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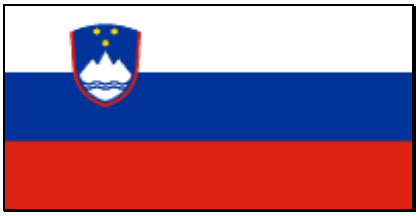
Study on the Social Protection Systems in the 13 Applicant Countries

Slovenia
Country Study



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Social Protection in Slovenia

1. INTRODUCTION: ECONOMIC, FINANCIAL AND DEMOPGRAPHIC BACKGROUND

1.1 Main influencing factors for social protection

1.1.1 Economic and financial indicators

Since 1995, Slovenia has been experiencing an increase in the gross domestic product (both total and per capita). The annual increase in GDP (in constant prices) has been 3.5%-5.2%; compared to this, in the first three quarters of 2001 it was somewhat lower (3.3%). It was only in 1998 that the GDP first reached its pre-transition level.

Slovenia's gross national product per capita in PPS amounted to 11,300 in 1995 and 16,100 in 2000. It is close to that of two European Union members countries (Greece and Portugal) and was at the level of 66% of the EU average in 1995, 67% in 1997 and 69% in 1998. In 1997, Slovenia surpassed the GDP per capita of Greece. Due to a 5.2% GDP growth rate in 1999, Slovenia achieved 71% of the 1999 EU-15 average. This level was kept in 2000 as well (SORS, Statistical Yearbook 2001). The GDP per capita amounted to 9.8 thousand Euro in 2000 (see Table 1.1).

A relatively high inflation rate is still characteristic for Slovenia. In 1995, the inflation rate was still two-digit, but later rates were between 6.1% and 9.9%. In the first half of 1999 the inflation rate decreased to 4.3% at the yearly level. However, the implementation of the value added tax in the middle of 1999 and the high increase in oil prices pushed the inflation rate towards almost 9% by the end of the year, resulting in a 6.1% annual average. In addition to these external factors, the increasing strength of the US dollar and the increasing inflation rate in the EU in 2000 showed their consequences for the Slovene inflation rate. Internal factors, such as the increase in wages, the state budget deficit etc. had a less noticeable impact on the inflation development in Slovenia.

Even during the early transition period, Slovenia has managed to retain its comprehensive social welfare system, with the share of social protection in the GDP around 24%. In 1997-1999 it was at the level of some 26%.

Public social expenditure (current transfers to individuals and households) accounted for 40-41 per cent of the state budget (Table 1.2). Two-thirds of all public social expenditure were used for pensions, 8-10 per cent for family benefits, 5-6 per cent for social assistance, and smaller shares for other groups of transfers. Health care and pensions were mostly funded through separate entities that collect social security contributions and not from the state budget (see Chapter 2).

Transfers to unemployed persons have reached the ceiling (1.5% share in the state budget) in 1997, and have been decreasing since. In 1998, the duration of entitlement to unemployment compensation as related to the insurance record was shortened. Moreover, strict eligibility rules were introduced, which exclude those beneficiaries from receiving unemployment benefits who cannot prove to be actively seeking work or do not accept the work offered or break other rules defined by the law. The period of entitlement to unemployment assistance was extended from six to 15 months. In case of older unemployed persons with only three years to their retirement (and having poor chances of getting a job), the entitlement period can be prolonged until the fulfilment of their retirement conditions. As a result of these changes, unemployment assistance replaced unemployment compensation as the major type of social disbursement for unemployed persons approaching pensionable age. This substitution is cost-effective in the sense that unemployment assistance is lower and means-tested.

The expenditure on health care has remained at the level of some 8% of the GDP in the period 1996-1999 (of that, 0.7% of GDP in 1996-1997 and 0.6% in 1998-2000 have been covered from the central government budget). Since 2000, health care contributions have not been enough to cover expenditures. In 2001, expenditure on pharmaceuticals increased by 13.7%; wages in health sector increased as well, and so did some other expenses. Consequently, outflows exceeded inflows of the National Health Insurance Institute by 10.4%.

Pensions and related expenditure accounted for about 14.5% of GDP in recent years. In 2000, some two-thirds were financed through contributions and one-third from the state budget.

Demographic indicators

The population of Slovenia is near to 2 million; 51% are women (Table 1.3). A downward trend in the number of population was reversed in 2000 (0.12% increase) due to positive net migration. The net natural increase has been negative since 1997.

The demographic dependency ratios indicate a progress in ageing. The dependency ratio between the old (60+) and the population in active age (15-59)

was 0.35 in 1995, and has increased to 0.36 in 1998-2000 (Table 1.4). The percentage of population below 15 years of age decreased from 18.5% in 1995 to 16.6% in 1999. In the same period of time, the percentage of people aged 65 years and more increased from 12.1% to 13.6%.

The total fertility rate in Slovenia is among the lowest in Europe. It was at the level of 1.2-1.3 in the period 1995-2000 (Table 1.5). In 1999, it was at its lowest level of 1.21. Only the Czech Republic, Russian Federation, Latvia, Liechtenstein, Armenia and Spain had lower total fertility rates. To these countries, Italy and San Marino were added in 2000. In 1999, Slovenia faced the lowest ever number of live births, which was lower than in 1945 and only half as many as in 1950.

An increase in the total fertility rate to 1.26 in 2000 – the first increase in the last 21 years – was obviously related to the ”magic number” of the year 2000 in which the parents wanted their children to be born. The total fertility rate fell to its 1999 level in 2001. In 2000, 18,180 births were registered; there was a total increase of 647 babies or 3.6% more in 1999. However, in 2001 the number of live births was even lower than in 1999 (SORS, Statistical Yearbook 2002).

Since 1995, the most fertile category of the population are women aged 25-29, with peaks at the ages of 26 and 27. However, the fertility among them has been decreasing as well. On the other hand, the fertility rate of women over 30 years of age has been increasing, but not enough to compensate for the decrease in the fertility rate in the age group 15-24. In 2000, as compared to 1999, the fertility of women between 35 and 39 years of age increased considerably.

In the period 1995-2000, the birth rate has been below 10 births per 1,000 inhabitants, the lowest level being 8.8 in 1999. The 2000 level was 9.1

The net reproduction rate decreased from 0.62 in 1995 to 0.59 in 1999, and then increased to 0.61 in 2000.

Life expectancy at birth has been increasing, reaching 71.9 years for men and 79.1 years for women in 2000; thus for women, it was by 7.2 years higher (Table 1.6). At the age of 65, this difference was smaller (4.3 years).

In 2000, 6,185 people immigrated to Slovenia (5,879 in 1995), which was a quarter more than in 1999 (Table 1.7). 935 persons or 15% of the immigrants were citizens of the Republic of Slovenia, compared to 37% in 1995 and 25% in 1999 (Table 1.11). In 2000, the number of foreigners immigrating to Slovenia increased significantly to 5,250 (3,688 in 1995 and 3,579 in 1999). The number of foreigners who emigrated from Slovenia in 2000 increased by 22% as compared to 1999 (Table 1.7).

Slovenian citizens mostly returned from former Yugoslav republics (768 in 1999 and 335 in 2000). In 2000, the number of Slovenians returning from the European Union member countries was 432, of which 241 returned from Germany and 92 from Austria. More men returned than women, giving a sex ratio of 119. The biggest change compared to the previous year was the average age of the people returning: it exceeded 40 years for the first time. This trend will probably continue as a result of an expected increase in the return of retired citizens (Council of Europe, 2001).

The number of emigrating Slovenian citizens also increased in 2000. A total of 1,559 Slovenians emigrated (776 in 1995), which was almost two thirds more than in 1999 (Table 1.12). The majority, 815 persons, left for EU member states, of which 348 went to Germany and 157 to Austria. 148 persons left for the US and Canada, which was almost double compared to 1999. Emigration of Slovenian citizens to former Yugoslav republics decreased further: 320 people or 20%. The average age of Slovenian emigrants was 35.2, which was similar to previous years (Council of Europe, 2001).

For the first time since 1993, the net migration of Slovenian citizens was negative in 2000 (-624); in 1995 it was at the level of 1,415. Slovenia has a positive net migration only with countries founded on the territory of former Yugoslavia (but only by 15 people, and negative for men). The negative net migration with EU member states was 383, of which 241 were women. Positive net migration was only registered for the age group 55-74 and is the result of retired people returning. The biggest negative net migration was recorded for the age group 20-34 (Council of Europe, 2001).

Migration data in Slovenia is only available on citizenship and not on the country of previous and next residence. Thus we can only assume that most foreigners come from, and return, to the countries of which they are citizens. The structure of foreigners is similar to previous years. 85% of immigrants were citizens of countries founded on the territory of former Yugoslavia. Almost half of them came from Bosnia and Herzegovina. 3.5% were EU citizens. A typical foreign immigrant is a man aged 20-39. The exceptions are immigrants from Ukraine, Russia, and Romania: 169 of the 275 persons from these three countries were women, mostly under 25 years of age. The average age of foreign emigrants is slightly higher than the average age of foreign immigrants (Council of Europe, 2001).

Social indicators

The labour force participation rate in Slovenia is above the EU average, and the participation rate of women is among the highest in Europe (Table 1.13).

Since 1993, the LFS unemployment rate (number of unemployed as percentage of the labour force) has been lower than the EU-15 average and slightly above the average for the OECD countries. The LFS unemployment rate was 6.9% in 2000: 6.8% for males and 7.1% for females (Table 1.15). In the third quarter of 2001, it was 5.9% (IMAD, 2002b).

The registered unemployment rate reached its highest level of 14.8% in 1997 (Table 1.14). The number of the unemployed has been slowly decreasing, but the high unemployment rate remains one of the major challenges for the employment policy in future. The unemployment rate for women was lower than that for men till 1996, mostly due to the fact that dismissals – as the consequence of economic transformation – were most intensive in industrial branches with a predominantly male labour force. The registered unemployment rate was 12.2% in 2000: 11.1% for males and 13.5% for females. Females accounted for 50.7% of all registered unemployed. In 2001, the registered unemployment rate decreased by 4.5% as compared to 2000 and reached the level of 11.6%.

Unemployment affects some groups disproportionately. Persons below the age of 25 (with a 18-19% LFS unemployment rate in the period 1996-2000) accounted for 23% of all registered unemployed in 2000; the share of young unemployed has been decreasing, partly due to the increasing enrolment in university education and partly due to educational and training programmes, which are part of the active employment policy measures. Persons with incomplete or only basic education and skills accounted for 47% of all unemployed in 1999. Persons older than 50 years accounted for 24.1% of all unemployed in 1996 and for 25.4% in 2000 (SORS, Statistical Yearbook 2001). The long-term unemployed (out of work for more than 12 months) accounted for 61% of all unemployed in 2000 (those who have been out of work for more than two years accounted for 34% of all unemployed).

The main challenge for future is to reduce the structural disparities in the labour market. Active labour market programmes have been launched to diminish the existing skill-mismatch. The National Employment Action Plan for the period 2000-2001 followed the EU four-pillar structure and the EU employment policy guidelines.

After several years of continuous decline, in the year 2000 the number of persons in employment reached again the 1993 level, partly as a result of a wide range of employment programmes launched by the government; however, it is still below the pre-transition levels. Employment in 2000 was only at 75% of the 1989 level, and even the labour force was only at 90% of the pre-transition level. In the last years, Slovenia has been facing stagnation in employment in

spite of economic growth. The number of persons in employment increased by 1.4% in 2001 as compared to 2000 (IMAD, 2002b).

The employment rate in Slovenia is above the EU average, mainly due to high employment of women and people aged 25-49 years. On the other hand, low employment rate among young people (15-24 years of age) reflects their increasing enrolment in education. This rate is below the EU average.

Women in Slovenia formally have equal rights and opportunities in the labour market as men. Slovenian legislation incorporates all principles of international conventions on women's rights. The labour legislation also guarantees equal opportunities to all and treats women in a different way only where their special protection in connection with pregnancy and rearing of small children is concerned.

The female employment rate in Slovenia is traditionally high; it reached almost 50% in 1998 (the corresponding rate for men was 61%) – see Table 1.18. As measured by the 2000 Labour Force Survey, the female employment rate was 47.9%, while the percentage for males was 59.6%. The difference may be largely explained by the shorter years of employment, as required for full pension rights of women as compared to that of men, and women's higher life expectancy. In the period 1995-2000, the female share in all the employed stabilised at the level of about 46%.

In the age group 20-44, just below 90% of women are employed. The fact that also in the families with small children usually both parents were/are employed is not only due to professional aspirations of women, but has also to do with the need arising from the relation between wages and the costs of living. Two wages are needed for a decent standard of living of a three- or a four-member family.

Another important feature of female employment in Slovenia is that the majority of women are employed full-time. It also applies to women with small children; typically, after the maternity and parental leave, women return to their full-time jobs, which surely has to do with the length of this leave (it is normally one year long with a 100% wage compensation). Both employers and employees prefer the full-time employment: the former consider it less expensive and more reliable, while the latter cannot afford earning less labour income. Part-time employment is mostly an individual choice due to illness, handicap or part retirement. A part-time employment almost did not exist in Slovenia until the 1990s; it was an exceptional employment arrangement.

According to the Labour Force Survey, 7.7% of women and 4.7% of men had a part-time employment in 2002 (Table 1.21).[1]

In spite of the relatively high education level of women in Slovenia, and in spite of their meeting with formal requirements for upward mobility, the number of women in management and leading positions in firms remains substantially lower than that of men. This may be explained by cultural patterns and prevailing values in the Slovenian society, the difference in the men's and women's expectations, and the different social frameworks of female and male lives (MoLFSA, 1994). Consequently, men have higher gross wages than women with the same education level. The greatest difference exists between male and female workers with lower vocational education (women's wages amount to 76% of the men's), while the smallest ones are observed between males and females with lower professional education (women's wages amount to 95% of the men's) (MoLFSA, 2002).

The number of self-employed, particularly farmers, has been declining, while the number of persons in paid employment has been increasing (Table 1.19). In 2000, 11.1% of all persons in employment were self-employed (4.5% were farmers).

Structural adjustment in the transition period manifested itself through the increasing employment in services and decreasing employment in agriculture and industry (Table 1.22). However, the shares of employment in industry and agriculture are still somewhat higher than in the EU on average. In 2000, 62% of women were employed in services, while the shares of men employed in industry and services were similar (46% and 45%, respectively) – see Table 1.23.

Regional mobility of labour is rather low in Slovenia and exists mainly due to daily migrations to urban centres.

Income distribution[2]

Cumulative distribution of income is presented by the Lorenz curve[3] in Figure 1.1. As can be seen, there was a positive shift of the income distribution curve

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1 A full-time equivalent is taken into account rather than the number of persons. This can be compared to the EU-15 average of 16.9% (5.8% of males and 32.4% of females) in 1997 (Eurostat, 2000, pp. 141-142).

2 Quoted from Stropnik and Stanovnik (2002). Equivalence scale used is the standard OECD scale (1, 0.7, 0.3).

3 This Lorenz curve shows the cumulative proportions of total income disposed of by cumulative income deciles of households.

for Slovenia in the period 1993-1999; in other words, income inequality has decreased.

In order to identify the reasons for this shift, another figure (Figure 1.2) was plotted showing the shares of the total income by income deciles (details are presented in Table 1.27). As we can see, the income shares of the first seven deciles have increased, except for the third decile where the income share remained unchanged. In contrast, the income shares of the top three deciles decreased.

The distribution of three groups of households by income deciles was analysed in more detail. These are the households that are generally supposed to be at the highest risk of poverty: households with unemployed members, with children up to age 18, and with persons aged 60 and over.

There are 10% of all households in Slovenia in each income decile. It is evident from the curves in Figure 1.3 that the households with unemployed members and those with a person aged 60 and over were over-proportionally represented in lower income deciles. This is particularly true for households with unemployed members, whose situation has also aggravated in the period from 1993 to 1997-1999. Their shares in the lowest four income deciles have thus increased and their shares in other deciles have decreased. On the contrary, the shares of households with persons aged 60 and over have decreased in the bottom two income deciles in 1997-1999 as compared to 1993, while their shares have increased in the higher half of deciles.

The distribution of households with children up to age 18 was rather equal. In 1993, these households were under-represented in the bottom two income deciles, showing that they were not at high risk of poverty. In 1997-1999 the situation was worse. It is true that households with children were still slightly under-represented in the bottom income decile, but their shares in the two top deciles have decreased considerably.

Poverty

The Slovenian Statistical Office employs the Eurostat methodology (modified OECD equivalence scale, poverty line at 60% of the median equivalent income). The poverty rate for the total population was 13.0% in 1993, 14.0% in 1998 (i.e. in the period 1997-1999) and 13.6% in 1999 (i.e. in the period 1998-2000).

The methodology employed by Stropnik and Stanovnik (2002) differs in one element: standard OECD equivalence scale was used. The results for total population and selected population groups are presented in Table 1.28.

In 1993 and in the period 1997-1999,[4] the following households were identified by the Statistical Office as the ones at high risk of poverty (poverty line was set at 50% of the mean equivalent expenditure, as it was previously defined by Eurostat):

- single households, particularly those of elderly persons (27.6%); elderly couples (19.5%);[5] families with three or more children below age 16 (13.7%); single parent families (15.2%);
- households without employed members (23.2%);
- households with low educated heads (25.3%),
- households where pensions and other social benefits are the main sources of income (19.6% and 41.6%, respectively);
- tenants in non-profit and social housing (23.1%) - (MoLFSA, 2002).

As regards gender of the reference person in the household, the difference is not so great. In 1998, the poverty rate in the households headed by women was slightly above the average one (13.3% as compared to the average of14%); in the households headed by men, it was 10.9%. Among the social assistance beneficiaries as well, there are only slightly more women then men (49%:51% in 1998; 50%:4% in December 2000).[6]

In both 1993 and in the period 1997-1999 (the years when household income and expenditure were registered by the Household Expenditure Surveys) the unemployed were identified as the population group with far the highest risk of poverty (Stropnik and Stanovnik, 2002). The situation of the unemployed has worsened in the observed period of time. If poverty line is set at 0.6 of median household equivalent income, 48.3% of the unemployed lived in poverty in 1997-1999 as compared to 33.5% in 1993. The poverty rate for the unemployed was 2.6 times higher than the average one in 1993, and 3.5 times higher than the average one in 1997-1999 (Table 1.28).

Family structure

Demographic changes in fertility, marriage and divorce have considerably influenced the size, composition and forms of a family in Slovenia during the

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4 These are two latest Household and Expenditure Surveys databases.

5 This result is obtained by using the old Eurostat methodology where poverty line was set at 50% of mean equivalent expenditure. Considerable discrepancy was identified between income and expenditure of elderly individuals and couples. Since elderly people tend to spend a lower proportion of their income, this measure overestimates the risk of poverty for this population group, which was proved by the research by Stropnik and Stanovnik (2002).

6 This information is not available for 4% of beneficiaries.

last twenty years. On average, 3.1 persons were living in a household in Slovenia in 1991 as compared to 3.34 in 1981. The decrease was mainly due to a smaller number of families with three or more children (7.6% of families in 1991) – see Table 1.25.

The percentage of single households, as registered by the last (1991) census, was 18.0% - 19.9% in urban settlements and 15.8% in other settlements. The percentage is lower for households with agricultural holding (11.2%) than for other households (20.2%). There are many atypical and new (as compared to the situation half a century ago) types of families, such as single-parent families, unmarried cohabiting partners, second and subsequent families formed after a divorce.

In 1976, matrimony and cohabitation were made legally equal; children born out of wedlock have the same rights as those born to married couples. Since then, the number of children born out of wedlock has been increasing, reaching 13.1% in 1980, 19.1% in 1985, 24.5% in 1990, 29.8% in 1995 and over 37% in 2000. Nowadays, there is almost no stigma associated with having a child out of wedlock or being born out wedlock. This, of course, somewhat depends on the regional and local conditions.

Compared to the 1981 census, the proportion of consensual units with children doubled in a ten-year period (Table 1.25). The proportion of single-parent families increased by four percentage points. Consequently, the share of married couples with children decreased.

Most families in Slovenia come close to the prevailing norm of two children per family as identified by fertility surveys (e.g. Černič Istenič, 1994, and Obersnel Kveder et al., 2001). For the replacement of generations, it would be necessary to shift to a norm of two to three children per family.

Postponing birth of the first child contributes to the rise in the average age of mother at birth of any child (28.2 in 2000) and at birth of the first child (26.5) – both figures are above the average ones for Europe. Since 1995, the average age of mother at birth of any child increased by 1.2 years, while the average age of mother at first birth increased by 1.6 years (Table 1.26). It is likely that, because of the postponement phenomenon, period indicators of fertility seriously underestimate its true level.

The number of divorces per year increased from 1,585 in 1995 to 2,125 in 2 000, which is 299 divorces per 1 000 marriages or 1.1 divorces per 1,000 population. 56% of all divorces involved dependent children. The total divorce rate rose from 0.14 in 1995 to 0.2 in 2000 (Council of Europe, 2001).

1.2 How does the described background affect social protection?

1.2.1 Forecasts and projections

The following assumptions for forecasts are quoted from IMAD (2001a).

The pick-up of economic growth in the USA and the EU may be expected in the second half of 2002. Lower export demand is expected in 2002, caused by the strong economic deceleration in most trading partners.

Economic forecasts were done in autumn 2001 for 2002 (IMAD, 2001a). Due to the impact of the international environment on export performance, the economic growth is forecasted at 3.6%. The average annual export growth of 4.8% will be significantly below the level of 2000 (12.7%) and 2001 (7.2%). Real imports of goods and services will rise by 4.7%. The deficit in the current account of the balance of payments will thus increase to 1.2% of the GDP.

The inflation rate is expected to drop to 6.4% in 2002. The GDP is expected to increase by 3.6% in 2002. The consolidated general government revenues are estimated to total around 42.5% of GDP in 2002 and around 43.5% in 2003. The total fiscal deficit will reach about 2.5% of GDP in 2002 and 0.7% of GDP in 2003.

IMAD (2001b) includes medium-term projections for the period up to 2005, which are not so much based on current economic trends but rather on a consistent economic policy aimed at restructuring the economy and society, as envisaged by the draft Strategy for the Economic Development of Slovenia.

According to the projections for 2003-2005, the GDP will increase by some 5% annually. The inflation rate will decrease from 5.2% in 2002 (which proved to be unrealistic) to 3.3% in 2005. The government consumption will account for a decreasing percentage of the GDP (20.0% in 2003 and 19.5% in 2005) - (IMAD, 2001b).

Demographic forecasts

Due to the persistently low birth rate and the relatively low net migration, Slovenia's population will continue to be stagnant in the forthcoming years. In 2005, the population will not exceed 2 million (1,986 million). Various demographic projections indicate that the population is becoming older. The share of people aged 65 and older will increase to 15.2% in 2005, while the share of the young will decrease to 14.6%. If no greater migration surpluses are achieved in the following few years, the population in active age will be more or less stagnant (IMAD, 2001b).

An increase in the number of people aged over 65 will slow down in the period from 2004 to 2012. This involves a less numerous generations born between 1939 and 1947. The working age population (aged 15-64), which stopped increasing in the period from 1992 to 1995, is set to increase until 2004, when it will begin to fall again, first slowly and then rapidly. The influx of young people will continue to fall, because the number of children below 15 years of age will continue to decline rapidly (Pirher et al., 2000).

A rapid decrease in the share of population aged 20-59 is predicted after 2010 in Slovenia; in the years following 2015 these shares will be lower than now (Van der Gaag et al., 1999).

According to the projections by the Statistical Office of Slovenia (Table 1.29), the population of Slovenia will increase by 1% between 2001 and 2012, and so will the share of those aged 0-14 years. The population in working age will decrease by 0.5% while the number of those aged 65 years and more will increase by 14%.

Forecasts for labour market developments

Employment should continue to rise and unemployment continue to fall, albeit at lower rates than before. This is based on the assumption that companies will adapt to less favourable economic conditions by reducing costs (lower investment and wage growth) rather than through lay-offs (IMAD, 2001a).

With gross domestic product growth being lower and labour productivity growth about the same as in 2001, the rise in employment in the full-time equivalent should be slightly lower in 2002 than in 2001 (up around 0.6%). Registered unemployment rate should be around 11.2% and the survey employment rate close to 6%.

The real gross wage per employee is estimated to rise by around 2.5% in 2002. This estimate takes into account the wage rises agreed for 2002, the more restrictive wages policy in the public sector, and the anticipated faster wage growth in the private sector relative to 2001.

Employment rate is expected to grow further and reach 67.3% in 2005. To reduce the unemployment rate to the level stated in the strategic goals for labour market development, the demand for the active population should increase at an average annual rate above 1%. By 2005, the registered unemployment rate should decrease to 9.0%, and the survey unemployment rate to 5.9% (IMAD, 2001b).

1.2.2 Influences of economic, demographic and social developments on the social protection system

According to the draft Strategy for the Economic Development of Slovenia, active social policy will be aimed at providing preconditions for social inclusion and at helping those who, due to objective reasons, are not able to provide for themselves. The new Slovenian development paradigm is based on the balanced economic, social and environmental development. The policy of social development will follow two objectives: to ensure social protection and promote social inclusion.

Economic, demographic and social developments are not expected to influence the social protection system in Slovenia to a great extent in the near future. The Employment and Unemployment Insurance Act was amended in 1998, a new Pension and Disability Insurance Act (1999 PDIA) was passed in December 1999, effective in 2000, and the Social Assistance and Services Act was amended in 2002. However, some important changes are envisaged in health care, which are expected to influence the cost of health care for the users of health care services and the population as a whole. Due to a deficit in the health care fund and an increasing trend in the costs – caused by ever more expensive methods of treatment, increasing expenditure on pharmaceuticals, increasing wages in the health sector, etc. – the contribution rate will have to be increased and the rights arising from the compulsory health insurance cut. A reform in the financing of health care institutions is also urgent and is related to the rationalisations to be implemented with the aim to decrease the costs of health care.

The greatest influence on social protection is expected from the population ageing (the funds needed for health and social care of the elderly, and structure of health care and social care programmes), the transition to the knowledge-based society (expenditure on education, life-long learning, new programmes) and increasing individualisation (development of the network of social services).

The age structure of the active population still does not point to a considerable annual increase of new retirements. The total number of pensioners will increase at an annual rate slightly over 1%. The number of pensioners will be more than one-quarter of the total population in 2004.

1.3 Annex to chapter one

Table 1.1: Macro-economic data, 1995 - 2001

Year	GDP in euro (1000 million)	Annual growth rate of GDP in constant prices	GDP per capita in PPS	GDP per capita in euro (1000)	Inflation rate	Social expenditure /social protection expenditure , as % of GDP
1995	14.3	4.1	11,300	7.2	13.5	24.1
1996	14.9	3.5	12,200	7.5	9.9	25.5
1997	16.1	4.6	13,200	8.1	8.3	26.1
1998	17.5	3.8	13,900	8.8	7.9	26.1
1999	18.8	5.2	15,000	9.4	6.1	25.9
2000	19.5	4.6	16,100	9.8	8.9	
2001		3.3*			8.4	

Sources: Eurostat, 2001a; IMAD, 2002b (inflation rate in 2001); SORS, Statistical Yearbook 2001 (social expenditure 1996-1999), IMAD, 2001a (social expenditure 1995).

Note: * Third quarter.

Table 1.2: Public social expenditure by type, as percentage of state budget

	1995	1996	1997	1998	1999	2000
Total current transfers to individuals and households	40.9	41.0	41.3	40.3	40.2	41.0
Transfers to unemployed	1.4	1.2	1.5	1.4	1.3	1.1
Family benefits	3.4	3.8	3.9	3.7	3.8	4.1
Social assistance	2.5	2.5	2.5	2.4	2.1	2.2
War invalids, war veterans and war victims	0.7	0.6	0.8	1.0	0.9	0.9
Pensions	28.6	28.6	28.1	27.5	27.3	27.5
Wage compensation	0.8	1.0	1.0	1.0	1.1	1.3
Sickness benefit	1.7	1.6	1.5	1.4	1.3	1.3
Educational grants	1.0	1.0	1.1	1.0	0.9	0.9
Other transfers to individuals	0.8	0.8	0.8	0.7	1.4	1.8

Source: SORS, Statistical Yearbook 2001.

Table 1.3: Population on 1 January, in thousand

Year	Total population	Men	Women
1995	1,989.5	964.4	1,025.1
1996	1,990.3	968.1	1,022.2
1997	1,987.0	968.6	1,018.4
1998	1,984.9	968.2	1,016.8
1999	1,978.3	963.2	1,015.1
2000	1,987.8	970.8	1,016.9

Sources: Eurostat, 2001a; SORS, Statistical Yearbook 1996.

Table 1.4: Age structure (%)

Year, 1st January	Proportion of the population aged less than 15 years	Proportion of the population aged 65 years and more	Proportion of the population aged 60 years and more	Demographic dependency ratio (60 years and more / 15-59 years)	Net population increase (excess of live births over deaths) – calendar year	Rate of natural increase, per 1000 population (calendar year)
1995	18.5	12.1	21.2	0.35	12	0.0
1996	18.1	12.5	21.5	0.35	168	0.1
1997	17.5	12.9	21.7	0.35	-763	-0.4
1998	17.0	13.2	22.1	0.36	-1183	-0.6
1999	16.6	13.6	22.4	0.36	-1352	-0.7
2000	15.1	17.3	22.7	0.36	-408	-0.2

Sources: Eurostat, 2001a; SORS, http://www.gov.si/zrs/slo/index.htmls (year 2000; proportion of population aged 60 years and more and demographic dependency ratio for 1995-2000).

Table 1.5: Fertility

Year	Birth rate per 1000 inhabitants	Total fertility rate	Net reproduction rate
1995	9.5	1.3	0.62
1996	9.4	1.3	0.62
1997	9.1	1.2	0.60
1998	9.0	1.2	0.60
1999	8.8	1.2	0.59
2000	9.1	1.3	0.61

Sources: Eurostat, 2001a; SORS, Statistical Yearbook 2001 (for net reproduction rate).

Table 1.6: Life expectancy

Year	Life expectancy at birth		Life expectancy at age 60		Life expectancy at age 65	
	Men	Men	Men	Women	Men	Women
1995	70.8	78.4	16.8	21.5	13.6	17.5
1996	71.1	78.9	17.0	21.7	13.7	17.8
1997	71.1	79.0	17.0	21.7	13.9	17.8
1998	71.3	79.0	17.2	21.8	13.9	17.9
1999	71.8	79.3	17.5	22.1	14.1	18.1

Sources: Eurostat, 2001a; SORS, *http://www.gov.si/zrs/slo/index.htmls* (life expectancy at age 60).

Table 1.7: International migration, 1995-2000

	1995	1996	1997	1998	1999	2000
Immigrants	5,879	9,495	7,889	4,603	4,941	6,185
- of them: Slovenian citizens	2,191	1,500	1,093	857	1,362	935
Emigrants	3,372	2,985	5,447	6,708	2,606	3,570
- of them: Slovenian citizens	776	803	807	705	963	1,559
Net migration	2,507	6,510	2,442	-2,105	2,335	2,615
- Slovenian citizens	1,415	697	286	152	399	-624

Immigration rate	3.0	4.8	4.0	2.3	2.5	3.1
Emigration rate	1.7	1.5	2.7	3.4	1.3	1.8
Rate of net migration (per 1000 population)	1.3	3.3	1.2	-1.1	1.2	1.3

Source: SORS, Statistical Yearbook, 1996 and 2001.

Table 1.8: Immigrants, by age and sex, 1995 and 2000, in %

	All immigrants			**Slovenian citizens**		
Age	Total	Men	Women	Total	Men	Women
	1995					
0-14	17.3	14.4	22.1	21.6	21.6	21.6
15-39	52.8	56.5	46.8	40.9	43.3	38.3
40-64	23.8	25.0	21.9	27.7	26.9	28.5
65 and over	6.1	4.2	9.2	9.9	8.2	11.6
Total	100.0	100.0	100.0	100.0	100.0	100.0
	2000					
0-14	7.7	5.3	13.4	10.4	10.6	10.1
15-39	64.3	66.2	59.7	39.0	36.1	42.5
40-64	25.1	26.7	21.2	38.9	42.4	34.7
65 and over	3.0	1.9	5.6	11.7	10.8	12.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: SORS, Statistical Yearbook, 1996 and 2001.

Table 1.9: Emigrants, by age and sex, 1995 and 2000, in %

	All immigrants			**Slovenian citizens**		
Age	Total	Men	Women	Total	Men	Women
	1995					
0-14	11.3	9.5	14.8	13.0	14.2	11.7
15-39	48.1	47.8	48.7	45.9	44.5	47.3
40-64	33.4	37.5	25.6	35.3	35.1	35.5
65 and over	7.2	5.2	10.9	5.8	6.1	5.5
	2000					
0-14	8.8	7.8	10.7	9.5	10.2	8.8
15-39	55.3	55.4	55.0	55.6	55.3	55.9

40-64	29.9	31.6	26.5	28.9	28.3	29.6
65 and over	6.1	5.2	7.7	6.0	6.2	5.7

Source: SORS, Statistical Yearbook, 1996 and 2001.

Table 1.10: Share of men in immigrants and emigrants, by age groups, 1995 and 2000, in %

	Immigrants		**Emigrants**	
Age	Total	Slovenian citizens	Total	Slovenian citizens
	1995			
0-14	51.8	51.8	54.9	55.4
15-39	66.5	54.9	64.9	49.2
40-64	65.3	50.3	73.3	50.4
65 and over	42.6	43.1	47.5	53.3
Total	62.2	51.8	65.3	50.6
	2000			
0-14	49.4	55.7	59.1	55.4
15-39	73.1	50.4	66.7	51.4
40-64	75.6	59.3	70.3	50.6
65 and over	44.8	50.5	57.4	53.8
Total	71.1	54.4	66.6	51.7

Source: SORS, Statistical Yearbook, 1996 and 2001.

Table 1.11: Immigrants to Slovenia, by country of citizenship, 1995 and 1995, % of the total

	1995	**2000**
Europe	97.0	97.1
- Slovenia	37.3	15.1
- Other republics of ex-Yugoslavia	53.0	72.1
- Bosnia and Herzegovina	14.3	32.6
- Croatia	12.7	14.6
- Federative Republic of Yugoslavia	19.7	10.7
- FYR of Macedonia	6.1	14.2

Source: SORS, Statistical Yearbook, 1996 and 2001.

Table 1.12: Citizens of Slovenia who emigrated from Slovenia, by country of next residence, 1995 and 2000

	1995		**2000**	
	Persons	% of the total	Persons	% of the total
Total	776	100.0	1,559	100.0
Europe	687	88.5	1,301	83.5
- Germany	194	25.0	348	22.3
- Austria	132	17.0	157	10.1
- Croatia	133	17.1	138	8.9
North and Central America	44	5.7	148	9.5
South America	2	0.3	18	1.2
Africa	8	1.0	9	0.6
Asia	5	0.6	49	3.1
Australia and Oceania	25	3.2	34	2.2
Unknown	5	0.6	-	-

Source: SORS, Statistical Yearbook, 1996 and 2001.

Table 1.13: Activity rate (ILO methodology); labour force as a % of population of working age (15 years or more)

Year	All persons			Persons aged 55-59			Persons aged 60-64		
	Total	Men	Women	Total	Men	Women	Total	Men	Women
1995	58.7	66.1	52.0	32.1	48.6	16.6	16.0	19.4	13.3
1996	57.6	64.4	51.3	30.6	43.1	18.4	16.1	20.4	12.6
1997	59.5	66.2	53.2	28.8	37.1	20.6	18.2	24.1	13.5
1998	59.4	66.3	52.9	34.1	44.5	23.3	17.8	21.0	14.9
1999	57.9	65.1	51.9	29.6	43.2	16.7	17.9	23.4	12.8
2000	57.9	64.1	51.7	31.4	44.2	18.5	14.9	19.2	11.4

Sources: Eurostat, 2000 and 2001a; SORS, http://www.gov.si/zrs (for age groups).

Table 1.14: Registered unemployment rate, as % of labour force, end of year

Year	All	Male	Female
1995	14.5	14.6	14.4
1996	14.4	14.2	14.5
1997	14.8	13.9	15.7
1998	14.6	13.5	15.9
1999	13.6	12.4	15.0
2000	12.2	11.1	13.5
2001	11.6	10.4	12.9

Sources: Eurostat, 2000 and 2001a; Employment Office of the Republic of Slovenia, http://www.ess.gov.si/html (for years 1999-2001).

Table 1.15: Unemployment rates from the Labour Force Surveys (ILO methodology), in %

Year	All	Male	Female
1995	7.4	7.7	7.0
1996	7.3	7.1	6.6
1997	7.4	7.1	7.6
1998	7.9	7.7	8.1
1999	7.3	7.2	7.5
2000	6.9	6.8	7.1

Sources: Eurostat, 2001a and 2001b (for 2000).

Table 1.16: Unemployment rate of people aged less than 25, by gender; % of labour force aged 15-24

Year	Total	Men	Women
1995	18.8	18.1	19.7
1996	18.8	16.7	16.5
1997	17.6	16.2	19.3
1998	18.6	17.6	19.7
1999	18.5	17.2	19.8
2000	16.4	14.8	18.5

Sources: Eurostat, 2001a and 2001b (for 2000).

Table 1.17: Long-term unemployment, by gender; % of all unemployed

Year	Total	Men	Women
1995	52.6	58.2	48.7
1996	50.0	51.4	48.2
1997	51.9	55.1	48.5
1998	45.4	44.6	46.3
1999	41.8	45.2	38.0

Source: Eurostat, 2001a.

Table 1.18: Employment rate (ILO methodology), in %

Year	Total population			Age group 55-59			Age group 60-65		
	Total	Men	Women	Total	Men	Women	Total	Men	Women
1995	54.4	61.2	49.0	30.7	47.0	15.5	15.3	18.7	12.7
1996	53.5	59.8	47.8	29.5	41.2	18.1	15.6	20.1	11.9
1997	54.5	60.6	48.7	27.9	35.3	20.5	17.7	23.5	12.9
1998	55.2	61.4	49.4	32.8	42.6	22.6	17.8	21.0	14.9
1999	53.6	60.1	47.6						
2000	53.9	59.6	47.9						

Sources: Eurostat, 2001a; SORS, 2000a and http://www.gov.si/zrs.

Table 1.19: Employed by professional status and sex, in %

Year	Employees			Family workers			Self-employed		
	All	Men	Women	All	Men	Women	All	Men	Women
1995	83.1	80.5	85.8	4.7	3.0	6.6	12.2	16.5	7.6
1996	83.2	80.1	86.8	4.2	3.2	5.6	12.6	16.7	7.6
1997	81.3	79.2	83.7	6.8	5.0	8.9	11.9	15.8	7.4
1998	80.9	78.3	84.0	6.6	5.1	8.4	12.5	16.6	7.6
1999	81.6	79.0	84.6	5.8	4.4	7.3	12.6	16.6	8.1
2000	83.9	81.4	86.9	4.9	3.3	6.6	11.2	15.3	6.5

Sources: Eurostat, 2001c (for 2000); SORS, Statistical Yearbook, 1997 and 2001.

Table 1.20: Persons in employment by activity, in % of all persons in employment

	Persons in paid employment			**Self-employed persons**			
Year	Total	In companies, enterprises and organisations	By self-employed persons	Total	Individual private entrepreneurs	Own account workers	Farmers
1997	87.6	79.8	7.8	12.4	6.3	0.8	5.3
1998	87.6	79.4	8.2	12.4	6.2	0.8	5.5
1999	88.5	80.0	8.4	11.5	5.9	0.8	4.8
2000	88.9	80.1	8.8	11.1	5.8	0.8	4.5

Source: SORS, Statistical Yearbook, various years

Table 1.21: Forms of employment, by gender; % of total employment (or gender employment, respectively)

Year	Full-time equivalent employment			Part-time employment			Fixed term contracts			Self-employed		
	Total	Men	Women	Total	Men	Women	Total	Men	Women	Total	Men	Women
1996	60.5	65.5	55.6	6.8	5.2	8.6	7.0	6.2	7.9	12.6	16.9	7.7
1997	60.9	65.8	55.9	8.2	6.7	9.9	11.6	10.8	12.6	12.0	15.8	7.5
1998	61.8	66.2	57.2	7.6	6.7	8.7	9.2	7.9	10.8	12.5	16.7	7.7
1999	60.8	66.5	56.2	6.6	5.6	7.8	8.8	7.9	9.9	12.6	16.6	8.0
2000	61.5	66.1	56.8	6.1	4.7	7.7	10.8	10.1	11.7	11.2	15.3	6.5

Source: Eurostat, 2001b.

Table 1.22: Employment by economic activity (NACE classification), in % of total

Year	**Agriculture**	**Industry (excluding construction)**	**Construction**	**Services**
1995	10.4	37.9	5.1	46.5
1996	10.2	36.5	5.4	47.7
1997	12.1	34.3	6.1	47.2
1998	12.0	33.7	5.6	48.2
1999	10.8	32.6	5.1	51.2
2000	9.6	37.7		52.7

Sources: Eurostat, 2001a and 2001b (for 2000).

Table 1.23:Employment by economic activity and gender (NACE classification), in % of gender employment

Year	Agriculture		Industry		Services	
	Men	Women	Men	Women	Men	Women
1996	10.7	9.6	50.4	32.3	38.8	58.1
1997	11.8	12.5	49.2	30.4	39.0	57.1
1998	11.9	12.3	47.8	29.9	40.3	57.8
1999	10.7	11.0	46.4	27.8	42.9	61.3
2000	9.5	9.7	45.7	28.4	44.8	62.0

Source: Eurostat, 2001b.

Table 1.24: Employment by economic activity (NACE classification), gender structure, in %

Year	Agriculture		Industry (excluding construction)		Construction		Services	
	Men	Women	Men	Women	Men	Women	Men	Women
1995	53.3	47.8	60.6	39.4	88.9	11.1	44.1	55.9
1996	56.0	44.0	60.6	39.4	87.5	12.5	43.3	56.7
1997	52.3	47.7	61.0	39.0	88.7	11.3	44.2	55.8
1998	52.8	47.2	60.9	39.1	89.1	10.9	44.7	55.3
1999	53.5	46.5	62.3	37.7	91.3	8.7	45.1	54.9

Source: Eurostat, 2001a.

Table 1.25: Families with children, by family type and number of children, 1991 census, in %

Family type	Number of families	Total	Number of children in a family				
			1	2	3	4	5+
Mother + children	85,214	100.0	70.1	24.7	4.2	0.7	0.2
Father with children	14,095	100.0	66.9	26.4	5.3	1.1	0.3
Married couple with children	109,594	100.0	39.6	49.4	9.0	1.5	0.5
Unmarried couple with children	12,408	100.0	60.5	32.3	5.6	1.0	0.6

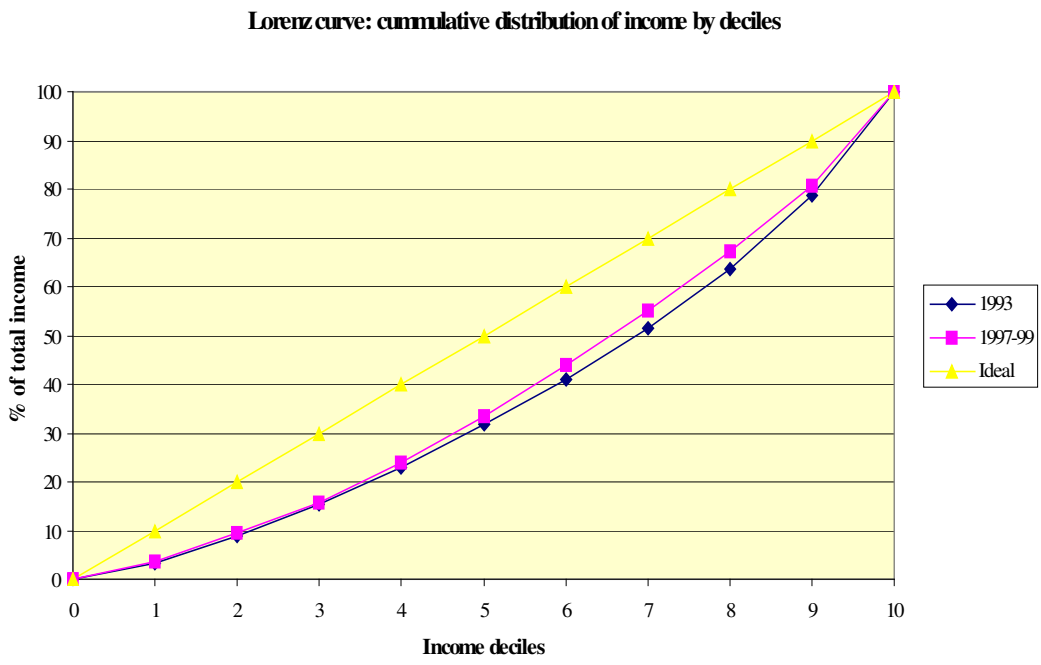
Source: SORS, Statistical Yearbook and http://www.gov.si/zrs/.

Table 1.26: Mean age of mother at birth, and crude divorce rate

Year	Mean age of mother at first birth	Mean age of mother at birth of any child	Crude divorce rate (divorces per 1000 population)
1995	25.2	27.1	0.8
1996	25.2	27.3	1.0
1997	25.5	27.5	1.0
1998	25.8	27.8	1.0
1999	26.1	28.0	1.0
2000	26.5	28.2	1.1

Sources: Eurostat, 2001a; SORS, Statistical Yearbook 2001 (for 2000).

Figure 1.1:



Note: Ideal = line of complete equality.

Source: Stropnik and Stanovnik, 2002, Figure 6.

Figure 1.2:

Source: Stropnik and Stanovnik, 2002, Figure 7.

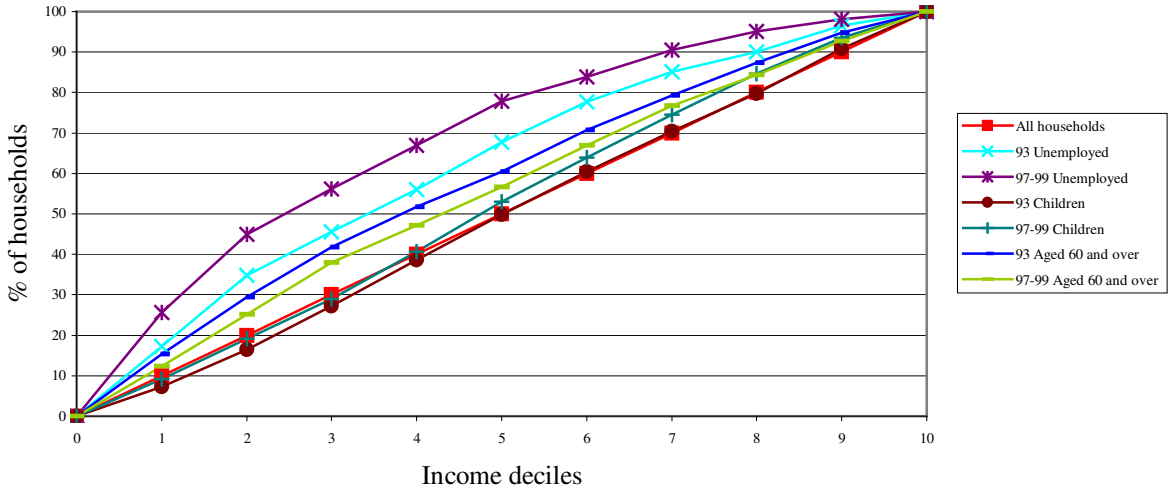
Table 1.27: Total income by income deciles, in %

Income deciles	1993	1997-1999	Differences (3-2)
1	2	3	4
1	3.4	3.6	0.2
2	5.5	5.8	0.3
3	6.5	6.5	0.0
4	7.7	8.1	0.4
5	8.8	9.6	0.8
6	9.2	10.2	1.0
7	10.4	11.3	0.9
8	12.2	12.1	-0.1
9	14.9	13.6	-1.3
10	21.4	19.3	-2.1

Source: Stropnik and Stanovnik, 2001, Table 7.

Figure 1.3:

Cumulative distribution of households in Slovenia, by income deciles, 1993 and 1997-1999



Source: Stropnik and Stanovnik, 2001, Figure 8.

Table 1.28: Poverty incidence in Slovenia in 1993 and 1997-1999; households, in %

Poverty line as % of median equivalent	**All persons**		**Pensioners**		**Unemployed**		**Children up to age 18**		**Persons aged 60 and over**	
household income	1993	1997-99	1993	1997-99	1993	1997-99	1993	1997-99	1993	1997-99
0.4	3.7	4.2	3.8	3.3	13.6	23.6	4.2	4.8	7.3	5.3
0.5	7.1	8.0	8.7	5.7	22.5	35.5	7.4	9.4	14.1	10.0
0.6	12.9	13.9	16.3	11.5	33.5	48.3	13.2	16.7	25.0	17.6
0.7	20.6	21.1	23.2	19.4	45.5	63.1	21.5	24.6	33.6	28.4

Source: Stropnik and Stanovnik, 2001, Table 13.

Table 1.29: Projection of de jure *population, excluding persons who have worked abroad for more than 1 year and members of their families living with them, by sex and age groups, for 2002, 2012 and 2020 – medium adjusted fertility*

	2002			**2012**			**2020**		
Age groups (years)	total	Men	women	total	men	women	total	men	women
TOTAL	1971062	955072	1015990	2011938	977103	1034835	2019399	981759	1037640
0-6	145010	74482	70528	159141	81749	77392	148285	76177	72108
0-14	322405	165497	156908	331146	170053	161093	330708	169843	160865
0-19	454035	232648	221387	433304	222303	211001	441156	226353	214803
7-14	177395	91015	86380	172005	88304	83701	182423	93666	88757
15-49	1024260	517081	507179	941827	170053	771774	888070	450539	437531
15-59	1264230	635588	628642	1224913	619216	605697	1168484	585622	582862
15-64	1365946	683373	682573	1359098	679223	679875	1306033	651255	654778
60 +	384427	153987	230440	446320	187834	258486	520207	226294	293913
65 +	282711	106202	176509	321694	127827	193867	382658	160661	221997
80 +	48080	13318	34762	79179	24086	55093	93276	31347	61929
85 +	21345	5562	15783	31555	7795	23760	43581	12819	30762

Source: Statistical Yearbook 2001.

Note: The basis for the projection are data from the Central Population Register as of 1 January 1992.

2. OVERVIEW ON THE SOCIAL PROTECTION SYSTEM

2.1 Organisational structure

2.1.1 Overview of the system

For the organisational chart, see Figure 2.1.

Unemployment compensation and assistance

Legal basis: Act on Employment and Unemployment Insurance, 1991, last amended in 1998.

Benefits in this field are administered by the employment offices.

The Ministry of Labour, Family and Social Affairs is responsible for labour legislation, employment policy, bilateral agreements etc. The Employment Office of the Republic of Slovenia (ESS) is handling all the individual cases related to employment or unemployment, including the employment of foreign workers.

Health care and sickness

Legal basis: Health Care and Health Insurance Act, 1992 and amended several times in subsequent years; Occupational Health and Safety Act, 1999, last amended in 2001; Pension and Disability Insurance Act, 1999

The Ministry of Health is responsible for health policy, legislation and bilateral agreements, while the National Health Insurance Institute (NHII) is handling all the individual cases related to health care, sickness benefits and industrial injuries. The Institute is an independent national institution.

Family benefits, maternity/parental benefit

Legal basis: Act on Parenthood Protection and Family Benefits, 2001.

Benefits are administered by the family department of the Ministry of Labour, Family and Social Affairs and the centres for social work.

The Ministry of Labour, Family and Social Affairs is responsible for policy-making, legislation and bilateral agreements on maternity and family benefits including parental benefits, child benefits etc. There is no national institution dealing with these issues on the central level, so the family department within

the ministry is responsible for the administration of the different benefits and also involved in the actual payment of the benefits.

Below the ministry, on the local level, there are 62 Centres for Social Work (CSW). They are primarily dealing with social assistance, but they are also handling individual cases regarding maternity/parental leave and family benefits. They are collecting the claims for benefits and preparing the decisions, but the cash benefits are paid directly by the ministry.

Social assistance

Legal basis: Social Assistance and Services Act, 1992, last amended in 2001.

Benefits are administered by the 62 centres for social work.

Old age and disability pensions

Legal basis: Pension and Disability Insurance Act, 1999

Benefits are administered by the National Pension and Disability Insurance Institute

In the pension sector, the Ministry of Labour, Family and Social Affairs is responsible for policy-making, legislation and bilateral agreements.

The Institute for Pension and Disability Insurance (IPDI) is responsible for the disbursement of old-age pensions, disability pensions, survivors pensions and a number of other social benefits. These »other social benefits« are mostly social assistance disbursements for old-age pensioners, or various allowances and benefits for disabled persons who have not yet reached conditions for retirement.

The regional offices are purely administrative units as there is a unified information system and a centralised payment of pensions.

Centralisation/De-centralisation of the system

The health insurance is under the responsibility of the NHII, whereas the pension and disability insurance is under the responsibility of the Institute for Pension and Disability Insurance (IPDI). Both institutions are autonomous, and the governing bodies are in essence multipartite bodies, comprised of representatives of employers, employees, the government and other relevant groups. Thus, the governing body of the IPDI includes two representatives of

pensioners and one representative of the work-disabled group of insured persons.

Together with the MoH and, in certain instances, the Government, the representatives of the health services providers take an active part in yearly negotiations on the health plan covered by the NHII. The representatives of media are invited to all the Assembly's meetings. The questions addressed to NHII by the public, the insured persons and certain interested public groups are answered and taken into consideration by the NHII.

The unemployment insurance is under the responsibility of the Employment Office of the Republic of Slovenia. This institution is also autonomous and governed by a tripartite body, comprised of employers, employees and government representatives. Unlike the NHII and IPDI, the NEO is not a separate entity regarding public finances but is part of the central governmental budget.

There exist regional offices for all three institutions; these regional branches are only administrative units, without any role in decision-making.

The role of NGOs is described in Chapter 4.2.9.

2.1.2 Supervision

Legal supervision:

Social assistance: The legal supervision is carried out by the Ministry of Labour, Family and Social Affairs.

Unemployment: The legal supervision is carried out by the Ministry of Labour, Family and Social Affairs.

The supervision over the implementation of unemployment assistance is performed by employment offices and authorised persons. In order to fulfil this task, employment offices are authorized by the 1998 amendments to the Employment and Unemployment Insurance Act to obtain and use personal data and data on income and property from registers and databases maintained by the tax authorities, Pension and Disability Insurance Institute, and Health Insurance Institute.

Health care: In terms of giving consensus to its statute, the proposed contribution rate, and financial plans and disclosures, supervision of the NHII is carried out by the MoH/Government. The Parliament has to vote on a consensus to the Director General elected by the NHII's Assembly. Financial supervision is the task of the Republic of Slovenia Court of Audit.

Pensions: The legal supervision of the IPDI is carried out by the Ministry of Labour, Family and Social Affairs.

Financial supervision: Outside financial supervision is carried out on a regular annual basis by the Court of Auditors.

2.2 Financing of social protection

2.2.1 Financing sources

Unemployment compensation and assistance are financed through unemployment insurance contributions and the central budget. The activities of the national Employment Office are financed mainly by state subsidies. The employers and the employees are paying some contributions for unemployment insurance (0.2% of the gross wages for both), which are collected to the state budget. In addition to that, however, the state budget is financing the difference between the contributions and the real expenditures, which means about 90% of the total costs (Axelsson, 2002).

Health care services and health care benefits disbursed by the NHII are in the largest part financed by current collected contributions from employers, employees, self-employed and others (approx. 80% of all revenue in 2000). These contributions are collected to a fund controlled by the NHII. A much smaller source of revenue (approx. 18% in 2000) for the NHII are transfer payments from other social security funds, communities and the state budget. Non-tax revenue, capital income and received donations represented the remaining 2% of the NHII's 2000 income.

Most of the family benefits are financed through general taxation, but maternity/parental benefits are insurance based and financed by contributions that are paid by employers and employees. These contributions are collected to the state budget. However, the contributions cover only a small proportion of total expenditure on maternity/parental benefits; the rest is paid from general government revenues.

The social assistance benefits are financed through the central budget.

The financing sources for the IPDI are contributions for pension and disability insurance. These contributions are paid by the employer and employee to a fund controlled by the institute. The current rates are 8.85% of the gross wage for employers and 15.5% of the gross wage for the employees. In 1996, the contribution rate for employers decreased from 15.5% to 8.85% and this resulted in a large decrease in the revenues of the IPDI. The gap between revenues and expenditures is being covered through subsidies from the state

budget. Until 1996, the state budget transferred funds to the IPDI for various disbursements of the non-insurance type, enacted for various special groups of insured persons (for example the military, police, customs duty officers etc). Since 1996, substantial state transfers, which amount to 28% of the total revenues of the IPDI in 2000, were also committed to insurance-type benefits.

Self-employed insured persons pay a joint contribution rate 24.35 (=15.5% + 8.85%), and their base is their assessed income (revenues minus expenditures). Within the self-employed group, farmers are somewhat privileged, as they pay only the employee contribution rate, whereas the employer contribution rate is covered by the state (from the state budget).

2.2.2 Financing principles

As described above, the larger part of the social benefits disbursed by the IPDI is financed by current collected contributions, thus the financing principle is the PAYG financing. This applies to the first pillar. The second pillar in Slovenia is in the form of voluntary collective and individual scheme, managed by pension funds. These schemes are funded, and cover only the risk of old-age. Also part of the second pillar is a mandatory supplementary pension scheme, which covers insured persons in certain occupations, for whom employers are obliged to pay higher contributions in order to finance earlier retirement. This additional contribution, above the normal contribution rate, is earmarked for this mandatory scheme, and the scheme is managed by the Pension Management Fund, which is a state owned institution.

Mandatory health insurance, unemployment insurance as well as maternity/parental allowance are also financed by social security contributions. These contributions do not suffice for all the expenditures and the social security schemes depend - to a larger or smaller degree - on transfers from the central government budget. These transfers represent some 25% of the IPDI expenditures and over 80% of the national Employment Office outlays (for unemployment benefits etc). Maternity benefits are also predominantly financed from the central government budget.

The annual work plan of the Employment Office of the Republic of Slovenia is used as the basis for allocating the money from the state budget (where it was collected through payment of contributions). Such organisation of financing is a guarantee for sufficient funds and prevents the possibility of unemployment insurance fund deficit.

Social assistance and family benefits are financed from the general government revenues.

2.2.3 Financial administration

The statutory insurance and contribution rates as % of gross wages are the following:

Table 2.1: % of contribution paid by employer/ employee

	Contribution paid by employer (%)	**Contribution paid by employee (%)**
Unemployment insurance	0.06	0.14
Health insurance	6.56	6.36
Injuries at work	0.53	-
Maternity/parental insurance	0.10	0.10
Pension and disability insurance	8.85	15.50
Total	16.10	22.10

A distinct characteristic of the Slovenian social protection system is that there is no upper ceiling (nor a floor) on the payment of social contributions. Basically, contributions are paid only on income from labour, though some forms of labour income are exempt (for example, income from contractual work).

The contribution collection mechanism is still centralised. The Payment Agency performs the role of the collector of social security contributions and personal income tax, collected as a withholding tax. This system works well, since wages cannot be disbursed if social security contributions have not been paid. Exemptions from payment are possible, but only by law passed by Parliament.

The deficit in the contribution collection rate for compulsory health insurance due to delayed or unpaid contributions was estimated to be around 12% in 2000. Part of this figure is due to regulations enacted by special laws.

The contributions paid for unemployment insurance go directly to the state budget, from where they are allocated to the national Employment Office, which is authorised to handle requests for cash benefits and to carry out active employment policy measures. The payments for unemployment benefits are made according to the annual budget breakdown and are controlled by the Ministry of Finance.

2.3 Overview of Allowances

2.3.1 Health care

Coverage: Persons covered by compulsory health insurance (CHI)[7] and their family members[8]. Despite the contribution system the coverage is almost 100%.

Qualifying conditions: In most cases, the insured person's need for medical services from a specialist or within a hospital must be established by the personal (chosen) general practitioner (GP) followed by an appropriate referral order[9]. Certain groups (children, pupils, students, expectant mothers and other women) are additionally eligible for special periodical prevention programmes.

Level of benefits: CHI covers the majority of health risks. In certain cases, it covers full costs of medical services and prescribed drugs, while for others the exact share of costs covered by CHI is determined by the NHII with governmental consent and is subject to periodic change. The Health Care and Health Insurance Act (HCHI) specifies the lower limits of these shares[10]. With the exception of disabled soldiers and civil invalids from wartime, some other disabled groups and social security benefits recipients, the balance is to be paid with out-of-pocket resources or by voluntary health insurance.

Length of provision: Medical services are provided until considered needed as certified by the physicians involved in treatment.

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7 Insured persons are persons employed in Slovenia, persons employed in foreign and international organizations, embassies and consulates, residents of Slovenia employed by a foreign employer unless agreed otherwise, self-employed persons, farmers and their family members, professional sportsmen and chess players, unemployed who receive unemployment benefits, persons receiving social assistance, foreigners who take part in educational programs in Slovenia, war veterans, victims of war violence and disabled soldiers, mentally and physically impaired persons, national servicemen who serve army as civil servants, residents of Slovenia who are not insured in any other way, nationals of Slovenia who are not insured in any other way .

8 Family members are defined as spouses or partners not insured otherwise, legitimate, illegitimate or adopted children, stepchildren, grandchildren, brothers and sisters without parents and reared by the insured person, parents, stepparents or adopters without sufficient financial means or are incapable for gainful employment. Children are insured by the age of 15 or 18 if not insured otherwise, or up to age 26 if at school (or longer, depending on the educational programme or the child's health). All these groups must have a permanent residence in Republic of Slovenia unless agreed otherwise by a bi- or multilateral treaty.

9 In certain cases, this GP may elect to transfer part of his powers concerning diagnosis and treatment to the specialist. The authorisation has a limited period of validity and must be renewed at least once a year.

10 See Chapter 5 for details.

Taxation of benefits: Medical services covered by CHI are not subject to personal income tax.

2.3.2 Sickness

Coverage: See 2.3.1.

Qualifying conditions: For medical services, see 2.3.1. In case of temporary incapacity for work, the GP (or, where applies, the NHII's medical board) has the authority to grant sick-leave with wage compensation. During the sick-leave no gainful employment is permitted and the compliance with the prescribed course of treatment is supervised.

Level of benefits: Besides the costs of the needed medical services and drugs, CHI refunds certain costs and pays death benefits and wage compensation for lost income.

Travel costs, *daily allowances* and *transport* are compensated up to the cost of travelling to the nearest service provider. This applies only if the patient has to travel more than once a month to another city for treatment or diagnostic procedures. If such medical treatment takes longer than 12 hours, the insured person is entitled to reimbursement of cost of food and accommodation in the amount determined by the NHII. The newest revision of HCHI from 2001 curtailed these benefits.

Funeral costs refund, payable to the person who paid for the funeral, range from 0 to 60% of the average monthly Slovenian gross wage from January to September of the previous calendar year, depending on income of the deceased in the previous year. *Death benefit,* payable to family members supported by the deceased, amount up to 25% of the average monthly Slovenian gross wage from January to September of the previous calendar year, again depending on income of the deceased in the previous year.

The amount of *wage compensation* depends on the insured person's average monthly salary in the 12 months prior to sick-leave, the cause of absence and valorisation method. It amounts to 100% of the average monthly salary in case of disabled soldiers and civil invalids from wartime, occupational disease, employment injury, transplantation of tissues or organs for the benefit of others, donation of blood and quarantine. It drops to 90% if the insured person is absent from work due to illness, or 80% in case of non-employment related injuries, nursing of a close family member, escort of others, or during the period of qualifying for rehabilitation of a handicapped child at home. In any case, it is not lower than the guaranteed wage or higher than the insured person's usual

salary. Latest revision: The regulations of wage compensations during temporary health-related absence from work will become more restrictive.

Length of provision: Wage compensation during sickness is paid for by CHI from the 31st day of absence from work and depends on the physicians' (or, where applies, the NHII's medical board) assessment of the state of sickness. There are no waiting days for this benefit. Though otherwise with limited maximum period of duration, in case of transplantation of organs or tissues for the benefit of others, donation of blood, caring for immediate family members, isolation or escort and certain employment injuries, wage compensation is paid by CHI from the first day of absence from work. If absence from work is longer than one year or if there is no prospect of recuperation, the insured person can be referred to the invalidity board at the IPDI. Funeral costs and death benefit are paid as one-time cash benefits.

Taxation of benefits: Wage compensation during temporary absence from work is subject to personal income tax. For medical services see 2.3.1.

2.3.3 Maternity (parental leave)

Coverage: Persons covered by health insurance and parental leave insurance. For details, see Chapter 2.3.1.

Qualifying conditions: All insured persons are entitled to parental leave. For entitlement to wage compensation, the person must be insured just before the day when the leave starts.

From 2005, the eligibility to wage compensation during parental leave will also be held by persons who were insured for at least 12 months in the last three years before the start of the individual part of parental leave.

Level of benefits: Wage compensation during the maternity leave and the child care and protection leave amounts to 100% of the average monthly gross wage of the entitled person during the 12 months prior to the leave. The minimum wage compensation amounts to 55% of the minimum wage and the maximum compensation is 2.5 times the average wage in Slovenia (the upper limit is not applied for the compensation during the maternal leave).

In case of unused child care and protection leave, there is a possibility to obtain the non-received amount of wage compensation (up to five monthly wage compensations) through payment for childcare services, payment of the housing rent or a housing purchase.

During the first 15 days of the paternal leave, the father will be entitled to a 100% wage compensation, while for the rest of the 75 days he will only be paid the social security contributions based on the minimum wage.

From 2005, the parental benefit for persons not insured at the time the leave starts will be 55%-83% of the minimum wage, depending on the insurance period.

One of the parents, who is taking care of a child below age three or a seriously handicapped child, can have social security contributions paid from public sources for the difference between the full-time working hours and the hours worked on a part-time basis. The contributions are based on the minimum wage. The hours worked must be equal or longer than a half of full-time working hours.

Length of provision: The total leave associated with childbirth in Slovenia (parental leave) consists of:

I. 105 days of maternity leave;

II. 260 days of a full-time child care and protection leave (520 days if taken as a half-time leave combined with a part-time work, i.e. half of the normal working hours per day), which can be used by either the mother or the father. If the mother is a student below age of 18, one of the grandparents is allowed to use this leave. The parents are allowed to use part of the child care and protection leave (up to 75 days) until the child is below eight years of age;

III. 90 days of paternal leave. Fathers are obliged to use at least 15 days during the maternal leave, while the rest of the 75 days can be used until a child's age of eight. However, due to the budget constraints, this right will be introduced gradually: 15 days in January 2003, further 30 days in January 2004, and the rest of 45 days in January 2005.

IV. Child care and protection leave is extended by 30 days if – at the birth of a child - parents already care for at least two children below age of eight, by 60 days if they care for three children, and by 90 days in case of four or more children.

V. In case of multiple births, the child care and protection leave is by three months longer for each additional child; in case of a birth of a handicapped child it is prolonged until the child is 15 months old; in case of a premature birth it is prolonged for as many days as pregnancy was shorter than 260 days. The rights on the basis of a premature birth, birth of more children, birth of a handicapped child and the presence of other two or more children below age eight may be summed up.

Taxation of benefits: Wage compensation during parental leave is subject to income tax.

2.3.4 Invalidity and long-term care

Disability disbursements cover a wide area with various benefits, which can be grouped in three areas:

1. Disbursements for disabled insured persons who have completely withdrawn from labour force; these are recipients of *disability pensions*.
2. Disbursements for disabled insured persons, who have temporarily withdrawn from active labour force, and (a) are undergoing a vocational rehabilitation programme or (b) are temporarily unemployed. The former receive *rehabilitation benefits* and the latter receive *disability benefits*.
3. Disbursements for disabled insured persons who actively participate in the labour force, but receive partial compensation from IPDI; these are (a) persons in part-time jobs and (b) persons reassigned to new jobs. The former receive *allowance for part-time work* and the latter receive a *reassignment allowance*.

Disability pensions are the most important type of disability cash disbursements and therefore, details will be given as follows:

Coverage and qualifying conditions:

In principle, the granting of disability pensions depends on the cause of disability. In case of an occupational disease or employment injury, the insured person can obtain a pension regardless of his insurance period. However, if the cause of disability is illness or off-the-job injury, a sufficient insurance period is required. As a general rule, the insurance period must cover at least one third of the period from age 20 to the date of the occurrence of disability.

Level of benefits: The computed disability pension is still somewhat higher than the old-age pension for two reasons. First, there are no penalties for pensioning prior to full pensionable age (63 for men, 61 for women); second, the minimum disability pension is more generous – it cannot be less than 45% of the pension base for men and 48% of the pension base for women. The pension base is calculated in the same way as old-age pensions.

Taxation of benefits: Most types of benefits remain untaxed. In some others, taxation is in large part »fictitious«. For details, see 2.3.5.

There is no special long-term care insurance in Slovenia. The long-term care services are mostly paid for individually by people who receive care (46% of

sources in long-term care); medical services are paid by health insurance (38% of sources), while 13% of all sources are paid by local communities for people who are unable to secure sufficient means to pay the fee themselves. Medical services received by people receiving long-term care are defined as specialist medical services, rehabilitation and nursing care.

2.3.5 Old-age

Coverage: Qualifying conditions: The 1999 PDIA introduced the concept of full pensionable age, which was set at 63 for men and 61 for women. This means that insured persons retiring prior to the full pensionable age receive »penalties« i.e. lower than normal or even negative accrual rates, and persons retiring after the full pensionable age receive accrual rates which are higher than the normal accrual rates. There are numerous exemptions to the penalty rule. For example, persons who retire at age 58 and have 40 years of service (men) or 38 years of service (women) are not subject to penalties. As a general rule, a person cannot retire before age 58; should he retire between 58 and 63 (men) or 58 and 61 (women) he would be – again, as a general rule – subject to penalties. It though has to be stated that the retirement prior to full pensionable age is also conditional on the accumulation of a sufficient number of qualifying years. Thus, a person must accumulate at least 40 years of a pension qualifying period – this consists of (a) years of service, i.e. years during which contributions were actually paid; (b) purchased period, i.e. insurance years which could be »purchased« *ex post* – for university studies, military service etc. Also, the employer could purchase a limited number of years for the employee; (c) special qualifying period, which is credited (d) added qualifying period, i.e. period which is relevant for achieving eligibility conditions, but is not relevant for the calculation of ones' pension. These included (non-purchased) years of university study, military service etc. The sum »a+b« refers to the insurance period, and the sum »a+b+c« refers to the pension qualifying period.

Level of benefits: The pension is calculated as a percentage of the pension base, which is simply the best 18-year average of net wages. The pension is then computed using this pension base, accrual rates and the pension qualifying period. Thus, for men the pension is computed as 35% of the pension base plus 1.5% of the pension base for each additional year of pension qualifying period.

Taxation of benefits: Most of benefits remain untaxed, i.e. taxation is in a large part »fictitious«. This means that the net pension is fictitiously grossed-up by the average income tax rate. To this grossed-up pension, a tax schedule is applied and if the computed tax is greater than the fictitious tax, the person actually pays the difference. If the computed tax is less than the fictitious tax, the person pays no income tax.

2.3.6 Survivors

Coverage: Survivors pensions are pensions granted to family members of the deceased.

Qualifying conditions: Except for the spouse, which does not have to fulfil this condition, it is required for the other members that they were dependent on the income of the deceased. The spouse can receive a widow's pension, provided an age criterion is met (53 years); if the spouse was not an insured person, he/she could obtain a widow's pension at the age of 48. Children can receive a survivors pension up to the age of 26, provided they annually submit an attestation of school attendance.

Level of benefits: The base for survivors pensions is the actual or computed pension of the deceased; the »computed« pension is relevant in the case that the deceased was still an active insured person. The computation of survivors pension is extremely non-transparent, particularly with regard to the widows pension. As a general rule, the amount of survivors' pension is dependent on the potential beneficiaries and their sources of income. For example, if the spouse is the sole beneficiary and has no sources of income (and meets the age criterion), he/she is entitled to a widows pension amounting to 70% of the base. If the spouse already receives a pension (old-age or disability) he/she can at most receive a widows pension amounting to 15% of the base. His/her pension and the widow »supplement« cannot however exceed the average monthly pension in Slovenia, disbursed in the previous year. Similarly, a cap exists on survivors pensions disbursed to children; the total amount disbursed to all children depends on the number of children, but cannot exceed 100% of the base.

Taxation of benefits: See Chapter 2.3.5.

2.3.7 Employment injuries and occupational diseases

Coverage: Persons covered by social (health, pension and invalidity) insurance, pupils, students and mentally handicapped children during internships and similar employments, disabled persons on vocational rehabilitation, unemployed persons in public works programmes, volunteers, prisoners with employment and related activities in prison, rescue workers, youth camps participants, soldiers, reservists, sportsmen and trainers in sports activities, firemen.

Qualifying conditions: The case of occupational disease or employment injury first has to be acknowledged as such[11]. The insured person is entitled to provision of medical treatment and rehabilitation services and also wage compensation if sick-leave is approved by the chosen personal GP or, where applies, by the NHII's medical board.

Level of benefits: The amount of wage compensation is 100% of the average monthly salary before employment injury or the onset of occupational disease; there is no deduction for work-free days (holidays, etc.). Medical treatment and rehabilitation services are covered in full value by the CHI. If employment injuries and occupational diseases result in invalidity, the benefits described in 2.3.4 apply. Their level is dependent on the extent of the damage done by the injury on the human body.

Length of provision: The length of provision of benefits is until needed as certified by the physicians involved in treatment or, if applies, by the NHII's medical board. In case of long-term (longer than one year) health-related absenteeism, invalidity pension is considered.

Taxation of benefits: See 2.3.1, 2.3.2 and 2.3.4.

2.3.8 Family benefits

Parental allowance

Coverage: Parental allowance is granted to persons who are not eligible for the insurance-based wage compensation during the parental leave.

Qualifying conditions: Qualified is a mother who is a national of Slovenia and has a permanent residence in Slovenia and is not receiving any wage compensation. A child must be a national of Slovenia and the father must not receive any parental leave wage compensation.

The father is qualified if the mother dies, abandons a child, is not able to live and work independently, or if she, during the period of entitlement, enters into employment or self-employment. There is no means test.

Level of benefit: The Level of benefit is 37,450 SIT per month (at 2002 prices). The benefit level is adjusted once a year in January in line with the consumer price index.

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[11] The disease or injury has to be classified as an employment-related one in agreement with the Pension and Disability Insurance Act, Ministry of Labour, Family and Social Affairs and Ministry of Health.

Length of provision: 365 days.

Taxation of benefits: Parental allowance is subject to income tax.

Birth grant

Coverage: A universal benefit.

Qualifying conditions: a child is born in Slovenia, and the mother or the father has permanent residence in Slovenia.

Level of benefit: This benefit is granted either in-kind or in cash. The cash benefit amounts to 53,500 SIT at 2002 prices. The benefit level is adjusted once a year in January in line with the consumer price index.

Length of provision: One-time benefit.

Taxation of benefit: Not subject to income tax.

Child benefit:
Coverage: Children from families where income per family member, in the calendar year prior to the submission of a claim, was below the average wage in Slovenia.

Qualifying conditions: Entitlement to child benefit is held by one of the parents for a child residing in Slovenia under the condition that:

- the child is a national of the Republic of Slovenia;
- the child is not a national of the Republic of Slovenia, on the condition of reciprocity (i.e. bilateral convention between two countries).

If at least one of the parents has an employment contract with an employer whose principal office is in Slovenia, child benefit can also be claimed for a child who does not have his/her residence in Slovenia under the condition that:

- the child is a national of the Republic of Slovenia and is not eligible to a child benefit in the country where he/she lives;
- the child is not a national of the Republic of Slovenia, but the right to a child benefit has been agreed upon by an international treaty.

Level of benefit: The level of child benefit depends on the average monthly income per family member in a calendar year prior to the submission of a claim and the birth order of a child. The following scale applies:

Table 2.2: Income per family/ child benefit

Income per family member, as a percentage of the average wage of all the employed persons in Slovenia in the previous year	Child benefit according to a child birth order (SIT per month)		
	Child 1	Child 2	Child 3+
up to 15%	18,870	20,760	22,650
from 15% to 25%	16,140	17,840	19,530
from 25% to 30%	12,300	13,750	15,190
from 30% to 35%	9,690	11,070	12,460
from 35% to 45%	7,930	9,250	10,570
from 45% to 55%	5,030	6,290	7,550
from 55% to 75%	3,770	5,030	6,290
from 75% to 99%	3,270	4,530	5,790

From January 2003, child benefits for pre-school children who are not included in subsidized childcare programmes will be 20% higher. From January 2004 child benefits for children in a single parent families will be 10% higher as compared to those for other children. The level of child benefit is adjusted once a year in January in line with the consumer price index.

Length of provision: The right to a child benefit is held until the child reaches 18 years of age, as well as for the period in which the child continues with full-time education - i.e. for as long as the child enjoys the status of a primary school pupil, a secondary school- or an undergraduate university student, provided the child is less than 26 years of age. If the university studies last five or six years or if the child did not complete regular schooling within the prescribed period due to prolonged illness, or injury, or the undertaking of military service during schooling, the right to a child benefit may be extended by the length of the period for which education was extended for such reasons.

Taxation of benefits: Child benefit is not subject to income tax.

Large-family supplement:

Coverage: A universal transfer to families with three or more children.

Qualifying conditions: Eligible are families with three or more children below age 18 or older, if fulfilling the age and status conditions for the entitlement to a child benefit. In order to qualify, the parents and children must be the nationals of Slovenia and have the same place of permanent residence.

Level of benefit: The level of benefit amounts to 74,900 SIT at 2002 prices. Large-family supplement will be implemented gradually, with the benefit level amounting to 26,750 SIT in 2002 and 53,500 SIT in 2003. The benefit level is adjusted once a year in January in line with the consumer price index.

Length of provision: Paid once a year as long as there are three or more children below age 18 or older, if fulfilling the age and status conditions for the entitlement to a child benefit, in a family.

Taxation of benefit: Not subject to income tax.

Childcare supplement:

Coverage: Seriously ill children and physically or mentally handicapped children.

Qualifying conditions: A child must be a citizen of Slovenia and have permanent residence in Slovenia.

The *level of benefit* amounts to 19,260 SIT per month (in 2002 prices); for seriously handicapped children 38,520 SIT. The benefit level is adjusted once a year in January in line with the consumer price index. Starting in 2003, one of the parents will be entitled to a partial compensation for lost income if he/she stops working or reduces working hours due to care of a child who need special care. The compensation will be equal to the minimum wage (or its proportional part, depending on the working hours).

Length of provision: A child has a right to childcare supplement for the period recommended by a medical expert commission, but not longer than his/her 18th birthday or until age 26 if in schooling.

Taxation of benefits: Childcare supplement is not subject to income tax.

2.3.9 Unemployment

Unemployment wage compensation:

Coverage: Persons covered by unemployment insurance. Unemployment insurance is compulsory for employees, but the following groups may voluntarily insure themselves: the self-employed, owners of enterprises, Slovenian citizens who were employed abroad but after returning to Slovenia may not claim unemployment benefits in the foreign country, spouses of Slovenian citizens employed abroad if they were previously employed in Slovenia.

Qualifying conditions: Employed for at least 12 months in the last 18 months prior to the termination of employment.

Permanent residence in Slovenia. Signing an individual employment plan, detailing steps to improve job chances.

Level of benefit: The basis for determining the level of unemployment compensation is a twelve months' average gross wage of the unemployed person prior to unemployment. The benefit level amounts to 70% of the basis in the first three months and 60% thereafter. The minimum benefit level is equal to the guaranteed wage[12] net of contributions and taxes, which is about 26% of the net average wage, while the maximum level is three times the lowest possible unemployment compensation. The beneficiaries are paid health-, pension- and disability insurance.

Table 2.3: Length of provision

Insurance record	**Duration of the entitlement**
1-5 years	3 months
5-15 years	6 months
15-25 years	9 months
Over 25 years	12 months
Over 25 years and over age of 50	18 months
Over 25 years and over age of 55	24 months

Those unemployed who are older than 55 and are lacking three years until retirement have their pension and disability insurance contributions paid by the employment office until they retire.

Taxation of benefits: Unemployment compensation is not subject to personal income tax.

[12] The guaranteed wage used to be the lowest possible pay for a full-time job in Slovenia. It had lost its connection to the labour market, but has remained a basis for determining the level of some social benefits, without its name being adapted to its only retaining function. Until the mid 1997 the government had a discretionary right to adjust the guaranteed wage level, and during that period the real value of the guaranteed wage decreased considerably. It amounted to 43% of the average gross wage in 1991 and to only 24% in 1997. Since the mid 1997 the guaranteed wage has been adjusted once a year according to the consumer price index (as a rule, by 85% of the rise in consumer prices). Currently, the guaranteed wage is at the level of 21% of the average gross wage.

Unemployment assistance:

Coverage: A means-tested contributory benefit payable once the unemployment wage compensation has been exhausted.

Qualifying conditions: See unemployment wage compensation. In addition to that, means test is applied: income per family member in the last three months must not exceed 80% of the guaranteed wage and the value of family assets must not exceed 3.6 million SIT.

Level of benefits: 80% of the net guaranteed wage. The beneficiaries have their health insurance contributions paid by the Employment Office.

The length of provision is 15 months. In case of older unemployed lacking up to three years to the retirement (and having minimum chances of getting a job) it can be prolonged until the fulfilment of the retirement conditions.

Taxation of benefits: Unemployment assistance is not subject to personal income tax.

2.3.10 Minimum resources/social assistance

Coverage: Eligible are persons who are, for reasons beyond their control, unable to secure sufficient minimum means for living for themselves and their families.

Qualifying conditions: Slovenian nationals or foreigners with permanent residence in Slovenia with income below the level of the relevant minimum income and savings or property below the level of 24 minimum wages. The minimum income for a family is obtained by multiplying the basic amount of the minimum income (40,599 SIT in 2002) by the weighted number of family members. A weight for the first adult in the family is 1, for every other adult 0.7,[13] and 0.3 for every child below 18 years of age or an older child in regular schooling whom the parents are obliged to maintain. In the case of a single parent family, the minimum income is increased by 0.3 of the basic amount of minimum income. The eligibility may be conditioned by signing a contract between the centre for social work and the beneficiary on active addressing of the beneficiary's socio-economic problem, in which his/her activities and obligations (inclusion in medical treatment, etc.) as well as the termination of entitlement to social assistance in case of an unjustified failure to carry out the contract are defined.

[13] Not considered a child for the purposes of the Social Assistance and Services Act.

Level of benefit: The basic amount of minimum income is set by the law and adjusted once a year in January according to the change in the costs of living in the last year. In 2002 prices, the monthly minimum income amounts to:

1. 40,599 SIT for the first adult in a family, [14]
2. 28,419 SIT for the second adult in a family,
3. 12,180 SIT for a child, and
4. additionally, 12,180 SIT for a single-parent family.

The benefit level is the difference between the minimum income for a single person or a family and their own income net of taxes and compulsory social security contributions. In addition to the general benefit, a one-time cash social assistance may be granted by the social work centre, too, to help alleviate an acute financial hardship. The amount of this cash allowance may not exceed, per year, the amount of two minimum incomes for a single person or a family.

Linked benefits: rent allowance (up to 25% of the basic amount of the minimum income per month) and attendance supplement (set by regulations governing pension and disability insurance; from February 2002, SIT 26,257.10-75,020.30, depending on the level of needs).

Length of provision: Entitlement to social assistance is first disbursed for a period of up to three months and then for a period of up to six months; for certain groups it is disbursed for up to one year. A permanent social assistance can be granted to persons who are permanently incapacitated for gainful employment.

Taxation of benefits: Social assistance is not subject to income tax or social security contributions.

2.4 Summary: Main principles and mechanisms of the social protection system

The social protection system of Slovenia is organised according to the principles of a Bismarck system. This means that the rights to social security are related to employment, and the social benefits and allowances are financed mainly by contributions from employers and employees. However, social assistance and family benefits are citizen-centred.

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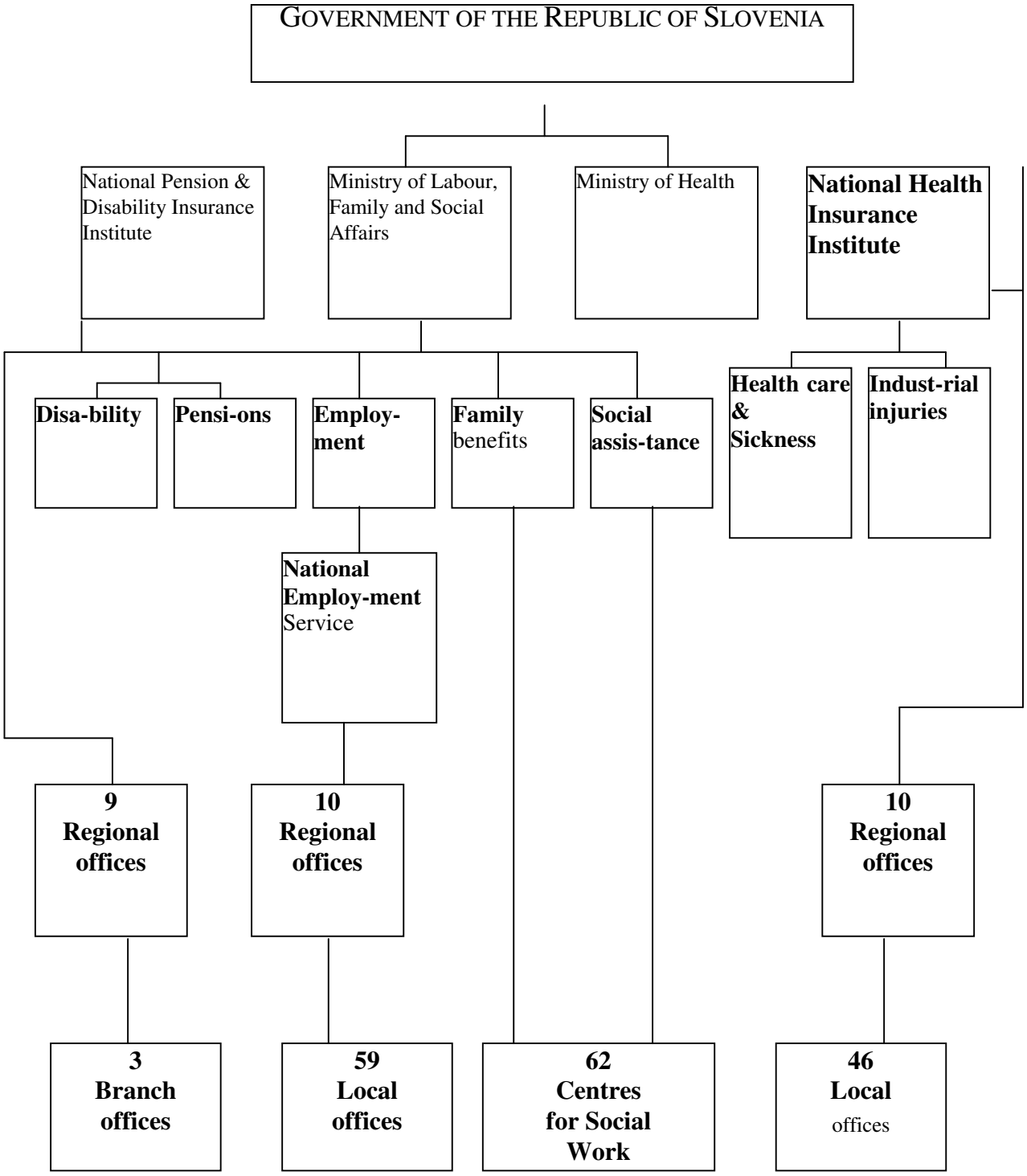
[14] As a matter of fact, the new level of minimum income for the first adult was only partly implemented in September 2001. The minimum income weight for the first adult in a family, which is equal to one, will be implemented only in 2003. From September 2001 to June 2002 it will be 0.8 and from July to December 2002 it will be 0.9. The quoted benefit level is the one after the full implementation of the law.

The coverage by health insurance is 100%. Only persons without work history and farmers with very low income are not covered by obligatory pension and disability insurance. However, everybody may join a voluntary old-age insurance.

The Slovenian social protection system follows the principle that insurance-based benefits are related to former wages of beneficiaries (except for unemployment assistance, which is a contributory flat rate benefit). Social assistance, unemployment assistance and some family benefits are means-tested, while some family benefits are the same for all eligible persons.

2.5 Annex to chapter two

Figure 2.1: Organisational structure of the Slovenian system of social protection



3. PENSIONS

3.1 Evaluation of current structures

3.1.1 Public - private mix

The three pillars

The Slovenian pensions system is a three pillar system, where the dominant role is still played by the first, public pillar. This part of the system is mandatory, and covers the risks of old-age, disability and survivors. It is mandatory in the sense that all employees and self-employed persons are part of the system. Other persons, which do not have an active status in the labour market, can join the system voluntarily - for example students, unemployed people who do not receive unemployment benefits etc. The mandatory first pillar is administered by the Institute for Pension and Disability Insurance (IPDI).

The second pillar was first introduced in 1992, when the new Pension and Disability Insurance Act (PDIA) provided the necessary legal framework. At that time, a pension fund was established within the IPDI, as an individual and voluntary pension scheme. There was never much life in this scheme, and upon its demise in 2000 there were only 739 individual contracts, i.e. members. The reasons for this lack-lustre performance lies not so much in the fact that a purely bureaucratic institution (IPDI) was given the task to set up a market-oriented institution, but perhaps even more in the fact that there were no tax incentives for such a scheme.

One could say that the second pillar was reintroduced in 2000, when the PDIA, passed by Parliament in December 1999, came into effect. This time, collective and individual voluntary supplementary pension schemes were introduced, and the conditions for the operation and management of these schemes are detailed in the 1999 PDIA. The schemes must be approved by the Ministry of Labour, Family and Social Affairs and by the appropriate regulator. For mutual pension funds the regulator is the Securities Market Agency, whereas for those pension management companies and pension schemes which are set up by insurance companies the responsible regulator is the Insurance Supervision Agency. At present, there are 16 pension funds and pension management companies, though consolidation will certainly occur, due to regulation on minimum requirements on number of insured persons and founding capital. Thus, a mutual pension fund must have at least 1000 members (insured persons) and 50 million tolars of initial capital. As for pension management companies, their requirements are higher: 15,000 members (insured persons) and 320 million of initial capital.

With some 753 thousand insured persons in the mandatory first pillar and some 82 thousand insured persons in the second pillar, this simply means that the coverage in the second pillar is 11% of all insured persons in the mandatory first pillar. It is expected that this number will increase to 200 thousand by the end of 2002. There is no doubt that these supplementary pension schemes are gaining ground and will eventually represent an important source of pension provision. Of course, in comparison to the first pillar the second pillar is still minuscule, and their total accumulated premiums (as of January 2002) represent some 7,5 billion tolars. To put this figure in proper perspective, the average monthly amount of pensions disbursed in the first pillar exceeded 45 billion tolars in 2001.

A strong incentive for the development of the second pillar was doubtlessly provided by the very favourable tax treatment. The lowering of the required threshold of employees enrolled in the collective scheme was also important for the employer, as tax incentives are conditional on this threshold. The threshold was initially set at 66% of the workforce, but has been lowered to 51% in January 2002. For employer contributions - these are of course contributions to collective schemes - the premiums are in effect ”tax free”, i.e. exempted from corporate income tax, social security contributions and personal income tax. The tax treatment of these premiums is actually more favourable than that of other fringe benefits provided by the employer, which are subject to social security taxation and (in part) to personal income taxation. On the other hand, employee contributions (premiums) to the supplementary pension schemes - either collective or individual - are paid out of wages, and are deductible for the purpose of personal income taxation, but remain subject to social security taxation. The overall ceiling, i.e. amount which is granted this favourable treatment is 24 percent of the individual’s mandatory social security contributions or an annual amount of some 440 thousand tolars, whichever is lower.[15]While it is obvious that it is more advantageous for the employer to ”use” the whole amount of the tax incentive, and the insured person in exchange consents to greater restraints in the demands for future wage increases, this tax incentive can in principle be shared between the employer and employee.

The 1999 PDIA, as well as the legislation preceding it, delegated a quite distinct position to *Kapitalska družba,* the Pension Management Fund. This 100 percent state-owned institution has not only been given a very specific role within the second pillar, but was also given a strong supportive role for the first pillar. *Kapitalska družba* manages three different funds, which have been introduced through different legal acts. First is the Capital mutual pension fund, the successor of the supplementary scheme introduced in 1992. Most of the

[15] This is the nominal value set in January 2002, and is subject to change.

original participants remained in the scheme, the only supplementary pension scheme permitted under the 1992 PDIA, although some opted out and joined other schemes. Second, it manages a mandatory supplementary pension scheme introduced by the 1999 PDIA. This is the only mandatory scheme within the second pillar, and covers insured persons in certain occupations, for whom employers are obliged to pay higher contributions in order to finance earlier retirement. This is not really novel, since even prior to the 1999 PDIA employers were obliged to pay higher contributions for employees in certain occupations, but these pensions were disbursed entirely from the first pillar. According to the 1999 PDIA, the employer is obliged to pay the 'normal' contribution to the first pillar (i.e. to the IPDI) and additional contributions to the mandatory supplementary scheme. These additional contributions are intended to provide the insured person with an occupational pension upon (early) retirement. Upon reaching the age 58, the person will then be entitled to an old-age pension from the first pillar and a reduced occupational pension from the mandatory supplementary scheme. This is a strong fund, with some 23 thousand insured persons and accumulated assets amounting to some 4,5 billion tolars. The third fund managed by *Kapitalska družba* is also stipulated by law - it is the First Pension Fund, which was created to absorb privatisation certificates. These certificates were mostly absorbed by investment management companies; but there still remained a certain amount of certificates which have not been traded. The investment management companies demanded an additional sale of government property, so as to match the nominal value of the remaining privatisation certificates; the government hoped that the First Pension Fund would absorb all the remaining certificates and trade them for pension coupons. In such a way the government would not be pressed to sell the government property outright. This manoeuvre was not successful as the number of persons who traded their remaining certificates for pension coupons was small.

The third pension pillar consists of voluntary individual savings for old-age, mostly in the form of life insurance, administered by insurance companies. Premiums paid to the third pillar are subject to tax relief, but with a fairly low cap (3% of taxable income), and this non-standard tax relief includes a number of other "commendable" expenses, not only life insurance premiums. It is though worth mentioning that annuities received from this pillar are - as yet - not subject to personal income taxation.

As we have seen, though the Slovene pension system is a three-pillar system, the second pillar is in its infant stage. Of course, the development prospects for the second pillar are bright, not only due to very generous tax incentives, but also to the decreasing pension rights within the first pillar.

Means-tested transfers among the elderly

Though the pension system contains various redistribution elements, some pensioners still receive very low pensions, due to low incomes during their contribution period and/or an incomplete contribution period. Pensioners with low incomes and an incomplete contribution period can apply for a pension income supplement, provided they fulfil a set of conditions, such as a) their pension is lower than the minimum pension for the full contribution period, b) the family in which the pensioner lives does not have other income sources which would suffice for a minimum standard of living and c) the family has negligible property. These conditions are tested every two years. If a pensioner satisfies all the three criteria, he is entitled to a pension income supplement, and the amount granted is obtained by multiplying a) the difference between his/her actual pension and the minimum pension for a full contribution period; the latter being set by the IPDI and b) a coefficient, which depends on the contribution period of the applicant; the smaller the contribution period, the lower the percentage. For example, for a 15 year contribution period this coefficient is 0.60, whereas for a 35 year contribution period the coefficient is equal to 1.00.

The pension income supplement is not only paid to old-age pensioners, but also to disability pensioners and recipients of survivor pensions. There were some 46,4 thousand recipients of a pension income supplement in the year 2000; this is to be compared with the total of 482,2 thousand pensioners (old-age, disability, survivors, farmers) in the same year. The amount of pension income supplement in 2001 was some 8.5 billion tolars.

The 1999 PDIA also introduced the national pension, which is in fact but a form of means tested benefit. As a social assistance measure, it has no place in the pension and disability insurance act; its inclusion was the result of considerable horse-trading among political parties, members of the ruling coalition. Unlike the pension income supplement, where one of the main criteria is that the person is entitled to a pension, i.e. has accumulated a sufficient contributory period, the national pension can be granted to a person who is not receiving any pension. There are a number of other conditions which the applicant for a national pension must fulfil: a) the applicant must have no pension from domestic or foreign sources, b) his / her own income sources should not exceed the minimum income (relevant for determining the condition for pension income supplement) c) his / her age should be at least 65 years d) he / she should have had thirty years of residence in Slovenia, between the age 15 and 65. For the first year, in 2000 applicants were required to present an attestation by the local Centre for Social Work, that he/she would in fact be entitled to social assistance, as well as an attestation for the thirty year residence in Slovenia. After this pension has been granted, there is no further annual

means testing. Following the first year, pensioners were only required to fulfil conditions a) to d). It is to be noted that this social assistance benefit is being introduced gradually: in 2001 the age limit was set to 70, and will reach the final age - 65 only in 2006. The number of recipients in 2001 was 4,538, but with a very strong upward trend. The pension amounts to 33,3% of the minimum pension assessment base, which is only slightly less than the amount an insured person (with admittedly low earnings) would receive for a 15 year contribution period.

The composition of income of the elderly

The elderly have undergone a certain homogenisation of income and homogenisation of household structure. In other words, pensioners increasingly depend only on pensions as their income source. Also, an ever increasing share of pensioners live in pensioner households; these are households with at least one pensioner and without any active members, be they employed, unemployed or self-employed. Thus, in 1993 some 56% of all pensioners lived in pensioner households. As for the changing structure of pensioner household income, this can be observed in table 3.1.

Table 3.1: Structure of pensioner household income (as percentage of disposable household income)

	1983	**1993**
Earnings	8.7	4.9
Pensions	79.2	86.4
Other social benefits	3.7	2.5
Other	8.5	6.2
All	100	100

Note: The category 'other' includes self-employment income, income from capital, gifts and interfamily transfers.

Source: Stanovnik and Stropnik (2000).

The capital market and the banking sector in Slovenia[16]

According to the FSAP (Financial sector assessment program) conducted by the IMF and the World Bank, the Slovenian banking sector has evolved in a sound and safe system with a strong capital base and the system is robust to external shocks. Nevertheless, it was being developed in a largely protected

[16] This section draws heavily on Lavrac (2002).

environment, and limited competition prevented consolidation. Privatisation of the two largest, state-owned, banks is under way, and the sale of a 34% share of the largest bank, the NLB, to the Belgian bank KBC is all but completed.

In Slovenia, the development of the capital market was mostly determined by the privatisation process. Privatisation was in fact a voucher privatisation in which the authorized investment companies (PID - *pooblaščene investicijske družbe*) played the role of financial intermediaries between the population that obtained privatisation vouchers and 'socially owned' firms that were to be privatized.

The primary market in Slovenia is rather underdeveloped; as it does not raise finance for business firms, but is active mostly for government short-term and long-term securities. A growth in the corporate share of the primary market is not to be expected in the near future, and the primary market will remain a source of financing for the government and the banks.

Pension funds, as new actors in the capital market were introduced in the pension legislation of 1999. They will doubtlessly have an important impact on the capital market in the future.

3.1.2 Benefits

Eligibility and benefits

The 1999 PDIA introduced very important parametric changes in the first pillar. Accrual rates were decreased and the gender divide considerably narrowed. Bonuses for late retirement, i.e. retirement after full pensionable age, were introduced, as well as 'maluses' or penalties for retirement prior to full pensionable age. This quite resembles the Italian approach toward flexible retirement. Full pensionable age was set at 63 for men and 61 for women. In other words, retirement prior to the age of 63 for men and 61 for women entails penalties - although this is only a general rule, and not valid for certain groups of insured persons. The system of bonuses is - in effect - regressive, whereas penalties are progressive. For example, a male insured person who retires one year after full pensionable age, i.e. at age 64, will have his computed pension increased by 3.6%. This scale is regressive: if he retires at age 65, his computed pension will be increased by 6% etc. On the other hand, if an insured person retires prior to full pensionable age and does not fulfil the insurance period criterion (40 years for men and 38 years for women) the decrease in pension is progressive. Retirement at age 58 implies that his/her computed pension will be decreased by 0.30% for each missing month to full pensionable age, whereas retirement at age 59 entails a penalty of "only" 0.25% for each missing month

to full pensionable age. We mention that there were penalties for ”early” retirement even according to the 1992 PDIA, but these penalties were small and lifted once the necessary age limit (58 for men, 53 for women) was reached.

The pension assessment base is now computed on the basis of the best 18 year average of net wages; under the 1992 PDIA it was the best 10 year average of net wages. There are strong redistributive (”solidarity”) elements in the first pillar, as the pension assessment base is truncated at both ends. In other words, one’s computed pension assessment base cannot be lower than the minimum pension base (which is set at 64% of average net wage) and not higher than the maximum pension base, which is set at 4 times the minimum pension base. The basic parameters of the system are presented in table 3.2.

Table 3.2: Basic characteristics of the 1999 PDIA (eligibility criteria and benefits)

	Men	**Women**
eligibility criteria	age = 58, p.q.p.= 40 age = 63,p.q.p.= 20 age = 65,ins.p.= 15	age = 58,p.q.p.= 38 age = 61,p.q.p.= 20 age = 63,ins.p.= 15
minimum insurance period	15 years	
pension assessment base	best 18-year average of net wages	
accrual rates	35% of pension base for first 15 years, then 1.5% for each additional year of p.q.p.	38% of pension base for first 15 years, then 1.5% for each additional year of p.q.p.
pension indexation	growth of net wages	
minimum pension assessment base	set nominally, but effectively at approx. 64% of national net wage	
maximum pension assessment base	4 times minimum pension assessment base	

Note: p.q.p.= pension qualifying period; ins.p= insurance period; these terms will be explained in section 3.1.6

Source: J. Kuhelj (2000) and the 1999 PDIA.

As an illustration, we provide the relevant calculation for a man with a 30 year pension qualifying period:
(35 percent for first 15 years + 1.5 percent times 15 years = 57.5 percent. This persons entry pension would be 57.5 percent of his pension assessment base.

Compared to the 1992 act, the 1999 PDIA tightened eligibility criteria, particularly for women, and considerably reduced benefit levels. Provided an

insured person is not subject to penalties, his pension will now be 72.5 percent of the pension assessment base after 40 years of work, compared to 85 percent under the 1992 PDIA. Considering further that the pension assessment base is the best 18-year average of net wages, instead of the 10-year average of net wages, the reduction in pensions is even greater. However, the new rules for eligibility and benefits are being introduced only gradually.

Persons older than 58 years and who have more than 40 years of service (men) or 38 years (women) are entitled to bonuses, i.e. higher accrual rates for all additional years of service; bonuses are similarly granted to persons older than 63 years (men) or 61 years (women), who have fulfilled conditions for retirement but nevertheless continue to work. Penalties, i.e. 'maluses' apply to men in the age bracket 58 to 63 who do not have 40 years of service; similarly, penalties apply to women in the age bracket 58 to 61, who do not have 38 years of service. Recall that under the new 1999 PDIA persons can retire when he/she reaches the age 58, provided the person has a sufficient pension qualifying period (40 years for men, 38 years for women). Of course, the criterion of pension qualifying period is a less stringent condition than years of service. The former can include purchased periods (period of military service, university education) or even a credited period for which contributions have not been paid.

Replacement rates

We define the replacement rate as the ratio between average net pension and average net wage; the values for the period 1991 - 2001 are presented in table 3. In the case of Slovenia, as well as most central and east European countries, the comparison based on gross values is meaningless, and, besides, the comparison based on net values provides a better indication of the standard-of-living of pensioners. The comparison based on gross values is meaningless because Slovenia has retained the net income concept for pensions. For personal income tax purposes, net pensions are fictitiously grossed-up by the average personal income tax rate, and a personal income tax schedule is applied. If the computed amount of tax is greater than the amount: 'gross' pension minus net pension, then the person pays tax. In effect this means that only high-income pensioners pay, albeit very small, income tax.

Table 3.3: Net replacement rates, (in percent) Slovenia 1991 - 2001

Year	Old-age pensions	All pensions
1991	73.0	66.0
1992	77.8	70.7
1993	73.9	67.0
1994	75.4	68.5
1995	76.2	69.2
1996	74.6	67.5
1997	74.3	67.3
1998	74.5	67.4
1999	75.8	68.5
2000	75.3	68.1
2001	73.2	66.3

Note: 'all pensions' include old-age, disability, survivors and widows pensions.

Source: 2001 Annual report of the IPDI.

Indexation

The valorisation of past earnings, which is relevant for the computation of the pension assessment base, is based on the nominal wage index. The indexation rule relevant for the up-rating of current pensions is also, broadly speaking, based on the growth of nominal wages, though the precise rule is quite non-transparent. In principle, pensions are up-rated at the same time as wages, with an additional checkpoint in September. In order to increase fairness among pensioners, i.e. to prevent differences among pensions with regard to the date of entrance into the pension system, the indexation mechanism for existing pensioners also takes into account the new (lower) pensions of new entrants; this measure is now being contested at the Constitutional court of Slovenia.

Poverty among pensioners

The income position of pensioners has been steadily improving in the past twenty years. The improvement during the period 1983 - 1993 is seen from table 4, and though an analysis for more recent years has not yet been performed, there is other "circumstantial" evidence that their income position has also been improving in the late 90s. As seen from table 3.4, pensioners in pensioner households had a poverty incidence slightly above the national average in 1993, whereas persons aged 60 and over had a considerably higher

poverty incidence than the national average. Thus, in 1993 12.6% of all persons aged 60 and over had equivalent household income below 50% of the median equivalent household income: the corresponding percentage for all persons was 7.1%.

Table 3.4: Poverty incidence based on 50% median equivalent household income, Slovenia 1983 and 1993 (as percentage of relevant population)

	1983	**1993**
All persons	7.3	7.1
Pensioners	9.2	6.7
Pensioners in pensioner households.	10.7	7.3
Persons aged 60+	15.8	12.6

Note: equivalent income obtained using the OECD equivalence scale.

Source: Stanovnik and Stropnik (2000).

Pensioner households are households with at least one pensioner and none of the members are employed, self-employed or unemployed. It can be a single pensioner household or couple pensioner household, meaning a household in which one member is a pensioner and the spouse (male or female) is a pensioner or dependant. As for the category 'other pensioner household', it includes for example a two person household in which one member is a pensioner and the other member (pensioner or dependant) is not a spouse. The poverty incidence, based on 50% of median equivalent household income, for the four subcategories of pensioners in pensioner households is given in table 3.5.

Table 3.5: Poverty incidence based on 50% median equivalent household income, four subcategories of pensioners in pensioner households.

	1983	**1993**
Pensioners in pensioner households	10.7	7.3
- single male pensioners	(12.8)	(12.7)
- single female pensioners	7.5	7.8
- pensioners in couple pensioner households	10.2	4.7
- pensioners in other pensioner households	15.2	11.2

Note: 1. Brackets denote small sample size.

2. Persons are taken with their equivalent household income.

Source: Stanovnik and Stropnik (2000).

Single male pensioners are a very small group, and thus does not merit particular attention. Of the three remaining subcategories, pensioners living in couple pensioner households had the lowest poverty incidence in 1993. This is not surprising, as a large majority of these households were receiving two incomes (pensions) at the time. On the other hand, in 1983 many couple pensioner households obviously consisted of one pensioner and one dependant. In 1993, single female pensioners still had a poverty incidence which was above the average for the whole population; 7.8% of all single female pensioners had equivalent household income below 50% of the median household equivalent income, whereas the corresponding figure for the whole population is 7.1% (see table 4). 'Other pensioner households' is a very heterogeneous group, though much smaller than single female pensioner households or couple pensioner households. What pensioners in these households do have in common with pensioners in couple pensioner households is that their poverty incidence decreased in the 1983 - 1993 period; this cannot be said for single female pensioners, as their poverty incidence increased from 7.5 to 7.8% of all single female pensioners.

Yet another view of the poverty incidence is obtained through a direct gender comparison, which is presented in table 3.6.

Table 3.6: Poverty incidence, based on 50% median equivalent household income; a gender comparison

	1983	**1993**
All persons aged 60+	15.8	12.6
- men aged 60+	17.1	11.9
- women aged 60+	14.9	13.1

Source: Stanovnik and Stropnik (2000).

In this analysis, as in the previous ones, one must bear in mind that we are comparing persons with their equivalised household incomes, and not their personal incomes. The reason for this is that personal incomes were not available on the household level. From table 6 we observe the quite strong improvement for elderly men, and a fairly weak improvement in the poverty incidence for elderly women. The explanation for this phenomenon is as follows. The improved income position of men aged 60 and above is - somewhat paradoxically - due to the fact that the proportion of women who receive pension entitlements has increased in this period; in 1983 40% of all elderly women were without pension entitlements, and this decreased to 31% in 1993. Elderly men - who mostly live in couple pensioner households - had thus experienced an increase in household equivalent income. This of course would also mean that the income position of women living in couple pensioner

households improved. Unfortunately, there was a contervailing force to this positive improvement: the number of single female households increased, and in these households women mostly receive low survivors pensions.

Legal and effective retirement age

According to the 1992 PDIA, the statutory retirement age was 53 for women and 58 for men, provided they accumulated a sufficient contributory period (35 and 40 years, respectively). These age limits are being gradually increased to the full pensionable age of 61 years for women and 63 years for men (to be reached in 2008 for men and 2022 for women) . Thus, in 2002 the age criterion for women was 54 and for men it was 59.5. It must though be reiterated that there is an interim period during which certain groups of insured persons can still be pensioned according to previous rules: the strongest of such groups being long-term unemployed persons. Due to this effect, the new PDIA did not cause an immediate increase in actual retirement age, as seen in table 3.7.

Table 3.7: Effective retirement age, by gender, 1992 to 2001

Year	Men	Women
1992	56.2	52.5
1993	56.2	53.3
1994	57.6	53.2
1995	57.5	53.1
1996	57.5	54.0
1997	58.3	54.9
1998	58.4	55.3
1999	58.2	54.8
2000	59.2	55.4
2001	59.3	55.4

Note: 'retirement' refers to old-age pensioners.

Source: Statistical office of the IPDI, 2002.

Taking into account (1) a fairly stable replacement rate, and (2) measures introduced in the 1999 PDIA, i.e. the national pension, one can, with a certain degree of confidence, state that the pension system is adequately performing one of its important functions, that is providing income security in old age and reducing poverty among the elderly. This is also confirmed through the analyses of pensioner well-being, based on household expenditure surveys.

3.1.3 Financing of the pension system

The pension system is financed mainly by employee and employer contributions. The employee contribution rate is 15.5 percent and the employer contribution rate is 8.85 percent of gross wages. The self-employed pay the joint rate, i.e. 24.35 percent of their income (revenues minus expenditures). Transfers to the IPDI budget from the central government's budget are in operation since the early 90s, as the government was obliged to honour its obligation to finance various benefits disbursed by the IPDI. The legal basis for these benefits was mostly in legal acts outside the PDIA, such as more favourable pensions for various groups of insured persons. Thus, the governments obligation was to cover the difference between the actual pension a 'privileged' pensioner received and the pension he would have received under 'normal' insurance, using the general formula for the computation of a pension.

Table 3.8: Revenues and expenditures of the Institute for pension and disability insurance, as percentage of GDP

Year	Revenues without state subsidies	State subsidies	All expenditures
1992	13.4	0.0	13.8
1993	13.9	0.5	14.0
1994	13.1	1.0	14.4
1995	12.9	1.0	14.7
1996	11.0	2.7	14.5
1997	10.1	4.0	14.4
1998	10.2	4.3	14.3
1999	9.9	4.3	14.4
2000	10.0	4.2	14.5

Note: 'All expenditures' include pensions and pension income supplements, pensioners' health insurance and administrative costs.

Source: For GDP: Statistical yearbooks of the Statistical Office of Slovenia; for revenues and expenditures of the IPDI: Bulletin of public finances, Ministry of Finance, no. 3, 2002.

In 1996 the government, alarmed by the gloomy predictions of a decrease in competitiveness, particularly in certain labour intensive industries - such a clothing, shoe and leather etc - decreased the employer social security contributions from 15.5 percent to 8.85 percent. The ensuing fall in revenues of the IPDI was compensated by a progressive payroll tax and tax on contractual work; these are though revenues of the central government budget and not of the IPDI. As seen from table 6, the large shortfall of revenues of the IPDI, which occurred in 1996 and the following years, was solved through transfers

from the central government budget. As a matter of fact, this obligation of the central government, i.e. to cover the financial deficits of the IPDI, is even written into the law.

In recent years, i.e. since 1999, the deficit of the IPDI has been mostly covered by the state-owned *Kapitalska družba,* in effect through the sale of assets (shares). In other words, *Kapitalska družba* is being ”striped” of assets which were acquired during the privatisation process.

Table 3.8 shows that pension expenditures (as a percentage of GDP) increased slightly since 1992, and that this increase was concentrated in the early period, i.e. up to 1995. This somewhat conceals the large increase manifest in the final pre-transition years and very first years of transition (i.e. the period from 1988 to 1992), when the system dependency ratio rapidly deteriorated. This was caused not only by a large decrease in employment, but also by a large increase in the number of pensioners, due to very favourable early retirement schemes. Not surprisingly, the system dependency ratio stabilized after 1992, as seen from table 3.9.

Table 3.9: Number of contributors, number of pensioners and system dependency ratio, 1990 to 2001

Year	**Number of contributors (in thousands)**	**Number of pensioners (in thousands)**	**Contributors/pensioners (3=1:2)**
1990	884.6	384.1	2.30
1991	816.9	418.9	1.95
1992	764.9	448.8	1.70
1993	782.6	457.5	1.71
1994	772.5	458.1	1.69
1995	769.0	460.3	1.67
1996	765.7	463.3	1.65
1997	783.2	468.2	1.67
1998	784.2	472.4	1.66
1999	800.5	476.4	1.68
2000	806.0	482.2	1.67
2001	812.6	492.5	1.65

Note: The ratio in column 3 refers to the inverse of the system dependency ratio.

Source: 2001 Annual Report of the Institute for Pension and Disability Insurance.

3.1.4 Incentives

Up to 1999, there were absolutely no incentives in the pension system for extending the active employment period of the insured person. For example, when a male insured person fulfilled the condition of a 40 year contribution period, additional years of service did not entail a higher pension. Also, the pension system allowed for early retirement under very generous conditions, i.e. only temporary reductions in pensions, until the early retiree reached the required age limit (58 for men, 53 for women). Of course, early retirement was conditional on the insured person reaching a minimum age (55 for men, 50 for women), minimum pension qualifying period (35 for men, 30 for women) and other conditions, such as bankruptcy of the firm or long term unemployment etc.

The new 1999 PDIA introduced incentives for late retirement, i.e. retirement after the full pensionable age (63 for men, 61 for women) , and disincentives for retirement before the full pensionable age is reached; these are the bonuses and penalties (‘maluses’) which we have already mentioned. Bonuses are also granted to insured persons aged 58 and over, for each additional year of service over 40. It remains to be seen whether - and to what degree - these bonuses (i.e. high and positive accrual rates) and penalties (i.e. negative accrual rates) will influence behaviour and extend labour participation of the relevant population.

The 1999 PDIA closed all gates for early retirement. The only sweetener, probably made as a concession to the trade unions, is that under certain conditions insured persons can retire at the age of 58 and with a pension qualifying period of 40 years (men) or 38 years (women) - and without penalties. This ”special offer” is provided to insured persons who are unemployed, or disabled etc.

Incentives for labour market participation are important, but so are incentives for payment of contributions. Though the 1999 PDIA improved the pension system in terms of horizontal equity (‘equivalence principle’) as the link between contributions and benefits (pensions) has been somewhat tightened, it has at the same time discarded some elements of redistribution (‘solidarity’) while introducing new ones. Thus, the ratio between the maximum and minimum pension (for equal contribution period) is now 4:1; under the 1992 PDIA it was 4.8:1. This compression of pensions was not matched by a ceiling on contributions, and Slovenia is among the small number of countries that does not have a ceiling on social security contributions. Obviously, this might act as a strong disincentive for contribution payment by the high income groups, as they will try to channel their wage income into various forms of non-wage income, which is not subject to social security contributions.

3.1.5 Coverage of the system

The public pension system (”first pillar”) is a mandatory system for the whole active population, the most important groups being employees, self-employed and farmers. Unemployed persons receiving unemployment benefits are also included. Part-time workers are included, and their contribution rate is the same as for full-time workers. Workers performing contractual work are not included in pension insurance: they are though obliged to be covered for disability insurance, health insurance and insurance for injury-at-work. Certain other groups can enrol into pension insurance: these include persons in military service, persons caring for a child or disabled person, , unemployed persons (who do not receive unemployment benefits), farmers with very low income, etc. The specific feature of this voluntary inclusion into the mandatory system is that these groups can be insured for an insurance base which is lower than the insurance base for persons in the mandatory system - which is set at some 64% of the average wage. The ”rationale” for such an extra provision in the 1999 PDIA is that these marginal groups have very low incomes, and paying contributions from the minimum insurance base which is set for the mandatory system would be a too great burden. These groups consequently also have a somewhat smaller bundle of pension rights than persons that cannot chose their contribution base.The pension legislation also provides the possibility of ‘opting out’; it is given to self-employed and farmers whose taxable income (for personal income tax) is less than 50% of the minimum wage in the previous six months.

The 1999 PDIA introduced important and substantial parametric changes which narrowed the gender gap. Eligibility conditions and the benefit formula is only slightly more favourable for women than for men, as seen from table 2 and section 3.1.2**.** Of course, in discussing the gender gap issue one must be aware that an essentially Bismarckian pension system reproduces inequalities which are present during the active period. In other words, lower wages and a less stable work and wage history for women during their active period are translated into lower pensions in the retirement period. The pension system is though not ‘gender-blind’ and it does not take into account the fact that women assume additional burdens during their active period. Thus, the 1999 PDIA decreases the age criterion for child rearing; for one child the deduction is 8 months, for 2 it is 20 months, for three 36 months and for each additional child it is 20 months. It is important to stress that this option will be introduced gradually and that these child-rearing deductions will be subject to a lower age limit, which is set at 56 for women.[17] Child rearing is also being credited, though this is relevant only for women who were not insured at the time. The

[17] We only mention in passing that this ‘child-rearing’ option is also - in principle - available for men. For them the lower age limit is 58 years.

credit amounts to one year of insurance period, and is of course not relevant for women on maternal leave, as these retain their employee (and insured) status. Women who were not employed at the time of child-rearing can also purchase up to three years of insurance (i.e. first three years of child-rearing).

3.1.6 Public acceptance of the system

There haven't been any public opinion surveys on the acceptance of the pension system. These surveys would monitor the trust that the general public has in the public pension system and it would be interesting to see what these surveys would reveal. Namely, the public pension system is certainly not transparent, particularly now, during the 'transition period' when pension rights for new pensioners are jointly determined on the basis of the old (the 1992 PDIA) and new system (the 1999 PDIA). Also, the adjustment period, during which the parameter values will reach their final values is quite long. For example, the full pensionable age for women (61 years) will be reached by the year 2022!

An extremely complex set of terms used in the assessment of one's eligibility conditions definitely does not improve 'transparency'. Thus, y*ears of service* is a 'high quality' contribution period, and refers to the period when a person was actually insured. *Insurance period* is of a somewhat 'lower quality' and refers to the sum of years of service and *purchased period*; the latter refers to a period which could be purchased. By 'high quality' we mean that eligibility conditions are more favourable (for example, no penalties) for persons with a sufficient amount of years of service, as compared to a person with the same amount of insurance period. Next in line ('quality-wise') is the *pension qualifying period*, which is the sum of insurance period and *special qualifying period*; this latter refers to years that are credited. Finally, a *period assimilated to insurance periods (*or *added qualifying period*) is relevant only for achieving eligibility conditions, but is not used in computing one's pension. Such periods include years of university education, military service etc. These years can also be purchased, in which case they become a purchased period.

The administrative costs of the system are low; these represented (in 2001) only some 0.8 percent of total outlays of the IPDI.

3.2 Evaluation of future challenges

3.2.1 Main challenges

The main challenge for the old-age security system in Slovenia is to continue performing its function as provider of replacement income for the elderly. In other words, preserving the financial viability and sustainability of the system remains a priority and also a challenge. Their ability to maintain the financial

soundness of the system lies not only within the system itself, but also depends on developments on which the pension system has no influence.

The pension system must not only be neutral with regard to the individual's choice for extending participation in the active population, but must provide strong ('non-neutral') incentives in this direction. Unfortunately, pension system incentives are a necessary but not sufficient condition for increased labour force participation, as a lot depends on the conditions of the labour market itself. A vibrant and dynamic labour market with many job opportunities will also favourably influence the elderly labour force in postponing the retirement decision. A weak labour market with a high unemployment rate will act as a disincentive for extended labour participation and result in continuous pressure for retirement at the first possible opportunity.

3.2.2 Financial sustainability

3.2.3 Pension policy and EU accession

No simulation exercise of the financial viability of the pension system has been performed following the pension reform in 1999. The simulation exercises performed prior to the reform, showed that the system was 'unsustainable' in the medium and long term. The measures introduced in the 1999 PDIA will certainly result in lower pension expenditures in the medium and long term, as compared to the no-reform baseline. In any case the decrease will not be spectacular, as the changes are introduced gradually and will mostly affect only new entrants. One must also bear in mind that certain measures will increase pension expenditures - such as the introduction of a national pension. In other words, the net effect (decrease) on pension expenditures might not be particularly large. Of course, a sizeable decrease in pension expenditures can be achieved only through a change in the indexation rule. Though this measure was considered during the reform activities, the basic concept of indexation according to net wages has been retained. What the 1999 PDIA did introduce is the (downward) adjustment of pensions of existing pensioners. This is performed in order to "equalise" pensions of new entrants and pensions of existing pensioners. It is though obvious that the quite generous indexation rule plays a dominant role in the increase of the nominal (and real) value of pensions; the aforementioned small decrease is but a minor 'nuisance'. Pension policy and EU accession

There has - as yet - been no discussion on the possible implications of EU accession on the pension system of Slovenia. It is quite well known that, with

regard to social security and social policy in general, the level of harmonization and coordination within the EU is rather weak, so there have been no special preparations and no relevant legislative action in Slovenia. This of course does not mean that the relevant EU legislation will not be without consequences on the relevant legislation of Slovenia; it only means that this is not perceived as a problem, particularly since 'the legislative mills' of the EU grind very slowly. The relevant EU legislation activity is currently concentrated on second pillar issues, as a recent directive proposal will enable private pension funds to operate a single pension scheme for several countries.

3.3 Evaluation of recent planned reforms

3.3.1 Recent reforms and their objectives

The recent pension reform was implemented in December 1999, with the passage of the Pension and disability act; this marked the end of an intensive and at times very difficult reform process, which started in 1996. The driving concern by the government in this reform process was to ensure long-term financial viability of the system, mainly by decreasing pension rights within the first pillar and partially privatising the system, through the introduction of a mandatory fully funded second pillar. The 1999 PDIA was the final result of a politically charged process and it is quite natural that the result somewhat deviated from the original pension reform proposals, i.e. fell short of the government's desires. Thus, the proposal for a mandatory fully funded second pillar was discarded, and in its place voluntary collective or individual pension schemes were introduced.

Different views and opinions with regard to reform proposals arose not only among pension experts but - what is even more important - among the social partners. Though consultations with the social partners are not formally required by law, the passage of relevant legislation is virtually impossible without the consent of the social partners. Unlike the employer's associations, which were rather meek and almost unconditionally sided with the government proposals, the trade unions proved to be a formidable opponent. They voiced very strong opposition to the introduction of the mandatory fully funded second pillar, and thus the government had to back out and abandon this proposal in Spring 1998. The swift withdrawal of the mandatory second pillar proposal was doubtlessly also caused by the fact that the Ministry of Finance was not supportive, as a mandatory fully funded pillar would worsen the fiscal position in the short and medium term.

The trade unions also succeeded in diluting the original proposals for the reform of the first, public, pension pillar. True, there was some 'give and take',

and the government succeeded in retaining some of its original proposals, such as the accrual rates (set at 1.5 percent). Most of the final values of parameters were reached through compromises. Thus, the original proposal of a full pensionable age of 65 years was lowered to 63 for men and 61 for women; the period relevant for the computation of the pension assessment base was lowered from the best 25 years to the best 18 years. The values of bonuses and penalties (for retirement prior to full pensionable age) were somewhat diluted, and the transition period stretched. For certain groups of insured persons retirement prior to the full pensionable age does not entail penalties.

Differences were present not only among social partners, but also within the ruling coalition, and the 1999 PDIA did accommodate the demands of the parties of the ruling coalition. Thus, 'credit' for the national pension, which is really a social assistance benefit goes to the Peoples party (SLS), a member of the ruling coalition, which was catering to its own (rural) electorate. The Pensioners party (Desus) insisted on the continuation of favourable indexation (in effect indexation according to net wages) and on the clause of government responsibility for financing any future pension deficits.

3.3.2 Political directions of future reforms

There is absolutely no discussion of any substantial changes within the pension system. Legislation following the 1999 PDIA was mostly concerned with removing obstacles to the development of the second pillar. There is no political divide or 'fault line' with regard to the future direction of pension policy. In the past, one could detect a certain 'fault line' with regard to the introduction of a mandatory fully funded second pillar, and two left leaning parties opposed this move. These were the already mentioned Desus, which was in the ruling coalition and the United league of social democrats (ZLSD), which was in opposition. Their opposition was caused by a suspicion (and fear) that the mandatory fully funded pillar would result in serious transition costs and fiscal problems, with a quite possible downsizing of the first, public, pillar. As the mandatory fully funded second pillar debate is irrelevant, there are now no clear pension issues which could sharply divide the public and the political parties.

3.3.3 Conclusions

The pension reform, which was concluded with the passage of the 1999 PDIA was a major reform. It was not only a parametric reform of the first pillar but also opened the door widely for the development of supplementary pension schemes. The changes introduced in the first pillar will be felt only gradually, and the improvement in - say - terms of total pension outlays will hardly be visible in the first years. One must also bear in mind that certain groups of

insured persons can retire under conditions of the old law; this provision is of a limited duration, and by 2004 one ought to expect a gradual increase in effective retirement age, both for men and women. This is a positive development as regards the pension system, though it might - on the other hand - seriously aggravate the social position of the groups of insured persons approaching retirement. It is well known that the unemployment rate among this group is quite high; for these persons the gates of early retirement are now being closed. Thus, improvements in one part of the social protection system might cause a deterioration of the social position of the elderly and more pressure for pre-retirement social assistance.

Will the reformed pension system be able to cope with future challenges? Pension expenditure scenarios seem to indicate that pension expenditures (measured as percentage of GDP) will remain stable for the next five years, and will start creeping up, as a consequence of the gradual worsening of the demographic situation. This is nothing new, as the demographic factor will doubtlessly play a key role also in pension systems in other European countries. It is therefore impossible to predict exactly how the pension systems will adapt to these new challenges - though it seems likely that private forms of pension provision, i.e. supplementary pension schemes, will be able to put much pressure off the public first pillar. In other words, there is no reason not to believe that the pension system will adapt - as it has already in the past.

4. POVERTY AND SOCIAL EXCLUSION

4.1 Evaluation of current profiles of poverty and social exclusion

4.1.1 Social exclusion and poverty within the overall social protection system

Research on poverty and income inequality had been neglected in Slovenia, as well as in other former socialist countries, until the transition process began at the end of the 1980s. The former regime, pursuing the target of maintaining full employment and allowing hardly any differentiation within the people's living standard, did not support research that would undoubtedly have led to an opposite conclusion, namely, that the system had actually failed to provide for everybody, or, even that a high proportion of people lived in concealed poverty. Though there were some surveys, which were periodically collecting the relevant data, the research on the economic position of people was rare.

In the beginning of the 1990s, the extent of poverty reached the level at which it could no longer be left unspoken out. It was mostly due to the widespread negative economic consequences of the transition. An increasing and relatively high unemployment rate as a consequence of a) the loss of markets following the break of ex-Yugoslavia and the war in the region, and b) the restructuring of economy in the transition from the mostly planned to a market economy. Unemployment, which had been almost unknown before, struck large masses of people regardless of their educational level or work experience. On the other hand, particular individuals and small groups took enormous economic advantages of the transition. Poverty and an increasing income inequality became unavoidably evident. In the newly established democratic society with a multi-party system, people now began addressing this issue, asking for its critical assessment and remedial measures.

Research on poverty has become one of the continuous tasks of the national Institute for Economic Research. The Statistical Office of the Republic of Slovenia, too, started this kind of research in the mid 1990s using the Eurostat methodology. Their results have been regularly published and made public in several other ways. In 2000, the Slovenian government adopted a National Programme on the Fight against Poverty and Social Exclusion. This programme - which is based on the findings of the research on poverty, social exclusion and income inequality, done mostly by economists, sociologists and social workers - draws recommendations and measures to be taken in future in order to diminish the extent of social exclusion and prevent it wherever possible.

Nowadays, poverty has been widely discussed in public, both by politicians and media. There are vast possibilities for having the poverty figures abused and misused by politicians, journalists and the general public. This is why the interpretation of the research results should be approached most seriously and professionally. It is, for instance, characteristic for journalists to quote sentences extracted from a context and to comment on them in an extremely simplified way. People usually quote bare figures and compare and non-critically discuss poverty indices obtained through application of different methodologies without pointing to their quite different meaning, most probably because they either do not understand the background and meaning of figures, or they do this intentionally to mislead those they are addressing.

Following the revival of economic growth in the second half of the 1990s, the preconditions were created for a comprehensive national social policy aimed at alleviating and preventing poverty among the population at risk, because it was obvious that not everybody's situation was improving. The urgent need was felt to solve this problem. As a consequence – and as a proof that the government was seriously determined to fulfil this task - the Slovenian National Programme on the Fight against Poverty and Social Exclusion was accepted by the Slovenian government in the year 2000. By doing so, the government proclaimed prevention of poverty and social exclusion as one of fundamental objectives of the social policy in Slovenia. All interested parties are expected to be involved in actions, from ministries responsible for individual areas and local communities to non-governmental organisations.

All areas that can contribute towards alleviation of poverty and social exclusion (employment policy, education, health care, housing, social assistance and services, family policy) have elaborated their existing programmes or developed new ones. The new quality is that these programmes now make part of a comprehensive national strategy, whose framework was set by the National Programme. By way of this, partial approaches were mostly overcome in solving a multidimensional problem, which is what poverty and social exclusion certainly are. Policy measures and programmes are interconnected and harmonised. It is clear that the aim set asks for a permanent activity. The awareness is also present, that social exclusion can only be alleviated and not fully eliminated, no matter how appropriate and focused the social policy measures are. The National Programme particularly aims at preventing the long-term exclusion of individuals and their families.

4.1.2 National definitions of poverty and social exclusion

The overall understanding is that poverty and social exclusion are a multidimensional problem, which may and should be illuminated in various ways, using different measures.

The national definition of poverty and social exclusion is the basis of the Slovenian National Programme on the Fight against Poverty and Social Exclusion. It builds on the 1984 definition of poverty by the Council of Europe, the concept of social exclusion encouraged by the European Union since the late 1980s, scientific approach and research done so far in the world. For its own purpose, the National Programme employs the definition of social exclusion as ”an accumulation of exclusions or restricted participation in the key resources, institutions and mechanisms that serve as a means of civil, economic, social and interpersonal integration of groups and individuals into society”.

Absolute poverty means deprivation of basic commodities and services, indispensable for satisfaction of minimum needs (food, housing, clothes, etc.). It is set in an indirect way through the level of cash social assistance, as defined in the Slovenian Social Assistance and Services Act for households of different size and composition.

The risk of absolute poverty could be judged from the average number of social assistance recipients (single persons or family heads), as presented in Table 4.1 in Appendix 4. However, once people start receiving social assistance, they should be pulled out of poverty, so they should not be treated as poor people anymore. On the other hand, the level of social assistance is sufficient only for covering basic needs in a short term. If the status is kept for a longer period, a person/family may nevertheless be living in poverty. This, of course, depends on other sources of occasional aid (financial and in kind). Other social transfers to families on social assistance should also be taken into account when estimating their economic situation. For a two-parent family with two children, the sum of social assistance, rent subsidy and child benefits reaches the level of 90% of average wage net of contributions and taxes. A single parent family receives 80% of the net average wage.

The numbers in Table 4.1 were influenced by changes in legislation ruling social assistance, too. In November 1992, the level of minimum income was in fact decreased, which is not evident from the number of social assistance recipients. A high rise in their number in the period 1993-1997 was primarily due to a new and rapidly increasing group of entitled persons: the unemployed. Having exhausted their insurance-based unemployment benefits (unemployment compensation and unemployment assistance), the long-term unemployed turned to centres for social work for assistance. In the late 1990s, about 70% of beneficiaries were unemployed. Among them were also first-time job seekers. Since parents are not obliged to provide for their adult children, these may apply for social assistance regardless of their parents’ economic position. Some 35,000 recipients were receiving social assistance for some

60,000 persons, i.e. about 3% of the total population of Slovenia living in about 6% of the Slovenian households.

It was only in 1998 that closer cooperation and exchange of information between centres for social work and the employment offices was established. The conclusion of a contract between the beneficiary and the centre for social work on actively resolving the social problem of the beneficiary became a condition for the entitlement to social assistance, and centres for social work checked the applicant's current status at the employment office. As a consequence, the number of social assistance recipients decreased in 1999.

In April 2001 the level of minimum income was increased, particularly for single persons and first adults in families. It was implemented in September 2001, resulting in a higher number of recipients. The recipients in August 2002 and their family members account for some 3-3.5% of the population of Slovenia.

Relative poverty is a state of relative deprivation, as compared to the level of well-being in a community. For that reason, the relative poverty line serves for measuring inequality among population. Relative measures employed by the Statistical Office of Slovenia are the same as the Eurostat's. Researchers use other standard measures as well (see Table 4.2).

Using 50% of the average equivalent expenditure as a poverty line, (Žnidaršič, 1995; SORS, 2002a) the households at highest risk of poverty were identified. Poverty rates in Table 4.3 should be compared to the poverty rates for all households, which were 11.0% in 1993 and 12.2% in 1999.

The research by Stropnik and Stanovnik (2002) has identified the unemployed as the population group in Slovenia with far the highest risk of poverty in both 1993 and in 1998 (see Table 4.4). 18% of the Slovenian households had at least one unemployed member in 1998. However, the share of such households in the bottom income decile was 46% (Stropnik and Stanovnik, 2002). The situation of the unemployed has worsened in the observed period of time. If poverty line is set at 60% of median household equivalent income, 48.3% of the unemployed lived in poverty in 1998 as compared to 33.5% in 1993 (standard OECD equivalence scale was applied). The poverty rate for the unemployed was 2.6 times higher than the average one in 1993, and 3.5 times higher than the average one in 1998.

The situation of families with children is discussed in Chapter 4.2.4.

Subjective poverty is the opinion of households concerning their financial situation and needs. The relevant data are collected through annual Household

and Expenditure Surveys. The answers obtained are presented in Table 4.5. The percentage of those considering themselves poor has been decreasing in recent years.

Subjective perception of poverty is evident from the Slovenian Public Opinion Survey data as well. The proportion of those who consider themselves as living in poverty has decreased from 0.9% in 1993 to 0.4% in 1999. If those who feel shortage of basic commodities and those who have to limit even their expenses on food are added, the proportion of the poor was 9.8% in 1993 and 4.6% in 1999 (Hanžek and Gregorčič, 2001).

4.1.3 18 EU Indicators of Social Exclusion

From the beginning of the year 2004, the Statistical Office of Slovenia will regularly provide information on the 18 EU indicators. However, most of the indicators have already been calculated and are presented in Table 4.6. The most important among them are:

I. income distribution share ratio S80/S20: 3.6,

II. percentage of population at risk of poverty before social transfers: 20.5%,

III. percentage of population at risk of poverty after social transfers: 13.6%, and

IV. relative low income gap: 22.9.%

Since a) there is no panel survey in Slovenia, b) some ECHP questions are not included in the Slovenian HES, and c) Slovenia does not have NUTS 2 level, some indicators will not be available. These are for example: persistence of low income (3), regional cohesion (5), self defined health status by income level (10), and persistence of low income (below 50% of median income) (15) - (Table 4.6).

The relevance and appropriateness of EU Indicators of Social Exclusion to the Slovenian national policy debates can be seen from the fact that these indicators have already been included in the draft report on the ”Implementation of the strategy of social inclusion with the report on implementation of the programme on the fight against poverty and social exclusion” (MoLFSA, 2002). The attitudes towards these indicators are positive by both the government and experts engaged in poverty research. There have been no objections on EU indicators in the public debate. On the contrary, these indicators are much more appropriate for the European countries than those by the UNDP or the World Bank because of the development level of these countries.

Most of EU indicators have already been calculated, evaluated and accepted in Slovenia, so people engaged in the analysis of poverty and social exclusion are familiar with them. This proves that they are considered relevant for Slovenia.

4.2 Evaluation of Policy Challenges and Policy Responses

4.2.1 Inclusive Labour Markets

The analyses of poverty in Slovenia were not focused on poor quality employment as a cause of poverty or non-active population in general, but rather on the unemployed.[18] Since the former two particular factors/characteristics were not investigated in detail as potential poverty generators, only some estimates can be provided in this respect. A low educational level may be used as a proxy for poor quality employment. Poverty rate among households with an employed head, who had completed elementary school at the utmost, was 17.7%.

The analysis done by the Statistical Office of Slovenia (SORS, 2001a), applying the poverty line at 50% of average equivalent expenditure, has shown that in 1998 the poverty rate was highest among households where nobody was working (23.3% as compared to the average of 11.9%). The above average rates were found among households where neither the head no his/her partner were employed (but at least one other household member was), too.

In 1998, 24.0% of households headed by men had no employed member, while the percentage was 36.4% for households headed by women. The poverty rate for households headed by men was 7.7% if a working member was present in the household and 20.8% if there was no working member. 6.5% of households headed by women were poor if there was a working member and 25.2% were poor in the absence of any working member.

Based on Stropnik and Stanovnik (2002), the share of unemployed persons in the horizontal structure of all household members in Slovenia is presented in Table 4.7, by income deciles and total. It is very well evident that the share of unemployed persons is decreasing from the bottom to the top income decile.

[18] General trends in unemployment in Slovenia are presented in more detail in Chapter 1 (1.1.3, and Tables 14-17 in Appendix 1), where also age, gender and educational level of the unemployed as well as duration of unemployment are analysed. Summarising the current situation we can state that about half of the registered unemployed are older than 40 years (a quarter is older than 50 years). Almost half of the unemployed have the primary education (8 years of schooling) at the utmost; among this group, some 60% are long-term unemployed. The average duration of unemployment has been increasing. The lower the educational level the longer period of unemployment.

From 1993 to 1998, the share of the unemployed in the lowest income decile increased from 11% to 22% of all household members in this decile. In the observed time period, households in eight income deciles experienced a rise in the share of unemployed members, with the biggest changes having occurred in the lowest income deciles. 50% of all unemployed were situated in the first two income deciles. This can be explained by the expiration of entitlement to unemployment compensation and a consequent shift towards the lower rate benefits: unemployment assistance and social assistance.

If poverty line is set at 50% of median household equivalent income, 35.5% of the unemployed lived in poverty in 1998 (Table 4.8). The poverty rate for the unemployed was 4.4 times higher than the average one compared to all persons.

Households with unemployed members had lower but still very high risk of poverty (the highest among selected household types) in comparison to other households (Table 4.10). Households with unemployed member were over-represented in lower income deciles. Almost half of them were situated in the bottom two income deciles in 1998. In 1998, 18% of all households had an unemployed member. An unemployed member was present in 46.1% of all households in the bottom decile (Table 4.9).

What needs an explanation is the large difference between poverty rates for the unemployed and for households in which they lived; the former ones were considerably higher. Also to be noted are the differences in the shares of unemployed among all household members and the shares of households with an unemployed member among all households (Tables 4.7 and 4.9). Unemployed persons accounted for 21.8% of all persons in the bottom income decile in 1998, while households with an unemployed member accounted for 46.1% of all households in the bottom decile. As for now, we can state that one of the reasons for this considerably high difference in poverty rates may be the fact that households with more than one unemployed member are mostly (or almost exclusively) located in the bottom two income deciles. Namely, since it is common in Slovenia that both partners are employed, the unfavourable economic of a family is even more stressed in the case of two (or more) persons in a household being unemployed. Different from this, unemployed persons may live with persons declaring income, so it is not that much probable that they will be situated at the bottom of income distribution. For instance, this is the case of young people sharing households with their employed or retired parents.

Had there been no social benefits (pensions are not included in social benefits), poverty rate (at 50% of median equivalent household income) would have been by 14.8 percentage points higher in 1993 and by 12.5 percentage points higher in 1998. Due to unemployment benefits, child benefits, social

assistance, educational grants and health insurance related cash benefits, this was not the case and the poverty rate was lower.

Low-income households with an unemployed member received considerable income through unemployment benefits. However, in 1998 they received less benefits in average compared to the year 1993: Less people were entitled and they received lower benefits for a shorter period of time. In 1998, unemployment benefits were received by 8.3% of all households and they accounted for 8.5% of the total income of households with an unemployed member.

A high increase in the number of unemployed in the early 1990s - along with a decreasing number of those paying contributions and a decrease in the contribution rates in order to enhance the competitiveness of the Slovenian economy[19] - caused a situation in which it was no longer possible to maintain high benefit levels for a long entitlement period. The ILO Convention No. 168, the EU recommendations and research findings concerning the behaviour of the unemployed also called for changes in legislation. In October 1998, important changes and amendments to the Law on Employment and Unemployment Insurance were adopted. Following the ILO Convention No. 168, active employment measures were given priority over the passive ones. Older and long-term unemployed were granted a higher degree of protection due to their low employability, while for others the conditions have become much more severe. One-off payments of unemployment cash assistance were abolished. Efficient supervision over fulfilment of obligations by the unemployed persons was introduced. At the same time they were offered more help in finding a new job, including education and re-training.

The amendments to the law introduced changes in the definition of an unemployed person. Only those capable of work are now counted as unemployed. These individuals may not be retired, students or pupils, and they must be registered at the Employment Office within 30 days of termination of employment contract, available for employment and actively seeking employment. The unemployment must be involuntary and not a fault of an unemployed person, except if he/she left his/her job due to non-payment by an employer.

Stricter conditions were introduced for both attaining and keeping the entitlement to benefits. To be eligible to benefits, a person must have been employed for at least 12 months in the last 18 months prior to the termination of

[19] In 1993, both employers and employees had been paying 2.35% of the gross wages for unemployment insurance, while in 1998 the employers were paying 0.06% and employees 0.14% of gross wages.

employment. Prior to the change, only 9 months of uninterrupted employment were necessary.

Both the number of unemployed and unemployment rate have been decreasing in recent years due to increased involvement of the unemployed in job search, changed status of persons included in public works, better supervision over fulfilling the conditions for the status of an unemployed person, and measures of the active employment policy.

Educational and training programmes for the unemployed have been performed since 1990 in the framework of active employment policy. Unemployed persons below age of 26 have priority in joining these programmes. In 1998, 50% of these persons were included in the continuing functional training, education, on-the-job training and off-the-job training. In 2000, some 23,400 unemployed persons - half of them below the age of 26, one-third long-term unemployed and 60% women – were included in the programmes of education and training in 2000, and some 18,900 persons in 2001.

In order to stimulate the creation of new jobs, the government has undertaken new programmes such as co-financing of new workplaces, promotion of entrepreneurship and self-employment, and investments in the development of human resources. Other programmes include subsidizing the labour force in companies employing disabled persons, programmes of awareness-raising and offering assistance to unemployed people in planning their professional careers, psychosocial rehabilitation programmes for long-term unemployed persons, etc. In addition, a programme for the preservation of workplaces has been introduced.

Programmes for encouraging self-employment were successful as well. Some 12,000 persons took part in them in 2000 and 2001, resulting in self-employment of 3,000 unemployed persons.

Active employment policy programmes in Slovenia can be classified according to the four-pillar structure of the European Employment Strategy: 1) improving employability, 2) developing entrepreneurship, 3) encouraging adaptability in business and their employees, and 4) strengthening policies for equal opportunities. The statistics related to the success of programmes and measures that are primarily aimed at (re)inclusion into employment is presented in Table 4.11. Temporary employment has been prevailing (some 80%). Numbers in Table 4.11 do not include persons engaged in public works although they get an employment contract. Some 10,500 unemployed were included in public works in 2000, with a 25% exit into employment. Also not included are those persons who received financial support at the start of their

self-employment (e.g. in 2000, some 10% of persons who successfully completed educational and training programmes). It should be taken into account that also the programmes aimed at social reintegration, personal development, stimulating further professional development, etc. have a positive impact on employability and entering the employment. However, no statistics on them is available.

Refunding of contributions is made to employers who take on unemployed persons from the following target groups: long-term unemployed, unemployed people over 50, recipients of unemployment benefit or assistance and first-job seekers who have been unemployed for more than 6 months. Employment in this programme lasts up to three years with the amount of subsidy being gradually decreased and it is also linked to the unemployment rate in the local labour market. Under this scheme, which started in 1998, 20,070 persons were employed in September 2001 (which was equal to one-fifth of all registered unemployed).

A number of programmes for the training and preparation of the disabled for employment have been developed in Slovenia in the second half of the 1990s. They are intended particularly for those categories of persons who have been handicapped from birth (MoLFSA, 2000).

Functional illiteracy and lack of qualifications make the employment and social integration of the Roma difficult. In Slovenia, the Roma may be included in specific programmes of preparation for employment.

In order to improve employability of young people, the government intends to organise educational programmes of initial vocational training in cooperation with the social partners. More emphasis will be put on encouraging employers to invest more in different types of training in and for companies, particularly as regards workers employed in enterprises undergoing restructuring in order to increase occupational mobility (Government of Slovenia and European Commission, 2000).

The delivery system and capacities of adult training will be improved in terms of content, methods, forms and structures. The retraining facilities will be more evenly spread over the country.

Public works are planned to increase to 1% of the total working population; participants will be employed 6 hours per day in order to enable their obligatory involvement in training programmes and job-search activities, with the aim to increase their employability and competitiveness on the labour market.

Expenditure on active programmes is planned to increase to 1% of GDP by 2006 (it was 0.4% in 1998).

The Employment Service of Slovenia (ESS) was reorganised and restructured in the second half of the 1990s, and the number of staff has doubled. Nevertheless there is still a great need to improve its technical and professional capabilities for more efficient operation (Government of Slovenia and European Commission, 2000). The ESS has been developing individual action plans (back-to-work plans) as well as effective control and monitoring system to prevent any abuses among the unemployed, sub-contractor organisations executing various employment measures and employers participating in job-subsidy and training schemes for unemployed and redundant workers.

Following the 1999 ”Strategic Aims for the Development of the Labour Market until 2006, Employment Policy and Programmes for its Implementation”, in November 2001 the ”National Programme of the Development of Labour Market and Unemployment until 2006” was adopted by the Parliament. Its strategic aims are:

I. an increase in educational level of active population,

II. decrease in structural imbalances in the labour market,

III. inclusion into active programmes of all young unemployed who do not find a job within 6 months, and of all other unemployed who do not find a job within 12 months,

IV. a decrease in regional imbalances in the labour market,

V. increase in employment,

VI. further development of social partnership in solving the problem of unemployment and increasing employment (MoLFSA, 2002).

A number of other acts were adopted as well, which are related to the implementation of active employment policy.

4.2.2 Guaranteeing Adequate Incomes/Resources

Regarding the guarantee of adequate resources through the tax and social protection systems, the following could be stated:

In Slovenia, marginal income tax rates range from 17 to 50 per cent (there are altogether six income tax brackets[20]). Basic tax allowance is equal to 11 per cent of the average wage of all the employed in Slovenia (henceforth: average

[20] Marginal tax rates are 17, 35, 37, 40, 45 and 50 per cent.

wage) in the year for which taxes are to be paid. Income tax in Slovenia incorporates some elements that prevent poverty. For instance,

I. a presence of dependent members in a family is taken into account;

II. only pensioners with high pensions, or pensioners with other sources of income have to file their tax return and pay income tax;

III. a quite considerable amount of student income is tax exempt (equivalent of 40% of a gross average national wage). Considering the standard tax allowance (11% of gross average national wage) this in effect means that students whose income is less than 51% of gross average national wage do not even have to file a tax return.

With regard to the tax burden, measured as the effective tax rate (personal income tax and social security contributions as percentage of gross wages), the tax burden of low-income persons is low in Slovenia and comparable to that of other European countries.

At present, a new personal income tax law is in preparation. It will raise the tax relief for children and also, quite conceivably, raise the value of the basic tax relief for all taxable persons.

As the draft new law on the personal income law was delayed, the parliament passed a law on additional tax relief in 2000, which further reduced the tax burden of the very low-paid workers, i.e. those that earn less than 45% of the average wage.

In 1992, the Social Assistance and Services Act was adopted, preserving the principles of the former law but decreasing the income threshold (minimum income level) by about 16%, reducing so the number of eligible persons. In the period from 1993 to mid-2001, the guaranteed minimum income (social assistance) in Slovenia was very low. Its level was the result of a political decision, and not based on any assessment of a basket of commodities necessary for subsistence. Research has shown that the minimum income was only sufficient to cover the costs of a rather poor nutrition, with nothing remaining to meet other basic needs. This meant that social assistance beneficiaries were not really pulled out of absolute poverty. If the proper poverty threshold had been taken into account, both the level of social assistance and the number of beneficiaries would have been higher. Another problem was in the benefit linkage to the guaranteed wage, which was not suitably indexed. It is true that the average number of beneficiaries more than doubled from 1993 to the late

1990s, but this was primarily due to a new and rapidly increasing group of entitled persons: the unemployed.[21]

The Social Assistance and Services Act was amended in April 2001. The new benefit levels have been gradually implemented from September 2001 to January 2003. Social assistance is no longer linked to the guaranteed wage, and the minimum income is set at a more appropriate level (e.g. it is now 26% higher for a single person or for the first adult in a household). Minimum income for a two-parent family with two children currently amounts to 59% of the average wage net of contributions and taxes, and for a single parent family with two children it is equal to 48% of the net average wage in Slovenia. If the rent subsidy and child benefit are taken into account as well, the sum of the three social transfers to a two-parent family amounts to 92% of the net average wage, while the one for a single parent family amounts to 80% of the net average wage.

There is no evidence of non-take-up of social assistance by individual population groups that might be in need of it. The number of beneficiaries increased in the period 1995-2001 from some 26,000 beneficiaries in 1995 to some 35,000 beneficiaries in 2001 (Table 4.1).[22] Among them, there are slightly more women then men (49%:51% in 1998; 50%:4% in December 2000).[23]

The number of persons receiving unemployment compensation (which is earnings-related) and unemployment assistance (which is income dependent) – 62,634 in 1995 and around 25,774 in 2001 - was lower than the number of the registered unemployed (129,087 and 101,857, respectively) – (see Table 4.13).[24] This was mostly due to the fact that: a) some unemployed did not meet benefit qualifying conditions (the unemployed youth, for instance) or had exhausted their benefit entitlements (the long-term unemployed, for instance), and b) the total period of the entitlement to unemployment benefits was shortened significantly in 1998. Some of the unemployed were beneficiaries of social assistance if they lived in families with no income or income below the threshold for entitlement; the unemployed accounted for about two-thirds of the social assistance claimants.

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[21] Having exhausted their insurance-based unemployment benefits (unemployment compensation and unemployment assistance), the long-term unemployed turned to centres for social work for assistance. In the late 1990s, about 70% of beneficiaries were unemployed. Among them were also first-time job seekers. Since parents are not obliged to provide for their adult children, these may apply for social assistance regardless of their parents' economic position.

[22] In Table 4.12, the structure of social assistance beneficiaries according to their social status is presented.

[23] This information is not available for 4% of beneficiaries.

[24] For more detail on unemployment benefits see Chapter 2.3.9.

The share of all beneficiaries among the registered unemployed has been decreasing since 1999 (see Table 4.14). In 2001, it was 25.5% as compared to 230.3% in 1995. The share of unemployment compensation claimants among all beneficiaries of unemployment benefits has increased considerably, from 68.0% in 1995 to 83.5% in 2001, meaning that the average amount of unemployment benefit was higher in 2001 than in 1995. The share of unemployment assistance beneficiaries among the registered unemployed was decreasing till 1999; then, the trend has reversed because the entitlement period was extended from 6 to 15 months in October 1998.

Unlike most other Central and East European countries in transition, pensions in Slovenia have remained a remarkably stable source of income during the 1990s. This can clearly be observed from Table 4.15, which shows fairly small oscillations in the replacement rate.

According to the 1999 Pension and Disability Insurance Act, a national pension is granted, on completion of 65 years of age to persons who have not completed the minimum insurance period required for entitlement to any other pension and who fulfil other eligibility conditions (for instance, residing in Slovenia for at least 30 years between the ages of 15 and 65, income below 35% of the minimum pension for the full pension qualifying period, etc.). Eligibility is individual and not related to the family financial situation. First national pensions were paid in March 2000. By the end of 2000 the number of beneficiaries was as low as 88, and amounted to 9,486 in October 2001. The benefit level is set at 33.3% of the minimum pension rating base. Starting from September 2001 it amounts to 28,394.40 SIT.

Slovenia is one of the few countries in Europe where there is no time limit for sickness leave. Sickness benefit amounts to a high percentage of the beneficiary's average monthly wage (80%-100%). Sickness benefit may not be less than the guaranteed wage or higher than the wage, which the person would receive if he/she were working (that is, the basis for his/her health insurance contribution payment during his/her absence from work).

To conclude, no serious gaps in coverage by social transfers guaranteeing adequate income/resources in the broad sense can be identified. If the take-up ratio is not 100%, it is mostly the result of a choice of potential beneficiaries. This is true for social assistance, transfers to the unemployed, health care, and old-age social security that are described above and in other chapters in more detail, but also for transfers to the disabled and war veterans. There are, of course, certain conditions for entitlement, but they cannot be evaluated as too strict, particularly not those requiring from the beneficiary his/her active co-operation in solving his/her unfavourable situation.

Social benefits (other than pensions) were a more important income source in 1998 than in 1993 for households across the income spectrum, and particularly for those in the bottom decile (see Table 4.16). *Social assistance* represented a notable share of household income only in the bottom income decile (4.4% in 1993 and 4% in 1998). Although rather low, *unemployment benefits* were still relatively important for people in the lowest income decile, where their share in the total household income was higher in 1998 than in 1993.[25] The same applies to *child benefits,* but we note that between 1993 and 1999, child benefits went through important changes in both the entitlement rules and their level.[26] *Health insurance related cash benefits* (which comprise the sickness benefit, maternity/parental leave wage compensation, birth grant, etc.) increased, for which no logical explanation could be found in data on sickness leave and maternity/parental leave. A detailed inquiry has shown that the reason for the change was of a purely administrative nature.[27]

The distribution of social benefits across income deciles is presented in Table 4.17. The shares of *unemployment benefits* have increased at the bottom of the income distribution. Obviously, more unemployed had very low income in 1998 than in 1993. In 1998, *social assistance* was better targeted than in 1993 – that is, much more concentrated in the low income deciles. Profound changes in the eligibility to *child benefits* were very well reflected in the distribution of this benefit across income deciles. In 1993, the child benefit was just a kind of basic social protection (social assistance), evident from a steep decrease in the share of this benefit from the bottom to the sixth income decile in 1993. In 1998, the child benefit was less a social assistance disbursement and more a family policy benefit. It was allocated to the great majority of children, though it was still income dependent. Its distribution was more even than in 1993, due to a high income ceiling for entitlement.

The importance of individual income sources for the recipient households is presented in Table 4.18 in Appendix 4. Had there been no *pensions*, the recipient households situated in the three lowest income deciles would have been the biggest losers. The importance of *unemployment benefits* remained almost the same – i.e. relatively high. This reflects the fact that the shorter

[25] Note that unemployment compensation is not income-tested, while unemployment assistance is targeted at unemployed persons with low income and who have previously received unemployment compensation.

[26] In the HES, child benefits include the childcare supplement as well.

[27] Namely, maternity/parental leave wage compensation was allocated among income from employment in 1993. This was the last year when such wage compensation was paid by employers, who then requested a refund from the National Health Insurance Institute. Following the enactment of the Family Benefits Act and starting from 1994, this wage compensation has been paid by the centres for social work. It was not possible to correct the 1993 Household Expenditure Survey in this respect.

duration of the entitlement was compensated for by a higher share of recipients of unemployment compensation, as compared to unemployment assistance. The importance of social assistance for the recipient households remained about the same over the period, too – neither on average nor in the three lowest income deciles. A decrease in the importance of child benefits was registered in all income deciles, which can only be explained by a relative increase in the importance of some other income sources, which were much higher than the child benefit in absolute terms as well.

4.2.3 Combating Education Disadvantage

Generally speaking, important improvements in the enrolment of the population of Slovenia in education and their educational attainment were achieved in the last decades. This placed Slovenia closer to the average of the EU as far as indicators of educational capital are concerned. In 2000, the percentage of the population aged 25 years and over with more than 8 years of schooling was more than 60%.[28] Slovenia still lags significantly behind most EU and OECD countries in the share of population with at least upper secondary education - this is however not true for young generations – and the share of those with tertiary education (13% of population aged 25 years and more in 1999). According to 1991 population census, the average years of schooling amounted to 9.6 years; in 2000 they were estimated to be equal to 10.1 years (Bevc, 2002).

According to the net enrolment ratios in formal education for the age group 7-19, achievements of pupils completing lower secondary education in mathematics and natural science, and the foreign language skills, Slovenia ranks higher than many developed countries (Bevc, 2002).

On the other hand, the enrolment of adults (aged 30 and over) in education is not satisfactory. Slovenia's drawbacks were also identified in the average level of functional literacy of adults. According to the 1998 survey, Slovenia ranked low by average score in all three types of functional literacy observed: prose, document and quantitative. The percentage of population with at least third level of literacy skills, which is considered as a suitable minimum skill level for coping with the demands of modern life and work, was 23% for prose literacy, 27% for document literacy and 35% for quantitative literacy. Particularly alarming is the fact that low scores were achieved by persons in the age group 16-25 as well, while in other countries this age group proved the highest literacy proficiency.

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[28] Eight years of schooling means completed primary education (i.e., according to ISCED, completed primary education and lower secondary education).

Slovenia is among the countries with highest influence of a person's and his/her parents' educational attainment on a person's literacy proficiency (Bevc, 2002). Intergenerational transfer of poverty may be one of the possible consequences. Namely, the economic benefits of education, as measured by earnings differentials between different educational categories of employees, are rather high and have been increasing since the early 1990s; they are high in comparison with other countries as well (Bevc, 2002). The unemployment rate is also strongly linked to educational attainment; it is lowest for those with attained tertiary education.

The legislation in the field of education (from the pre-school to the secondary level), adopted in 1996, enables wider enrolment of children with disabilities in appropriate educational programmes within regular forms of schooling. This applies to the cases where such children are – considering their psycho-physical status and with additional assistance – capable of absorbing at least the minimum standard of knowledge as defined by the individual programme. The legislation lists methods and models of education of children with disabilities at various levels of education.

There are school counselling services at all levels of education from pre-school to secondary school. The counselling service is involved in search for and provision of adequate support and assistance to families where, due to social and economic distress – the child's physical, personal and social development as well as educational attainments are at risk. The school counselling service shares its work with teachers, school management, parents and corresponding external institutions such as centres for social work.

Vocational guidance has been performed in Slovenia for a long time in primary and secondary schools, and namely by the school counselling services (full-time specialized counsellors that account for some 2% of all teachers in primary and secondary schools) and vocational advisors of the national Employment Office. Their aim is to enhance – by way of expert advice, study visits, etc. - the effectiveness of young people's search for further educational programmes and occupational career before starting secondary education and when completing it.

Analysing the 1993 Household Expenditure Survey data, Stanovnik (1995) has found out that the average income of an adult (25-64 years of age) with more than 12 years of schooling was double that of an adult with up to 4 years of schooling. While the average years of schooling per adult amounted to 10.2 years, they were only 7.7 years in the bottom income decile increasing continuously up to 12.7 yeas in the top income decile (the difference of the whole of 5 years!). This clearly shows that more years of schooling imply higher income.

With higher level of education, the poverty rate decreases in Slovenia. If the poverty line is set at 50% of average equivalent expenditure, 25.3% of households, where the head has completed elementary schooling at the utmost, were poor in 1998 as compared to the average poverty rate of 11.9% (SORS, 2001a). Poverty rate was only 1.6% among households where the head had high or higher education. Poverty rate among households where the head had completed vocational education was slightly above the average (13.1%). Absence of education is one of the reasons for social exclusion of the Roma (also because it is a frequent cause of their unemployment).

Low educational attainment has low employability as a consequence. The unemployment rate among persons with no formal education or incomplete primary and low secondary education (i.e. with less than 8 years of schooling) was 15.4%, while it was 8.5% among those with completed lower secondary education (i.e. 8 years of schooling). It should be also noted here that persons with attained lower secondary education at the utmost, account for about half of the unemployed. About a half of social assistance recipients have only primary education or less (55% in December 1998 and 48% in December 2000). The correlation between the degree of education and entitlement to social assistance is as high as –0.83 (MoLFSA, 2000).

According to the 2000 Labour Force Survey, persons in employment have on average 11.4 years of schooling while the unemployed have 10.4 years of schooling. Among the population aged 40 years and more, the average years of schooling are 11.1 and 9.6, respectively.

In the school year 1999/2000, 90.8% of preschool children over age one were included in programmes lasting 6-9 hours per day (SORS, 2000b). the share of children aged 1-2 attending programmes in day-care centres was 26.4%, while it was 70.2% for those aged 3-6. The share of children – in particular those aged 4-5 - not attending any pre-school educational programme is relatively high. There are 21 children included in day-care centres per 100 employed women.[29]

Parents may include their pre-school children in any pubic or private day-care centre, in any Slovenian local community. The existing childcare facilities (most of them being public day-care centres) almost fully meet the demand for pre-school childcare. 1.9% of children whose parents applied for a place in the day-care centre were rejected in the school year 1999/2000.[30]

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[29] In the recent years, the activity rate of women aged 20-44 has been about 85%.

[30] It does not mean that those children were not placed in any day-care centre; they just could not be included into a particular centre which first received their application. It may also well happen that the same child is counted as having been rejected several times if his/her parents have repeatedly applied in day-care centres with no vacancies.

Childcare services in Slovenia are not only available but also affordable due to high subsidies from public sources. In the last several years, public resources set aside for subsidising childcare have amounted to approximately 0.7% of the GDP. The average subsidy amounts to some 65%-70% of the costs per child. All approved programmes of public and private day-care centres/providers are entitled to a subsidy. A subsidy depends on the income per family member as compared to the average salary. If more than one child from a family attend the subsidised childcare programme, the fee for older children is decreased by one income group. Families on social assistance and those with income per family member below 25% of the average salary are exempt from paying fees altogether (in this group there were 4.2% of all children attending organised childcare in 2000). The pre-school educational programme in the year before the start of schooling is free of charge for all children.

Slovenia is now in the process of gradually extending compulsory education from eight to nine years. This means that, according to ISCED (International Standard Classification of Education), compulsory education in Slovenia consists of four/five years of primary education and four years of lower secondary education.

During the eight years of compulsory education, Slovenian pupils have lower number of minimum hours taught time then the average ones in the EU countries and the candidate countries (583 hours around age 7 and 662 hours around age 10). On average, one foreign language is studied (in higher grades of primary education and in lower secondary education). There are final exams at the end of compulsory education.

In the 1999 international study that evaluated knowledge of pupils in the last grade of compulsory education, Slovenia ranked high, but lower than in the mid 1990s. Among pupils from 38 countries, the Slovenians ranked 11th in mathematics (10th in 1995) and 13th in natural science achievements (7th in 1995) (Bevc, 2002). In the 1995 study, the Slovenian students scored very low in problem-solving and creativity, which are the skills that increase competitiveness and entrepreneurship. Obviously, high mathematics and natural science achievements are not successfully applied in practice. The 1999 study has shown a worsened attitude towards mathematics and natural science, lower hours of independent work and higher hours of work under supervision as compared to other countries. The majority of pupils were taught by teachers convinced that their work was not appropriately valued by the society (this indirectly influenced the pupils' performance). The achievements of Slovenian pupils were influenced by family factors (number of books at home, learning equipment at home, parents' educational attainment) rather than the factors associated with school.

The drop-out has decreased from 9.2% of generations of primary and lower secondary school pupils in the school year 1995/1996 to 4.4% in the school year 2000/2001 (MoLFSA, 2002).[31]

Various forms of education (branched educational system) and a multifaceted model of individualisation and differentiation were introduced with the aim to provide an opportunity for the education of children with disparate needs, capacities and demands. The ministry responsible for education devotes additional fund for work with gifted pupils and for those with learning difficulties. It is important to note that the diversity and variety of educational forms do not preclude the vertical and horizontal mobility.

The 10th year of primary education is being introduced for pupils who are not successful at final exams and those who want to improve their attainment.

Following the compulsory education (at age 14-15), the net enrolment ratio in formal education exceeds 90% till age 17. For age groups between 15 and 29 years, net enrolment ratios are higher in Slovenia than in the EU on average or in the OECD countries (Bevc, 2002).

The availability of upper secondary school programmes has been increasing. Minimum number of taught time (912 hours) is higher compared to that in the EU countries (866 hours) and the candidate countries (857 hours); the data refer to school year 1997-98. The average of two foreign languages is studied.

The quality of programmes has been improving. There are external exams art the end of upper secondary education. The vocational final exam was introduced as well , which widens the opportunities for further education. New guidelines for programmes of vocational and professional secondary education were adopted (open curricula, modular educational programmes). Several inter-enterprise educational centres were established, which is one of the indispensable preconditions for the quality dual system of secondary education.

High drop-out rates remain one of the main problems in the upper secondary education. The drop-out is the highest in lower and middle vocational education, and the lowest in grammar schools (MoLFSA, 2002). The national Employment Office co-operates with schools in helping those children who quit the school during school year to choose the most appropriate educational programme or get a job. Half of drop-outs react to the invitation by the national Employment Office, and the outcome is mostly positive. The drop-out decreased from 15.6%, on average, for the generation 1989-1994 (16.7% for boys and 14.5% for girls) to 13.0% (15.0% for boys and 10.8% for girls) for the

[31] These are children who either do not complete primary school or do not continue with their education.

generation 1993-1998. By type of school, it increased from 22.1% to 31.9% for lower vocational education, and decreased from 20.3% to 16.6% for middle vocational education, from 13.3% to 11.9% for middle professional and technical education, and from 11.3% to 6.5% for general middle education (gymnasiums).

In the last twenty years the number of students in tertiary education has increased by 83% while the number of bachelor's diplomas has increased by 64%, and the number of master's and doctor's degrees by 388%. The net rate of enrolment of the age group 19-23 in tertiary education has been increasing and amounted to 36% in 1999. The gross enrolment ratio amounted to 55% (Bevc, 2002).

Within tertiary education, institutional and programme diversification was increased in the last years. The total number of students in tertiary education has been increasing very quickly since the second half of the 1990s; this is particularly true for the share of part-time students. In many fields of study, access to full-time study is limited; the criteria for enrolment are the success of upper secondary education and/or preliminary exams organised by high schools and faculties. Due to that, part-time enrolment has been increasing. The former is free of charge, while full cost tuition fee has to be paid in the latter.

The studies have shown unequal access of different social groups to tertiary education. A correlation between enrolment in tertiary education, and the parents' educational attainments and a family economic situation was proven.

A considerable increase in the number of students in tertiary education will result in an improved educational attainment of adults only if the wastage in the system (drop-out and repetition rate) decreases. Research has shown that only half of students who started tertiary education in the school year 1991-92 have completed their studies in the period of eight years (Bevc, 2002).

In order to better adapt vocational education and training (VET) to the labour market needs, a modern education and training policy framework has been established aligning VET in Slovenia with mainstream developments in Europe. The emphasis of the reform is on practical training in VET programmes (dual system), participation of business in the decision-making process, greater responsibilities for employers in VET programmes as well as provision of financial support by the social partners and the introduction of various possibilities for acquiring occupational qualifications (nevertheless, problems often arise over financial responsibilities). VET issues were given priority and ministries are highly committed to reforms (Government of Slovenia and European Commission, 2000). In 2000, 28,298 unemployed persons participated in education and training programmes: 59% of them were women,

49% of them were under 26 years old, 31% were first-job seekers and 34% were long-term unemployed.

The participation rate of age group 16-65 in continuing education and training (other than full-time studies) amounted to 32% in 1998, which was quite low. The average duration of all types of continuing education and training per adult amounted to 67 hours (Bevc, 2002).

A survey conducted in 1999 showed that only 48% of the Slovenian enterprises were providing continuing vocational training to their employees; the percentage was increasing with the enterprise size. The participation rate was 46% and the average duration of courses per participant was 24 hours.

4.2.4 Family Solidarity and Protection of Children

Following a considerable decrease in the number of marriages and the total marriage rate, the number of divorces has also fallen in Slovenia. The total divorce rate (0.14 in 1995 and 0.21 in 2000) is relatively low and has been fairly constant over the last thirty years with an increase registered since 1996. The numbers would clearly be higher if official statistics included dissolutions of consensual units. The crude divorce rate (divorces per 1000 population) in Slovenia was 1.1 in 2000, which was one among the lowest rates in Europe. Slovenia is also the country with the highest median duration of marriage (14 years) - (Council of Europe, 2001). For more information see Table 1.26 in Chapter 1.

Due to high employment rate of women as well as available and affordable childcare, family breakdown does not mean that a single parent remains without any regular income. Also, social assistance, child benefits and other family policy measures usually prevent poverty in such families. Indications given by absolute and relative poverty measures somewhat differ

In 2000, the alimony fund was established. In the case of one of the parents not fulfilling his/her obligation to pay alimony for a child below age 15 (or 18, if not employed and living in a family with income per family member not exceeding 55% of the average wage in Slovenia in the previous year), the child is entitled to the compensation of alimony from the public alimony fund. The amount of alimony compensation is then refunded from the parent who is obliged to pay. So far, the experience is positive. Some 10% of parents regularly pay to the fund while quite a number of parents reached an agreement on the regular payment of alimony.

The compensation amounts to 11,431 SIT for a child below age 6, 12,574 SIT for a child aged 6-14, and 14,860 SIT for a child over 14 year of age. In 2000,

the number of beneficiaries was 2,018, and in 2001 it was 2,323, most of them living in most socially deprived families. Some half of all beneficiaries come from families with income per family member below 25% of the average income in Slovenia, which proves how very much important is the regular receiving of the alimony for them.

The fact that single parents (both those divorced and those never married) are not particularly hit by absolute poverty is proven by the data on the social assistance beneficiaries. These data indicate which population groups cannot provide for themselves. Single parent families account for 16% of all beneficiaries while the share of two-parent families is some 13%; the rest are single persons.

Nevertheless, according to the relative poverty measures, in 1993 and in 1998, families with three or more children below age 16 and single parent families were identified by the Statistical Office as the ones at high risk of poverty (poverty line was set at 50% of the average equivalent expenditure, as it was previously defined by Eurostat). Average poverty rate was 11.9%, while it was 13.7% for couples with three or more children below 16 years of age, and 15.2% for single parents with children (for single parents with children below 16 years of age it was 8.2%) – (SORS, 2001a). It should be noted here that not only single parent families but two-parent families, too, had the above average risk of poverty, and that the difference between the two poverty rates was not great. Also, relative poverty measures reflect income distribution within a country rather than a sufficiency of means for covering basic needs.

The main findings by Stropnik and Stanovnik (2002) concerning poverty among children in Slovenia in the period 1993-1999 are the following (see Table 4.19):

- poverty incidence among children has remained higher than that for all persons,
- it has somewhat increased in this period,
- the difference between poverty rates for children up to age of 18 and all persons has also slightly increased.

Increased poverty rates in 1998, as compared to 1993, are the common characteristics for children up to age 18 and the households in which they live (Table 4.4). Poverty incidence was however lower among these households than the average one for all households in both 1993 and 1998. If poverty line is set at 50% of median household equivalent income, 9.4% of children up to age 18 lived in poverty in 1998 as compared to 7.4% in 1993 (standard OECD equivalence scale was applied).

Regarding the policies that (also) combat poverty and social exclusion of children and families in Slovenia, the following could be stated:

- Social assistance is described under 4.2.2.
- There are also family policy measures aimed at raising the level of living of families with children. A detailed description of benefits and their impact is provided in Chapter 2.
- Information on subsidized childcare is given in Chapter 4.2.3.

4.2.5 Accommodation

Based on the poverty line set at the level of 50% of average equivalent expenditure, the tenants in non-profit housing had the highest risk of poverty in 1998; 23.1% of them were poor, compared to the average of 11.9% (SORS, 2001a). Poverty among those who lived in dwellings owned by their parents or other relatives and were not paying any rent (13.6%) was also higher than the average one.

There is a great difference between poor and non-poor households with regard to household and accommodation equipment that are considered to be common. Each fifth poor household does not dispose of a bathroom, and 8% of them do not have a toilet. 47% are without central heating. 7% do not have piped water, and some 17% are not connected to a sewage system.

The rent and other housing-related expenses (water, electricity, gas and other fuel) accounted for some 19% of consumption expenditure of poor households, as compared to some 10% of expenditure of all and non-poor households in Slovenia (SORS, 2001a).

The research of the Roma population proved that in most cases they have an exceptionally inferior accommodation (MoLFSA, 2000). Sanitation in their settlements is also usually poor. However, this is not easy to change, although the effort was made by some local communities in which the Roma live to provide them with decent housing. Apart from the Roma population, there exists no other group or area in Slovenia where substantial problems with potable water, sanitation, basic shelter or other basic subsistence necessities arise.

There are homeless people in Slovenia, in particular in the capital, but their poverty and social exclusion cannot be prevented or alleviated using the same measures as for the rest of the population. Even the number of homeless people is only a rough estimation (some 300 in Ljubljana). An increasing trend is evidenced in the number of homeless people in the capital due to greater possibilities to get some money from people passing by. On the other hand,

there are only 30 beds in the Ljubljana shelter; others have to find other places for an overnight stay (streets, abandoned buildings, etc.).

The homeless are coming from various social classes and they are not exclusively from the low ones. In recent years, there have been also whole families visiting shelters for homeless; the reason for their situation (sudden loss of accommodation) may have been found in non-adequate regulation of a tenant's status. In addition, alcohol addiction is quite frequent among homeless people.

Regarding policies undertaken to combat such aspects of poverty and social exclusion in Slovenia, the following can be stated:

Providing affordable and appropriate housing is a key task of the Agenda Habitat, which is one of international obligations of the 2000 National Housing Programme (Hanžek and Gregorčič, 2001).

Currently, the social assistance beneficiaries renting an apartment are entitled to a rent allowance. It amounts up to the level of the non-profit rent to be paid in social housing, but cannot be higher than 25% of the basic amount of the minimum income. The number of beneficiaries is however very low, some 2,500 in the last years.

The so-called object subsidies, related to the construction and renting of apartments, were implemented in 1999 as well. The public Housing Loans have been disbursed by the National Housing Fund to non-profit housing associations for the construction of non-profit rentals. In the period 1999-2001, some 1,350 non-profit apartments were constructed; still, some 6,000 are needed. The government decree on non-profit rents defines upper limits of these rents.

As far as measures to help homeless people are concerned, there are shelters for them, kitchens that offer them one warm meal a day and organise celebrations of major holidays, one of 36 volunteering medical doctors is available for check-ups and prescription of pharmaceuticals, distribution of clothes and Christmas gift packages is organised, etc.

The National Housing Programme keeps social housing and financial assistance (subsidies, rent allowances) as main instruments of social policy related to housing. The priority in renting social apartments is given to low-income applicants, who are most often families with more children, families with a smaller number of employed, young families, as well as disabled persons and families with disabled members. The same applies to the renting of non-profit apartments and housing loans. In the Programme, the housing problem of the Roma is stressed in particular, as their housing situation aggravates so much

that help is needed in order to prevent or at least alleviate their social exclusion (MoLFSA, 2002).

The 1999 Housing Act improved the financial position of tenants in social housing by decreasing rents, i.e. by implementation of the social rent. In the period 1999-2001, some 550 social dwellings were constructed; the current housing gap is some 7,000 apartments. However, some 6,000 non-profit apartments and 7,000 apartments in social housing are still missing.

4.2.6 Ethnicity

Ethnic minorities in Slovenia that are at risk of poverty are mostly temporary refugees from Bosnia and Herzegovina and Kosovo – the number of which has been decreasing - and the Roma. Some 7000 Roma have been registered in Slovenia. The refugees, who mostly came during the war in the former Yugoslavia, have been provided with shelter, financial assistance, medical care, educational services etc.

The number of primary schools[32] with Bosnian-Herzegovinan curriculum was decreasing in the 1990s because children were increasingly included into Slovenian classes. In 1995/1996, only one last primary school had the Bosnian-Herzegovinan curriculum and none one year later. The number of primary school children from Bosnia-Herzegovina has been decreasing, reaching 475 in 1999/2000 due to emigration from Slovenia. In 1998/1999, 95% of children successfully completed the grade they were attending (MoLFSA, 2002). The number of refugees from Kosovo in the Slovenian primary schools amounted to 233 in May 1999.

The number of all children-refugees who attended secondary school programmes decreased from 886 in 1995/1996 to 176 in 1999/2000. Since 1996/1997, the refugees from Bosnia-Herzegovina who completed primary education may attend secondary schools in Slovenia under the same conditions as Slovenian children.

In 1995, the government of Slovenia adopted the programme of measures intended to provide the Roma with assistance and help in the area of housing, education, employment, social assistance, health care, crime prevention, care of a family, cultural development, information, self-organising, and integration into local governance. It should be noted that they are a specific ethnic group, which does not allow much interference with their way of living. The NGOs provide assistance to the Roma population in the form of food, basic goods for personal hygiene, clothes, shoes, furniture and households appliances. The

[32] Primary schools provide primary and lower secondary educational programmes.

official social assistance and care statistics does not include information on ethnicity.

Information on the housing conditions of the Roma population is scarce as well. Some estimates show that, on average, the housing standard of the Roma is much worse that that of the rest of the population of Slovenia. A relatively high proportion of the Roma live in unplanned settlements that lack even the basic communal infrastructure and thus provide bad and unsuitable living conditions. This is one of the indicators of poverty among them. Expert and financial help is provided in the planning of the Roma settlements, and social and non-profit housing.

Measures have been taken with the aim of broadening the opportunities for education of the Roma children (MoLFSA, 2000). These children are positively discriminated in the pre-school childcare in public day-care centres. They have been provided with special norms and standards for formation of classes By these standards, a Roma class in a primary school should consist of 16 pupils, while a class including at least 3 Roma pupils should consist of 21 pupils. Schools that have Roma pupils are paid additional hours of work with these pupils. The Roma pupils are also included in after-school day care. Some after-school classes are intended for the Roma pupils only, but most of the Roma are integrated into usual after-school day care classes.

A lot of effort has been devoted to the inclusion of the Roma children into primary education in Slovenia - and it was rather successful. This cannot be said for the education of Roma pupils at the secondary level. Higher lunch subsidies are granted to schools with Roma pupils. Textbooks and workbooks are subsidized for the Roma as well. Additional funds are granted for each Roma pupil as assistance to costs of school appliances, transport and entrance fees for cultural, nature and sports events.

Measures aimed at increasing employment opportunities for the Roma are described under 4.2. Special programmes are planned for the Romany ethnic minority within the 4th pillar of the European Employment Strategy (strengthening policies for equal opportunities) (Government of Slovenia and European Commission, 2000). On the other hand, NGOs provide information of prejudices automatically accompanying a Roma person seeking employment. It is much harder for them to get one, and they are also the first ones to be dismissed if such a need occurs regardless of their work effort. Due to that, the Roma may be considered to be the ethnic minority with the lowest chances to get a job and the highest one to loose one, from which we can conclude on their high risk of poverty.[33]

[33] Namely, households with no person in employment are at the highest risk of poverty.

Centres for social work organise activities aimed at integration of the Roma into the life of the community, self-help, preventive programmes, and solving the particular social problems of the Roma population. Preventive programmes are also organised in health care, teaching the Roma about the healthy way of living and solving major health problems of this ethnic group.

4.2.7 Regeneration of Areas

In 1999, the GDP per capita in the least developed statistical region of Slovenia (NE of the country) was 23% lower than the national average; it amounted to 52% of the EU-15 average (IMAD, 2002a). The region with the highest GDP per capita (centrally located in the country) was 34% above the national average (91% of the EU-15 average). The ratio between the least and the most successful regions was 1:1.75 (in 1996 it was 1:1.70). In 2001, regional indices of gross wages per employed, as compared to 100 for Slovenia, were in the range from 85 to 115.

In the western part of Slovenia, registered unemployment rate is considerably lower than the national average; the opposite is true for the eastern part of the country. The highest regional registered unemployment rate in 2000 was at the level of 18.7%, which was 53.5% higher than the average for Slovenia. Three regions with the above average unemployment rate are characterised by old industrial structure; in the past, they were important industrial and mining regions. Their current unfavourable position is, to a great degree, a consequence of a major economic transformation going on for about a decade now. They suffered from insecure political situation in Slovenia and elsewhere, non-competitive old industrial structure with mostly labour-intensive industries and a loss of their former foreign markets. The ratio between the lowest and the highest regional registered unemployment rate was 1:2.7 in 1997 and 1:3 in 2000 (the rates were lower in 2000 than in 1997 in all regions) and its increasing trend is expected in the future (IMAD, 2002a).

Consequently, poverty is not distributed equally among Slovenian regions. The highest share of social assistance beneficiaries is in the north-east of the country (twice the average), while the smallest shares (1%-1.5% of the population) are in the central, western and south-western parts of Slovenia.

Regional differences with regard to poverty are similar to differences in life expectancy across regions of Slovenia. Obviously, poverty affects the health status of the population through poor nutrition (primarily in terms of its quality), worse housing conditions than in other regions, often bad habits such as alcohol abuse, less frequent and delayed medical check-ups, etc. As a consequence, people's lives are 2-3 years shorter on average in the east part compared to the west part of Slovenia. This difference equals the prolongation

of life expectancy in Slovenia in the decade 1981-1991. In general, it can be stated that the eastern part of Slovenia lags behind the western part for about ten years (SORS, 1997).

The dispersion of population and its settlements is high in Slovenia, while jobs are more concentrated in towns. One of the main reasons for regional labour imbalances is the traditionally low labour mobility in Slovenia. This is partly due to a housing problem, including differences in the price of accommodation among regions and relatively high percentage of people who reside in their own dwellings (Government of Slovenia and European Commission, 2000). Labour migrations are usually limited to short distances; they take place mostly between neighbouring municipalities (38.7% of the employed work in municipalities other than those of their residence). The municipality of Ljubljana is the only one that attracts labour force from the whole territory of the region; its gravitational area comprises 30% of the territory of Slovenia and 38% of the total population (Sicherl et al., 2002).

In the 2nd quarter of 2001, 41.4% of all unemployed resided in cities, compared to a 35.5% average for the total population. This was particularly true for men (42.4% as compared to 34.8% of women). Unemployed women were more than proportionally present in cities and suburban settlements (SORS, 2001b).

The Slovenian government realizes the importance of the coherence between employment policy and regional development policy for solving the regional unemployment problems. It has already financially supported the establishment of 26 regional development partnerships, which are regarded as a unique ”infrastructure” for implementation of integrated development policy (Government of Slovenia and European Commission, 2000).

The Government is granting scholarships to young people from regions with a great shortage of highly qualified labour force. It also intends to monitor carefully the development of regional mobility in order to reduce structural imbalances across regions.

In Slovenia, there is no evidence of ghettos with the concentration of poverty, deprivation and associated problems like violence or crime.

4.2.8 Other factors influencing poverty and social exclusion

The population of Slovenia is covered by the obligatory health insurance. This includes also persons who do not have any own income or have income that is too low to be subject to payment of health insurance contributions. In those

cases, the municipalities pay the contribution for their residents. Health care of non-insured persons is paid for from the state budget.

There is wide access to a range of benefits – wide also if compared to those in other European Unions Countries. The rights cover health, non-health related and financial risks in case of illness or injury. No participation in costs of health care is required from children, pupils and students, pregnant women, handicapped persons and those who suffer from chronicle illnesses. Obligatory health insurance covers also the costs of hospitalisation, sickness benefit over 30 days, funeral grant, death grant, and reimbursement of travel costs.

In 2000, the National Programme of Health Care – Health for All until 2004 - was adopted. It includes measures related to fight against poverty and other forms of social exclusion as well. One of the priority aims is a decrease in differences in health care and health status of the population, meaning equal access to health care for everybody. The health care system of Slovenia intends to continue its special care for the health of people living in poverty, those threatened by social exclusion or those at risk (MoLFSA, 2002).

The number of unemployed disabled persons has been increasing. Their share among all unemployed reached 16.4% at the end of 2000. (MoLFSA, 2002). On the other hand, the number of employed disabled persons has increased as well.

Slovenia has adopted a Development Strategy of Protection of Disabled Persons, which forms the basis for relevant legislation and regulation, as well as for dealing with the issue of disability in various other development programmes (e.g. national Housing Programme, National Social Assistance and Services Programme, Disabled Persons Employment Programme, etc.) - (MoLFSA, 2000). In the Development Strategy of Protection of Disabled Persons, one of the main global aims are education and training of children and young persons with some mental and physical disorders, who are potentially disabled persons. The Development Strategy of Protection of Disabled Persons also deals with the fact that 86% of unemployed disabled persons are disabled because of their former job performance.

Some 2,100 disabled persons are included annually in the programmes of professional rehabilitation, education and training, aimed at creating possibilities for their employment and eliminating possible obstacles (architectural adaptations, adaptation of equipment, technology and methods of work).

Employers had some 50 new working places for disabled persons co-financed from public sources in both 2000 and 2001. Firms founded by disabled persons

received partial compensation of costs related to the employment of some 6,000 disabled persons a year.

In the last decade, violence against women became an issue which is discussed in public although, quite often, it still remains hidden behind the walls. Consequently, the treatment of victims both in the legislation and practice has improved. There is an anonymous telephone available to victims to report on their cases and ask for help and advice. There are 6 maternal homes, 5 shelters, 1 crisis centre and 1 similar organization where threatened women are assisted and given shelter. In 2000, 270 women reported some kind of violence in public while 3,040 reported violence at home (Office for Equal Opportunities).

The survey conducted by the Institute for Health Care has shown a considerable increase in drug (grass) abuse among the population aged 15-19 years (upper secondary school students), while the problem of alcohol abuse remains. Due to the latter too many young people dye in traffic and sports. Ever younger persons abuse tobacco, grass and alcohol. In the period 1996-1998, the share of females among the registered drug abusers increased and approached one-quarter. About three-quarters of drug abusers lived with their parents, some 12% with their partners, 8% alone, some 0.5% were homeless, etc. A half of drug abusers were unemployed or performed occasional jobs, while one-fifth was in regular employment (Institute for Health Care). This indicates the interrelationship between unemployment and drug abuse, where the cause may not always be the same.

The consequences of alcohol abuse may be traced in the social, economic and development (personal and social) sphere. The average alcohol consumption amounts to 8.6 litres of pure alcohol per inhabitant or 10.9 litres per person over 15 years of age (Government of Slovenia, 2002). Non-registered alcohol consumption, such as household own production, illegal production, import without duty paid, etc., is not included and may add some 5-8 litres per inhabitant per year (depending on the source of estimation). At the age of 15, some youngsters may already be considered alcoholics; about 15% of them drink alcohol and get drunk regularly (the 1999 survey data). Among the adult population of Slovenia there are about 11% of alcohol abusers whose average age is 42 years, while more than one-fifth of the population consumes more that the safe quantity of alcohol daily. Alcoholics account for more than a third of persons who commit suicide. There is a frequent link between the alcohol consumption and violent behaviour (in a family or in public). Alcohol abuse threatens regular employment and thus regular income as well, thus resulting in poverty.

4.2.9 Administration, Access to and Delivery of Services

In 2000, the Slovenian government adopted the National Programme on the Fight Against Poverty and Social Exclusion. This programme draws recommendations and measures to be taken in future - in order to diminish the extent of social exclusion and to prevent it wherever possible. All interested parties are expected to be involved in concerted actions - from ministries responsible for individual areas and local communities to non-governmental organisations. The report on the implementation of the strategy of social inclusion with the report on implementation of the programme on the fight against poverty and social exclusion was accepted by the government in April 2002.

The cooperation among ministries and institutions that are responsible for alleviating poverty - as planned and introduced in recent years within the National Programme on the Fight against Poverty and Social Exclusion – has been improving, but it still cannot be evaluated as fully satisfactory. There is more staff dealing with the related issues, the targeting has been improving as is the time in which the problems are dealt with and hopefully solved. In particular, the cooperation between Centres for Social Work and Employment Offices was very much developed in order to better target social assistance and unemployment benefits, as well as to include the unemployed into active employment policy programmes and thus support the (re)integration of people into the labour market.

At the local level, Centres for Social Work are involved in the alleviation of poverty and social exclusion. They act both as providers and co-ordinators of services, and they also disburse social benefits. They have a discretionary right to judge various aspects of an individual's or a family's socio-economic situation as the basis for granting benefits. The individual rights for the access to the provision of such benefits are protected and enforced by the Slovenian legislation ruling individual social benefits.

The significance of NGOs for the efficient national strategy for alleviation of poverty and social exclusion is recognised in the National Programme on the Fight Against Poverty and Social Exclusion. Their activities are complementary to governmental measures and public services, and are often focused on specific marginal population groups. The aim is to inter-connect public sector, private sector and NGOs into a uniform system of social assistance and services. The upsurge of NGOs committed to humanitarian activities and providing of social services was facilitated by the revision of the social protection legislation in the 1990s. The role of charity organisations has been partly taken over by religious organisations. The largest NGOs are the two humanitarian organisations: the Red Cross of Slovenia and the Slovenian Caritas. In the area of social

integration, the central role is taken by disability organisations as the basic form of self-organisation of the disabled. Their number has been increasing, and the role of voluntary work has been growing in importance.

NGOs are mostly active in providing social care services and implementing programmes for population groups in need of special treatment. These activities include organising of maternity homes and shelters for battered women, residential communities for persons with long-term psycho-social disturbances and disabilities, SOS telephone lines for people in personal need, counselling and social rehabilitation of addicts, programmes for prevention of addiction, self-help groups, preventive programmes for children with difficulties in growing up, those living in families with problematic relations and abused children, psycho-social help to victims of violence, care of the homeless, advocacy, counselling and informing, legal aid, informal education and training of adults, organising of holidays as well as leisure and holiday programmes for children and young people from socially deprived surroundings, financial help to people in need, etc.

The activities of NGOs are partly financed through the state and local budgets (through public bids), but also by foundations, direct donations and membership fees. It should be stressed that considerable amount of the state budget is allocated to NGOs for financing their programmes in the sphere of social assistance and care.

4.3 Evaluation of future challenges

4.3.1 Main challenges

Considering the results of the poverty analysis, fighting unemployment (see Chapter 4.2) and increasing the educational level of the population of Slovenia are the main challenges for the Government of Slovenia in its fight against poverty and social exclusion. It is interesting to note here that in the 1990s the prolonging of youth education was a reaction to poor employment opportunities. This increased the average educational level of the population of Slovenia. However, the share of population with tertiary education should be increased further, which is true for the functional literacy as well.

The adult population should increase its inclusion in education, i.e. the concept of life-long education should be promoted. The analyses have shown that the adults would increase their employability by completing upper secondary education. In this respect, the education of the adults should be aimed at solving the structural discrepancies in the labour market. Namely, due to these discrepancies, persons with upper secondary education account for a high share of all unemployed.

At the local level, the provision of social housing remains one of the major challenges. The demand has always been exceeding the supply, so that families have to live in unsuitable housing for many years, and they also have to pay rents that take unreasonable shares of their income.

Particular attention should be given to small population groups that live in poverty or may easily drop into it, but are not identified as such by general surveys. These population groups are: people living in shelters, refugees, some groups of Roma population, homeless, alcohol and drug abusers, victims of violence, mentally ill, etc. Currently, it is the NGOs that focus their activities at such marginal groups. People belonging to these groups often stay socially excluded for a long period of time or for all their lives. The problem with temporary refugees (and temporary may mean quite a number of years), for instance, is that they are not allowed to get into employment and so earn for living and increase their standard of living.

In order to achieve better results, the coordination of efforts and activities by the central government, local governments, NGOs and other parties in the civil society should be planned in advance. This would lead to a more systematic action aimed at alleviating poverty and social exclusion. Currently, even the coordination and cooperation among different ministries and governmental institutions is only limited in its extent. Thus, although the situation has been improving, there is still a lot to do in this respect.

4.3.2 Links to other social protection policies

Pension and health care systems are not inducing poverty in Slovenia since they are very generous. Active employment measures promise to increase the employability of the unemployed and thus partly overcome structural imbalances in the labour market.

The social protection system has been revised in the 1990s and in the recent period, thus no major changes are envisaged except for the introduction of the obligatory long-term care insurance. A revision will be needed in the pension system in a decade or so again, because the reform introduced recently was not profound enough to cope with the consequences of the ageing process in Slovenia. It is expected that any possible decrease in the rights derived from the obligatory health care insurance (in order to balance inflows and outflows of the Health Insurance Fund) will exclude negative consequences for the population with low income.

The following revisions are in the process of preparation or envisaged in near future, which may affect the economic and social position of various population groups in Slovenia:

1. A new Income Tax Act, which will introduce changes in the redistribution of income through the tax system. One of its intentions is to decrease the tax burden in lower income brackets through tax relieves and the treatment of social transfers. It is planned to be implemented in 2003;
2. Annual Programmes of the Active Employment Policy;
3. Amendments to the Employment and Unemployment Insurance Act, which will have impact on the socio-economic position of the employed, unemployed and those whose jobs are threatened;
4. Housing Act, in particular with regard to regulations of social housing, subsidies and temporary accommodation for people in financial and social hardship or hit by elementary catastrophes;
5. Long-term Care Insurance Act, covering health, social and other services for the elderly, disabled persons and other persons in need of long-term care, as well as allowances related to these services;
6. Act on Training and Employment of Disabled Persons, which will regulate the employment rehabilitation of the disabled;
7. Act on Equalising of Opportunities of the Disabled Persons.

4.3.3 Political directions of future reform

As for now, the drafts of those reform policies have not yet been the object of a wide public debate, but it is expected that the Income Tax Act in particular will cause political polarisation in spite of a consensus regarding its main objective.

4.3.4 Social exclusion, poverty and EU accession

The four freedoms which are the core of the integration process (free flow of goods, services, persons and capital) will to a certain degree impact the rate of employment, the wage level, migration of labour (from and to Slovenia), standard of living and indirectly also the social security level of population in Slovenia.

Thus, the EU integration on its own is not expected to have great impact on the Slovenian social security system and its benefits for the population. Moreover, future will be determined primarily by the development of the economic situation as well as the demographic development. The economic situation as well as business activities are important because of their impact on employment rate and employment policy. If the economic development is positive,

- wages increase and stabilise the social security system,

- there is higher inflow of money in social security funds,
- the demand for social security expenditures is smaller (for guaranteed minimum income and unemployment benefits).

Potential negative impact of the integration of Slovenia into the EU on social security costs may be twofold:

- lower social security of the population of Slovenia because of a lower competitiveness of Slovenian goods and services in comparison to those from other EU states and consequently, decrease in production and loss of jobs,
- increase in social benefits and costs due to persons who will immigrate into Slovenia because of free flow of labour.

The Economist (Europe's Immigrants ..., 2000) quoted migration estimates as a consequence of EU integration. The research was made in December 1999 by the John Salt's Migration Research Unit at the University College London. Interesting enough, the same results are quoted by the German institute IZA as well as the British Department for Education and Employment (IZA, 2000). As for Slovenia, the simulation outcome shows that in a scenario of limited migration possibilities only 0.22% of the population would emigrate to other European member countries, which is also the lowest percentage obtained for eleven non-member countries. Also Borjas (1999) expects only very small migration flows from Slovenia since empirical evidence suggests that differences in GDP per capita are a key determinant of the size and direction of migration flows.

4.3.5 Conclusions

The Slovenian National Programme on the Fight against Poverty and Social Exclusion is a comprehensive document, and its in-depth follow-up two years after its implementation proves the government’s serious intention to fulfil the objectives set in 2000. Regular updating of tasks and their fulfilment, with naming the ministries and institutions that are responsible for them, is the most appropriate way of identifying problems and their interrelation, as well as for planning actions aimed at solving those problems. Quantifications of aims and achieved results are also very important, so that the level and trends in indicators can be observed and analysed.

In the recent report by the Ministry of Labour, Family and Social Affairs (MoLFSA, 2002) considering the current situation regarding poverty and social exclusion in Slovenia and the measures in force to alleviate it, the government set the following priorities:

1. widening of opportunities for an increase in the educational level, and improving of opportunities and incentives for education,
2. widening of opportunities for inclusion of the unemployed into programmes of active employment policy, particularly those programmes that improve employability through attaining new knowledge and skills,
3. faster solving of problems related to education, training, employment and independent living of disabled persons,
4. improving access to social and non-profit housing and introduction of a more appropriate support in paying rent.

4.4 Annex to chapter four

Table 4.1: Social assistance recipients in the years 1985-2002

Year	Recipients	Index
1985	10,709	
1990	6,993	
1992	8,466	
1993	17,544	1993/1985 = 164
1994	22,623	
1995	26,466	1995/1992 = 313
1996	31,482	
1997	35,644	1997/1995 = 135
1998	34,351	
1999	33,196	
2000	33,955	
August 2002	39,849	August 2002/2000 = 117

Sources: SORS, Statistical Yearbook, various years; MoLFSA.

Note: Except for 2002, these are the average annual numbers of recipients.

Table 4.2: Percentage of persons living in poverty

Year	Statistical Office	Stropnik and Stanovnik
1993	13.0	12.9
1998	13.8	13.9
1999	13.7	-

Sources: SORS, 2001a and 2002b; Stropnik and Stanovnik, 2002, Table 13.

Note: Poverty line is set at 60% of the median equivalent income. The Statistical Office applies the modified OECD equivalence scale while Stropnik and Stanovnik apply the standard one. The definition of income may somewhat differ as well.

Table 4.3: Household types at highest risk of poverty

Household type	**1993**	**1999**
Single person aged 65 and above	48.4	23.5
Single person up to age 64	27.1	14.3
Elderly couples without children	25.7	15.9
Single parent with children aged up to 16 years	6.9	14.3
Nobody is working	31.4	21.8
Household head has not completed or has completed only elementary education	25.4	26.8
Pensions are the main source of income	28.3	18.5
Other social benefits are the main source of income	40.0	40.1
Tenants	27.2 *	19.7 **
All	11.0	12.2

Sources: Žnidaršič, 1995; SORS, 2002a.

Notes: Poverty line is set at 50% of average equivalent expenditure.
* Tenants in a private dwelling.
** Tenants in a non-profit dwelling or social housing.

Table 4.4: Poverty incidence in 1993 and 1998 (persons, %)

Poverty line **As % of median equivalent**	**All persons**		**Pensioners**		**Unemployed**		**Children aged 18 and under**		**Persons aged 60 and over**	
Household income	1993	1998	1993	1998	1993	1998	1993	1998	1993	1998
40	3.7	4.2	3.8	3.3	13.6	23.6	4.2	4.8	7.3	5.3
50	7.1	8.0	8.7	5.7	22.5	35.5	7.4	9.4	14.1	10.0
60	12.9	13.9	16.3	11.5	33.5	48.3	13.2	16.7	25.0	17.6
70	20.6	21.1	23.2	19.4	45.5	63.1	21.5	24.6	33.6	28.4

Source: Stropnik and Stanovnik, 2002, Table 12.

Table 4.5: Households' opinion about their income (% of households)

With its monthly income, the household meets its ends ...	**1998**	**1999**
With great difficulties	11.7	10.9
With difficulties	25.0	24.6
With some difficulties	41.4	42.9
Fairly easy	13.7	13.9
Easy	7.6	7.2
Very easy	0.6	0.5

Sources: SORS, 2001a and 2002a.

Note: Comparison with 1993 cannot be made due to a different scale used then.

Table 4.6: Indicators of social exclusion, Slovenia

	Indicator	**Value**	**Data sources + most recent year available**	**Notes**
1a	Low income rate after transfers with breakdowns by age and gender	total = 13.6 men = 13.0 women = 14.2 0-15 years = 12.1 men = 12.3 women = 11.8 16-24 years = 12.7 men = 13.3 women = 12.0 25-49 years = 11.4 men = 11.8 women = 11.0 50-64 years = 12.4 men = 12.0 women = 12.8 65 years or more = 24.7 men = 20.6 women = 27.1	HES 1999	
1b	Low income rate after transfers with breakdowns by most frequent activity status	employed = 5.3 self-employed = 20.9 unemloyed = 38.2 retired = 16.4 other economically inactive = 22.4	HES 1999	
1c	Low income rate	one person household,	HES 1999	

	after transfers with breakdowns by household type	under 30 years = 26.7* one person household, between 30 and 64 years = 25.4 one person household, 65 years plus = 39.3 one person household, total = 33.4 two adulsts, no dependent children, both adults under 65 years = 14.4 two adulsts, no dependent children, at least one adult 65 years or more = 23.6 other households without dependent children = 11.7 single parent household, one or more dependent children = 23.6 two adults, one dependent child = 9.3 two adults, two dependent children = 6.9 two adults, three or more dependent children = 17.6 other households with dependent children = 13.9		
1d	Low income rate after transfers with breakdowns by tenure status	owner or rent free = 13.2 tenenat = 19.6	HES 1999	
1e	Low income threshold (illustrative values)	699,491 SIT 5,525 PPS 3,596 EURO For a household consisting of two adults and two children: 1,468,931 SIT 11,603 PPS 7,552 EURO	HES 1999	
2.	Distribution of income (S80/S20 quintile share ratio)	3.6	HES 1999	
3.	Persistence of low			HES is not a

	income			panel
4.	Relative median low income gap	total = 22.2	HES 1999	
5.	Regional cohesion			Slovenia does not have NUTS 2 level
6.	Long term unemployment rate	men = 4.4 women = 4.3 total = 4.3	LFS 2000	
7.	Persons living in jobless households		LFS	
8.	Early school leavers not in education or training		LFS	
9.	Life expectancy at birth	men = 71.8 women = 79.3	Eurostat Demography Statistics, 1999	
10.	Self defined health status by income level	bad: low income = 25% high income = 4% total = 11%	Slovenian Public Opinion, 2001	
11.	Dispersion around the low income threshold	40% cut-off = 3.9 50% cut-off = 7.9 60% cut-off = 21.2	HES 1999	
12.	Low income rate anchored at a moment in time	10.8	HES 1996	
13.	Low income rate before transfers	20.5	HES 1999	
14.	Gini coefficient	0.25	HES 1999	
15.	Persistence of low income (below 50% of median income)			HES is not a panel
16.	Long term unemployment share (one year and more)	men = 64.9 women = 60.3 total = 62.7	LFS 2000	
17.	Very long term unemployment share (two years	men = 35.6 women = 39.9	LFS 1998 (2)	

	and more)	total = 37.6		
18.	Persons with low educational attainment (share of those with incomplete and complete elementary school)	men = 33.3 women = 27.4 total = 30.5	LFS 1998 (2)	

Sources: Eurostat, 2001a, 2001b and 2001 c; SORS, 2002b; Center za raziskovanje ..., 2001.

Notes:

HES 1999 is a joint 1998, 1999 and 2000 data base in May 1999 prices.

* Innacurate data.

Table 4.7: Distribution of unemployed persons, in %

Income deciles	**Share of unemployed persons in all household members in individual income deciles**		**Distribution of unemployed persons across income deciles**	
	1993	1998	1993	1998
1	11.4	21.8	20.6	30.3
2	8.8	13.5	17.2	19.6
3	6.0	8.0	11.5	10.5
4	4.9	6.4	9.9	9.6
5	5.3	6.5	11.1	10.3
6	4.8	3.7	9.0	5.4
7	3.7	4.0	7.1	5.8
8	2.3	2.9	4.6	4.1
9	2.9	2.1	5.9	2.8
10	1.8	1.2	3.2	1.6
Total	5.2	7.1	100.0	100.0

Source: Stropnik and Stanovnik, 2002, Tables 1 and 2.

Table 4.8: Poverty incidence in Slovenia in 1998; persons, in %

Poverty line as % of median equivalent household income	All persons	The unemployed
40	4.2	23.6
50	8.0	35.5
60	13.9	48.3
70	21.1	63.1

Source: Stropnik and Stanovnik, 2002, Table 12.
Note: The equivalence scale used is the standard OECD (1, 0.7, 0.5).

Table 4.9: Shares of households with unemployed member as percentages of all households in an income decile, 1998

Income deciles	Households with unemployed member
1	46.1
2	34.4
3	20.2
4	19.2
5	19.6
6	10.9
7	11.7
8	8.3
9	5.3
10	3.4
Total	17.9

Source: Stropnik and Stanovnik, 2002, Table 8.

Table 4.10: Poverty incidence in Slovenia in 1998; households, in %

Poverty line as % of median equivalent household income	All households	Households with unemployed members
40	4.6	12.7
50	8.1	21.8
60	13.8	34.5
70	21.1	47.0

Source: Stropnik and Stanovnik, 2002, Table 13.
Note: The equivalence scale used is the standard OECD (1, 0.7, 0.5).

Table 4.11: Employment of persons who successfully completed educational and training programmes in individual calendar years

	Year		
	1998	2000	2001
% of persons who got employment in 6 months following the end of a programme	52.9	40.3	
Among them:			
- persons below age 27		41.9	
- persons older than 40 years		21.3	
- unemployed for more than 12 months		24.1	
% of persons who got employment till the end of a calendar year	65.5	50.8	
Among them:			
- persons below age 27		41.3	
- persons older than 40 years		22.2	
- unemployed for more than 12 months		24.5	

Source: Employment Office of the Republic of Slovenia.

Table 4.12: Social assistance beneficiaries according to social status, December 1998 and 2000

Social status	**Number of beneficiaries**		**Structure in %**	
	December 1998	December 2000	December 1998	December 2000
Employed	1,255	966	4	3
Farmer	641	724	2	2
Other self-employed	21	25	0	0
Performing odd jobs	29	63	0	0
First-time job seeker	4,275	7,979	13	24
Unemployed, receiving benefit	709	542	2	2
Unemployed, without benefit	17,207	19,016	54	57
Student	76	59	0	0
Retired	250	203	1	1
Housewife	1,379	1,283	4	4
Incapable of work	1,400	1,175	4	3

Other	4,746	1,547	15	5
Total	31,988	33,582	100	100

Source: MoLFSA, 2000, Table 31.

Note: Elderly beneficiaries (aged over 65), recipients of social assistance as the only source of income, are not included.

Table 4.13: Unemployed persons and beneficiaries of unemployment compensation and unemployment assistance

	Year				
	1995	**1998**	**1999**	**2000**	**2001**
Registered unemployed [(1)]	129,087	126,080	118,951	106,601	101,857
LFS-based unemployed [(1)]	85,000	77,000	73,000	68,000	60,000 [(3)]
Persons receiving unemployment compensation [(2)]	42,582	36,082	31,227	27,264	21,525
Persons receiving unemployment assistance [(2)]	20,052	2,818	3,283	3,754	4,249

Sources: Employment Office of the Republic of Slovenia, Annual reports, various years; SORS, Monthly Statistical Review, various issues.

Notes: [(1)] Annual average. [(2)] End of year. [(3)] Average of the first three quarters.

Table 4.14: Registered unemployed persons and beneficiaries of unemployment compensation and unemployment assistance (annual average)

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Registered unemployed	121,483	119,799	125,189	126,080	118,951	106,601	101,857
Unemployment compensation beneficiaries	29,021	31,424	36,603	37,734	33.860	27,264	21,710
% of the registered unemployed	23.9	26.2	29.2	29.9	28.5	25.6	21.3
Unemployment assistance beneficiaries	7,803	4,919	4,188	3,331	3,045	3,737	4,225
% of the registered unemployed	6.4	4.1	3.3	2.6	2.6	3.5	4.1
Total % of beneficiaries among the registered unemployed	30.3	30.3	32.6	32.6	31.0	29.1	25.5

Sources: Employment Office of the Republic of Slovenia, Annual Report, various years, and http://www.ess.gov.si/

Table 4.15: Pension expenditures (as % of GDP) and replacement rates, 1990 - 2000

Year	Pension expenditure as % of GDP	Replacement rate (in %)
1995	14.7	77.9
1996	14.7	75.8
1997	14.9	75.4
1998	14.3	75.6
1999	14.4	76.8
2000	14.6	76.1

Sources: Institute for Pension and Disability Insurance, annual reports; MoLFSA, 1997; Bank of Slovenia.

Note: Replacement rate refers to average net old-age pension/average net wage. ”Net” is equal to ”gross” minus social security contributions and income tax.

Table 4.16: Social benefits as % of all income sources, by income deciles, 1993 and 1998

1993					
Income deciles	**Pensions**	**Health insurance related cash benefits**	**Unemployment benefits**	**Social assistance**	**Child benefits**
1	37.8	0.3	4.7	4.4	4.9
2	31.5	0.6	4.9	1.3	2.6
3	31.2	0.3	2.3	0.4	1.8
4	23.3	0.3	2.6	0.7	1.2
5	21.4	0.5	2.2	0.4	0.7
6	25.4	1.8	1.8	0.3	0.4
7	23.8	0.7	0.8	0.5	0.6
8	20.7	0.6	0.5	0.1	0.0
9	17.3	0.5	0.9	0.0	0.1
10	11.4	0.2	0.1	0.0	0.0
Total	21.1	0.6	1.4	0.4	0.7
1998					
1	32.8	2.1	6.2	4.0	6.4
2	32.7	2.6	3.8	0.9	3.9
3	34.0	1.4	1.8	0.3	3.0
4	24.7	1.8	2.0	0.2	2.5
5	25.0	1.0	1.9	0.0	2.2
6	27.3	1.5	1.2	0.1	1.5

7	25.3	1.5	1.5	0.0	1.5
8	21.4	0.7	0.8	0.0	1.0
9	23.8	0.7	0.6	0.0	0.6
10	19.7	0.9	0.3	0.0	0.1
Total	24.9	1.2	1.4	0.3	1.6

Source: Stropnik and Stanovnik, 2002, Table 3..

Note: Rows may not sum to 100 due to rounding.

Table 4.17: Distribution of social benefits across income deciles, 1993 and 1998 (%)

1993					
Income deciles	**Pensions**	**Health insurance related cash benefits**	**Unemployment benefits**	**Social assistance**	**Child benefits**
1	6.1	1.6	11.2	34.3	22.6
2	8.2	6.0	18.7	16.7	19.4
3	9.6	3.9	10.3	6.4	15.9
4	8.5	4.1	13.9	11.7	12.8
5	9.0	7.9	13.6	8.7	8.9
6	11.1	29.3	11.5	5.8	4.9
7	11.7	12.6	5.5	10.8	8.4
8	12.0	13.7	3.9	2.8	1.6
9	12.2	14.3	9.4	0.3	2.8
10	11.6	6.6	2.1	2.5	2.8
Total	100.0	100.0	100.0	100.0	100.0
1998					
1	4.7	6.0	15.6	56.5	14.3
2	7.6	12.5	15.2	20.9	13.9
3	8.8	7.2	8.0	8.1	12.0
4	8.1	12.3	11.3	5.7	12.7
5	9.6	8.0	12.9	1.0	13.0
6	11.1	12.3	8.7	4.3	9.2
7	11.5	13.5	12.2	2.0	10.6
8	10.4	6.5	6.6	0.7	7.6
9	13.0	7.4	5.9	0.7	5.0
10	15.2	14.3	3.6	0.0	1.7
Total	100.0	100.0	100.0	100.0	100.0

Source: Stropnik/ Stanovnik, 2002, Tbl 4./ NB: Columns may not sum to 100 due to rounding.

Table 4.18: Percentage of income coming from individual social benefits, for households receiving that particular social benefit, by income deciles, 1993 and 1998

1993					
Income deciles	**Pensions**	**Health insurance related cash benefits**	**Unemployment benefits**	**Social assistance**	**Child benefits**
1	64.9	16.6	37.9	33.8	18.2
2	55.9	22.0	25.4	14.9	12.4
3	57.7	14.7	24.7	11.8	12.0
4	53.2	41.3	19.9	20.0	9.4
5	48.5	13.0	19.0	12.4	7.2
6	54.6	29.3	19.5	7.9	6.7
7	56.6	24.4	12.7	16.7	8.1
8	48.7	29.4	9.8	6.5	5.5
9	52.6	41.5	13.7	2.3	6.0
10	43.1	7.4	6.2	12.7	3.2
Total	52.4	22.0	18.9	16.4	9.9
1998					
1	62.7	21.8	30.1	33.5	13.8
2	57.6	18.9	24.0	14.9	8.0
3	65.9	17.9	21.5	12.7	5.9
4	51.0	18.2	17.5	8.9	4.6
5	52.9	14.7	17.2	2.9	4.3
6	54.9	16.8	15.9	9.7	3.0
7	51.3	17.6	16.6	3.0	3.5
8	52.3	12.6	20.6	4.2	2.3
9	55.0	15.1	14.5	7.4	1.8
10	47.7	24.2	10.8	0.0	1.0
Total	53.7	17.7	19.0	16.3	4.1

Source: Stropnik and Stanovnik, 2002, Table 6.

Table 4.19: Comparative indicators of poverty incidence among children up to age of 18, in percentage points

Poverty line as % of median equivalent household income	Difference between poverty rates among children in 1993 and 1998	Difference between poverty rates among children and those for all persons, 1993	Difference between poverty rates among children and those for all persons, 1998
40	0.6	0.5	0.6
50	2.0	0.3	1.4
60	3.5	0.3	2.8
70	3.1	0.9	3.5

Source: Stropnik and Stanovnik, 2002, Table 14.

5. HEALTH CARE

5.1 Evaluation of current structures

5.1.1 Organisation of the health care system

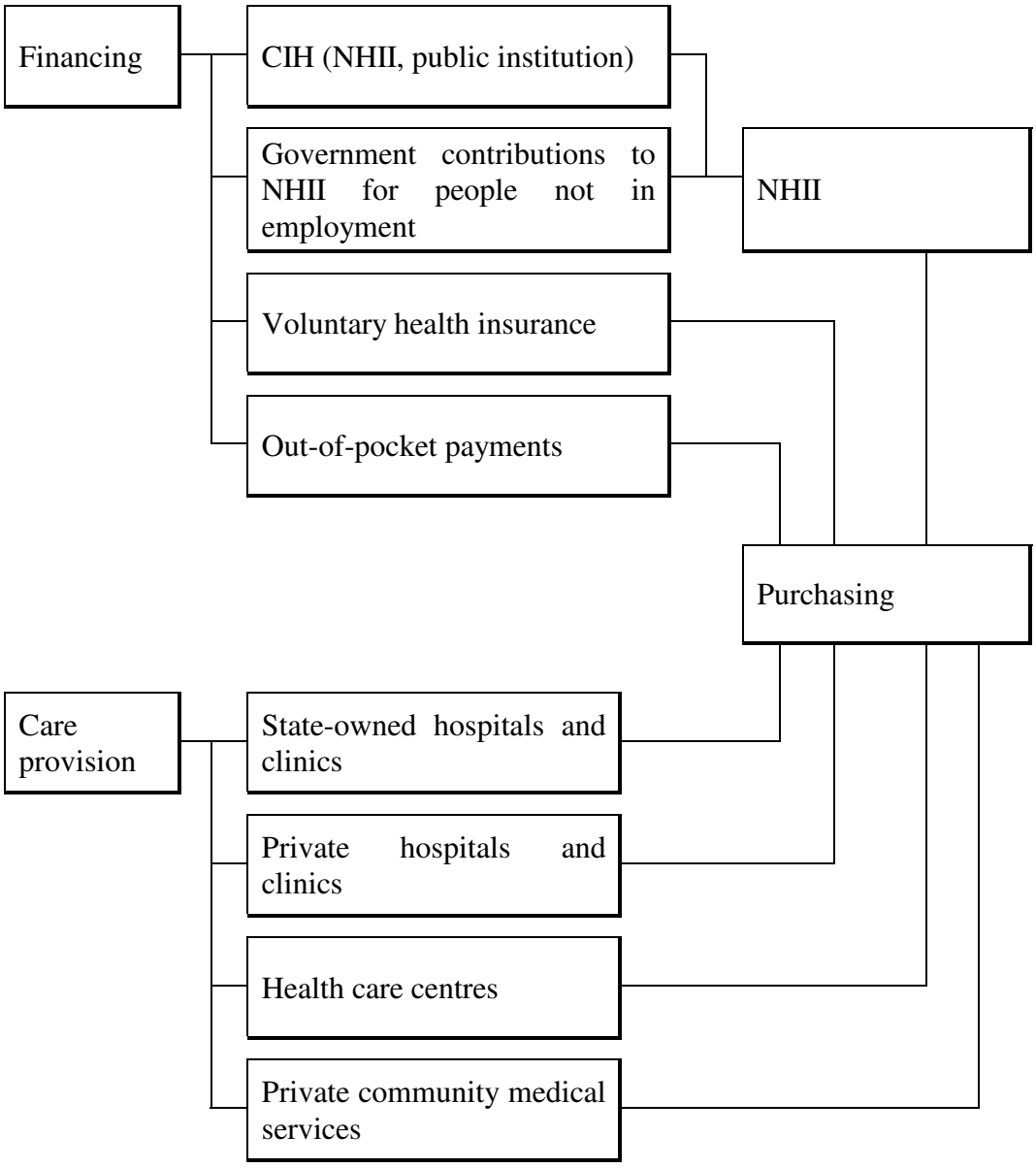
In general, the Slovenian health care sector is quite transparent, well structured and is financially more stable than some other systems in East European countries. Its overall organisational structure (in terms of funding, purchasing and delivery) is relatively simple. It can be well illustrated in Figure 5.1. Funding, purchasing and delivery are under governmental supervision. Most of the population is covered by compulsory health insurance (CIH), administered by the National Health Insurance Institute (NHII)[34], a public institution, which collects contributions from employers, employees, self-employed, farmers and some citizens (e.g. professional sportsmen, artists etc.); in other cases (the retired, the unemployed), the contributions need to be paid by the Institute for Pension and Disability Insurance (IPDI) and Employment Service of Slovenia (ESS).

Voluntary health insurance (VHI) covers payments for health services above the share covered by CHI, and for services that represent low value for money (and are, therefore, not covered by CHI). There are two VHI schemes. The most powerful is a mutual insurance Vzajemna, over which NHII retained some level of control; the commercial insurance company Adriatic controls the other. VHI is *de facto* compulsory in Slovenia and most of the population is voluntarily insured. Incomes from voluntary insurance are officially defined as private means, although in reality the picture is different; especially the poorer population groups are forced to pay for VHI, otherwise out-of-pocket payments in case of sickness are too large a burden on them. VHI is criticized for enlarging social inequity in Slovenia.

Most of purchasing is carried out by NHII. Contracts between hospitals, primary care units and NHII are negotiated on a collective basis each year (through standard contracts covering multiple care providers). The Ministry of Health (MoH) plays an important role in ensuring the maximum degree of consensus. Unfortunately, such a system is getting worse each year and representatives of the three negotiating parties (MoH, NHII and providers) have been unable to reach the consensus in signing the contracts in 2001.

[34] Zavod za zdravstveno zavarovanje Slovenije (ZZZS).

Figure 5.1: Funding, purchasing, and care provision in Slovenia



The institutional framework is characterized by the following structure:

- MoH: policymaking, priority setting, coordination of public health measures, investments;
- NHII: purchasing the needed high quality health services;
- Institute of Public Health (IPH): monitoring and analysing data for MoH needs;
- Health care providers: quality service delivery and health care management; and

- Ministry of finance and Court of Audit: fiscal monitoring.

Most health care providers - including hospitals and primary health clinics - are state-owned, while the staff are public sector employees. However, the number of private doctors, particularly specialists, dentists and increasingly GPs, has been growing slowly, and there are also some private hospitals. Still, private health care comprises only a small fragment of health care and is tied to the public health care system by way of financing. The "real" private sector comprises only a few physicians as most of the private doctors have contracts with NHII and the part of their incomes collected by direct payments is relatively small. In financial terms, private health care providers spent 8,42% of all financial means for health care services in 2001.

The infrastructure is relatively well designed and effective while the workforce is ethical and motivated. Staff is well qualified, technical competence is high in most clinical disciplines. There indeed have been some individual cases of under-the-table payments detected, however, such practice is very likely relatively rare among medical professions and does not represent a serious problem in Slovenia.

The issue of centralisation / decentralisation does not play a significant role in Slovenia as Slovenia is too small. Apart from a wide net of primary level of healthcare centres, each major region has a regional hospital. They are approximately equally developed and equally financed. Additionally, there are two major tertiary medical centres, one in western Slovenia in Ljubljana, and one in Maribor for the eastern part of the country, and a specialized hospital Centre for lung diseases Golnik. Their financing is settled separately. No speciality is centralised only in one region; each region has all specialities more or less developed. The development depends mostly on the number of specialists as a big lack of specialists can currently be observed in Slovenia.

In the previous health care system, the primary sector was underestimated and almost every patient was sent to the secondary level. Due to the remains from that system, the secondary system is now much more developed. Because of the higher demand of patients for health care and the unfavourable demographic tendencies, the waiting lists are getting longer, and in the last decade much more emphasis has been put on the primary level. The patient is led through the entire illness by the primary care physician and not by secondary level specialists. In the future, even greater emphasis is expected to be placed on the primary care physician. All the physicians in primary care must be specialists in family medicine; if not, they are not allowed to work according to the General Practitioners Services Act.

5.1.2 Benefits

CHI provides all the insured persons with two basic types of rights: a) entitlement to health services delivered in Slovenia (or, in specified instances, abroad) at the primary, secondary, and tertiary levels, including drugs and

technical aids; b) specific cash benefits, such as wage compensation in case of temporary incapacity for work exceeding 30 days, reimbursement of travel costs, death and funeral benefits.

As already noted in Chapter 2.3.1, CHI covers the majority of health risks. In certain cases, such as preventive medical examinations other than those that are the responsibility of the employer, early detection of disease, maternal care, compulsory vaccination, detection and medication of communicable diseases, treatment of certain other diseases[35], emergency medical treatment, treatment and nursing in nursing homes and certain drugs, CHI covers full costs of health services. In other cases, the exact share of costs of health services covered by the CHI is determined by NHII with consent of the government and is subject to periodic change. The Health Care and Health Insurance Act (HCHIA) specifies their lower limits; as a general rule, the higher the financial burden of these services, the higher the coverage of the CHI, and *vice versa*. These shares are as follows:

- at minimum 95% for organ transplantations and other exacting operations, medical treatment in foreign countries, intensive care, radiotherapy, dialysis, urgent and exacting diagnostic, therapeutic and rehabilitation procedures;
- at minimum 85% for infertility treatment and artificial insemination, sterilization or abortion, specialist out-patient, hospital or spa treatment following the initial hospital treatment, non-medical care in hospitals and spas, certain primary level health services, treatment of dental and oral cavity diseases, orthopaedic, orthotic, hearing and other aids;
- at minimum 75% for specialist out-patient, hospital and spa services (including non-medical services) as a continuation of hospital treatment, orthopaedic, orthotic and other aids in case of non-employment related injuries, as well as for certain drugs;
- at maximum 60% for non-urgent transportation with ambulance and spa treatment that is not considered as continuation of hospital treatment; and
- at maximum 50% for certain drugs, dental prosthetics and ophthalmic aids for adults.

The difference is to be paid by out-of-pocket resources or by VHI. Disabled soldiers and civil invalids from wartime, some disabled groups, and social security benefits recipients are excepted from these regulations; in their cases, the balance is paid from other sources (e.g., the state budget). In the future, it is foreseen that the insured persons will not be paid for medical treatment from CHI anymore in cases of self-inflicted health damage.

The right of the employed and farmers to wage compensation during sickness is comparatively more extensive than in other European countries. In Slovenia,

[35] Malignant cancers, muscular and neuromuscular diseases, paraplegia, tetraplegia, cerebral palsy, epilepsy, haemophilia, mental illness, various forms of diabetes, multiple sclerosis and psoriasis.

it ranges from 80-100% of the wage before sick leave, whereas in the EU countries it is considerably lower. There is also no time limitation to sick leave and, consequently, to wage compensation. Such a system does not offer enough incentives to return to work as quickly as possible. As a result, the health-related absenteeism rates in Slovenia are among the highest in Europe. It is estimated that the wage compensation during temporary absence from work amounts to more than 1,3%, while the loss in value added is close to 5% of GDP. Among the long-term sick leaves, part of the unfavourable situation is caused by in some cases unnecessarily long IPDI invalidity board procedures during which the insured person is entitled to normal wage compensation. NHII and IPDI are currently acting on this problem. Additionally, NHII supports the introduction of waiting days, setting of the upper limit for the longest possible duration of sick leave, the transfer of the major responsibility of health-related absenteeism to the employer (with major changes in terms of insurance of employment-related health problems), the incentives to sharpen the discipline of the employees to comply with the restrictions during sick leave, and a partial delegation of the right to determine the level of compensation to the NHII, with the VHI to provide the balance of the benefits.

The statutory system is adequate, and sometimes even too generous with regard to a sufficient provision of health care services. In the last few years, the rights are tried to be cut, especially in the case of medical aids and medicines.

5.1.3 Financing of the health care system

Throughout the 90's, after the change in healthcare legislation in 1992 and the gradual reform of the healthcare sector, relatively stable and balanced funding has been ensured in Slovenia. Health care expenditures, measured as % of GDP, can be seen from Table 5.1.

In the last five years, the proportion of public expenditure on healthcare has been stable and has not greatly exceeded 7% of GDP. Out of these 7%, the majority of sources were accounted for by CHI, approximately 0,20% by the state budget including investments in the sector, and less than 0,10% by community budgets. The level of private funding, measured as Vzajemna VHI, has been rising since 1992, and accounted for approximately 13% of total NHII and Vzajemna expenditure, or 1% of GDP in 2001. If in addition to this funding the total private funds spent by insured persons for various healthcare purposes (personal purchases of medicines, self-payment services, Adriatic VHI and other health care expenditure) were taken into consideration, the total proportion of healthcare funding in Slovenia accounted for by private funds would be over 20%, and thus comparable to EU countries. More detailed figures are presented in Table 5.1.

The level of private funding for healthcare has been rising not only because of VHI, but above all because of the higher level of out-of-pocket specialist and hospital healthcare services, and because of longer waiting lists within CHI. The

waiting lists grew longer during the time, as the regulations for expanding private practice in healthcare were incomplete.

According to the 1999 figures, Slovenia spent US$ 758per capita on healthcare. In PPP terms the figure was US$ 1.119 per capita. Of the US$758, US$ 657 came from public and US$ 101 from private sources (Vzajemna VHI). It is necessary to note that the PPP method of comparison is not suitable for the cost structure of healthcare expenditure: almost 50% of healthcare expenditure is accounted for by material costs which are primarily linked to imports and thus to the price of materials and products on foreign markets. A standardised international methodology would be required for an appropriate comparison of figures on expenditure. The figures available indicate that estimated healthcare expenditure in Slovenia is below the European average, as the funding of healthcare, considering this comparison, is at the lower limit of EU countries.

Table 5.1: Health care expenditure in Slovenia in 1996-2001 in billion SIT and % GDP

	1996		1997		1998		1999		2000		2001	
	SIT	%GDP	SIT	%GDP	SIT	%GDP	SIT	%GDP	SIT	%GDP	SIT	%GDP
1. Public expenditures	**175,4**	**6,88**	**198,8**	**6,84**	**254,5**	**6,90**	**247,1**	**6,80**	**280,5**	**6,88**	**325,6**	**7,17**
CHI	*168,9*	*6,62*	*191,3*	*6,58*	*246,3*	*6,64*	*237,8*	*6,55*	*270,4*	*6,64*	*313,4*	*6,90*
Payments of health care services	117,0	4,58	133,5	4,59	148,8	4,57	166,1	4,57	190,4	4,67	217,5	4,79
Payments for drugs and technical aids	25,2	0,99	28,0	0,96	33,9	1,04	37,4	1,03	42,9	1,05	51,4	1,13
Other	26,7	1,05	29,8	1,03	33,6	1,03	34,3	0,95	37,1	0,91	44,5	0,21
NATIONAL BUDGET EXPENDITURE	*4,8*	*0,19*	*5,4*	*0,19*	*5,7*	*0,18*	*6,2*	*0,17*	*6,8*	*0,16*	*8,9*	*0,20*
For health care programmes	3,0	0,12	3,6	0,12	3,7	0,11	4,1	0,11	4,3	0,10	5,2	0,12
Investments	1,7	0,07	1,8	0,07	2,0	0,07	2,2	0,06	2,2	0,05	3,6	0,08
MUNICIPAL BUDGETS	***1,7***	*0,07*	*2,1*	*0,07*	*2,5*	*0,08*	*3,1*	*0,08*	*3,3*	*0,08*	*3,3*	*0,07*
2. VHI	**21,4**	**0,84**	**25,7**	**0,88**	**32,5**	**1,0**	**37,5**	**1,03**	**46,4**	**1,14**	**57,9**	**1,28**
- Vzajemna	21,4	0,84	25,7	0,88	29,5	0,91	33,8	0,93	41,7	1,02	48,0	1,06
- Adriatic	n.a.	n.a.	n.a.	n.a.	3,0	0,09	3,7	0,10	4,7	0,12	9,9	0,22
3. Total	**196,7**	**7,70**	**224,5**	**7,72**	**254,0**	**7,81**	**280,9**	**7,72**	**322,2**	**7,91**	**383,5**	**8,45**

Source: ZZZS, 2002.

Health care is financed by contributions paid to NHII by employers, employees and other groups of contributors. Employers and employees each contribute 6.36% of gross wages, and employers additionally pay 0,53% for professional diseases and injuries at work. Law defines contribution rates and bases for other groups of population. The collective contribution rate for CHI decreased four times from 1992, when the major health care reform was implemented, until 1994 (from 18,15% of gross wage to 12,70%). In 1996, it increased for the first time and remained at 13,25% level till 2002. Normal financing of health care was becoming impossible, mostly because of a high increase in costs of medicines, a high wage growth of medical staff, particularly physicians, unfavourable demographic trends, technological development and innovations in health care, introduction of VAT and a higher demand for health care. Thus, the contribution rate had to be increased. In the end of 2001, it increased by 0,2% for employers and the retired. The increase was too small and too late to fill the gap created by fast-growing health care outlays. If the rights of patients to health services are not to be restricted, the financing of the health care system has to be reformed.

Table 5.2: Breakdown of sources of revenue for CHI in 2001 in %

Source	**Share in %**
Employer, employee contributions	77,9
Contributions from the retired	16,3
Contributions from farmers	0,2
Other contributions	4,2
Other sources	1,4
Total	*100,0*

100,0%=301,6 billion SIT

Source: ZZZS, 2002.

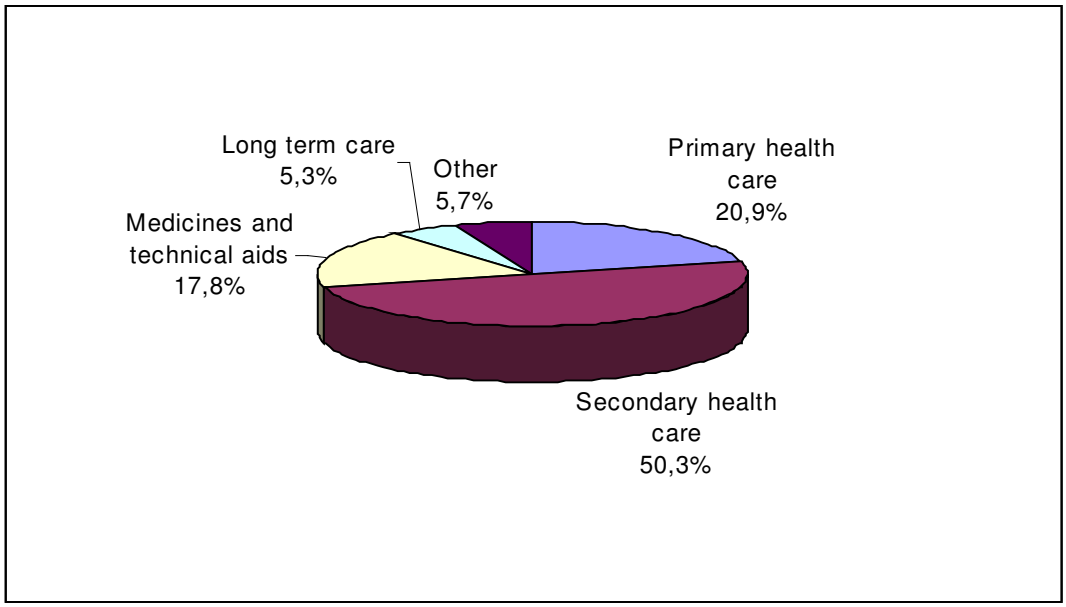
Out of total expenditures of approximately 1.5 billion Euro spent on health care out of CHI in 2001, 28% was spent on primary and 62% on secondary and tertiary care.

Outlays from CHI increased by 15,9% in 2001/2000. In real terms, growth was 6,9%, mostly due to wage increases of health care sector employees, growth of prices of medicines, and higher wage compensations. The structure of expenditures of CHI (without wage compensations) shows that more than a half of the outlays go to secondary health care, around 21% to primary health care and 18% to medicines and technical aids. The rest is divided between long-term care, conventions for treatment in foreign countries, health resort treatment and other purposes (see Figure 5.2).

It is impossible to specify the shares for primary and secondary care spent from VHI, as data from Vzajemna and Adriatic are not completely available.

For out-of-pocket payments, no data is available other than rough estimates provided by MoH based on the Statistical Office's Household Survey.

Figure 5.2: Structure of CHI expenditure in 2001 (without wage compensations)



Source: ZZZS, 2002.

5.1.4 Incentives

Citizens of Slovenia have been used to a high level of health care provision and accessibility. Equal accessibility to health care services when they are needed is still among the most important principles of CHI. A relatively high coverage of health care costs and health-related benefits by CHI (especially coupled by VHI) gives the insured persons an idea of these services and benefits as being free of charge to them. Such a "safety net" is surely among the incentives to utilize health care services and benefits to the highest desired level.

To curtail the incentives for unnecessarily high levels of health care utilization, the legislation and the institutions involved (and sometime everyday practice) introduced several mechanisms. Among them is the role of the chosen GP as a statutory first-contact physician and a gatekeeper to higher (specialized) levels of health care and to the right to temporary health-related absence from work (see also Chapter 5.1.5). In case this rule is violated, CHI will not cover the cost of the service (except in urgent cases). However, this restriction did not prove to be as effective as first intended. Partly due to capitation, primary level physicians have tended to send patients massively to higher levels of care. This was one of the reasons for long waiting lists and a rise in costs. To ensure a more founded and efficient use of public resources, starting in 2001 a GP is guaranteed to receive 92% of the total value of the services he performs. The

additional 8% are only paid by NHII if the GP performs the whole prescribed program of preventive services; the number of his or her referrals to secondary level must not deviate from the Slovenian average for more than two standard deviations; and the GP should not have waiting lists.

The tripartite negotiations in which the range of services purchased by CHI and the capacities needed are determined *ex ante*, could also be seen as an instrument to restrict the availability of services - especially when the funds are close to running out. Due to long waiting lists, however, these contracts in certain years include some extra funds to ensure extensions to certain programmes. These negotiations also need to provide for a regionally equal access to medical services for all. It is implemented by the enforced system of financing according to which the funds are distributed between regions depending on the number of people living in these. The allowed deviation in providing services is then +/- 3% from the Slovenian average, though in reality the deviations are much larger. Indexes of provision in the regions are presented in Table 5.3.

Table 5.3: Regional medical service provision indices in 2001 (Slovenia=100)

Region	GP, child care	Dispensaries for women	Adult dentistry	Youth dentistry
Celje	101,32	94,07	95,41	72,34
Koper	102,03	86,02	100,28	108,74
Kranj	100,31	91,88	96,90	90,57
Krško	99,38	104,03	88,98	82,76
Ljubljana	97,87	105,44	103,60	112,94
Maribor	100,94	93,89	105,51	113,23
Murska Sobota	102,55	119,82	98,56	94,38
Nova Gorica	101,00	103,12	107,67	115,56
Novo mesto	97,81	95,32	92,58	82,25
Ravne na Koroškem	102,16	103,51	91,05	85,23

Source: ZZZS, 2002.

These negotiations therefore also determine the number of health care staff. There are rather conflicting views as to whether the coverage of population with GPs, specialists and nurses is adequate or not. The number of these per 1.000 people is somewhat lower than in most other EU and accession countries. This could be seen as giving scope to more rational utilization of public funds. Despite the relatively high remuneration of health care staff (especially physicians), an estimated shortage of 600 physicians and a lack of competent

knowledge in health care management, the system places a heavy burden on the health care staff.

An especially unpopular measure to curb the demand for health care are waiting lists, partly a result of inadequate capacities, and partly of some other factors (see below for details, Chapter 5.1.5). Besides additional funds for certain programmes, these are to be reduced by an increased reliance on preventive policies.

CHI, together with VHI, ensures the covered population a sufficient provision of health care services. Hence, as very low level of required additional out-of-pocket payments in needed. However, as discussed in Chapter 5.1.3, there is no reliable statistical data other than estimates as to how much an average household spends on out-of-pocket health care.

5.1.5 Coverage of the system and access to care

In articles 50 and 51, the Constitution of the Republic of Slovenia assures CHI for all citizens under the State's regulation and as specified in the corresponding Act. The HCHIA further lays the legislative ground for the establishment of the NHII as the exclusive national CHI provider, and specifies all the population groups and their family members (see Chapter 2.3.1) for which the CHI is mandatory. Once the conditions for CHI are met, there is no chance of opting out notwithstanding, e.g. the citizen's income. The coverage of the population with CHI in recent years has thus been, despite the contribution system, between 98 and 99%, though the NHII acknowledges the possibility of errors and omissions in its databases. The system rests on the principle of solidarity, as the funds are redistributed from the rich to the poor, from the healthy to the sick and from the young to the old.

In its Pre-accession Economic Programme (PEP) (2001: 19-20, 66), the Government wrote that it will "[…] prepare amendments to the health care legislation, and introduce additional financial burdens on individuals whose habits and behaviour and other forms of unhealthy living represent an increased risk to health." As intuitively appropriate as such a intention may be at the first glance, it is unfortunately in direct conflict with the subsequent statement that the "[s]tructural reform within the system of paying health care costs will ensure greater fairness […][and] greater responsibility of citizens for their own health", as such an imposition might place an unacceptably heavy burden on the socially weak groups of population resulting in a hindered access to medical care and a deviation from the solidarity principle.

The insured person is entitled to select his or her own first-contact physician: a GP and a dentist, and, if applicable, a gynaecologist and a paediatrician. In the most part, the primary level thus "regulates and restricts" access to care and the insured person's freedom of choice However, the restriction only applies to the obligatory contact with the first-contact physician in order to receive health care services at the higher levels of care. The insured persons are otherwise free to

change their first-contact physician in case they wish to do so. In this way, the freedom of choice is virtually complete, and the primary care physician acts only as a barrier to cut the costs as the specialist's services are expensive and waiting lines are long. In the future, the conditions for referral to higher levels of care will be made more restrictive (see also Chapter 5.1.4).

Due to threats to financial sustainability of the system, the trend is in incremental retrenchment of rights stemming from CHI, and the gap between an ever-increasing demand and what is covered is widening. The NHII estimates that, compared to West or Central European countries, the insured persons in Slovenia do not enjoy a more extensive range of rights derived from CHI. Moreover, for some of the health services the share of costs covered by CHI is considerably lower and the corresponding difference to be covered by some type of private funds is therefore larger. The access to primary care is comparable to that in other countries, while there is a lag in some outpatient and inpatient specialist services, long-term care and medical treatment and care at home[36], the introduction of the most complex and state-of-the-art diagnostic and therapeutic services (i.e. transplantations, cardiology, magnetic resonance, etc.). In cases such as health resort treatment, certain dental services, etc., it is considered that the rights granted are still too extensive and might be curtailed or even eliminated in the future. On the other hand, unjustified claims of rights from CHI such as in the case of non-urgent transportation, certain medications and instances of moral hazard, however, are a sign of inconsistent execution of CHI regulations rather than of extensiveness of rights. The field of access to care is therefore certainly one of those that will need to be given more regulative and administrative attention.

The access to care is in some cases hindered by non-market instruments such as waiting lists. In mid-90's, the insured persons could avoid sometimes absurdly long waiting lists in public health care facilities by opting to pay for the services that were otherwise covered by CHI. Those who could afford to pay for mainly specialist services were thus given priority while the principle of equal access to care was violated. This anomaly showed that the waiting lists were in major part not based on objective factors such as a sub-optimal ratio of demand to supply; moreover, they more likely served as an instrument to force the patients to pay for the rights that they had already assured by CHI. Waiting lists are now regulated by yearly tripartite negotiations, with the agreed stipulations being obligatory and sanctioned. Currently, there should be no waiting lists for public and private GP's and paediatricians; in hospitals, the maximum waiting periods should not exceed one year (though in reality this has not been achieved yet), while they are still the longest (up to three or more years) in orthodontic care. Further reductions in waiting periods are stimulated with additional financial resources from NHII.

[36] For this reason, the NHII proposed the enactment of a new type of compulsory long-term care insurance.

The article 14 of the Constitution declares equal treatment regardless of gender; the infringement of social insurance rights is further incriminated by the Penal Code. There are no special provisions in the health-related social security legislation concerning equal treatment or discrimination. The health-related social security schemes are insurance schemes; they are uniform for the entire working population and their family members. The *de facto* position of men and women therefore depends on their position on the labour market. CHI is obligatory for men and women working full or part time and regardless of their earnings, marital or family status and under equal conditions. The entitlements are provided in a gender-neutral way, though in the wording of the legal documents, the male form is used. On the benefits side, it is estimated that the statutory wage compensation for a parent caring for a sick child has adverse effects on employment of women who are potentially more absent from work for these reasons (especially in the case of one-parent families). The employer's obligation to cover sick pay for the first 30 days of health-related absence from work might have the same effect. On the basis of this provision, employers cover the expenses of sick leave of pregnant workers, which is estimated to be quite a frequent occurrence. In the case of occupational diseases and work injuries, there could also be cases of *de facto* discrimination, if it could be proven that women or men are treated unequally in procedures of evaluation of their working capacity, which is key to determining their right s to invalidity pension, other benefits and professional rehabilitation.

5.1.6 Public acceptance of the system

Used to the pre-1992 system of health care and access to treatment, the citizens greeted the new system of CHI and VHI with a certain degree of disapproval. However, as they in the end became accustomed to having to devote part of their earnings to health insurance, many perceive the above-mentioned incremental retrenchment of CHI rights as inappropriate.

The WHO Health Report 2000 ranked Slovenia as 37th regarding its achievement in the level of responsiveness assessed by the informants' evaluation of the health system.

Slovenian Public Opinion Survey data for 1994, 1996 and 1999 (Tos et al., 1994; 1996; 1999; authors' computations) shows that the general population is not completely satisfied with the health care system and do not have full trust in the care providers. Throughout the survey years, they exhibited a rather high level (more than 40%) of disbelief that in case of need, the providers would make sure the respondents receive all the appropriate medical care. Among those who had been seeking medical care in the 12 months prior to the survey, approximately 70% believed that the doctor had done everything within his or her power to cure them. The respondents were most annoyed by long waiting lists (more than 70%), bureaucracy (approx. 60%) and giving some patients a privileged position (approx. 66%). On the other hand, they showed a relatively high level of trust in the quality of medical services (70% of respondents and more), and a 60% level of satisfaction with how medical personnel treats

patients (interestingly, females were less satisfied with the doctor-patient relationship). Between 50 and 80% of the respondents were satisfied with the dental, GP and specialist services in their area, the levels being the lowest for the latter, while the levels of dissatisfaction with these were around 12 to 25%. Especially for the dental and GP services, the levels of satisfaction were rising and levels of dissatisfaction were decreasing between 1994 and 1999. Slightly more than a half of the patients greeted introduction of private health care practice with approval, and among those who had seen a private doctor, the majority said it was more satisfied than with doctors in public institutions. Between a fourth and a third of the respondents strongly believed that shifting the health care financial burden from the state onto the individual was not appropriate, while approximately 10% feared that the introduction of VHI would result in lower service quality and public health.

The Government assured in its PEP (2001: 65) that it will introduce a system that will, inter alia, "show […] the level of satisfaction with the system in comparison to public investment in the health service and the health system [and] set up institutions for the protection of citizens' rights."

The insured persons are becoming more acquainted with their CHI rights and the enacted complaint procedures. Those can be filed at the NHII and its boards (especially frequent in cases of determining the temporary incapacity to work, authorization to health resort treatment and reimbursement of travel costs), the service providers, the Constitutional and specialized courts, MoH, Ministry of Labour, Family and Social Affairs, Parliament, certain NGOs (e.g., Consumers' Association), the Ombudsman, etc. Generally, the complaint procedures are fairly long.

There still remains scope for increasing transparency of complaint procedures. In general, there are three different kinds of inspection. The service provider is responsible for the internal supervision, though most of these complaints have been ruled as unfounded what has given rise to doubts in their fairness. The Medical Chamber (MC) implements expert inspection. This has been a constant issue dealt by the Ombudsman; the right to this kind of inspection used to be *de facto* limited by the high price charged by MC in advance. This barrier has recently been made less prohibitive. However, due to the mission of the MC to safeguard for the rights and interests of the physicians, doubt in its impartiality is still present; the media and the public are still occasionally outraged by its rulings. Finally, MoH is in charge of the administrative and legal inspection though it occasionally relegates the cases to MC.

5.2 Evaluation of future challenges

5.2.1 Main challenges

The main goal of the Slovenian health care system for the future is raising the level of public health, adaptation and improvement of the system's functioning

given the financial possibilities. There are many challenges defined in the Slovenian National Program Health for All by 2004[37] (HfA2004) to achieve that. They are as follows:

1. Regarding **CHI** there is a tendency to preserve the system that was introduced in 1992. Its role is ensuring health and social security of the whole population of Slovenia through coverage of costs for healthcare services. It was implemented along the principles of solidarity among insured persons, equality of treatment and entitlements to healthcare services, concern for quality assurance and protection of the insured persons' rights. The CHI system preservation is not a possibility anymore but downright urgency.

2. In **VHI,** the main challenge is to introduce a system that will promote quality in the range of insurance possibilities available and regulate the cost of insurance through competition. Long-term insurance that will ensure the beneficiaries good health and social security in old age should be introduced. It should be based on principles of mutuality and inter-generational relations among insurants.

Particular emphasis will be placed on development of other forms of health insurance, particularly for costs and services that are not included in CIH, or those, which at the request of the insured persons will be performed at a higher or different standard from that guaranteed by CIH. This applies to services that are covered by the CIH programme but are more difficult to access, to treatment abroad and certain other services. Through amendments to the existing legislation, employers could be given the possibility, within the framework of VHI, of insuring their employees for specific healthcare services.

3. Decisions on professional development and the scope of healthcare activities will be adopted on the basis of assessments of health and economic benefits, with costs being taken into consideration (**cost benefit analysis**).

4. **Primary health care:** The healthcare centre shall remain the central provider of basic healthcare activities in the network of public healthcare services, which should be taken into consideration by the contractor when deciding upon the issue of concessions.

In order to coordinate healthcare activities within the network of public healthcare services and to efficiently manage the common tasks of public healthcare institutions and concessionaires, it will be necessary to found councils for public healthcare services in the area of several municipalities or in a region as an advisory body of the founder of a public healthcare institution or of the contractors.

Priority will be given to provision and funding of preventive programmes.

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[37] Nacionalni program zdravstvenega varstva Republike Slovenije – Zdravje za vse do leta 2004.

5. **Pharmaceutical activities** can be gradually switched over from public to private. With an increase in the number of pharmacies and pharmacists, the pharmaceutical network and the level of competition in supply of medicines will be improved. Through an equal distribution of pharmaceutical branches, better access to medicines should be ensured.

6. Professionally oriented **specialist healthcare for non-hospitalised patients** are planned to be provided.

7. In order to reduce the costs of **hospital activities**, new types of hospital healthcare will be introduced that will lower the hospitalisation period or the number of patients staying in hospitals overnight. Therefore nursing hospitals, hospital treatment at home, hospitals in which patients stay for short periods and day-care hospitals are planned to be introduced.

The details of their functioning and the conditions for their introduction are not yet defined. The introduction of new forms of hospital will condition the gradual adaptation of personnel norms, while in the area of nursing, cooperation with GPs and the field of social care will be stimulated.

8. The development of **emergency medical aid** at all the three levels of service operation (pre-hospital emergency aid, hospital emergency aid and emergency ambulance services) is to be developed. In this area of operation close links with non-medical participants in the provision of medical aid will be established. Appropriate transport for patients in acute danger will be organised, and the possibility of introducing new approaches to provision of emergency medical aid to those injured in traffic accidents (e.g. motorcycle paramedics) studies will be set up.

9. In the area of **long-term care**, the main challenge is to set up a unified system of long-term care throughout the country and to ensure adequate substantive coordination of care providers. These should provide high-quality healthcare, social and other services to the elderly, physically handicapped people and other individuals who need long-term care. To achieve this, it will be necessary to establish uniform compulsory public insurance for long-term care in Slovenia. Those entitled would have rights in kind (services at institutions) and/or rights in the form of monetary benefits. Such a system of long-term care based on a single organisational structure and public insurance will not require a significant increase in public funding; it is expected to bring greater justice and thereby public satisfaction.

10. **Quality** will be assured through training of healthcare staff, the appropriate use of technology, and the uniform definition of quality procedures and programmes. The real challenge is to gradually introduce an integral quality approach to the handling of patients during treatment procedures.

11. The health care system is experiencing a lack of services in the **post-hospital care**. New programmes of community care for people with long-term mental health problems will be designed. The programmes will be oriented towards rehabilitation and prevention, with a particular emphasis on resolving crisis situations.

12. Estimates show that currently there is a **lack of physicians** in Slovenia. An important challenge is to assure that in the near future, either by higher enrolment at the Faculty of Medicine or by immigration of physicians, the appropriate number of physicians is achieved. The predictions show that the demand for new healthcare workers within the network of public healthcare services will rise additionally because of retirements, departures to private practice, the adjustment of working time to the EU directives, etc.

Enrolment at the Faculty of Medicine and other healthcare schools should proceed from the professionally estimated and verified demand for specific healthcare professions, both within the public network and outside of it (private practitioners without a concession, Slovenian doctors abroad, foreign students, those paying for themselves, etc.).

13. **Health care funding**: the main challenge is to ensure that healthcare remains on at least the same level as it is now, which means that the share of public expenditure spent on healthcare shall remain at 7% of GDP in the years ahead. Given the progress in medical technology and state-of-the-art medical procedures it will only be possible to preserve healthcare programmes at the current level through consistent control of costs and setting of priorities.

14. **Health Information System**: the setting-up of a unified health information system in order to provide the required information for policymaking, planning, steering, development and effective and efficient functioning of the health care system, will be one of the main challenges in the years ahead. It is also a precondition for a continuing rise in the level of expertise and quality in the healthcare sector, the possibility of exchanging information and opinion among physicians (telemedicine), greater transparency in commercial developments and in monitoring of efficiency and operating costs. Investment policy at healthcare institutions and employee training will also be adjusted along these guidelines.

In collaboration with other relevant government departments and institutions within the system of healthcare and health insurance, MoH will in the period in question prepare a project of modernising the health information system at the national level. The project envisages the creation of a national centre for the exchange of information from health departments (the National Health Information Clearinghouse (NHIC)) and data storage points at providers of public healthcare services. In this process the internationally valid standards in the area of health information will be consistently applied, and all the necessary data protection measures will be ensured.

15. **Training of Experts for Managerial Functions**: the healthcare management must be ensured the maximum possible level of autonomy within the framework of regulations of public finance management. At the same time, a greater level of deregulation and decentralisation will be aimed at, particularly in the field of hospital administration, with the objective of achieving maximum efficiency in the management of the assets available. A separation of the administrative and professional functions of the managerial personnel at healthcare institutions shall be insured.

5.2.2 Financial sustainability

The health care system, as we know it today, is not financially sustainable in itself. This can be seen from the financial statements of the NHII for CHI, which showed a deficit of 11,03 billion SIT in 2001 (approx. 50,6 million EUR in 2001 prices). The outlays grew very fast due to a fast rise of outlays for medicines, a rise in physicians' wages and some changes in legislation. Based on the level of public health, its demographic characteristics (primarily the rise in the proportion of those aged over 60), its socio-economic characteristics (the growing number of poor), *we can expect greater demand for health care services and thus a rise in the costs of healthcare programmes*. Given the demographic projections, the population of Slovenia will fall slightly in the years ahead. It is expected to drop by 5% by 2020 as a result of a low birth rate and minimal net immigration. Changes can also be expected in the age structure of the population. A fall in the proportion of the population under 19 years of age is expected, while the proportion of the population aged over 65 will rise. According to estimates of changes in the number of pensioners and the size of the working population, a slight growth of the share of active population (aged 15-64) is expected until 2003, when it will begin to fall. The ratio of pensioners to working population will fall to 0,5 in 2005, but will begin to rise again in 2010, reaching 0,6 in 2020.

If the health care system is to become financially sustainable, a reform is urgent in all the segments of its funding. Depending on the types of institutions in health care system, the following changes in funding should be introduced:

a) In case of basic healthcare activities, the system of capitation will continue to be used. This should bring all of the revenue to general clinics, school and children’s clinics and clinics for women. The costs of laboratory activities will continue to be a component of the costs of services and capitation. The services system (where the payment depends on the number of services provided and reported) will be abandoned.

b) Funding of nursing at home will be based on a service system, which will only contain a few differently priced tasks, while the financing of outpatient clinic activities will be based on a system of realisation of an annual plan.

c) The service system will be retained in dentistry, whereby it is necessary to significantly reduce the number of services, and to make the number of services

provided dependent on the number of allocated insured persons. Prices for these activities will also continue to be the same throughout Slovenia.

d) Within the ambulance service, the cost of kilometres travelled on non-emergency trips will be the standardised. Emergency rides will only be performed by ambulance stations at public institutions and within the framework of the lump-sum amounts agreed.

e) In hospital healthcare services the system of funding will be changed in the direction of DRG, while payment by hospital care day (and transitory cases) will be abandoned.

f) Within the field of health resort activities, the system of payment for the non-medical ("hotel") and medical parts of a day of care will continue to apply.

g) Within specialist outpatient activities, the service system will remain valid, but will undergo a fundamental overhaul and modernisation, where greater emphasis will be given to direct work with the patient, particularly in the initial examination. The possible percentage of functional diagnostic investigations will be defined. In addition to the total number of services, the number of initial examinations performed will be the criterion for the achievement of the programme and the level of entitlement to planned agreed revenue.

h) The funding of pharmaceutical activities will be harmonised with the European system.

i) In social care institutions, the system of funding will continue to rest on charging for three types of day care and the price of a particular type of care will be the same throughout the country.

j) The prices of services from healthcare providers, who are not contractual partners of NHII but will provide services otherwise covered by CHI, will have to be approved by MoH. They will be based on the same calculation elements that apply to NHII contractual partners.

5.2.3 Health care policy and EU accession

Slovenia managed to come out of the transition period with a health care system that is relatively stable, and a comparatively good level of public health. It has reached the standards of the southern member states and is striving for the level of the more developed members. The system in one way or another requires further short-, medium- and long-term reform efforts to remain in financial balance, and gradual upgrading and equipping for a more dynamic responsiveness to new market and demographic challenges. Though health-related legislation in general has not been the Parliament's priority, Slovenia is trying to meet the imposed deadlines to enact all the so-called "EU" health-related laws, and, where needed, to adapt the existing legislation to EU directives. Unfortunately, due to frequent haste, the legislation drafts tend to be

of inadequate quality, demanding a great number of subsequent amendments and consequential longer-than-needed procedures. However, a large number of health-related laws have been passed with special shortened or rapid parliamentary procedures. Once passed, a further challenge to the legislation is generally its implementation and administration.

In the process of joining the EU, the national HfA2004 identifies the following development areas in the process of joining the EU: better access to health care by an extensive and improved public health care system, a bigger emphasis on health education, health promotion and prevention, especially in the case of chronic diseases, enforcement of the legislation concerning adverse effects of physical, chemical, biological and social risk factors, protection of the environment, interdisciplinary research and international cooperation in combating public health problems, continuous monitoring of the HfA2004 implementation and the legislative compliance with EU directives.

No major transitional difficulties are expected in the field of health care and CHI due to accession to EU and the adoption of the *acquis communautaire*. The essence of article 152 of the Treaty of Amsterdam can already be found in HCHIA. For 2001, the EU Commission estimates that the adoption progress in the field of free movement of labour and health issues has been small. The needed changes in the legislation are not expected to bring about major changes in the level and structure of rights that are already laid down in the existing legislation and bilateral agreements. Above all, they will need to accommodate these rights for the citizens of other Member States in order to provide equal treatment of individuals and facilitate free movement of labour.

As a future member state, Slovenia will have to sign administrative agreements regulating the implementation of CHI, where those will be needed. The Accession agreement already enables Slovenia to take part in framework programmes, specific programmes, projects, etc., in the field of health care and all the other health-related fields of public policy. Some of their major goals are strengthening of administrative capacities in the health care sector and facilitation of coordination and cooperation at the EU level.

The existing Slovenian legislation does not directly discriminate migrants from EU countries. However, as some rights in HCHIA are conditional upon permanent residence in Slovenia, they will have to be adjusted so as to conform to the Regulation 1408/71 of the EU. Additionally, the changes will have to address the issue of comparability of legislative terminology such as residence, family members, etc.

The rights determined by the existing bilateral agreements are already similar to the EU coordination regulations in case of health services provision. In case of pensioners and their family members temporarily living in other member states, there might come to an increase in costs due to treatment that is not restricted to urgent states. Similar consequences of harmonization of the legislation can be expected in case of the unemployed seeking employment in

other member states, students receiving education in other member states and similar groups and their family members. As the majority of the health services are already provided on a high enough level at a lower price than in the member states, it is not expected that a great many of patients will opt to receive those abroad.

EU case law such as Kohll/Decker and Smits/Perenboom judgements and their consequences still need to be given thorough consideration. Most of these could be accommodated by appropriate changes in the documents on the regulation of CHI, which are under the competence of the NHII; it is possible, though, that they will be reflected in a change of the CHI legislation itself.

One of the major expected legislative changes is in the field of recognition of sufficiency of the doctors' qualifications. However, larger influx or outflow of the medical personnel is not expected. The reason for this is partly the language barrier. Besides, the health care staff's remuneration in Slovenia is relatively high.

It is expected that especially the VHI market will open to new, domestic and foreign, competitors. This should result in a wider range of insurance possibilities offered at competitive prices, but possibly also dependence of the premium on the risk factors such as smoking, excessive intake of alcohol, high-risk sports, etc. A more thorough adaptation of the existing legislation on VHI will be needed when accessing EU than in CHI.

5.3 Evaluation of recent and planned reforms

5.3.1 Recent reforms in health care

In 1992, HCHIA introduced CIH. It also gave a legislative foundation to NHII, which took over the major part of health care financing. VHI was introduced and therefore the payments system had to be changed. The service system, where different services were defined and had their prices laid down in the so-called "Green paper", had to be abandoned. It was, however, abandoned only in two sectors: in hospital financing and in primary care. In the following years, the system changed the financing of social care institutions for which three types of care were defined. A capitation fee was partly introduced in primary care in 1993. In hospital care, the service system was changed for the system of payments based on hospital days. Private healthcare practice was reintroduced. Until then, the changes in health care were mostly non-systematic and were not seen as a proper reform; rather, changes were introduced each year through partner negotiations.

The most recent reform took place in 1998. It had the objective to stabilise the share of public health-care expenditure at 6.5-7.0% of GDP by 2000, along with retaining the maximum possible level of solidarity in the health care system and keeping the existing level of rights from CHI. On the basis of justice, equality principles, unified standards of service quality and other rights,

CHI was to assure equal treatment of all the insured persons regarding health-care services. Additionally, the goal was an improvement in the existing health insurance, as well as organising and providing health care services. Heath care system should develop on the basis of public-private financing and supply of health care, characterised by an adaptation in line with the EU systems. The goal was an increased public health care network performance and efficiency of the resource use. It has been expected to be achieved by moving the accent of health care activities from curative, mostly hospital, to basic health-care areas. The health care quality has to be increased in order to increase the satisfaction of users and improving public health. One of further objectives of the reform was development of various forms of additional VHI. An individual's health was to be better protected by concerted efforts to change health-damaging life styles and by adopting the national programme of preventive health care. Since 1997, no further reform took place until 2002. In 2002 some major changes started to be introduced, which mostly refer to the system of financing and funding of different segment of health care (mostly hospitals, but also basic health care activities, nursing at home, dentistry et al). However, Ministry of Health refuses to call these changes "a reform" as they are introduced slowly and gradually. For more detailed description of the changes please refer to 5.2.2.

5.3.2 Political directions of future reforms

The major goal of the planned reform is to secure long-term stability of the system and to found its managing on provable and verifiable data focussed on the patient. There are six main impacts expected from the planned reform:

1. An adapted and improved reimbursement system, what stands for a more efficient, transparent and flexible system of payment of services to health care providers in order to enhance equity of access to clients.
2. A strengthened health sector management, which means that management function in the health care sector should be refined by introducing and implementing new efficient management tools (e.g., business operation planning model, organisation efficiency model, management information system, etc.), and improvements in resource management.
3. Standardisation of guidelines of diagnostic and other procedures to improve the comparison possibilities and to enable the same diagnostic procedures for the same illness for all patients. Standardised clinical guidelines will form the basis for financing, professional and financial comparisons and for estimation of quality of services, as well as a basis for determining priority areas in the Slovenian health care.
4. Development of an integral quality approach in health care: it is believed that the quality of the health care system in Slovenia is very high based on standard indicators such as infant mortality, life expectancy etc. However, there are no specific indicators that would get to the bottom of specific matters in health care. Therefore, no systematic control over integral quality has been installed. Standard procedures and clinical guidelines are not defined, information system and technology are bad and there is no basic

awareness and knowledge as yet that quality is very important. Besides, patients in Slovenia are not in any way involved in the evaluation of the health care system.

5. Enhancement of efficiency of collecting health care contributions: the health care contributions are collected only from gross wages and not from other personal incomes. The sum of uncollected contributions is growing larger each year; mostly they are not collected in full from farmers and the self-employed. The supervision over collecting should be improved.
6. Stronger emphasis on health promotion and prevention: until now, there has been no systematic programme on health promotion and prevention. All the activities that have been performed were sporadic. Besides, most of the activities performed were of passive nature. The goal in this field is to set up a detailed programme of health promotion and prevention and to actively promote such actions among the population.

Consensus among all parties, particularly MoH and NHII, is needed for an effective reform to take place. A reform of the hospital payment model, or better, the broader reimbursement system is especially critical in this sense. There is an agreement on the general model, but the speed at which the changes should occur is a source concern. MoH supports an immediate change, whilst NHII feels that sudden modifications would not allow enough time to introduce a new system of data collection and billing to support the new model. In their view, an immediate introduction of changes will create an atmosphere of confusion amongst hospitals and undermine the initial efforts.

There is a strong consensus in the country about the direction and general principles of the reform, but there is no explicit strategy to outline the approach for achieving the stated objectives. This could create problems, as there might be different priorities and indeed objections underlying the current processes. There have been a number of problems created, as the available information databases are not sufficient.

Despite the political and social consensus about the direction and objectives of the reform, pressure has been created by clinicians. These argue that introducing a new payment model will interfere in their clinical practice. In general, however, according to MC, there appears to be support for clinical pathways and a general understanding of the benefits of a new, refined per case model of hospital financing. Some opposition also comes from the hospital management side, as hospitals will have to become more accountable at all levels. On the side of NHII, enjoying a high level of public support because the health care system financing has been quite stable until now, there appears to be a feeling that *status-quo* would be the best and doubts have been expressed in the ability to make substantial progress in practice.

The unexpected problem that appeared is a problem with the media: the planned reform, particularly the reimbursement system, has become a matter of unprecedented media interest, mostly because of political disagreement between

MoH and NHII regarding the timing of introducing the new payment model. Various articles about the proposed approach to changes in hospital reimbursement system have been published and some of them have had the potential of undermining the search for consensus.

5.3.3 Conclusions

In the period since 1992, the year of the major reform, changes to Slovenian health care policies have been incremental rather than thorough. These have been predominantly marked by narrowing the rights stemming from CHI, and claims to increase the contribution rate. The system functions through tripartite negotiations in which the representatives of NHII, providers and MoH (as the three main policy actors in the field) determine its dimensions in each following year. These have recently began showing traits of imperfection that have their origins in relatively inflexible standpoints of the negotiators, as well as in contextual factors. NHII is the principal financier of the system, controlling the majority of the funds spent on health care in Slovenia. It is a relatively autonomous institution, with not much control over how MoH policies are made. Size-wise, the largest providers are hospitals. The hospital market is explicitly concentrated, with one major hospital and approximately ten others, much smaller in size. Their size shows in their importance (in expertise, the number of patients treated, number of specialised departments, etc.), and their importance shows in their negotiation power. It has not been uncommon that the MoH staff has come from the largest hospital(s) and after the mandate was finished, it returned to the same hospital. Except for the very first, all the Ministers of health have been physicians. The close connections between the providers and politics have therefore not been completely excluded from running the system.

Increasingly, the emphasis has been given to health promotion and health prevention. These will have to address regional differences and a lag in the main health indicators such life expectancy at birth, infant mortality, mortality rates before age 65, etc. In cooperation with some domestic, foreign and international agencies, the main proponent of such policies has been MoH who initiated some interesting and, design-wise, comprehensive programs. Among them were those of stimulating regional economic growth as a proxy goal in raising the level of public health, and those of combating most prevalent risk factors. As these programmes are middle- and long-term in their nature, it is not yet clear what benefits these efforts will actually yield. However, it is clear that the nature of health policies is inclining towards considering a wider scope of factors affecting health, i.e. not merely medical but also socio-economic.

The main threat to the system and its sustainability are by far unfavourable demographic changes. The share of the old in the whole population is on the increase while the share of the young is decreasing; the population is ageing and the population growth is low or, in some years, even slightly negative. The tendency is therefore to a decrease in the number of active population and an

increase in the number of the older population where the highest health care costs are concentrated.

Health policy design, implementation and control have been hampered by the lack of high-quality health data, with the bulk of data collected under the responsibility of IPH and NHII. It has recently been proposed to organize data collection in NHIC and thus making sure the same piece of data is not collected twice, while taking care of the appropriate level of data quality and reliability. Data collection will be coupled by an increased reliance on modern information methods and means within the whole health sector.

From the current viewpoint, it seems that required compliance with the EU-regulations within the health sector and health insurance will not bring about major changes. The 1992 HCHIA and other legal documents based on it already contain the most important provisions. More significant adjustments will have to be made within the VHI field as it is expected that the competition will increase once the market is completely open to both domestic and foreign VHI providers.

There is a political consensus not to violate the in-built principle of solidarity and equality of access. Therefore, it is expected that the system will preserve these traits, though it is clear that the proposed changes, such as the incorporation of the individual's risk into the contributions imposed, might cause a divergence from this ideal.

In order to provide adequate medical care to the population, it is an imperative to introduce relevant standards of care, enhance the quality level of services provided and ensure an appropriate level of state-of-the-art technology development. This, together with the unfavourable demographic situation, but also with the principle of solidarity, brings into question the long-term financial sustainability. This issue will be the main issue that will need to be addressed by future reforms. It is unlikely, however, that the prevailing politics of incremental changes will be enough to ensure future stability within the health care system.

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