
# ESPN Thematic Report on Inequalities in access to healthcare

## Slovenia

**2018**

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*May 2018*

**EUROPEAN COMMISSION**

Directorate-General for Employment, Social Affairs and Inclusion
Directorate C — Social Affairs
Unit C.2 — Modernisation of social protection systems

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## European Social Policy Network (ESPN)

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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## Summary/Highlights

Healthcare coverage in Slovenia is universal, as more than 99% of the population is covered by compulsory healthcare insurance, provided by the Health Insurance Institute of Slovenia. A few people are uninsured on a temporary basis, due to status changes (e.g. from student to employee). Undocumented migrants and entrepreneurs in bankruptcy do not have access to healthcare services, on the grounds of not having paid contributions: but neither group is counted in the official statistics as uninsured.

As much as 95% of the population liable to co-payments for healthcare is also covered by complementary health insurance (CHI), which is the main reason for low out-of-pocket expenditure on healthcare in Slovenia. In practice, CHI is very important as it covers co-payments for health services that can account for as much as 90% of the service value.. For persons not covered by CHI, access to most services is seriously hindered as co-payments can be very high. CHI has helped ensure the financial stability of the healthcare system over the last decade through a series of increases in the percentage of services it covers. On the other hand, CHI is regressive as it is based on flat-rate payments. During the economic crisis (2008-2010) there was an increase in the number of individuals who could not afford CHI any longer and were thus exposed to co-payments and the danger of unmet medical need. The government subsidises CHI premiums in the case of some poorer households. Slovenian households are largely protected from the costs of healthcare: in 2012, just 1% of households experienced catastrophic spending.

The share of households without any out-of-pocket (OOP) health expenditure halved between 2006 and 2015, indicating that households are increasingly prone to the need to spend on healthcare. Before the crisis, the increase was primarily associated with the rapid expansion of the private practice network. During the crisis, OOP spending increased, particularly because the decline in income forced households to lower their expenditure for other purposes relatively more than their OOP spending on healthcare. Currently, the main reason for increases in OOP spending is hindered access to healthcare services, due to long waiting lists in the public healthcare network. The whole period is also marked by increasing expectations and concerns of the population regarding their health (Zver and Srakar, 2018).

Slovenia has consistently had one of the lowest levels of unmet healthcare need in Europe for all income groups (Eurostat, 2017b). It should be noted, however, that the robustness of these data for Slovenia has been questioned, because of what may be a different understanding of the respective question in the EU-SILC questionnaire. This issue has been flagged. There are other indicators, such as waiting lists and the number of physicians per capita, that can be used to estimate unmet needs.

The resolution on the national healthcare plan for 2008-2013 (2008) pointed to the shortage of primary care physicians in some areas of the country, especially rural areas, as a particularly pressing issue. Since the resolution was passed, various measures have been taken in order to tackle the problem, notably an increase in the number of publicly financed training places in family medicine relative to other specialties, as well as additional financing of rural health centres. At the secondary level, the main issues on the policy agenda have been regionalisation and specialisation. Relatively small regional hospitals often offer a wide range of specialised services, raising concerns about patient safety and economic efficiency. Proposals to reduce the number of hospitals that offer specific procedures, or reduce the number of hospital departments in various areas of the country, have met strong public opposition in local communities. There are some positive examples of regionalisation and specialisation as well.

In the last four years, the major challenge has been long waiting lists that thwart timely access to healthcare. Waiting times are the cause of much public debate in Slovenia and are probably the major source of patient dissatisfaction with the healthcare system. Waiting lists have been lengthening consistently in spite of measures such as occasional additional financing, and penalties for referrals that do not follow the set criteria.

Two examples are presented of good practice that is aimed at reducing inequalities in access to healthcare: one concerning the potential for using nutrition and physical activity to reduce health inequalities among children and adolescents, and the other for integrating vulnerable people in a preventive programme called 'Together for health'.

There are currently no healthcare reforms planned in Slovenia, since there is only a caretaker government pending general elections on 3 June 2018.

# 1 Description of the functioning of the country's healthcare system for access

The resolution on the national healthcare plan 2016-2025, 'Together for a healthy society' (2016), was adopted by the Parliament on 29 March 2016. According to the plan, the universality, solidarity, equality, equity of financing, accessibility, quality and safety of healthcare remain the core values of the healthcare system in Slovenia.

The Slovenian healthcare system is based on solidarity, with universal coverage. The centralised compulsory health insurance system entitles virtually all persons with permanent residence in Slovenia — insured persons and their dependants — to all health services and benefits covered by the scheme. It includes self-employed people. At the end of 2017, there were just 3,733 uninsured persons, or 0.18% of the population (4,083 at the end of 2016 and 3,979 at the end of 2015) (HIIS, 2018). In addition, there were 20,298 persons with unpaid contributions, meaning that their rights to healthcare services were suspended and that they only had access to emergency services.

The healthcare benefit package includes preventive, primary, secondary and tertiary healthcare services. It covers dental care (orthodontic care for children) and mental care, rehabilitation services, pharmaceuticals, medical devices, sick leave exceeding 30 days, and travel costs within a defined percentage. Almost universal coverage by health insurance results in the low availability of some services due to long waiting lists, and also puts the financial sustainability of the system in jeopardy.

Some healthcare services (family planning, prevention, screening, occupational diseases, donations and transplantations, and long-term nursing care) and services for certain population groups (pregnant women and children) are fully financed from the compulsory health insurance system. For all other healthcare services, cost-sharing through co-payments applies. Public healthcare insurance contribution rates for different categories of insured people are set as a percentage of the relevant income base applicable to each category (e.g. personal gross salary or income, average salary, or allowance). The funds are raised predominantly (>90%) from salary-based (employees' and employers') contributions and general taxation. Pensioners' contributions are financed from pension funds by means of monthly financial transfers to the Health Insurance Institute of Slovenia (HIIS): however, only an employer's contribution rate of 5.96% applies, which is less than half of the total contribution rate that applies to the active population (13.45%, made up of the employees' contribution rate of 6.36% and the employers' rate of 7.09%).

Relatively high levels of co-payments for healthcare (up to 90% of the price of services) are counterbalanced by complementary health insurance (CHI) (see details in Section 2), which is purchased by 95% of the population liable for co-payments.[1] CHI is regressive, as it is based on flat-rate payments. However, the government subsidises CHI premiums in respect of some poorer households from the central budget (Healthcare and Health Insurance Act, 1992).

At the time of their introduction, the purpose of co-payments was to limit unnecessary visits to doctors and to raise awareness of the costs of services among the population. However, as co-payments increased, they became a financial burden for patients and thus limited necessary access to services. This is the reason why people in Slovenia tend to opt for complementary health insurance – although it is formally voluntary, it is *de facto* essential, as it covers up to 90% of service costs. As discussed in Section 2, a lack of CHI can result in very high co-payments for healthcare services.

[1] Only persons with compulsory health insurance cover can be insured through complementary health insurance.

In 2017, the Slovenian healthcare system was predominantly financed from public sources (72.9%), with private financing accounting for 27.1% of total healthcare expenditure (THE). Private financing consisted mainly of: 1) payments through CHI schemes (13.9% of THE); and 2) OOP spending (12.0%), primarily to purchase goods and services not covered by the HIIS and to access healthcare provided by the private sector. Public healthcare expenditure amounted to 5.88% of GDP in 2017 (HIIS, 2018b) (Table 1).

**Table 1: Healthcare expenditure, in € million and as % of GDP, 2017**

| | € (million) | % of GDP |
|---|---|---|
| **Total expenditure** | **3,450.07** | **8.07** |
| **Public expenditure** | **2,515.40** | **5.88** |
| Central government budget | 56.23 | 0.13 |
| Local government budgets | 42.77 | 0.10 |
| HIIS | 2,333.38 | 5.46 |
| **Private expenditure** | **934.67** | **2.19** |
| Voluntary complementary health insurance | 478.28 | 1.12 |
| Out of pocket | 413.60 | 0.97 |

*Source: HIIS, 2018b.*

The proportion of private expenditure in healthcare is higher in Slovenia than the EU average of 26.7% (Eurostat, 2017a). Payments through CHI account for more than half of private expenditure. OOP payments are consequently relatively low on an international comparison. They amounted to 12.0% of THE in Slovenia in 2017, compared with 21.8% in the EU on average. The second reason for low OOP spending is the universal basket of care (depth of coverage). The largest share of OOP spending goes on medicines and medical devices (almost 60%), followed by primary care services and alternative medicine (around 20%), dental services (13%), diagnostics (5%) and hospital services including plastic surgery (3%).

Slovenian households are largely protected from OOP payments for healthcare. Only 1.0% of households experienced catastrophic health expenditures in 2012, more than half of which was for dental services not covered by the HIIS (Albreht et al., 2016). For most households, OOP payments do not expose them to poverty. More than half of OOP spending in Slovenia is related to dental services.

According to the EU-SILC data (Eurostat, 2017b), Slovenia has consistently had one of the lowest (if not the lowest) levels of unmet healthcare need in Europe for all income groups. Waiting periods at secondary level are the main reason for unsatisfied needs. Only slightly more than 1% of the total population reports unsatisfied needs, which is the least among all EU and OECD countries. This is related to the focus of the survey on the availability of primary healthcare, for which in Slovenia there are no waiting times as well as no financial constraints on access (OECD/EU, 2016; Zver and Srakar, 2018). It should be noted, however, that the robustness of the EU-SILC data for Slovenia has been questioned because of what may be a different understanding of the respective question in the questionnaire (EC, 2016). The SHARE and EHIS surveys show good availability of healthcare. According to the EHIS, as many as 13.4% of respondents reported unmet need as the result of waiting times in 2014, which was approximately equivalent to the available data on the number of all persons waiting for health care services in Slovenia (Prevolnik Rupel, Hren and Srakar, 2015; Zver and Srakar, 2018).

As concerns access to healthcare services, there are geographic variations in hospitalisation, possibly attributable to regional variation in supply and morbidity. in response to regional shortages of physicians in primary care, the number of publicly financed residency places in family medicine has been increased, most significantly in 2008, and the concept of a healthcare network in family medicine and paediatrics was initiated in 2010. At the secondary care level, proposals to restructure the hospital sector and reduce capacity in various areas of the country have met strong public opposition from local communities (e.g. Sečen, 2009). Furthermore, certain marginalised population

groups (e.g. undocumented migrants or Roma) usually have no health insurance (Albreht et al., 2016).

In the last four years, the major challenge has been long waiting lists that thwart timely access to healthcare. Waiting times are the cause of much public debate in Slovenia and probably are the major source of patient dissatisfaction with the healthcare system. Waiting lists have been lengthening consistently in spite of the occasional allocation of additional financing to solve the problem. The additional financing of healthcare by the Ministry of Health in May 2016 did not solve the problem (Marušič, Prevolnik Rupel and Kuhar, 2017). In 2017, waiting lists were lengthening further in spite of additional funding of services with long waiting lists and additional funds for healthcare providers through multiple service price increases. The latest data (as of 1 December 2017) show an increase in the number of people waiting to 234,632 (229,549 on 1 November 2017) (NIPH, 2018). In the same one-month period the number of people waiting for health services for longer than the maximum allowable time increased from 56,486 to 58,359.

It was expected that a new system of nationally integrated e-referral and e-waiting lists will allow more detailed and accurate monitoring of waiting times for a broad set of services. The e-health application, which should have provided clear and undisputed data on waiting times across 1,033 healthcare services by December 2017, and extended to cover all services in the following years, is not in full operation yet. According to the 2015 Eurobarometer survey (EC, 2015), 52% of those surveyed in Slovenia (EU average 34%) were willing to travel to another EU country to receive medical treatment more quickly.[2]

In the special Eurobarometer report on corruption (EC, 2017), Slovenia was one of seven countries where the healthcare system was the most frequently mentioned reason for corruption (giving and taking of bribes and the abuse of power for personal gain). This result for Slovenia may be related to extended waiting times and reduced access to healthcare services. Irregularities are also found in the public tendering system, as in the current high-profile case of stents (STA, 2018).

The number of healthcare practitioners has been increasing in Slovenia. There were 2.8 practitioners per 1,000 population in 2015 (2.2 in 2000), which was still below the OECD average (3.4). Almost a quarter (23%) of practitioners were general practitioners (the OECD average is 30%). The number of nurses in Slovenia (8.8 per 1,000 population) was close to the OECD average (9.0) in 2015: this amounted to 3.1 nurses per practitioner, which was above the OECD average of 2.8 (OECD, 2018). Consideration needs to be given to the skill mix required of nurses as well as the relative roles of practitioners and nurses.

# 2 Analysis of the challenges in inequalities in access to healthcare in Slovenia and the way they are tackled

While it is encouraging that Slovenia has a comparatively low level of income inequality as a whole, with a Gini index of 25.6 (World Bank, 2015), the data on inequalities in health status represent a clear call for action. A special report on these inequalities (Lesnik et al., 2018b) highlights the differences by gender and income.

The health status of the unemployed is significantly worse than that of employed persons (Lesnik et al., 2018a). This applies to obesity and malnutrition, recommended physical activity, smoking and excessive alcohol consumption. Unemployed people are also less likely than those who are employed to assess their health as well. They are more likely to suffer from long-term illnesses or other health problems. Their social links are typically weaker and they are more likely to have several severe and moderate obstructions to carrying out day-to-day activities due to health problems. They are more likely to be

[2] For all other reasons (price of services, availability of services, reputation of specialists), the difference between the EU average and Slovenia was insignificant (EC, 2015).

anxious and depressive, and to have other mental problems. Significantly lower proportions of the unemployed – as compared with the employed – use dental services, and they have more unmet dental needs. They also less likely to take part in screening tests, such as ZORA and SVIT (Lesnik et al., 2018a).

A needs-assessment report concerning health promotion and prevention featured an extensive chapter on marginalised population groups (NIPH, 2014). Undocumented migrants are excluded from access to health services due to their lack of health insurance (although they are not counted in the official statistics as uninsured). Ethnic minorities (such as Roma), migrants and homeless people, are marginalised groups with specific needs. In order to meet these needs, the report calls for measures such as the training of healthcare workers to gain cultural competencies to enhance care for these groups, and a proactive approach in the area of prevention and health promotion activities.

Provided health insurance contributions have been paid, access to healthcare services does not differ across various population groups. There are, however, important differences between employment types (self-employment and atypical employment versus 'regular' employment), If self-employed and atypically employed people fail to pay contributions, they are refused access to all healthcare services except emergency services, whereas those in 'regular' employment continue to have access to all healthcare services. The difference does not apply to children; they have access to all healthcare services in any case.

An important obstacle to healthcare access is a lack of complementary health insurance. In the Slovenian health insurance system, some healthcare services (family planning, prevention, screening, occupational diseases, donations and transplantations, and long-term nursing care) and services for certain population groups (pregnant women and children) are fully financed from compulsory health insurance. Certain shares of all other services are financed through CHI, which covers 5% to 90% of co-payment costs. The share covered depends on the seriousness of the condition: the more serious the condition, the lower the share covered. CHI is offered by three companies in Slovenia: one mutual fund (Vzajemna d.v.z.) and two insurance companies (Adriatic and Triglav Zdravstvena zavarovalnica). CHI premiums are flat-rate and almost the same for everyone, at around €27 per month (depending on discounts, group insurance and the selected insurance company).

CHI is basically an insurance against co-payments. At the time of their introduction, the purpose of co-payments was to limit unnecessary visits to the doctor and raise awareness of the costs of services among the population. However, as co-payments grew higher, they became a financial burden for patients and thus limited necessary access to services. The state subsidises CHI for certain categories of the population: the disabled, persons whose income does not reach the level set by the Social Assistance Act, and persons whose co-payments exceed the amount set by the HIIS (approximately twice the annual CHI premium). The 5% of the population not covered by CHI face high co-payments that can reach up to 90% of the costs of healthcare services. It is important to note that approximately 22,000 fewer people were covered by CHI in 2014 than in 2008. So far, no study has identified the categories of population not covered by CHI.

Due to the existence of CHI and its very high coverage, OOP payments are relatively low in Slovenia, amounting to 12.0% of THE in 2017. In the pre-crisis period (before 2009), the share of health spending increased in all income groups, but mostly in the top income brackets. This increase may have been associated with income growth and increased concerns over personal health issues over the whole period. At the same time, in the years before the crisis, privatisation of parts of the public healthcare network was promoted as well as the opening of private dental and specialist clinics, which increased OOP payments as well (Zver and Srakar, 2018).

During the economic crisis (2009-2013), increases in OOP healthcare expenditure were recorded for medical goods and therapeutic appliances, while decreases in OOP

expenditure were recorded for dental care, specialist outpatient care and various other health services (e.g. physiotherapy and alternative medicine). Households in the lowest two income brackets began to reduce their OOP health expenditure (as an increasing share of disposable income was earmarked for food and other essential items) and postpone purchases of health services and goods that are subject to OOP payments (such as dental care, prosthetics and corrective glasses). On the other hand, the share of health expenditure in total consumption was rising in households in the top income brackets. Even in these households, the level of income and consumption declined sharply during the crisis, but their spending on health declined less than their spending on other goods (Zver and Srakar, 2018). The share of healthcare expenditure in total household consumption declined for low-income households (from 2.8% in 2009 to 2.5% in 2012), while the respective share increased for households with higher incomes (from 1.7% in 2009 to 2.1% in 2012).

In the post-crisis period ( 2013-2015), the share of OOP spending declined in most households, with the exception of households in the top income bracket, where it significantly increased. The decline was partly due to the gradual increase in household spending on other goods (of which households had deprived themselves during the crisis), while the increase in the top income brackets may be to a great extent linked to the rapid increase in waiting times in the public healthcare network[3] and increased expectations and concern for personal health, which have become more pronounced in recent years, especially among more educated people (Zver and Srakar, 2018).

The geographic availability of healthcare services will be discussed in the framework of the healthcare network. The resolution on the national healthcare plan for 2008-2013 (2008) defined the healthcare network as "the distribution in space and time of the capacities of public healthcare providers and concession holders, including human, material, spatial and other resources, whereby the state ensures optimal access to health services at primary, secondary and tertiary level to its residents". The resolution states that the lack of primary care physicians in some areas of the country, especially in rural areas, was a particularly pressing issue. Various solutions were prepared and implemented, notably an increase in the number of publicly financed residency places in family medicine relative to other medical training specialties (Medical Chamber of Slovenia, 2015), as well as the designation and additional financing of rural health centres (MoH, 2011a). The strategy was to set specific criteria for the definition of rural areas, such as level of development of the area as well as distance from major cities. While these steps are expected to have important medium-term and long-term implications, ensuring the availability of primary care physicians in some areas continues to be a short-term challenge.

At the secondary level, the main issue on the policy agenda has been regionalisation and specialisation. Relatively small regional hospitals (e.g. Brežice, Topolšica, Ptuj and Trbovlje) offer a wide range of specialised services, which implies that providers sometimes perform only a few procedures of a specific type per year, raising concerns about patient safety and economic efficiency. In the past, proposals to reduce the number of hospitals that offer specific procedures, or to reduce the number of hospital departments in various areas of the country, have met strong public opposition from local communities who feared a loss of services (Petek, 2017). Two examples of such proposals are the 2010 strategy on upgrading the healthcare system (MoH, 2011b) and the strategy for development and comprehensive governance in the area of obstetrics and gynaecology (MoH, 2010), neither of which was finally adopted, for various reasons. Furthermore, measures were undertaken to ensure the quality and safety of medical procedures by preventing the HIIS contracting regional hospitals that performed only a few procedures of a specific type: article 54 of the general agreement for 2011 laid down 50 annual procedures of the same type as a minimal condition (HIIS, 2011). Moreover, there were successful steps taken in 2010 and 2011 regarding specialisation and

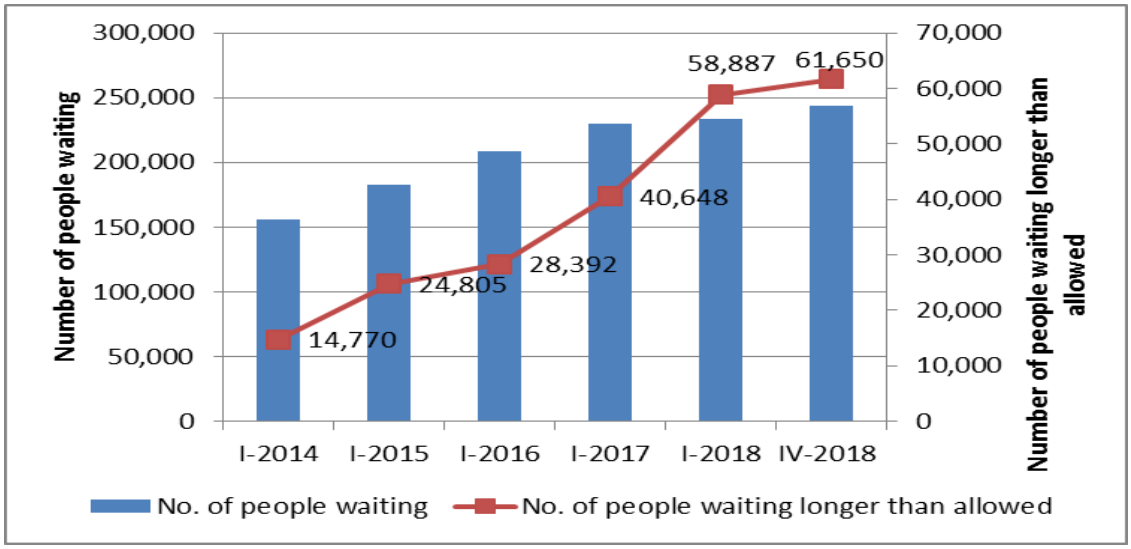
[3] The proportion of spending accounted for by outpatient services and dentistry has increased significantly.

regionalisation through networking of hospitals themselves. A positive example is the networking agreement concluded among the hospitals of Slovenj Gradec, Celje and Topolšica on the exchange of specialists both between the hospitals and between the primary and secondary levels, following the hospitals' specialisation for certain types of procedures (STA, 2010).

Perhaps the most striking feature of the public debate on the healthcare network is the shortage of Slovenian studies linking the availability of services with outcome indicators, such as patient mortality, notwithstanding the international evidence on the issue. For example, research investigating the relationship between the number of procedures performed by an individual physician or hospital and the outcome for patients is extremely rare (one example is Prevolnik Rupel and Ogorevc, 2014). Similarly, there is no study relating general physicians' workload, which is higher in under-served areas, to patient outcomes.

In spite of all the actions and initiatives presented here, waiting lists have remained the main obstacle to healthcare access in Slovenia in the last four years. It seems that all the measures undertaken by the MoH (additional funds, cleaning of the waiting lists for possible irregularities such as double entries, and penalising primary care physicians for referrals outside the set criteria) only prolonged the waiting lists further. The 2018 general agreement (HIIS, 2018a) introduced penalties for primary care physicians for referrals that are not in line with the criteria set by special committees for each medical specialty. If the primary care physician does not take them into account at the point of referral, the costs of the specialist's check-up must be paid by the primary care physician. This rule upset primary care physicians as it requires them to follow criteria set by other physicians (specialists). The latest data show an increase in the number of people on waiting lists (Figure 1).

**Figure 1: Number of people waiting for healthcare services, Slovenia, 2014-2018**




*Source: NIPH, 2018.*

Rules on the management of waiting lists, and on the maximum waiting times for individual health services, were adopted in 2010. They define three degrees of urgency and the respective maximum permissible waiting times: 'urgent', with up to 24 hours of waiting; 'fast', with up to 3 months of waiting; and 'regular', with up to 6 months of waiting. In 2017, an interim level was added ('very fast', with up to 14 days of waiting) (Act Amending the Patient Rights Act, 2017). While the rules had a strong initial impact on waiting times, the effect wore off by 2014 as no further measures were passed to keep waiting times within the defined limits.

There are many arrangements in Slovenia that may be considered good practice in terms of reducing inequalities in access to healthcare, especially in health promotion and preventive healthcare. We present two examples here. The first one concerns nutrition and physical activity policy in Slovenia aimed at reducing health inequalities among children and adolescents. The second one is the inclusion of vulnerable people in the preventive programme 'Together for health'.

A. Potential for nutrition and physical activity policy in Slovenia to reduce health inequalities among children and adolescents (Gabrijelčič Blenkuš and Kralj, 2018)

The school fruit scheme is one of a number of cross-sectoral measures within the framework of the national nutrition and physical activity programmes for 2005-2010 and 2015-2025. In the last observed school year, 2015/2016, the school fruit scheme increased knowledge of the importance of the consumption of fruit and vegetables as well as other nutritional factors related to health – both for boys and (particularly) girls. Supported by the scheme, schools helped increase understanding of the importance of the consumption of fruit and vegetables among children from socially and economically less favourable environments. Despite the implementation of the scheme, the consumption of fruit and vegetables in school decreased between 2012 and 2017. This could be explained by general environmental factors that promote obesity, which may outweigh the effects of an isolated initiative. The effects are only evident in a comprehensive overall evaluation of all food policy measures. Within the framework of comprehensive measures, the school fruit scheme could contribute to countering the downward trend in consumption of fruit and vegetables among children.

In the last five years, a decline in the reported frequency of fruit and vegetable consumption in schools is observed primarily in children with lower and middle socio-economic status. At the same time, in absolute terms, children with higher socio-economic status typically consume less fruit and vegetables at school than pupils with lower or middle socio-economic status, which has been observed since the beginning of the scheme evaluation.

Many complex environmental factors (aggressive marketing aimed at children and the low costs of unhealthy foods) are strong negative influences. Complex systemic measures are therefore needed to improve the nutritional status of children and adolescents.

B. Integration of vulnerable people in the preventive programme 'Together for health' (Vrbovšek and Farkaš Lainščak, 2018)

The 'Better health and reduced health inequalities - Together for health' project was carried out to identify health inequalities. Key groups of vulnerable people were identified: migrants, homeless people, elderly people, illicit drug users, the unemployed, people with mental health problems, the Roma, the self-employed, persons with insecure employment, overworked employees, and persons with various forms of obstructions to carrying out day-to-day activities due to health problems. Obstacles were identified for vulnerable persons in access to and within healthcare institutions, with an emphasis on the obstacles they encounter in accessing preventive programs.

Women aged 52 years were identified by the project as the most vulnerable persons. Typically, vulnerability has been associated with unemployment, socio-economic vulnerability and mental health problems. Vulnerable people reported lack of information, health problems and lack of motivation as the most common obstacles to accessing preventive programmes. The site of the first screening of a vulnerable person was most often a regional office of the employment service, but was also carried out by non-governmental organisations, home-care services and health promotion centres. Wider local teams were set up, based on a community approach, in order to offer vulnerable people the complete basket of support they needed.

# 3 Discussion of the measurement of inequalities in access to healthcare in the country

Additional indicators at the national level that would highlight the issue of inequalities in access to healthcare services could include the following.

Healthcare coverage:

1. percentage of insured people not in regular employment who stopped paying contributions due to bankruptcy (and hence do not have access to healthcare except emergency services, but are counted as insured);
2. percentage of persons who do not buy CHI but are compulsorily insured and eligible for CHI (according to income group);
3. characteristics of persons who are not covered by compulsory health insurance.

Affordability of care:

4. OOP expenditure on healthcare by income quintiles (or deciles), available on an annual basis (this information is currently available from the Statistical Office on request and for the purpose of individual projects; the indicator should be in a standardised form and made available on a regular basis).

Availability of healthcare:

1. a revised Slovenian translation of the EU-SILC indicator for unmet need, in order not to refer to primary care and making it comparable with other countries;
2. indicators for measuring waiting time for all healthcare procedures and not only for selected ones;
3. outcome indicators for (at least) elective procedures in connection with the volume and distance of care according to known criteria.

Basket of care:

A thorough economic analysis is needed at a national level in collaboration with medical professionals in each of the specialties. The basket of care is outdated; it includes services that no longer exist, while the prices of the services do not reflect their costs. Due to a lack of quality control, the services are of poor quality. Unless the basket is thoroughly analysed and newly defined, no indicators on depth of coverage make sense. As the prices are not clearly defined, even the long-awaited central tender for medicines (the procedures lasted 2 years and 7 months) resulted in higher prices of medicines than without the central tender (Zupanič, 2018).

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