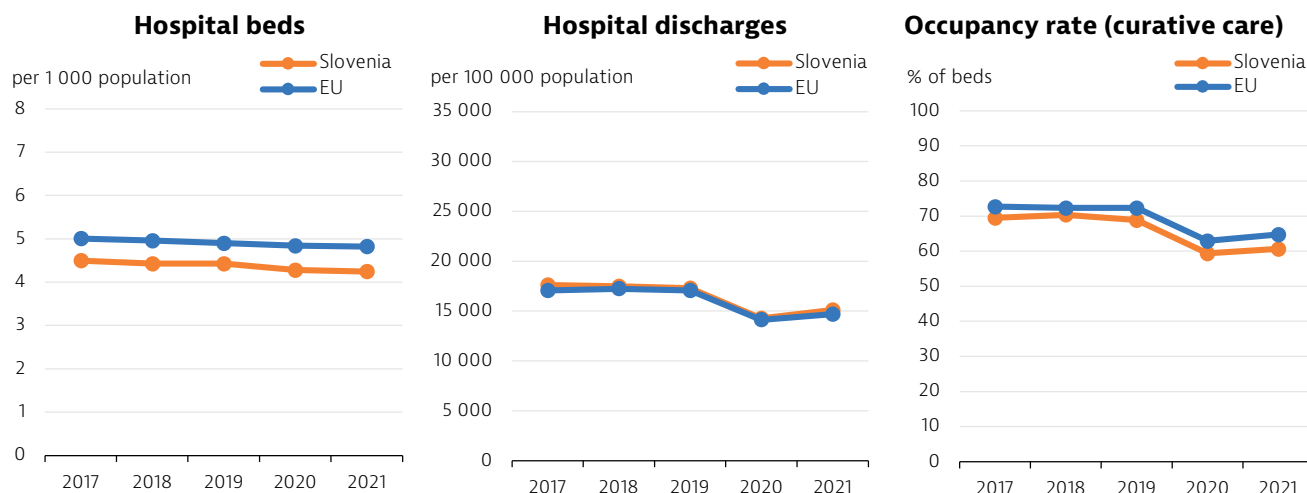
⁴ The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.

⁵ 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 Assessments, 2020).

– particularly in orthopaedics, ear, nose and throat, and ophthalmology departments. As in other European countries, the volume of non-urgent surgical procedures in Slovenia fell significantly in 2019-20. For example, hip replacements fell from 199 per 100 000 population in 2019 to 165 per

100 000 in 2020, while knee replacements dropped from 137 per 100 000 in 2019 to 105 per 100 000 in 2020. As with hospital capacity and occupancy rates, hip and knee replacement rates slightly increased in 2021.

Figure 17. Slovenia's hospital discharge and occupancy rates fell sharply in 2020, in line with EU trends



Note: The EU average is unweighted.

Sources: OECD Health Statistics 2023; Eurostat Database.

Slovenia's waiting times for elective surgery are high but remained relatively unaffected by the pandemic

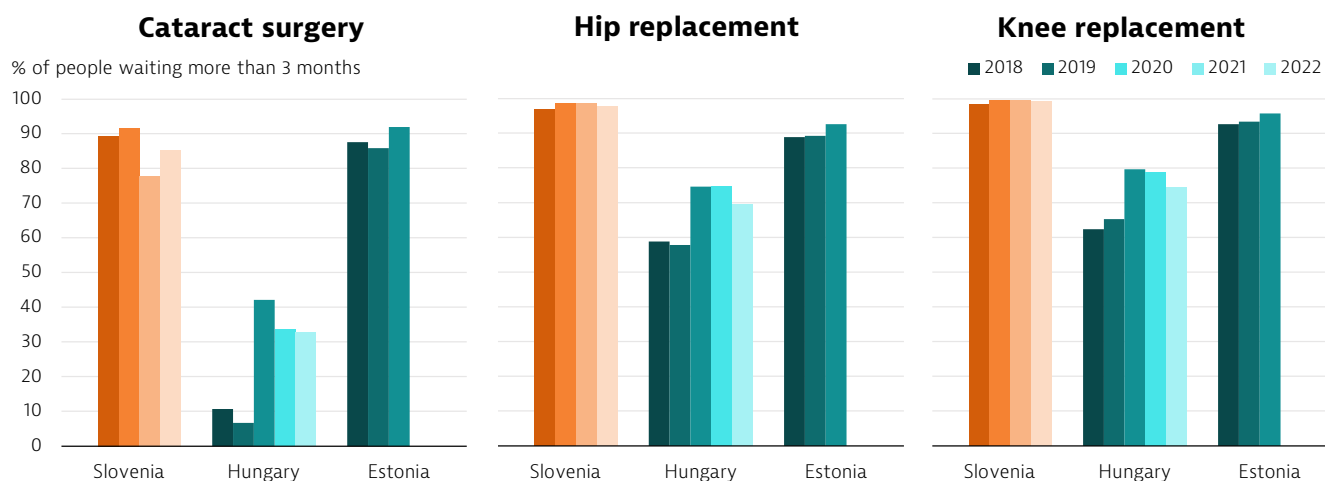
The share of the population waiting more than three months for hip and knee replacements and cataract surgery in Slovenia is consistently the highest among countries for which data are available, including comparator countries Hungary and Estonia. However, Slovenia saw smaller increases during the pandemic (Figure 18). Notably, the population experiencing waiting times of three months or more for cataract surgery in Slovenia

even decreased in 2021 (77.8 %) compared to 2020 (91.7 %), before rising to 85.3 % in 2022.

Public spending on health in Slovenia has grown consistently since 2012, reaching high growth rates in 2020-21

After a reduction in the immediate aftermath of the global financial crisis over a decade ago, annual growth in public spending on health in Slovenia has generally increased since 2012. The country's pandemic response injected further public financing into health, resulting in the largest

Figure 18. Waiting times for elective surgery remain higher in Slovenia than in comparator countries



Source: OECD Health Statistics 2023.

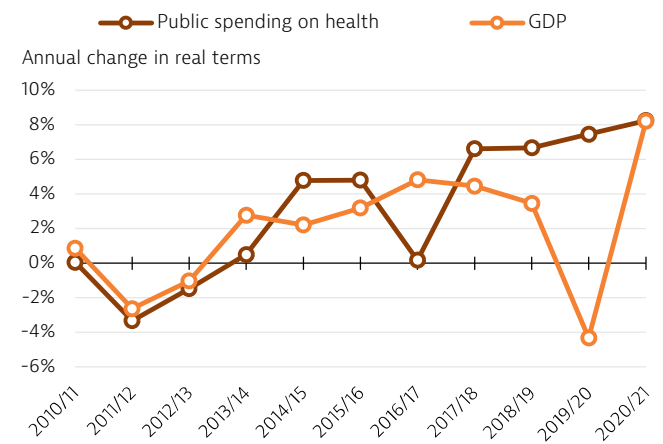
growth rates recorded in the past 10 years of 7.5 % in 2019-20 and 8.2 % in 2020-21. In contrast, Slovenia's GDP grew between 2013 and 2019, but shrank by 4.3 % during the first year of the pandemic in 2020 (Figure 19); thus, the accelerated increase in public expenditure on health took place despite a significant decline in GDP (OECD/EU, 2022). In 2021, GDP grew sharply, reaching 8.2 % – the highest growth rate since 2010.

European Commission funding will mainly support digitalisation and future treatment of communicable diseases

Under its national Recovery and Resilience Plan for 2021-26, Slovenia is scheduled to receive almost EUR 225 million, which is equivalent to 4.7 % of GDP. Around three quarters will come from grants, and about 9 % of the total allocation is intended for health. Around half of the Recovery and Resilience Plan allocation for health is dedicated to treatment for communicable diseases, and roughly one third will support the digital transformation of healthcare. The rest will be spent on improving health system accessibility and training for the health workforce on quality of care (Figure 20).

This support will be complemented by the rollout of the EU Cohesion Policy 2021-27 programme. Co-financed at 68 % by the EU, Slovenia is set to invest over EUR 103 million in its healthcare system, with almost EUR 28 million from the European Regional Development Fund (ERDF) for health equipment. From the remaining EUR 75 million from the European Social Fund Plus (ESF+), 80 % will be used to invest in enhancing the accessibility, effectiveness and readiness of the Slovenian health system, and 20 % will be spent on healthcare digitalisation.⁶

Figure 19. The significant growth in public spending on health during COVID-19 coincided with a striking reduction in GDP in 2020

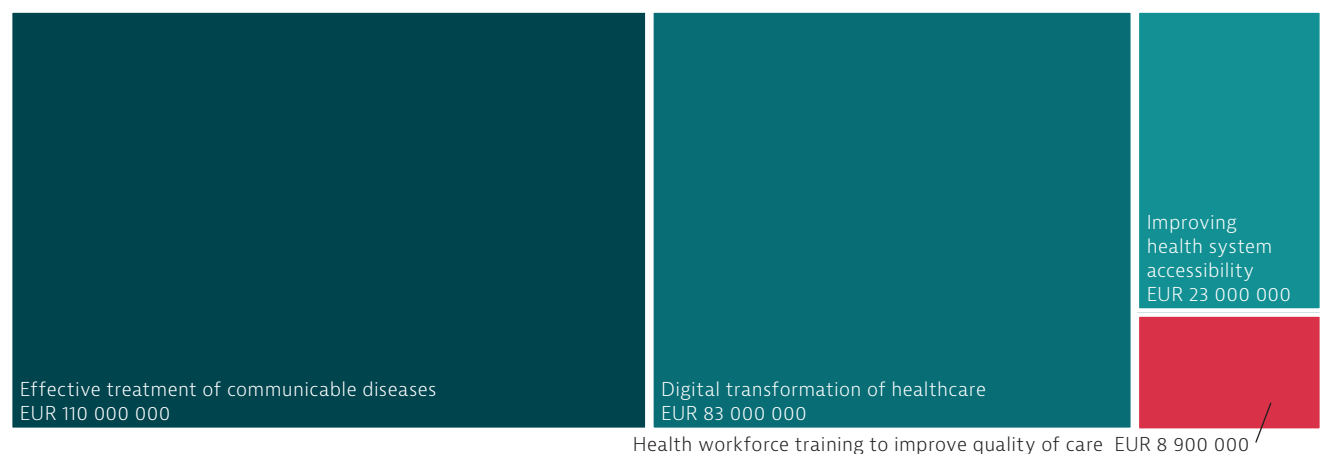


Source: OECD Health Statistics 2023.

Multiple reforms specifically targeting the health workforce are ongoing or under discussion

Like many countries across the EU, Slovenia faces a demographic and epidemiological transition, with an ageing population and increasing numbers of patients with complex health problems. At play is also the emergence and multiplication of technological advances to support care delivery. These developments, together with the aftermath of the COVID-19 crisis and ongoing health worker shortages, burden Slovenia's current primary healthcare model. Financial interventions for the health workforce to tackle primary healthcare challenges were implemented, but long waiting times and access challenges – including to primary care physicians and emergency care – persisted in 2022 (see Section 5.2). Additionally, reforms of the public sector salary system, which would affect

Figure 20. Slovenia will benefit from substantial funds under the EU Recovery and Resilience Facility



Notes: These figures refer to the original Recovery and Resilience Plan. The ongoing revision of the Plan might affect its size and composition. Some elements have been grouped together to improve the chart's readability.
Source: European Commission – Recovery and Resilience Scoreboard.

⁶ These EU Cohesion Policy figures reflect the status as of September 2023.

physicians' and nurses' salaries and give public providers more managerial freedom, are under consideration.

Digitalisation of healthcare is high on Slovenia's health agenda

Digitalisation of healthcare has been a health system priority in Slovenia for the last 10 years. A digital health programme was launched in 2015 to enhance the country's digital infrastructure and improve continuity and access to care through new digital tools. The COVID-19 pandemic became a catalyst to implement many aspects of this programme (see Section 5.2). Slovenia's commitment is sustained through its national Recovery and Resilience Plan and a new health system reform process launched in autumn 2022, with the support of the European Commission's Technical Support Instrument. As part of this process, a Law on Digitalisation of Healthcare, adopted on 8 June 2023, proposes to dedicate 10 times more money to digital health and digitalisation over the next three years compared to 2023, and to establish an independent agency to oversee digital health and digitalisation infrastructure, financed by a fixed percentage of the total SHI budget. It also includes harmonisation of data collection within five national registries, although details about the governance of these registries and their compatibility with other international registries, like those of Eurostat and OECD, are unclear.

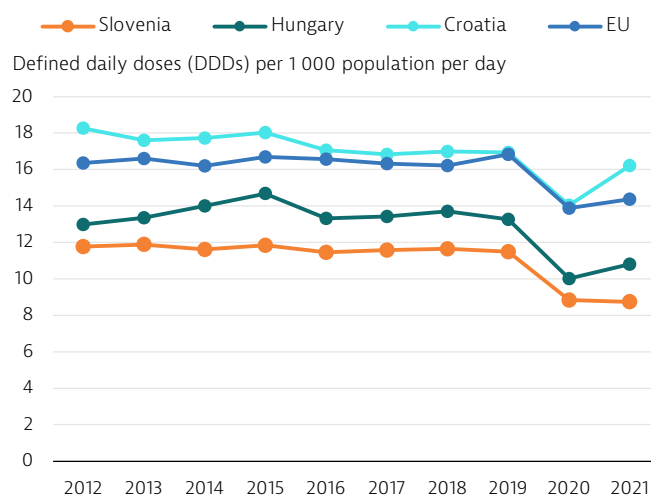
Slovenia has low antibiotic consumption and has adopted a national plan targeting antibiotic resistance

Antimicrobial resistance (AMR) is a major public health concern in the EU, with estimates of about 35 000 deaths (ECDC, 2022) in the EU and European Economic Area (EEA) due to antibiotic-resistant infections, and healthcare-associated costs of around EUR 1.1 billion per year (OECD/ECDC, 2019). Because antibiotic overprescription and overuse in humans are major contributors to the development of antibiotic-resistant bacteria, antibiotic consumption data are a useful tool to evaluate the risk of AMR and the efficacy of programmes to promote their appropriate use.

While Slovenia's antibiotic consumption was stable for the last 10 years at around 11.0 defined daily doses (DDDs) per 1 000 population, antibiotic consumption in the community dropped during the COVID-19 pandemic. Slovenia had among the lowest antibiotic consumption in 2021 at 8.7 DDDs per 1 000, which is well below the EU average of 14.4 per 1 000. While antibiotic consumption in

other EU countries, such as Hungary and Croatia, increased in 2021, Slovenia maintained these low levels (Figure 21). Nevertheless, while Slovenia's estimated antimicrobial resistance rate is half the EU average, it is still higher than the rate in one third of EU countries. In September 2019, Slovenia adopted the 2019-24 One Health Strategy – a national plan for surveillance, detection and reporting of antimicrobial-resistant pathogens (GHS Index, 2021). However, the country does not have a policy addressing AMR specifically in long-term care facilities (ECDC et al., 2022).

Figure 21. Slovenia maintained its low levels of antibiotic consumption after a drop during the pandemic



Notes: The EU average is unweighted.
Source: ECDC ESAC-Net.

Slovenia aims to be fully adapted to the impacts of climate change by 2050

Slovenia is strongly committed to fostering sustainable growth and encouraging the green transition, notably through a substantial package of policies to reduce greenhouse gas emissions (Ministry of the Environment and Spatial Planning, 2018). These policies are accompanied by a European Commission Strategic Framework for Climate Change Adaptation, which was adopted by Slovenia in 2016 and guides the country's ambition to be fully adapted to the impact of climate change by 2050 (European Commission, 2018). The framework has provided national agencies and experts with the structure, tools and resources to assess the impact of climate change and Slovenia's vulnerability to it in various sectors. Some interventions specific to population health have already been implemented, such as the National Institute of Public Health's Safe in the Sun Programme.

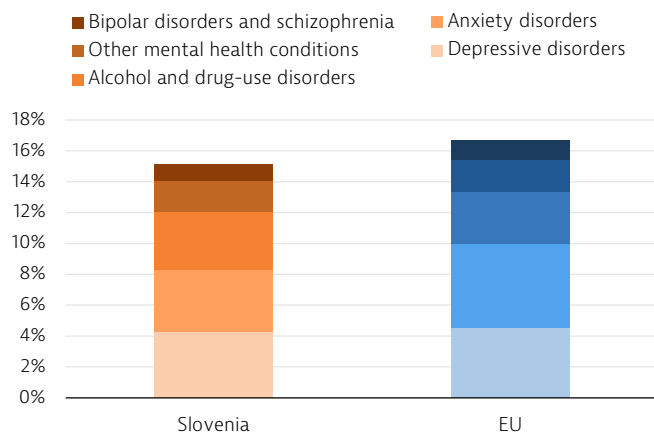
6 Spotlight on mental health

Mental health issues affect one in six people

Available evidence suggests that the prevalence of mental health conditions in Slovenia (15 %) is lower than the EU average (17 %): one in six people suffered from a mental health issue in 2019. The most common conditions are anxiety, depressive, and alcohol and drug-use disorders, each representing 4.0 % of mental health disorders (Figure 22).

The direct and indirect economic costs of mental health problems in 2015 were around EUR 1.6 billion, accounting for 4.13 % of Slovenia's GDP, which was about the EU average (4.1 %) (OECD/EU, 2018).

Figure 22. The prevalence of mental health disorders in Slovenia is below the EU average



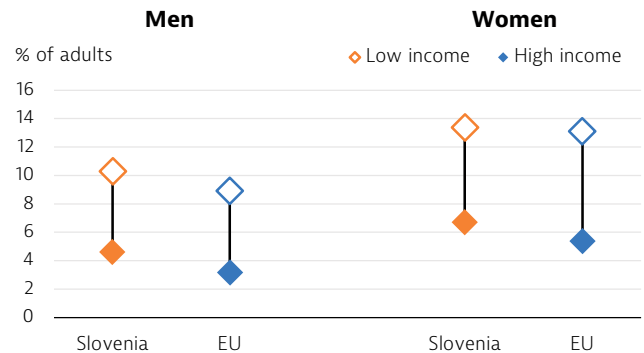
Note: The EU average is unweighted.
Source: IHME (data refer to 2019).

Depression is more common among women

Before the pandemic, 7.9 % of Slovenian adults reported depression – a slightly higher share than the EU average (7.2 %). Overall, depression was more commonly reported by women; further, people in the lowest income quintile in Slovenia were twice as likely to report depression as those in the highest quintile (Figure 23). Additionally, Eurofound's Living, working and COVID-19 e-surveys carried out between 2020 and 2022 found a much higher share of adults at risk of depression among respondents reporting financial difficulties (50 %) than among those who did not report financial difficulties (29 %) (Eurofound 2021; 2022). While the COVID-19 pandemic reinforced the links between mental health and socioeconomic status in Slovenia, the impact was less severe than across

the EU, where 62 % of people reporting financial difficulties and 37 % of those with no financial difficulties were at risk of depression.

Figure 23. Slovenia has slightly higher rates of depression for both sexes than the EU averages



Note: High income refers to people in the top income quintile (20 % of the population with the highest income), whereas low income refers to people in the bottom income quintile (20 % of the population with the lowest income).

Source: Eurostat Database (based on EHIS 2019).

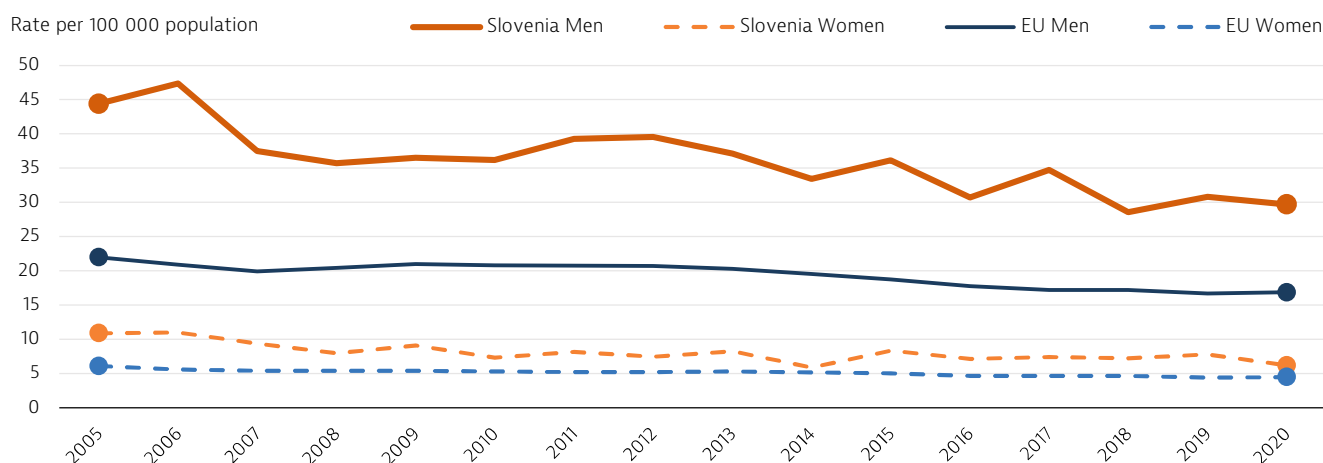
Men are five times more likely than women to commit suicide

Suicide rates in Slovenia in 2020 were significantly higher than the EU average, at 17.0 per 100 000 population compared to 10.2 per 100 000 across the EU. However, men (29.7 suicides per 100 000) are five times more likely to commit suicide than women (6.2 per 100 000) (Figure 24).

Fragmentation and health workforce shortages undermine access to mental health services

The Mental Health Act (2008) was adopted to guarantee basic human rights in mental health services in Slovenia, although this was ruled unconstitutional by the Constitutional Court in 2019. Currently, mental healthcare in Slovenia is mainly hospital-based, although efforts have been made to establish conditions for deinstitutionalisation. Outpatient care is provided at the primary care level in the framework of public health services in CPHCs and by newly established mental health centres. Treatment for disorders such as depression, psychosis and bipolar disorders are covered by SHI. Access to psychiatrists does not require a referral for basic treatment (Depression Scorecard, 2022). Various non-governmental organisations focus on mental health prevention and rehabilitation.

Figure 24. Suicide rates in Slovenia are higher than the EU averages



Source: Eurostat Database.

Governance of the mental healthcare system is split between the Ministry of Health, the Ministry of Labour, Family, Social Affairs and Equal Opportunities, and the recently created Ministry of Solidarity-Based Future. This results in fragmentation of service planning, financing and provision, and undermines cross-sector collaboration. Meanwhile, despite recent increases, Slovenia still has a comparatively low number of psychiatrists per population vis-à-vis other EU countries, and the demand for care exceeds workforce capacities (WHO Regional Office for Europe, 2020). Other access issues included uneven geographical distribution of providers – with a concentration in urban areas and specialised facilities and hospitals – and long waiting lists to access clinical psychology services. Quality is also not sufficiently accounted for, as service provider payment rates are based on quantity and do not consider indicators of quality and outcomes.

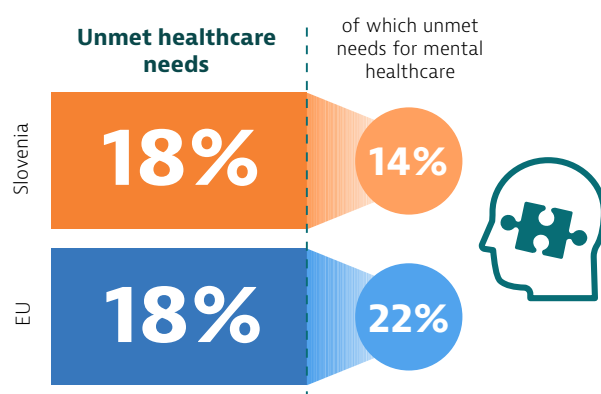
Despite challenges, Slovenia reports lower levels of mental healthcare-related unmet needs than the EU average. According to the Eurofound survey in 2022, although the level of unmet medical needs reported for Slovenia was similar to the EU average (18%), fewer respondents reported unmet needs for mental healthcare (14%) than the EU average (22%) (Figure 25).

Policy measures tackle unmet needs and access issues, shifting towards integrated mental healthcare

Since 2005, Slovenia has implemented systematic depression screening, facilitating provision of mental healthcare at the primary care level. Broader integration of services was planned in the first National Mental Health Programme 2018-28, which focuses on care delivery at the community level and prevention of mental health disorders.

Specifically, it set out plans for a network of mental health centres located at CPHCs across Slovenia, providing comprehensive services. By the end of 2020, accelerated by the demand for mental healthcare during the COVID-19 pandemic, 25 mental health centres for adults and 27 for children and adolescents had been established. More recently, the Association of Psychiatrists of the Slovenian Medical Association adopted guidelines in 2021 for the treatment of depression, which include pharmacological treatments and individual-oriented approaches such as psychotherapy and psychoeducation (Depression Scorecard, 2022).

Figure 25. One seventh of unmet healthcare needs reported in Slovenia during the pandemic were for mental healthcare



Note: Survey respondents were asked whether they had any current unmet healthcare needs and, if so, for what type of care, including mental healthcare.

Sources: Eurofound (2021; 2022).

7 Key findings

- Life expectancy at birth in Slovenia rebounded to 81.3 years in 2022 after dropping by 1 year in 2020. While the main causes of death were circulatory diseases and cancer, COVID-19 had a significant impact on mortality rates, accounting for 14.4 % of deaths in 2020.
- Over one third of deaths in Slovenia are linked to behavioural and environmental risk factors, driven by poor diet and alcohol consumption. Additionally, obesity is becoming a major public health issue, with more than half of adults being overweight or obese; meanwhile, the rates for adolescents have been increasing steadily over the last two decades. In response, the government has developed a comprehensive and multi-sectoral National Nutrition and Physical Activity Strategy 2015-25 to improve the nutrition and exercise habits of the population and to tackle obesity. However, the COVID-19 pandemic may have hampered these efforts, especially for children aged 6-15.
- At EUR 2 665 per capita, Slovenia's health expenditure is about two thirds of the EU average. For the past 10 years, public spending on health has increased gradually. Slovenia's COVID-19 response increased public spending on health precipitously to reach 73.7 % of total health expenditure in 2021.
- Slovenia's social health insurance-based system provides near universal coverage via a single payer. Extensive utilisation of complementary health insurance, a generous public benefits package and strong financial protection measures contribute to low out-of-pocket expenditure and low health-related catastrophic spending. Catalysed by a steep rise in premiums, a reform of the Health Care and Health Insurance Act abolished complementary health insurance in July 2023; it will be replaced by a fixed compulsory contribution.
- Cancer is a top priority for Slovenia's health agenda. Successive structured national approaches, including screening programmes for breast, cervical and colorectal cancers, have improved detection since 2000. In 2021, the breast and colorectal cancer screening rates for target populations were above the EU averages; however, disparities by geography, age and income constrain further progress. The third National Cancer Control Programme aims to mitigate increasing cancer incidence, increase cancer survival rates and improve the quality of life of patients with cancer.
- Several persistent factors challenge access to care in Slovenia. Waiting times for secondary specialist care contribute to high self-reported unmet needs for medical care, and people in the lowest income quintile still report higher unmet needs than those in the highest. Recent reforms and investments to tackle this issue have not yet produced results. Meanwhile, workforce shortages – especially in primary healthcare settings – and uneven geographical distribution accentuate access issues. Following the pandemic, further reforms targeting primary healthcare and health workforce issues are under discussion.
- Funding under Slovenia's Recovery and Resilience Plan and EU Cohesion Policy will be invested in treatment of communicable diseases and digital transformation of healthcare. Other financing is dedicated to enhancing health system accessibility, effectiveness and resilience, as well as investing in health equipment.
- Anxiety, depressive, and alcohol and drug-use disorders make up the bulk of Slovenia's mental health burden. Although Slovenia reports a lower prevalence of mental health disorders than the EU as a whole, there are wide gender and income disparities. During the COVID-19 pandemic, around one seventh of reported unmet healthcare needs were related to mental healthcare. Several measures, including the National Mental Health Programme 2018-28, aim to tackle unmet needs for mental healthcare and access inequalities by encouraging a shift from hospital-based to community-based and integrated care.

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Country abbreviations

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

State of Health in the EU

Country Health Profile 2023

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2023 edition of the Country Health Profiles provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- For the first time in the series, an account of the state of mental health and related services within the country.

Complementing the key findings of the Country Health Profiles is the Synthesis Report by the European Commission.

For more information, please refer to: ec.europa.eu/health/state

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