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REVISED EUROPEAN SOCIAL CHARTER

8th National Report on the implementation of
the European Social Charter (revised)

submitted by

THE GOVERNMENT OF SLOVENIA

(Articles 3, 12 and 13
for the period 01/01/2005 – 31/12/2007
Articles 11, 14, 23 and 30
for the period 01/01/2003 – 31/12/2007)

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CYCLE 2009

REPUBLIC OF SLOVENIA

Eighth Report of the Republic of Slovenia

on the implementation of the European Social Charter (revised)

Articles 3, 11, 12, 13, 14, 23, 30
(areas of health, social security and social protection)

Reference period:

- *1 January 2005 to 31 December 2007 (**Article 3, Article 12 and Article 13 of the ESC**)*
- *1 January 2003 to 31 December 2007 (**Article 11, Article 14, Article 23 and Article 30 of the ESC**)*

In accordance with Article C of the Revised European Social Charter and Article 23 of the European Social Charter, this report has been presented to the Economic and Social Council of the Republic of Slovenia (ESC), which is the highest-level body representing the social partners in the country.

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Article 3: The right to safe and healthy working conditions

3/1 Health and safety at work

Information required by the European Committee of Social Rights (Conclusions 2007, page 1000):

Negotiations between social partners on the preparation and implementation of the national policy of safety and health at work are held within the Economic and Social Council, a tripartite body bringing together social partners and the Government of the Republic of Slovenia. The Economic and Social Council participates in the preparation of legislation and gives opinions and recommendations, provides initiatives to adopt new legislation or amend applicable law, and formulates positions and opinions concerning working documents, regulations and legal drafts and proposals.

3/2 Legislation in the field of health and safety at work

Information required by the European Committee of Social Rights (Conclusions 2007, page 1001):

The agricultural sector falls under a uniform health and safety at work system. Pursuant to the Health and Safety at Work Act, a farmer who alone, or with any member of his household or family, performs an agricultural activity as his sole or main occupation is considered an employer.

Information required by the European Committee of Social Rights (Conclusions 2007, page 1001):

In accordance with Council Directive 83/477/EEC, Council Directive 91/382/EEC, Council Directive 98/24/EC and Directive of the European Parliament and of the Council 2003/18/EC amending Council Directive 83/477/EEC, the minister responsible for labour issued, in 2005, the **Rules on the protection of workers from the risk related to the exposure to asbestos at work** (*Uradni list RS*, No. 93/2005). The Rules lay down occupational limit values for asbestos, as well as other special requirements, and govern all activities where workers are exposed to, or run the risk of being exposed to, asbestos dust or materials containing asbestos in the course of their work.

As to the question of the maximum dose limits of exposure to radiation, it should be noted that pursuant to the Ionising Radiation Protection and Nuclear Safety Act (UPB1, *Uradni list RS*, No. 50/2003; UPB2, *Uradni list RS*, No. 102/2004), the Government of the Republic of Slovenia adopted the **Decree on dose limits, radioactive contamination and intervention levels** (*Uradni list RS*, No. 49/2004) which transposes the provisions of Council Directive 96/29/EURATOM laying down basic safety standards for the protection of the health of workers and the general public against the dangers arising from ionising radiation.

The Decree sets forth:

1. dose limits for exposed workers, apprentices, students, unborn children and the general public;
2. mandatory measures linked with dose limits and the method of calculating dose constraints and their use in designing and optimising activities involving radiation;
3. the method of calculating dose constraints for comforters of patients, i.e. individuals knowingly exposed to ionising radiation while voluntarily helping, other than in their occupation, in the care, support or comfort of patients undergoing medical diagnosis or treatment, or volunteers in medical and biomedical research who are informed about the risks;
4. limit values for radioactive contamination of air, surface and underground water used for the preparation of drinking water, food, radioactive contamination of the human body, working and living environments, soil, feeding stuffs, products for personal hygiene and care, tobacco and tobacco products, building materials and other products;
5. intervention levels;
6. dose limits of ionising radiation set for workers carrying out intervention measures.

Pursuant to the Health and Safety at Work Act, training of workers in safe and healthy work practices is one of the basic obligations of employers and applies to workers under permanent employment contracts as well as to those working under temporary employment contracts.

The Act stipulates that training must be tailored to a specific work process and carried out according to a programme; employers must amend the programme in line with changes in the work process that could affect the level of risk.

The Act specifies that the employer must introduce mandatory periodic tests on theoretical and practical competence in safe and healthy work practices for workers in workplaces where, according to the risk assessment, there is a high risk of injury or damage to health, and for workers in workplaces with increased incidence of injury and health damage. The periodic testing referred to above must be carried out at least every two years.

3/3 Supervision

Information required by the European Committee of Social Rights (Conclusions 2007, pages 1003–1004):

The Labour Inspectorate of the Republic of Slovenia is a body affiliated to the Ministry of Labour, Family and Social Affairs. Its field of work is defined by the Labour Inspectorate Act (*Uradni list* RS, Nos. 38/1994, 32/1997 and 36/2000) and the Inspection Act (*Uradni list RS*, Nos. 56/2002, 26/2007). The Labour Inspectorate of the Republic of Slovenia **inspects the implementation of laws, regulations, collective agreements and general acts governing employment relationships, salaries and other income from the employment relationship, employment of workers at home and abroad, workers' participation in the management, strikes and safety of workers at work, unless otherwise provided by the regulations**. The Labour Inspectorate also supervises the implementation of those regulations expressly stipulating such supervision. The reporting obligations and reporting contents are laid down in Article 5 of the Labour Inspectorate Act. In 2007, the Labour Inspectorate conducted inspections in the field of employment relations, health and safety at work, as well as in the field of social assistance. Inspectors employed by all three inspection services within the Labour Inspectorate, namely **the Inspection Service for Safety and Health at Work, the Labour Relations Inspection Service and the Social Affairs Inspection Service,** conducted

18,297 inspections last year and imposed **9,285 various sanctions** for detected irregularities and deficiencies. In all, **23,692 administrative cases** were conducted under the General Administrative Procedure Act, while **6,520 cases** were conducted outside administrative procedure. Within the framework of statistical, analytical and other tasks, **more than 17,000 reports on accidents at work** were examined and analysed.

In 2007, the Labour Inspectorate of the Republic of Slovenia employed **82 inspectors and a total number of 105 permanent employees**. The average age of the employees was over 48 years of age.

INSPECTION IN THE FIELD OF SAFETY AND HEALTH AT WORK

Table 1: Number of inspections conducted in the field of safety and health at work in the period 2000–2007

Year	Regular	Extraordinary	Control	Total
2000	2,007	2,718	1,648	6,373
2001	2,276	2,520	1,651	6,437
2002	1,408	4,869	1,593	7,870
2003	1,968	4,819	1,373	8,160
2004	1,952	4,685	1,525	8,162
2005	1,521	5,733	1,425	8,679
2006	1,799	5,101	1,633	8,533
2007	1,486	5,007	1,676	8,169

Last year, there were **8,169 inspections conducted** in the field of safety and health of work**,** which is a figure slightly lower than the year before. The number of established infringements in the field of safety and health totalled to **12,318.**

Table 2: Number and type of measures imposed by inspectors in the field of safety and health at work in the period 2000–2007

Year	Decisions under Administrative Procedure Act	Decisions on offences	Criminal complaints	Reports to misdemeanour judge	Mandate penalties	Payment orders	Charging instruments
2000	2,973	/	34	193	528	/	/
2001	3,028	/	29	161	465	/	/
2002	3,386	/	26	197	503	/	/
2003	3,411	/	33	254	475	/	/
2004	3,473	/	37	229	565	/	/
2005	3,341	132	25	7	/	505	/
2006	3,517	194	40	/	/	733	33
2007	3,413	153	19	/	/	678	18

In most cases, regulatory decisions were imposed for improper fulfilment of employer's obligations regarding preventive health examinations. Violations established in this area represent more than 13% of all established violations. Following are irregularities concerning the training of workers in safe work practices, the risk assessment procedure, the inspection and measurement of electrical installations and lightning conductors, the examination and testing of work equipment, the content of safety statement with risk assessment, etc. We cannot ignore the fact that the most frequently established irregularities relate to those safety and health requirements which represent basic employers' obligations in the field of safety and health at work. We believe that the main problem in ensuring safety and health at work lies in insufficient commitment on the part of employers to address this issue. We have established that in most cases small business employers are satisfied with minimum formal arrangements, which, according to these employers, represent a legal minimum; furthermore, these arrangements are often viewed as unnecessary bureaucratisation with no substantive value. Often, these employers perceive the activities of some European Union bodies, which focus on simplifying the area of safety and health at work and bringing it to the broadest possible audience, as actions aiming at abolishing all their formal obligations in this field, while every measure or required record is viewed as an administrative obstacle.
In recent years, we have noticed a continuing trend towards better discipline in reporting occupational accidents among employers. Based on Article 27 of the Health and Safety at Work Act, the Labour Inspectorate of the Republic of Slovenia recorded **17,086 accidents** at work. In 2007, there were **29 occupational accidents with fatal injuries** in the workplace itself. We have also recorded **3 fatal cases** of road accidents where fatalities were workers employed as drivers, and **one fatal case** of violence at work. The **construction industry** is most exposed to workplace fatalities; most often, workplace fatalities occur in small businesses.

3/4 Occupational medicine

Information required by the European Committee of Social Rights (Conclusions 2007, page 1005):

The adult population participating in the labour market undergoes preventive health examinations provided by occupational medicine. The frequency and scope of health check-ups depend on the workplace burden. Health check-ups are paid for by employers on the basis of a contract entered into with an authorised physician specialising in occupational medicine.

Table 3: Number of reported preventive medical examinations provided by occupational medicine in Slovenia in the period 2000–2006

Year	No. of check-ups	No./100 employees	No. of employees
2000	**291,790**	**377.3**	773,319
2001	**272,384**	**351.7**	774,475
2002	**282,836**	**365.7**	773,374
2003	**229,793**	**296.2**	775,863
2004	**244,890**	**312.6**	783,456
2005	**229,037**	**289.0**	792,641
2006	**236,391**	**290.6**	813,480

Source: Institute of Public Health of the Republic of Slovenia, edition ZUBZS

Article 11: The right to protection of health

11/1 Remove the cause of ill health

Information required by the European Committee of Social Rights (Conclusions 2005, pages 635–637):

1. Information on the main causes of death in the Republic of Slovenia – dominant diseases causing death and types of ill health currently representing the most serious health problems in our country due to their frequency, severity and consequences, and a description of measures to reduce high mortality due to "external causes".

Life expectancy at birth

In the period 2003–2006, Slovenia saw life expectancy rise by two years in both genders (Table 1). In 2006, male life expectancy at birth was 74.55 years and female life expectancy at birth was 82.03 years.

Table 4: Life expectancy at birth, Slovenia, 2003–2006

Year	Overall	Men	Women
2003	76.53	72.6	80.35
2004	77.32	73.58	80.87
2005	77.58	74.04	80.93
2006	78.35	74.55	82.03

Source: WHO/European HFA Database, available at *http://www.euro.who.int/hfadb*

The most common causes of death in Slovenia

The most common causes of death in Slovenia are cardiovascular disease, malignant neoplasm and external causes of injuries and intoxication.

Table 5: Age-standardised death rate (SDR) for all causes and all age groups, Slovenia, 2003–2006

	All causes, all age groups
Year	SDR per 100,000
2003	795.49
2004	738.61
2005	729.44
2006	680.46

Source: WHO/European HFA Database, available at *http://www.euro.who.int/hfadb*

The age-standardised death rate (SDR) of the total population decreased gradually during the period 2003–2006 (Table 3) and, in 2006, dropped to 85.5% of the 2003 value.

Table 6: Age-standardised death rate due to cardiovascular disease, Slovenia, 2003–2006

	Cardiovascular disease, all age groups
Year	SDR per 100,000
2003	78.76
2004	72.02
2005	63.00

2006	53.86

Source: WHO/European HFA Database, available at *http://www.euro.who.int/hfadb*

Table 7: Age-standardised death rate due to malignant neoplasms, Slovenia, 2003–2006

	Malignant neoplasms, all age groups
Year	SDR per 100,000
2003	203.66
2004	198.81
2005	196.96
2006	197.96

Source: WHO/European HFA Database, available at *http://www.euro.who.int/hfadb*

Table 8: Age-standardised death rate due to external causes of injury and intoxication, Slovenia, 2003–2006.

	External causes of injury, all age groups
Year	SDR per 100,000
2003	70.09
2004	65.15
2005	61.84
2006	66.39

Source: WHO/European HFA Database, available at *http://www.euro.who.int/hfadb*

The mortality rate due to individual causes of death decreased as well. In 2006, the age-standardised death rate due to cardiovascular disease stood at 68.4% of the 2003 value (Table 3). In the observed period, the SDR from malignant neoplasms did not change significantly; the 2006 value represented 97.25% of the 2003 value (Table 4).

As regards external causes of injury and intoxication, a minimal drop was recorded; the 2006 value stood at 94.7% of the 2003 value (Table 5). Among external causes of injury and intoxication, suicide was the most common cause of death (in 2006, the SDR was 22.79/100,000), followed by falls (in 2006, the SDR was 16.34/100,000) and road accidents (13.7/100,000).

2. Description of measures to reduce the high mortality rate among women who have recently given birth, and accessibility of health care to pregnant women (*Infant and maternal mortality*)

The maternal mortality rate (expressed per 100,000 live born infants) varies considerably from year to year because of the small number of live born infants in Slovenia (between 17,000 and 20,000, annually, during the last five years) and a very low absolute number of maternal deaths. Great caution is therefore necessary in interpreting trends; multiple annual averages must be used.

In the period from 2000 to 2002, the average maternal mortality rate was 15.1 deaths per 100,000 live born infants; in the period from 2003 to 2005 it was 9.4 deaths per 100,000 live born infants. We must underline that these quoted numbers are not based solely on vital statistics, as in most countries. In Slovenia, cases of maternal death are actively searched for and two special methods are used to identify such cases. Thus, rates are much more reliable and comparable with countries that monitor the situation in a similar way.

With a view to reducing maternal mortality and morbidity rates, a special multidisciplinary working group was appointed at the Institute of Public Health of the Republic of Slovenia; its task is to analyse all maternal death cases in the country and prepare a report on maternal mortality every three years. The report includes expert recommendations for clinical and public health measures to reduce the maternal mortality rate.

Legal rights of women to health care have not changed since the last report. All women are entitled to free preventive and curative health care during pregnancy and childbirth provided within the system of compulsory health insurance. Preventive care includes ten systematic examinations, at least two ultrasound examinations and individual counselling. These health services are provided by personal gynaecological teams that operate within the system of primary health care.

3. Information about health care and health examinations of women and children (*Counselling and screening*)

Primary health care, including not only curative, but also systematic preventive examinations, is provided to children by paediatricians and school medical doctors and to women by gynaecologists. Women, children and youth under 19 years of age are entitled to choose a personal gynaecologist, paediatrician or school medical doctor specialising in a particular field of medicine who provides services within the primary health care system.
Preventive activities carried out in the field of reproductive health and for newborns, children and youth are laid down in the **Rules for carrying out preventive health care at the primary level**. All activities falling within the scope of preventive programmes are covered by compulsory health insurance and are hence provided free-of-charge to users.

Reproductive health care
The Republic of Slovenia ensures the right to comprehensive preventive health care for women in the field of reproductive health, pregnancy and childbirth.
The objectives of these health care programmes are: to reduce the risk of disease related to reproduction and unplanned and unwanted pregnancy, to detect cancer early, to exercise reproductive rights and to promote reproductive health. The following programmes are carried out:
– examinations and counselling on family planning, the use of contraceptives and the prevention of sexually transmitted infections and consequent infertility. Means of birth control are paid for by compulsory health insurance and are hence free-of-charge for women;
– preventive examinations during pregnancy, comprising a total of 10 systematic examinations, at least two ultrasound examinations, individual counselling and laboratory tests (testing for the presence of syphilis, toxoplasmosis and hepatitis B). The examinations are carried out by gynaecological teams in community health care centres;
– pregnant women between 35 and 37 years of age undergo a screening test for trisomy 21 (Mb Down), while pregnant women over the age of 37 undergo amniocentesis;
– examinations and counselling after childbirth, spontaneous and permitted termination of pregnancy and extra-uterine pregnancies;
– examinations and counselling on menopause;
– preventive health activities in nursing care (preventive home nursing visits to pregnant women, and postpartum home care for mothers and newborns);
– preventive examinations for cervical cancer and early detection of breast cancer, as described in the response to point 6 of Article 11/2.

Perinatal information system data show that in the period from 2004 to 2006, a pregnant woman paid on average 9.7 visits to a consultation room and had four ultrasound examinations.

In the period 2004–2006, the primary reproductive health care system recorded 429 preventive visits per 1000 women aged 15 years and over. Next to preventive examinations during pregnancy, the highest share was recorded in preventive visits aiming at early detection of cervical cancer and preventive visits for contraception. The rate of preventive visits by women according to age group is shown in the table.

Table 9: Rate of preventive visits to primary reproductive health care, Slovenia, 2004–2006

Age group	15–19	20–29	30–39	40–49	50–59	60–64	65 +	**Total 15+**	**Total 15–49**
No. of preventive visits/1000 women	252	1061	829	326	203	144	37	**429**	**672**

Source: Institute of Public Health of the Republic of Slovenia, Outpatient health statistics information system 2004–2006

A national screening programme for breast cancer was launched in 2008; therefore, data are not yet available.

A national screening programme for cervical cancer (ZORA) has been carried out throughout the country since 2003. ZORA Registry data show that the percentage of women aged 20–64 years with at least one Pap test performed in the period 2004–2007 reached 70.5%; thus, a minimum target value has been attained, namely to examine 70% of the target female population (Source: Institute of Oncology, Epidemiology and Cancer Registry, ZORA Registry, Report on the results of national programme ZORA in 2006 and 2007, Ljubljana, 2007).

Health care of children and adolescents

Preventive activities in health care of children and pupils are laid down in the **Rules for carrying out preventive health care at the primary level**. Systematic examinations of children, pupils and students are fully covered by compulsory health insurance, which means that they are completely free-of-charge for users.

Health care of newborns

The majority of babies (over 99.8%) in Slovenia are born in maternity wards. In 2005, an amendment to the rules dealing with the preventive health care of newborns in maternity wards was adopted. Childbirth and postnatal care of women and newborns are fully covered by compulsory health insurance.

Newborns undergo systematic examination within 24 hours after their birth, examination at their discharge from hospital, screening for certain metabolic diseases, ultrasound examination of hips and a hearing check; activities to promote breast-feeding are also carried out.

Twelve out of fourteen maternity wards attained UNICEF baby-friendly hospital status, which means that they carry out activities for promoting breast-feeding. Slovenia has achieved very good results as regards the share of newborns breast-fed at discharge from hospital.

Health care of infants and pre-school children

Pre-school children are also entitled to systematic preventive medical examinations paid for by compulsory health insurance (free-of-charge to users). Examinations are carried out by a paediatric specialist team at the primary level. One-month-old infants receive invitations for a medical examination either from home nursing services or from maternity wards. Invitations to attend systematic examinations at the ages of three, six, nine, twelve and eighteen months are given at each preceding examination. Children aged three and five years are sent a written invitation to attend the examination.

Infants and pre-school children are entitled to the following preventive examinations:
– systematic examination of the child at the age of one month
– systematic examination of the child at the age of three months
– systematic examination of the child at the age of six months
– systematic examination of the child at the age of nine months
– systematic examination of the child at the age of twelve months
– systematic examination of the child at the age of eighteen months
– systematic examination of the child at the age of three and five years
– special purpose examinations (in the event that a change detected during a systematic examination needs to be traced)
– obligatory vaccination as laid down in the vaccination programme
– programmed health education and individual consultation

The examination of a child at the age of three years also includes an examination by a psychologist, while the examination at the age of five years includes an examination by a speech therapist.

According to the 2004–2006 period data, an infant up to the age of one year attended, on average, six preventive examinations per year. On average, children aged one to six years attended one preventive examination per year, while school children and pupils attended one examination per two years.

Table 10: Rate of preventive visits of children to primary health care, Slovenia, 2004–2006

Age group	2004	2005	2006	Average 2004–2006
<1 year				
No. of visits/1000	**5906**	**6267**	**5783**	**5985**
1–6 years				
No. of visits/1000	**1210**	**1274**	**1138**	**1207**
7–19 years				
No. of visits/1000	**668**	**686**	**607**	**654**

Source: Institute of Public Health of the Republic of Slovenia, Outpatient health statistics information system, 2004–2006

4. Health care budget

In Slovenia, the health care model (Bismarckian model) is based on the principle of statutory compulsory public insurance; the framework of the insurance, which is autonomously managed by representatives of employers and insured persons, is defined by law. All employed persons must pay insurance contributions to insurance institutions according to their financial ability (the principles of solidarity and non-profitability apply). In managing the programme of health services, the principle of negotiations between partners is established. The programme, the method of its evaluation and price formation are agreed upon between representatives of service providers and payers. The Bismarckian model of health insurance was re-established in Slovenia in 1992 with the adoption of the Health Care and Health Insurance Act.

In recent years, total health care expenditure as a share of GDP has not changed considerably in the Republic of Slovenia; the expenditure structure shows that a relatively low real increase in public expenses has been accompanied by an increase in private expenses. In 2004 and 2005, the share of health care expenditure within GDP (recently available internationally comparable data from SORS – the Statistical Office of the Republic of Slovenia) totalled 8.5% (EU-27 average in 2004: 8.2%; EU-15 average in 2005: 9.2%. Source: SORS, Expenditures and Sources of Health Care Financing, first publication – 21 December 2007). In 2005, Slovenia's total health care expenditure was estimated at SIT 576 billion (EUR 2.4 billion) or 8.5% of GDP. Translation into current prices in euros shows that Slovenia devotes EUR 1,228 per capita for health care, of which EUR 979 are funded by the public budget, while EUR 249 are contributed from private funds (in-house calculation: System of Health Accounts, 2007).

In 2006, public expenditure on health, including expenditure for sickness benefits, amounted to SIT 471,519,950,000 (EUR 1,967,618,000), or 6.46% GDP. The bulk of public funding came from compulsory health insurance (93.8%), followed by the state budget (4.7%) and municipal budgets (1.5%). Compared with 2005, public expenditure in 2006 was SIT 26.6 billion (EUR 111,003,000) higher in nominal terms and 0.11 p.p. lower, expressed as a share of GDP (in 2005, it stood at 6.57% GDP).

In 2007, public expenditure on health, including expenditure for sickness benefits, amounted to EUR 2,062,509,000, or 6.22% GDP. The bulk of public funding came from compulsory health insurance (94.6%), followed by the state budget (4.0%) and municipal budgets (1.4 %).

Table 11: Health care expenditure

	1999	2000	2001	2002	2003	2004	2005
Total health expenditure, in current prices (SIT million)				476,304*	520,694 *	542,977 *	576,659 *
Public health expenditure as % of total health expenditure	87.5	86.6	86.7	78.5	78.8	79	72*
Total health expenditure as % of GDP	7.7	8.6	9.0	8.9	8.8	8.6T	8.5*

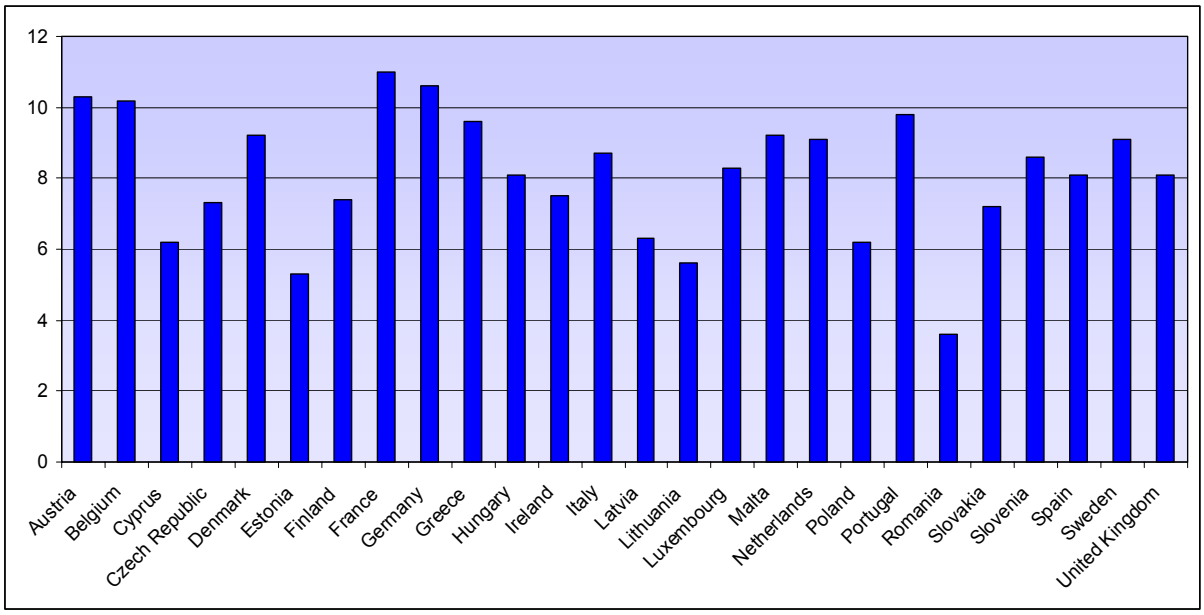
Source: SORS*, 2007; WHO/European HFA Database, 2007

Table 12: Public expenditure on health in 2006, in EUR (mio) and GDP share

YEAR	Public expenditure	Compulsory health insurance	National budget	Municipal budgets
2006	1,967,617	1,845,443	92,106	30,068
% of GDP	6.46	6.06	0.30	0.10

(Source: Ministry of Finance).

Figure 1: Total health expenditure, EU Member States, 2004 (% of GDP)



Source: WHO/European HFA Database, 2007

On 1 January 1993, voluntary health insurance was introduced in Slovenia with a view to reducing the burden on the public finance sector for ensuring the rights from compulsory health insurance. Voluntary health insurance covers insured persons' costs of health services, provision of medicinal products and assistive devices. Furthermore, voluntary insurance also includes payments of cash benefits for illness, injury or specific medical conditions.

For the most part, hospitals and health centres are financed under a contract with the Health Insurance Institute of Slovenia. Partners' negotiations on general and regional agreements specifying the scope and value of the programme of health services in Slovenia are conducted yearly. A mixed system of capitation and fee for services is used for primary health care services (outpatient facilities, children's and school dispensaries, and women's dispensaries), where approximately 50% of a medical team's income is provided through capitation and 50% through service fees.

As regards specialised outpatient clinics, a system of fees for services is applied. Standards are set for services provided by individual specialised outpatient clinics; they define the annual plan of financial resources per team. In 2003, a system of payment by groups of comparable cases (SPP) was introduced for acute hospital treatments. The system applies the

method of payment based on the complexity of a particular treatment. SPP enables a more transparent classification of health services and provides for more precise criteria.

The ageing of the population and the rapid development of science and technology that offers more efficient but also far more expensive and successful prevention, diagnosis and treatment lead to an increased need for health services. Due to the rising share of elderly people, health care is faced with chronic and degenerative diseases that should be treated differently than acute diseases. Furthermore, public awareness of new possibilities for the prevention and treatment of diseases has been increasing. A long-term care and long-term care insurance act and the Concessions act are under preparation. The Ministry of Health also drafted the **Resolution on the national plan of health care 2008–2013 "Satisfied users and performers of medical services",** which was adopted by the Government on 25 April 2008 and sent into parliamentary procedure for adoption.

5. Detailed and up-to-date information (statistics and practice) about the accessibility of health services to marginalised social groups

The Ministry of Health supports professional efforts to improve integrated protection of marginalised social groups, particularly as regards the provision of quality medical treatment, prevention and promotion of health. The **Resolution on the national plan of health care 2008–2013 "Satisfied users and performers of medical services"**, which was adopted by the Government on 25 April 2008 and sent into parliamentary procedure for adoption, is a fundamental instrument for the development of health care in the upcoming five-year period. It builds upon Article 6 of the Health Care and Health Insurance Act and *envisages an increase in the percentage of funding for prevention activities from the current 3–4% to 5%.* Priority development tasks, in line with present and future needs, are to reduce health inequalities (gender, regional and between social groups), which would respond to the specific needs of the ageing population, and to reverse the increasing trend in the incidence of chronic diseases and other risks associated with demographic, technological and social changes.

The Ministry of Health, namely the Sector for Health Care of Vulnerable Groups, translated, published in a special publication, and promoted the implementation of Recommendation of the Council of Europe No. R(2001)12 on the Adaptation of Health Care Services to the Demand for Health Care and Health Care Services of People in Marginal Situations (Recommendation from the Committee of Ministers to the Member States, Ministry of Health, 2006: 7–11). This publication, issued by the Ministry of Health, also includes translations of other European Council Recommendations concerning the quality of health care of vulnerable groups (translations of Recommendation (1989)11 on the organisation of health care services for the chronically ill, Recommendation (2004)10 concerning the protection of the human rights and dignity of persons suffering from mental disorders, Recommendation (2003)24 on the organisation of palliative care, and Recommendation (1998)7 concerning the ethical and organisational aspects of health care in prison).

With a view to raising awareness amongst professionals and the lay public of the needs of vulnerable and marginalised groups, the Ministry of Health issued a publication entitled *Javnozdravstveni vidiki obravnave ogroženih in ranljivih skupin prebivalstva* (Ministry of Health, 2007) and also provided for the English translation (*Population Groups at Risk in the Perspective of Public Healthcare;* Ministry of Health, Sector for Health Care of Vulnerable Groups, Ljubljana, 2008). In the publication, Slovenian public health and clinical experts address various aspects of care of patients with chronic diseases, the severely ill, the elderly at

risk and persons with disabilities, children, youth, women, as well as other groups at risk and the issue of Roma health care.

In Slovenia, statistical data on health, including mortality and fertility, are not collected separately according to nationality and other categories, mainly due to numerous ethical and legal issues that arise in this respect. Since data on nationality are optional and unchecked, they are not used in practice when developing strategies for positive measures or in fighting discrimination. Approaches used in these areas are based on project work and expert studies; the Institute of Public Health of the Republic of Slovenia, for example, applied such methods in the process of establishing the health status of Roma and in evaluating the accessibility of health care to Roma and some other marginalised groups, notably as regards the prevention and treatment of contagious diseases and, for example, in assessing immunisation coverage among Roma pre-school and school children.

At its 61st session on 16 February 2006, the Government adopted the **Report concerning the implementation of the national action plan on social inclusion 2004–2006**, drafted by a working group appointed within the Ministry of Labour, Family and Social Affairs and comprising representatives of the Government, trade unions, non-governmental organisations and local communities. Social inclusion is dealt with through an overview of the situation in different areas which contribute to social inclusion, including access to health care and reduction of regional differences. The Report also presents an overview of the situation in the area of assistance to the most vulnerable population groups. A statistical annex provides collected and chronologically arranged indicators reflecting the situation in the country and showing the comparison with other EU Member States.

In line with the development policy of the Ministry of Health and due to its importance and special nature, the improvement of health status of Roma is included in the national programme for health promotion. At its 61st session on 16 February 2006, the Government of the Republic of Slovenia also adopted a response concerning the allocation of funds for resolving Roma issues. The legal basis for regulating the status of Roma community members in the Republic of Slovenia is provided in Article 65 of the Constitution, which grants power to the legislature to provide that the Roma community, as a special ethnic community living in Slovenia, be granted not only general legal rights pertaining to all, but also special rights. Article 65 of the Constitution is implemented through sectoral legislation. A special project working group was formed to address the issue of Roma health care; it organised a meeting with representatives of the Slovenian Roma Association and field health institutions. The group continued its work towards promoting healthy nutrition among Roma children. Within the framework of public tenders for co-financing programmes for protection and promotion of health in 2004 and 2005, the Ministry of Health supported the programme "Raising nutrition culture for promotion and protection of health of Roma", carried out by the Institute for Education and Culture, Črnomelj. Based on the decision of the Government, the Ministry of Health also co-financed the programme "Investment in health and development – Mura" in 2005 and 2006; the programme was carried out by the Institute of Public Health Murska Sobota. Part of this programme also covered the promotion of healthy lifestyle among the Roma community and the minority Hungarian community. An analysis of risky behaviour among the Roma population has been made. The Institute of Public Health Murska Sobota conducted a study entitled "Risk factors for non-communicable diseases in adult Roma community members" (from 2001 to 2004). The study provides a basis for drafting programmes and projects to promote health or reduce health inequalities. The Institute has

been incorporating the issue of Roma health into the national health programme since 2006, it has employed a Roma community member on the public health team, and it has established cooperation with the Slovenian Roma Association.

An example of good practice within the programmes and projects aiming at reducing health inequalities can be given — namely, the "Strategy for promoting health and action plan for reducing health inequalities in the Pomurska region", prepared by the Institute of Public Health Murska Sobota within a bilateral partnership with the Flemish Institute for Health Promotion. The overall objective of this strategic plan is to improve the state of health of the regional population and thus reduce health inequalities between regions; furthermore, the plan addresses health inequalities within the region. The programme to promote health focuses particularly on individuals and vulnerable groups within the population; through this programme, the region aims at improving health indicators regarding inequalities in health. The Strategy is based on analysis of the current situation and on regional priority tasks; it forms part of the Regional Development Programme 2007–2013. The English version is available on *http://www.zzv-ms.si*. The Strategy's objectives include the promotion of healthy lifestyle among minorities and ethnic communities (Hungarian and Roma community members). The programme has been specifically designed for the Pomurska region, but can also be used as an initiative and an example of applying a strategic planning approach to setting priorities and building strategies and objectives to develop measures to reduce health inequalities, in particular of vulnerable and marginalised groups.

On the national level, activities for monitoring the health conditions and promoting health of marginalised groups are carried out by the Institute of Public Health of the Republic of Slovenia. Special attention is paid to the area of drug dependence prevention. Within the "Correlation" project, in 2007, the Institute of Public Health of the Republic of Slovenia conducted a research project entitled "Barriers to accessibility of assistance programmes in Slovenia: drug users' perspective". In 2008, research activities concerning alcohol and health care of homeless persons are envisaged. The aim of this research is to obtain as much information as possible from users in marginal social situations and information about their need for health and social assistance. Data were collected from drug users using the questionnaire method; in 2007, interviews with 53 problematic drug users were conducted in Ljubljana, Celje and Ig. The target group was recruited in the field (using the snowball method), within the high threshold programme, and in prison. Research results show that high risk behaviour persists among drug users; namely, 28% of users shared syringes/needles and 45% of users shared other devices in the last year. Approximately 70% of surveyed users have already had an HIV, HBV or HCV test. According to injection drug users' comments, they had the most experience with the exchange of sterile syringes, methadone treatment and various forms of counselling. Drug users assessed their satisfaction with their relationship with professionals and their participation or decision-making regarding their treatment; they were also asked to assess to what extent the treatment was acceptable to them, how much privacy they were allowed during the treatment, and their overall satisfaction. Users rated the non-governmental low-threshold sector with the highest score, followed by the non-governmental high-threshold and health sector, while the social sector was scored the lowest. When asked why they did not seek the help they needed (such behaviour is typical of marginalised groups which, as a rule, are much less likely to use health services, in particular with respect to their needs), they replied that the reasons were discrimination, unfulfilled needs, too long waiting lists and too expensive assistance; they largely disagreed with the

statement that professionals lack knowledge and that users are insufficiently informed about the accessibility of programmes.

6. Average waiting period for hospital admission, description of measures and results concerning the reduction of waiting periods

In 2006, the Ministry of Health established a working group with the aim of reducing waiting periods and dealing with waiting lists. According to the Ministry of Health, waiting periods for the majority of surgical interventions have been reduced; however, these trends must continue, particularly as regards the reduction of waiting periods for specialist outpatient services.

The working group has defined the methodology for data collection and has pointed out major problems in establishing a single national waiting list. It has established that waiting lists in hospitals are not managed with a uniform methodology and, consequently, patients who have the right to choose specialised services throughout Slovenia are often on several waiting lists at the same time.

In the reference period, the Institute of Public Health of the Republic of Slovenia developed and used a computer application for data processing and managing waiting lists of different hospitals with a view to establishing a uniform computerised system at the national level. University Medical Centre Maribor, for example, has already begun to carry out a project relating to a national list for orthopaedic surgery.

Reports on waiting lists, submitted by hospitals, are also gathered by the Health Insurance Institute of Slovenia, which takes them into account in planning and financing health care programmes and in concluding contracts with providers.

In the period 2002–2007, the following amounts were allocated to reduce waiting periods:
– EUR 50,790,011 (permanent enlargement)
– EUR 52,927,608 (single supplementary programmes)

The above-mentioned programmes to reduce waiting lists were based on the adopted "General agreements and Annexes to general agreements", *http://www.zzzs.si*.

Table 13

	Permanent enlargement	Single programmes	Total
2002	9,228,425.97		9,228,425.97
2003	3,428,058.75		3,428,058.75
2004	7,744,950.76	6,382,805.76	14,127,756.52
2005	13,891,457.19	22,574,601.78	36,466,058.97
2006	15,522,001.36	7,865,720.42	23,387,721.78
2007	975,116.62	16,104,480.26	17,079,596.88
TOTAL			**103,717,618.88**

The **Resolution on the national plan of health care 2008–2013 "Satisfied users and performers of medical services"**, which was adopted by the Government on 25 April 2008 and sent into parliamentary procedure for adoption, provides for measures to reduce waiting

periods (Chapter 7.2.3). The Resolution plans to reduce waiting periods by applying information technologies and by way of precise planning of work, appointments made within a defined time, regular checking and upgrading of the national waiting list, and managing image and diagnostic data via the Internet. Its aim is to achieve waiting periods shorter than the maximum permissible periods for concluding treatment of the primary disease with regard to individual treatment groups, as follows:

- urgent treatment, promptly or on the same day
- treatment by a family physician (or other doctor at the primary level of health care) for non-urgent conditions, up to one week
- malignant disorders, up to one month
- non-chronic disorders, up to three months
- chronic degenerative diseases, up to six months

The aim of new legislation in the field of patient's rights, adopted at the beginning of 2008, is to make the national waiting list accessible to all citizens via websites. It will be necessary to adopt a new public health registers act, which is a prerequisite for an overall information system aimed at supporting the public health service network.

7. Data on the number of private health care institutions

Data on concessions:

Table 14: Number of newly granted concessions at the primary and secondary level from 2000 to 2007.

	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
Primary level	30	33	20	22	33	76	117	55
Secondary level	7	8	7	11	11	43	51	30

The number of all granted concessions, including those granted in 2007, was 2,515; companies were granted 240 concessions and sole proprietors and private health professionals 2,275. Data from the Ministry of Health on granted concessions cover the period from 1992 to 2008; in this period, some concessions were terminated, returned or modified. Data from the Ministry of Health on granted concessions cover all concessions granted in the field of health care and dental care services (excluding the pharmacies sector and nursing). It is legally possible to register as a sole trader without obtaining prior authorisation to perform private health activities; by law, such authorisation must be obtained prior to taking up this activity.

11/2 Counselling and educational opportunities

Information required by the European Committee of Social Rights (Conclusions 2005, pages 637–639):

1. Health education must be ensured at all educational levels and included in curricula; what measures have been taken to achieve this objective?

The initiative to amend primary school curricula so as to include health content was given in 1999, when the Ministry of Education and Sport appointed the National Curricular Council,

as well as the Inter-subject Curricular Commission for Health, to prepare expert bases for reforming the programme of health educational activities in the nine-year primary school. The Commission prepared basic chapters for the Programme of education for health within primary school, issued in 1999 in the publication of the Institute of Public Health of the Republic of Slovenia. The Expert Council discussed the content but did not approve the proposal because additional lessons in first aid, sex education and safe use and misuse of substances were required.

At that time, experts did not share the same view regarding the inclusion of health in the curriculum, whether as an optional school subject or only within inter-subject integration. Research conducted by the National Education Institute showed that certain topics of education for health were well-defined within individual school subjects, notably in biology, physical education, ethics and society, home economics and within special activity days, while the content of lessons in first aid, sex education and safe use of substances – drugs (content well-represented in the eight-year primary school) was completely omitted. There is no systematic education on these topics; the initiative is left to the schools.

The Programming Council for Health, appointed by the Ministry of Education and Sport, prepared the Concept of integrating health into the curriculum; the document was adopted at the meeting of the Council of Experts for General Education, 20 May 2004.
This provided a basis for the decision, adopted by the Secretariat-General of the Government of the Republic of Slovenia at its session on 14 June 2004, to set up an inter-ministerial working group for the implementation of the concept of promoting health in schools, tasked with drawing up an action plan to implement the integration of health into the curriculum and defining responsible persons and a time schedule. Because the responsible persons in the government alternated, the group did not prepare the action plan.

The Ministry of Labour, Family and Social Affairs has coordinated various line ministries with a view to shaping a vision of the future for Slovenian children and youth and to providing guidance with measures to implement it. At its session on 5 October 2006, the Government adopted the Programme for Children and Youth 2006–2016, which defines the field of health in Chapter III (p. 8–11), Healthcare Policy: A – Create conditions for the healthy lifestyle of children and youth (3 objectives); B – Promote mental health at every stage of childhood and adolescence and prevent the most common causes of death among children and youth (3 objectives); C – Health care (4 objectives). Each line ministry is responsible for achieving the planned objectives.

With a view to linking different line ministries responsible for children and young people's health, the Institute of Public Health organised a National conference on children and young people's health WITH and FOR young people. One of the important achievements of the conference was the signing of the Commitment of three ministries on a joint action plan for the improvement of children and young people's health (Ministry of Education and Sport, Ministry of Health and Ministry of Labour, Family and Social Affairs). Furthermore, a group for the school environment proposed that topics concerning health be included in national school curricula as part of primary and secondary school curriculum reform.

Last year, the Ministry of Education and Sport adopted the Education for sustainable development guidelines from pre-school education to university education, which lay down that education for sustainable development in Slovenia includes the following priorities:

- respect for common human values

- active citizenship and participation
- intercultural dialogue and linguistic diversity
- nature conservation and protection of the environment (ecological awareness and responsibility)
- quality education — supportive working and learning environments
- quality relationships, development of competent social abilities (non-violence, tolerance, cooperation, respect, etc.)
- healthy lifestyle (mental and physical health)
- promotion of self-confidence and healthy self-image
- quality leisure time
- development of entrepreneurial spirit contributing to the development of society and the environment
- learning about different areas of culture and the promotion of creativity and activity

In May 2008, the Ministry of Education and Sport issued a tender for the co-financing of professional training for experts in education for the next three years, which also included a theme on healthy lifestyles; a public tender for the co-financing of projects in the area of social competence and competent citizenship will be issued shortly and will also include a focus on healthy lifestyles to cover the designing/development of models for the inclusion of additional topics to be implemented in curricula.

Projects that applied under a target-research programme are currently in the selection process; the following themes were proposed: impact of education on interpersonal relations, gender differences and sexuality, and related themes (e.g. health and violence); analysis and proposal for upgrading social inclusion of blind and visually impaired persons in the education system; and education for sustainable development. The results will provide the basis on which the Ministry of Education and Sport will be able to draw up further documents relating to this field.

2. Is a programme of the WHO, the European Commission and the Council of Europe ("Health Promoting Schools") that promotes health education included in the regular school programme, and which age groups participate?

Slovenia started to participate in the project "European Network of Health Promoting Schools" as early as in 1993 with 12 pilot projects. Since 1998, there have been 100 primary schools, 25 secondary schools and 25 student residence halls participating. The decision to participate was taken on a voluntary basis; schools have undertaken to make efforts to raise awareness among children, parents and teachers of healthy lifestyles through school activities and thus protect, promote and improve their health. We should emphasise that the principle of project work is applied and it is an example of good practice.

Topics, concepts and the philosophy of health promoting schools are included to the fullest possible extent in the national curriculum for public kindergartens, primary and secondary schools.

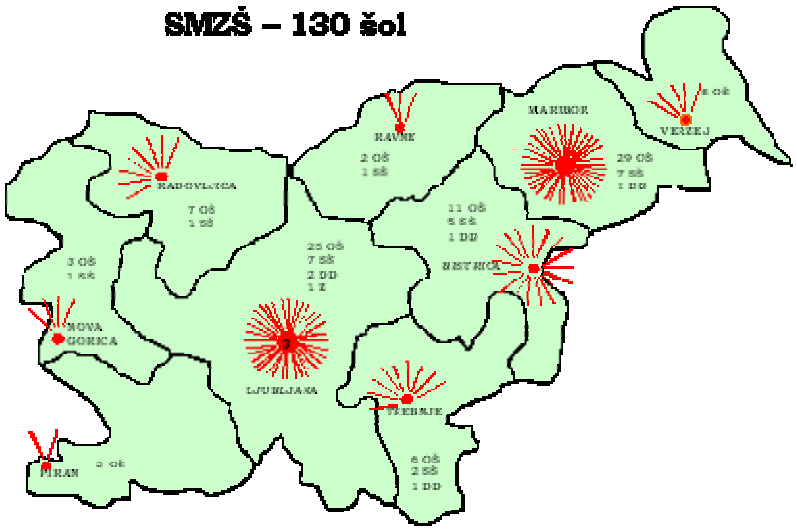
3. What is the geographical distribution of health promoting schools participating in the programme?

The geographical distribution is shown on the map of the health promoting schools network in Slovenia.

Map of Slovenia's health promoting school network:

12 pilot schools (1st circle) are located throughout Slovenia, in all nine regions.

A total of 118 other schools play the role of regional centres for promoting health in their environment and serve as examples of good practice.



4. Description of measures to raise public awareness concerning drug addiction, healthy nutrition, sex education and environmental education; which regions are covered; are measures intended for both urban and rural populations?

<u>Raising public awareness concerning tobacco</u>

Slovenia has long been striving to reduce the smoking epidemic and has already taken the following measures:

– since 2003, large and clear health warnings have been affixed to tobacco products; in 2007, the printing of the telephone number of the "stop smoking help line" on the packaging of tobacco products was introduced;

– in 2005, a ban on advertising and promotion of tobacco products was enacted;

– since August 2007, smoking has been prohibited in all closed public areas and workplaces, including catering facilities;

– in August 2007, the age restriction on the purchase and sale of tobacco products was set at 18 (in line with the World Health Organization Framework Convention on Tobacco Control);

– smokers who wish to give up smoking have the "stop smoking help line" and information about how to give up smoking available. There are different programmes, free-of-charge, to help give up smoking, ranging from individual counselling to group smoking cessation programmes;

– the programme prepared by the Institute of Public Health "Let's promote non-smoking" and other similar programmes aiming at promoting non-smoking are carried out in primary schools.

Raising public awareness about healthy and balanced nutrition

A) Implementation of measures to raise public awareness in the area of healthy nutrition

In 2005, the National Assembly of the Republic of Slovenia adopted the **Resolution on the national nutrition policy programme 2005–2010**. The Resolution is designed comprehensively and includes three pillars: security, healthy and balanced nutrition, and local sustainable food supply. It covers all key population groups and also aims at decreasing health inequalities among the Slovenian population. The programme is implemented pursuant to the adopted action plans which are coordinated with the line ministries by the Ministry of Health. Annual plans include activities for raising awareness among the general population: in 2005 and 2006, attention was focused on children and adolescents; in 2007, on raising awareness among the professional public; and in 2008, among health professionals and the private sector. In 2004 and 2005, two broad media campaigns (for youth and for the general population) were launched to promote the consumption of fruits and vegetables as well as regular daily physical activity. The "fruit circle" logo was designed and is a distinctive symbol of nutrition policy and related activities.

B) Measures to raise awareness about healthy nutrition among young families, in kindergartens and schools

In 2005, the Ministry of Health adopted the amended **Guidelines for healthy nutrition in educational establishments**. Using a soft approach, the Guidelines ensure school and kindergarten environments that are favourable to healthy nutrition; by way of a hidden curriculum, the Guidelines significantly support the teaching of healthy dietary habits to children and adolescents. All Slovenian kindergartens and primary schools have their own kitchens, employ kitchen personnel and offer up to four meals a day to children; all school children are provided with a subsidised morning snack, and approximately one third of primary and secondary school children from low-income bracket families receive an additional subsidy; the percentage of kindergarten children entitled to an additional subsidy is slightly higher.

Food quality standards for the purpose of public procurement in educational institutions are being prepared. The menus that follow the Guidelines for healthy nutrition in educational establishments are currently being drawn up and will be used as an aid by personnel responsible for planning and preparing balanced daily meals.

C) Awareness-raising measures in the field of healthy nutrition for the general adult population

In the reference period, training of health workers was carried out within the framework of the programme "Counselling on healthy nutrition, physical activity and weight maintenance", which is part of a national programme for prevention of cardiovascular disease in the adult population within compulsory health insurance.

The programme "Lead a healthy life" that was aimed at promoting healthy nutrition and physical activity among rural population was carried out in all Slovenian regions. The programme builds on three pillars: healthy community, healthy nutrition, including physical activity, and a healthy tourist offering.

D) Measures to promote balanced nutrition and prevent undernourishment in hospitals and residential homes for the elderly

In 2006, the **Recommendations for nutrition treatment of patients in hospitals and residential homes for the elderly** were drawn up.

Awareness-raising measures in the field of alcohol and traffic accidents

Several programmes, including one entitled "Alcohol? Parents can make a difference", were prepared to aid discussions on alcohol abuse. Peer counselling on the harmful use of alcohol and drugs is organised in schools. With a view to increasing road safety, the programme "Young drivers – safer on the road without alcohol" was developed. The programme is carried out in driving schools in the form of a standard school lesson.

Awareness-raising measures in the field of drugs in the period from 2003 to 2007

The majority of activities in the field of awareness-raising were carried out during a month dedicated to the prevention of addiction. Activities were aimed at raising awareness among the general public and particularly among youth.

In the month dedicated to the prevention of drug addiction, experts' meetings and media campaigns using appropriate media tools and other events were organised and publications issued.

5. How frequent are school medical examinations?

Preventive systematic examinations of school children are regulated by the **Rules for carrying out preventive health care at the primary level**. All examinations regulated by the Rules are covered by compulsory health insurance (i.e. free-of-charge for users) and are therefore accessible to children.

Children just starting school are invited by post to attend an examination. Medical examinations are scheduled to take place in the first, third, fifth and seventh grades of primary school and in the first and third years of secondary school; written invitations are sent by the school physician's team or through the school itself. Young people aged 18 years who are not enrolled in regular schooling are invited in writing by the school physician's team. Young people aged 18 years who are employed are invited by an occupational medicine specialist.

School children and youth up to 19 years of age have the right to the following preventive examinations by a school medical specialist team:

– systematic preventive examination prior to entering school (first enrolment)
– systematic preventive examination in the first grade of primary school
– systematic preventive examination in the third grade of primary school
– systematic preventive examination in the sixth grade of primary school;
– systematic preventive examination in the eighth grade of primary school
– systematic preventive examination in the first year of secondary school
– systematic preventive examination in the third year of secondary school
– young people who do not continue their education have the right to undergo a preventive examination at the age of 18 – systematic preventive examination in the first and third years of high or higher degree education
– special purpose examinations (in the event that a change that was detected during a systematic examination needs to be traced)
– obligatory vaccination as laid down in the vaccination programme
– programmed health education during each systematic examination

A systematic preventive examination includes: review of health records, anamnesis, somatic examination and screening tests (depending on the child's age), conversation with the child, educational health activities, and vaccination if necessary (depending on the child's age).

Statistical data on systematic medical examinations conducted on school children and adolescents are provided in point 3 of Article 11/1.

Children with developmental and behavioural disorders undergo yearly preventive medical examinations of the same scope, but adjusted to their specific needs. In the interim period, if necessary, the child undergoes special purpose examinations that are adjusted to his/her special problems. In the period from 2000 to 2006, the share of children attending schools with modified curriculum who underwent a systematic examination was 96.7%. During this period, all children undergo regular annual preventive systematic examinations with a dentist and are provided health education in this area.

The network of child development surgeries

There is a network of development surgeries operating in Slovenia intended for early detection and early intervention in cases of children with developmental disabilities, for monitoring their development and for providing professional assistance to children and families. Teams in child development surgeries provide early intervention for all children with developmental disabilities. The majority of children with developmental disabilities are detected during the first year of life and are monitored up to 18 years of age. A child development surgery team consists of a developmental paediatrician who must have additional knowledge in developmental paediatrics and neurology, a nurse, two neurophysiotherapists, a work therapist and a speech therapist, the latter two employed half-time. Work load distribution throughout the network presents each team with the task of providing services to a population of 20 to 23,000 children aged 0–18 years.

6. How frequent and accessible are systematic medical examinations for adults?

Systematic preventive medical examinations of adults focus mainly on two priority areas: prevention of cardiovascular disease (and also, through common risk factors, to prevention of other chronic non-communicable diseases, e.g. diabetes), and early detection of precancerous conditions and cancer.

Preventive activities in the field of cardiovascular disease are intended for the early detection of persons who are likely to develop cardiovascular disease and have risk factors for the development of other chronic non-communicable diseases. All men aged 35 to 65 years and all women aged 45 to 70 years have the right to preventive medical examinations. Individuals in the target population are invited to take the medical examination by their personal physicians. Preventive check-ups are carried out every five years; they are financed by compulsory health insurance and are hence free-of-charge for users. Based on the anamnesis, laboratory research and somatic examination of the patient, the presence of chronic non-communicable diseases and the presence of risk factors for their development are established during the examination. All persons who respond to the invitation are offered treatment of the disease and the possibility to participate in different health education workshops with regard to risk factors (workshops on healthy lifestyles, healthy nutrition, physical activity, smoking cessation, alcohol abuse, etc.). The programme is carried out uniformly throughout the country.

Systematic medical examinations in the field of early detection of precancerous conditions and cancer are carried out through three programmes (programmes for the early detection of cervical cancer, breast cancer and colorectal cancer). By the end of 2008, Slovenia will introduce organised screening programmes for the three types of cancer for which screening has been proven to produce positive effects on public health and which are included in the

European Commission's recommendations calling for the implementation of organised screening programmes to cover the entire country.

A) An organised programme for early detection of cervical cancer was introduced in 2002 and has been carried out throughout the country since 2003. It is intended for all women aged 20 to 75 years; it is covered by compulsory health insurance and is free-of-charge for women. Women aged 20 to 65 years are invited personally (in writing) to a gynaecological examination with a PAP test. Women have the right to an examination every three years after two negative PAP smears taken in sequence with an interval of 12 months. The first results of the programme are already visible; the incidence of cervical cancer has decreased by more than one fourth (in 2003, cervical cancer developed in 209 women, and in 2006, in 153 women) over the period 2003–2006 (after three years of the organised screening programme). The programme is managed with a central register for the entire country.

B) A screening programme for early detection of breast cancer was launched in March 2008 in one region. It was planned to cover the entire country in the following three years and thus replace the current opportune screening. It is intended for all women aged 50 to 69 years. Women from the aforementioned target group are personally invited in writing to mammographic screening every two years. The programme ensures further diagnosis of screening-detected breast changes. All the activities under the programme are covered by compulsory health insurance and are free-of-charge for invited women. The programme is managed with a central register for the entire country.

C) A programme organised for early detection for colorectal cancer has been prepared and will be launched throughout Slovenia in June 2008. It is intended for the whole population aged 50 to 69 years. Residents will be invited to participate in the programme every two years. The aim of the screening test is to establish gastrointestinal bleeding with an immunochemical test. The programme provides a further diagnosis of bleeding in the lower digestive tract as established in the screening test. All the activities under the programme are covered by compulsory health insurance and are free-of-charge for all invited residents. The programme is managed with a central register for the entire country.

Pursuant to the applicable legislation, preventive medical examinations are also provided to workers, as outlined in point 1 of Article 11/1. The scope of such check-ups and their frequency depend on the demands of the job and/or the complexity of the workplace. Medical examinations are fully paid for by the employer and are free-of-charge for the worker; they are provided by an occupational, traffic and sports medicine specialist's team.

11/3 Disease prevention

Information required by the European Committee of Social Rights (Conclusions 2005, pages 639–642):

1. Activities of the Environmental Agency of the Republic of Slovenia.

The Environmental Agency of the Republic of Slovenia is a body within the Ministry of the Environment and Spatial Planning. It performs expert, analytical and regulatory and/or administrative tasks in the field of environment at the national level. The Agency monitors, analyses and forecasts natural phenomena and processes in the environment and thus reduces natural threats to humans and property. These tasks are carried out through national services

for meteorology, hydrology and seismology. One part of the Agency's mission is to monitor environmental pollution and provide quality public information on the environment; for this purpose, the Agency has at its disposal a suitable measuring network as well as laboratories. A very important part of the Agency's mission is to fulfil the environmental protection requirements arising from applicable regulations, to conserve natural resources and biodiversity, and to ensure that Slovenia develops in a sustainable manner.

The Environmental Agency of the Republic of Slovenia contributes to solving environmental issues mostly through the implementation of environmental legislation. The Agency conducts administrative procedures with persons liable for environmental taxes such as water fees, taxes on water pollution, taxes for the pollution of air with emissions of carbon dioxide, and waste disposal taxes.

Environmental taxes are a very efficient and sophisticated environmental protection instrument. A large portion of these funds is used by taxable persons themselves for reducing environmental burdens. The Agency issues various environmental permits; the most demanding project is the introduction of the environmental permit for activities and installations that could cause large-scale environmental pollution (IPPC permit). The Agency maintains a record of emissions, and directs and monitors the implementation of rehabilitation plans, etc. It takes an integrated approach to solving climate change issues. One of the causes of climate change is excessive greenhouse gas emitted into the atmosphere. The Agency monitors these emissions, records them and contributes to their reduction through relevant systemic measures.

The Environmental Agency of the Republic of Slovenia devotes special attention to the raising of public awareness on the environment and environmental issues.

2. How is legislation concerning the quality and control of drinking water put into practice and how does the Institute of Public Health of the Republic of Slovenia cooperate with regional institutes responsible for control?

In 2004, Slovenia adopted the **Rules on drinking water**, which transpose Council Directive 98/83/EC (*Directive on the quality of water intended for human consumption*). In accordance with the aforementioned Rules, the monitoring of drinking water has been carried out for four years. The programme of monitoring drinking water is prepared by the Institute of Public Health and carried out by the regional institutes of public health. Monitoring data are collected in the **Database on compliance of drinking water** and maintained by the Institute of Public Health along with the **Database on drinking water supply systems**. Monitoring data are processed yearly and are publicly accessible; data on the quality of drinking water in a distribution network must be available at all times to users at operators of water supply systems.

The results of the monitoring show that the compliance of drinking water with the provisions of the Rules is satisfactory. Certain problems concerning the quality of drinking water occur in very small water supply systems (serving less than 50–100 people).

In addition to national monitoring, internal monitoring of drinking water is carried out by each operator and must follow the HACCP system. To a large extent, such monitoring is carried out in cooperation between operators of water supply systems and regional institutes of public health. Public information thereof is provided by the operators.

The Institute of Public Health of the Republic of Slovenia and regional institutes of public health cooperate closely with the operators of water supply systems, mainly by providing expert advice if the quality of drinking water does not comply with the provisions of the Rules.

In the initial stage of the implementation of the Rules, a special commission was established to address issues relating to drinking water. Subsequently, the activities of the commission were taken on by the Institute of Public Health of the Republic of Slovenia. Both the commission and the Institute of Public Health kept regular contact with regional institutes of public health and coordinated views on particular issues; problems were solved in a uniform way. Common doctrinal positions for numerous areas linked with healthy drinking water were established; the operators of water supply systems, the Ministry of Health and the Health Inspectorate of the Republic of Slovenia were informed thereof. All information is also published on the websites of the Institute for Public Health of the Republic of Slovenia.

3. Legislation in the field of ionising radiation

The content of Council Directive 96/29/EURATOM (*basic safety standards for the protection of the health of workers and the general public against the dangers arising from ionising radiation*) was fully transposed into national legislation by the following regulations:

- **Ionising Radiation Protection and Nuclear Safety Act** (ZVISJV-UPB2 *Uradni list RS* 102/2004) – first publication, *Uradni list RS* 67/2002
- **Natural and Other Disasters Protection Act** (ZVNDN-UPB1) – first publication, *Uradni list RS* 64/1994
- **Rules on the requirements and methodology of dose assessment for the radiation protection of the population and exposed workers** (*Uradni list RS* 115/2003)
- **Rules on health surveillance of exposed workers** (*Uradni list RS* 2/2004)
- **Rules on the obligations of the person carrying out a radiation practice and person possessing an ionising radiation source** (*Uradni list RS* 13/2004)
- **Rules on the method of keeping records of personal doses due to exposure to ionising radiation** (*Uradni list RS* 33/2004)
- **Decree on activities involving radiation** (*Uradni list RS* 48/2004)
- **Decree on dose limits, radioactive contamination and intervention levels** (*Uradni list RS* 49/2004)
- **Rules on the monitoring of radioactivity** (*Uradni list RS* 20/2007).

4. Noise regulation

Environmental permits

In accordance with Article 82 of the Environmental Protection Act, an environmental permit must be obtained for the operation of an installation or for a substantial change in the operation if an activity is pursued in that installation that causes emissions into air, water or soil for which limit values are prescribed. An installation means any stationary or mobile technical unit for which it has been established that it can cause environmental burden as a consequence of one or more specified technological processes taking place in that installation, and of any other technology-related processes taking place at the same site. Given that

installations are listed among the sources of environmental noise pollution, the operator must obtain an environmental permit for the operation of a source of noise.

An environmental permit for the operation of a source of noise is issued under the following conditions:

- with regard to noise emissions, the source of noise must ensure operation in accordance with the provisions of the **Decree on limit values for environmental noise indicators**;
- the operator of the source of noise must implement noise protection measures;
- the installation operator must ensure operational monitoring in accordance with the programme specified in the environmental permit.

Permit for temporary excessive environmental burdening

In accordance with Article 94 of the Environmental Protection Act, the Ministry may issue a permit for temporary or periodical excessive environmental burdening to a polluter, subject to consent of the municipality concerned. The public is informed by announcement on the Internet.

Persons authorised to carry out noise assessment

The operator of a source of noise must ensure the monitoring due to noise pollution from the source of noise in accordance with the **Regulation on initial measurement of noise and operational monitoring for sources of noise**. Initial measurement of noise and operational monitoring for sources of noise may be carried out by persons holding the authorisation of the Ministry. Pursuant to the Environmental Protection Act, a person may obtain the authorisation to carry out operational monitoring subject to the following conditions:

- they must be registered to perform the activity of technical consultancy
- they must have the equipment available to carry out operational monitoring
- they must be trained to carry out operational monitoring
- they must not be subject to bankruptcy proceedings
- they must not have been conclusively convicted of a commercial crime in the last five years

5. Asbestos

At the beginning of 2003, Slovenia completely abolished the production, trade and use of asbestos and asbestos products based on the Act on the Prohibition of Production and Trade in Asbestos Products and on the Provision of Funds for Restructuring the Asbestos Industry into Non-Asbestos Industry (*Uradni list RS*, No. 56/1996) and the **Decree prohibiting and restricting production, trade in and use of asbestos and asbestos products** (*Uradni list RS,* No. 49/2001). Only those asbestos products which were already in use on 28 June 2001 may be used.

In Slovenia, asbestos is mainly encountered when removing materials containing asbestos.

Before planning the reconstruction or removal of construction and maintenance work, an investor must establish whether workers will be exposed to asbestos dust or materials containing asbestos in the course of their work.
When in doubt whether a structure or installation or plant has asbestos materials built in, a sample of the material must be submitted to testing that is carried out by an expert organisation qualified for such research.

6. Legislation and food safety control

As regards foodstuffs hygiene, next to the conclusions of the report of the European Social Rights Committee on laying down standards and systematic preventive measures, the following Regulations, adopted at the European level, also apply:

1. *Regulation (EC) No. 852/2004 of the European Parliament and of the Council of 29 April 2004 on hygiene of foodstuffs (as amended by 1791/2006/EC, 1662/2006/EC, 2076/2005/EC, 2074/2005/ES)*
2. *Regulation (EC) No. 853/2004 of the European Parliament and of the Council of 29 April 2004 laying down specific hygiene rules for food of animal origin*

In the field of ensuring foodstuffs hygiene, the following also apply:

3. Regulation (EC) No. 854/2004 of the European Parliament and of the Council of 29 April 2004 laying down specific rules for the organisation of official controls on products of animal origin intended for human consumption
4. *Regulation (EC) No. 882/2004 of the European Parliament and of the Council of 29 April 2004 on official controls performed to ensure the verification of compliance with feed and food law, animal health and animal welfare rules*
5. *Commission Regulation (EC) No. 37/2005 of 12 January 2005 on the monitoring of temperatures in the means of transport, warehousing and storage of quick-frozen foodstuffs intended for human consumption*

In addition to the aforementioned Regulations, the following Directive also applies:

6. Directive 2004/41/EC of the European Parliament and of the Council of 21 April 2004 repealing certain directives concerning food hygiene and health conditions for the production and placing on the market of certain products of animal origin intended for human consumption and amending Council Directives 89/662/EEC and 92/118/EEC and Council Decision 95/408/EC

In the period from 1 January 2003 to 31 December 2007, the Ministry of Health prepared the following national provisions in the field of food safety, which transpose the Regulations and Directives:

7. Decree on the implementation of certain Regulations (EC) concerning foodstuffs, hygiene of foodstuffs and official control of foodstuffs (*Uradni list RS*, Nos. 120/2005 and 66/2006)
8. Rules setting out the health requirements to be met by workers coming in contact with foodstuffs (*Uradni list RS*, No. 82/2003)
9. Rules on hygiene requirements of individual foodstuffs transported by sea (*Uradni list RS*, Nos. 86/2003 and 64/2004)
10. Rules on frozen foodstuffs safety (*Uradni list RS*, Nos. 63/2002, 117/2002, 46/2006 and 53/2007)

In the field of monitoring the incidence of diseases associated with food poisoning, the following apply:
11. Regulation (EC) No. 2160/2003 of the European Parliament and of the Council of 17 November 2003 on the control of salmonella and other specified food-borne zoonotic agents
12. Commission Regulation (EC) No. 2073/2005 of 15 November 2005 on microbiological criteria for foodstuffs (as amended by 1441/2007/EC)
13. Directive 2003/99/EC of the European Parliament and of the Council of 17 November 2003 on the monitoring of zoonotic agents, amending Council Decision 90/424/EEC and repealing Council Directive 92/117/EEC
14. Rules on monitoring of zoonoses and zoonotic agents (*Uradni list RS*, No. 67/2004)

5. Legislation, Statistics and Trends in the Field of Tobacco, Alcohol and Drugs

Tobacco:

It is estimated that 75% inhabitants of Slovenia are non-smokers. The share of smokers among the mature population of Slovenia (aged 18 or more) is decreasing. The share of smokers differs in terms of age, education, social class, employment status and living environment. The share of smokers increases until 40 years of age, then decreases. It is highest among persons with vocational education, actively employed, in lower social classes and in the urban environment. As many as 72% of the present smokers express a fundamental willingness to give up smoking. There are no differences among age groups in this respect.

Data:

a) According to the *Slovenian Public Opinion* survey, the share of smokers among the adult population of Slovenia was 32.4% in 1981 and 25.3% in 2001. In 2006, we noted the lowest share of smokers since 1981, namely 22.8% smokers in the mature population of Slovenia, therefore about 376,200 persons. The share of smokers is higher in men, amounting to 26.5%, while that in women amounts to 19.5%. Among smokers, 81.1% smoke regularly, therefore every day. On average, regular smokers smoke about 18 cigarettes daily.
b) Between 1995 and 2003, the *European School Survey Project on Alcohol and Other Drugs (ESPAD)* noted an increased share of smokers among young people and a decreased share of those who have never smoked.
c) The surveys *Health Behaviour in School-aged Children (HBSC)* of 2002 and 2006 were conducted among 11, 13 and 15-year-olds attending schools. The comparison of the findings of the HBSC 2002 and HBSC 2006 surveys indicates a statistically significant decrease of tobacco use in young people; we note a statistically significant smaller number of first attempts at smoking, a statistically significant lower percentage of regular smokers and a statistically significant higher average age at the time of smoking the first cigarette.
d) The research conducted in 2006, therefore before the introduction of the absolute ban on smoking in all enclosed public and work places, revealed that 64.6% of all mature Slovenians had been exposed to tobacco smoke to different degrees of frequency and duration. A total of 27.1% of the mature inhabitants of the Republic of Slovenia, therefore 447,150 persons, were exposed to passive smoking every day or almost every day. They were most frequently exposed in catering establishments (52.4%), in the workplace (47.4%) and at home (34.6%). On average, these persons spent 2.7 hours daily in a smoky environment, the time periods ranging from a few minutes to more than 16 hours. This exposed group included 46.3% non-smokers.
e) In 2006, the Institute of Public Health of the Republic of Slovenia, in cooperation with experts from all nine regional health protection institutions, conducted a research study in primary schools (PS) throughout Slovenia on the implementation of health education (HE) content and programmes with emphasis on tobacco and alcohol. Of 463 PSs in Slovenia,

slightly less than three quarters participated in the research. Almost 90% of Slovenian PSs implement HE programmes or activities, or activities concerning tobacco and/or alcohol, which reflects the stress placed on HE content in both fields by Slovenian PSs.

Legislation in the area of restriction of the use of tobacco products:
Policy concerning the restriction of the use of tobacco products in Slovenia observes the provisions of the WHO Framework Convention on Tobacco Control, which was ratified by Slovenia in March 2005 and is based on the Restriction of the Use of Tobacco Products Act (Ur. l. RS (Official Gazette of the Republic of Slovenia), No. 93/07), imposing an absolute ban on smoking in all public and working places, including restaurants and bars. Furthermore, the legislation reflects Directive 2001/37/EC and Directive 2003/33/EC concerning the maximum tar, nicotine and carbon monoxide yield of cigarettes and the health warnings and other information provided on individual tobacco product packs, and the rules on the advertising of tobacco products and related sponsorship.

Drugs
Drug policy in Slovenia observes all UN conventions and is based on the Manufacture and Trafficking of Illicit Drugs Act, the Act Regulating the Prevention of the Use of Illicit Drugs and the Treatment of Drug Users, the Resolution on the 2004–2009 national programme on drug control, the EU Strategy in the Field of Drugs (2005–2012), and the Action Plan to Combat Drugs (2005–2008).

Slovenia has not yet conducted epidemiological research in the general population on the use of illicit drugs, so these data are not available. The available data are the following:

Data from the field of drugs in 2003
According to information supplied by the Information Unit for Illicit Drugs at the Institute of Public Health of the Republic of Slovenia (IUID IPH RS), in 2003 Slovenia had 2860 recorded drug users seeking help in seventeen centres for the prevention and treatment of addiction to illicit drugs. Of these, 504 persons sought help for the first time, while 2356 had sought help before. The average age of all persons addressed was 26 years; the youngest person included in the help programme was 13 and the oldest 54. In all, 76 % of help seekers were men. Over 90% of all recorded illicit drug users sought help in these centres because of a heroin problem, the others because of problems with cannabis, cocaine and other stimulants. Almost 70% of the recorded persons took several drugs at the same time. The most prevalent among additional drugs were heroin and cannabis, and every third person used cocaine; tranquilisers (anxiolytics) and alcohol were present as well. A total of 80% of help seekers had injected drugs in their life, while almost half of all persons treated shared injection accessories. The share of users smoking or inhaling their primary drug increased; this method of drug taking was used by 22% of recorded persons. The average age of all recorded persons upon the first use of any illicit drug was 16, while the average age upon the first injection of a drug was 20. A good half of all recorded illicit drug users had been dealt with by the police, in court or in prison, and the same share of recorded persons had been vaccinated against hepatitis B.

In 2003, the 504 recorded first-time help seekers in the centres for the prevention and treatment of addiction to illicit drugs consisted of 122 women (24%) and 382 men. The average age of all persons in the programme addressed for the first time was 23. Among new help seekers, heroin was the primary drug for which they most frequently sought help; it was followed by cannabis and cocaine. The average age of new help seekers upon the first use of

any illicit drug was 16, while the average age upon the first injection of a drug was 21. More than half of the firstly addressed persons had injected drugs at some point in their life; almost a third had shared a needle or syringe. Two thirds of new help seekers took additional drugs besides the primary one; these were most often cannabis, followed by cocaine, alcohol, other stimulants and heroin.

Data from the field of drugs in 2004

According to information collected by the Information Unit for Illicit Drugs at the IPH RS, 2902 "Register of Treatment of Drug Users" forms were completed in 2004; this was done in seventeen centres for the prevention and treatment of addiction to illicit drugs and in the Centre for the Treatment of Drug Addiction at the Ljubljana Psychiatric Clinic. In comparison with the year before (2860), the number of registered persons in 2004 increased by 42 persons included in the programme. The number of firstly addressed drug users was 521 (18%), 592 persons (20%) were re-addressed, and 1789 persons (62%) were continuously included in the programme. All registered persons consisted of 78% men and 22% women. The average age of all registered drug users was 27. In terms of employment status, almost 22% of registered users were regularly employed. A good half (56%) were unemployed or partially employed. In all, 17% of addressed persons were still in the process of education – pupils, secondary school or university students. In 2004, the majority of registered drug users (91%) listed heroin and other opioids as the basic reason for seeking help; this was followed by cannabis (7%), cocaine (1.3%), stimulants (0.3%) and hypnotics and sedatives (0.3%). The average age upon the first use of the primary drug was 19 for heroin and other opioids, 15 for cannabis, 21 for cocaine, 18 for hypnotics and sedatives and 17 for stimulants. As regards the method of use, most registered persons injected the drug (68%), 23% smoked or inhaled it, 8% sniffed it and 0.9% ate or drank it. The average period of drug use was almost 5 years (57 months).

In comparison with 2003, more help seekers fell into the category of single drug users (42%), the most prevalent among the drugs being heroin (74%), followed by cannabis and cocaine, and in the category of users of more than two drugs (22%), the most frequent combination being that of heroin, cocaine and cannabis; the share of persons using two drugs was lower (35%), combining heroin and cannabis in 52%, the other combinations being that of heroin and cocaine and cocaine and alcohol. The difference was more apparent in women.

Data from non-governmental organisations

In the first six months of 2005, 255 illicit drug users sought help at eleven non-governmental organisations cooperating in the pilot project of collecting data on illicit drug users under the heading of non-governmental organisations. Most of the help seekers were men. The prevalent group in terms of employment status were unemployed (66%), followed by pupils, and secondary school and university students (22%). Two thirds of registered persons (66%) sought help in non-governmental organisations on their own accord; they were followed by those who entered a programme at the request of their parents, a spouse or a partner, or a relative. A third of the registered persons sought help for an illicit drug problem for the first time and had not been treated by other help programmes. A total of 70% of those registered also sought help in other programmes, in most cases in a methadone programme. Almost 80% of those registered sought help due to a heroin problem, while a small part did so due to a problem with cannabis, cocaine or methadone. As many as 75% of those registered took several drugs simultaneously; the most frequent among additional drugs were heroin, cannabis and cocaine. The most frequent methods of drug intake were injecting and smoking or inhaling. The average period of use of the regular drug was six and a half years, the shortest a month and the longest as many as 34 years. The average age upon the first use of

the main drug was 18; the person youngest upon the use of the main drug was 10 years old and the oldest 33.

HBSC Research

In 2006, the Institute of Public Health of the RS, with the support of the Ministry of Health, carried out a second consecutive survey on health behaviour in school-aged children (HBSC). The survey also included questions about smoking marijuana among 15-year-olds. Compared to 2002, the percentage of regular users in 2006 decreased (from 4.2% in 2002 to 1.3% in 2006), as well as the percentage of recreational (from 12.7% to 5.8%) and experimental (from 7.5 to 5.6%) users, and the percentage of those who had not yet used cannabis increased (from 72% to 82%).

Data from the European School Survey Project on Alcohol and Other Drugs (ESPAD)

The ESPAD results show that the percentage of those who did not use any illicit drugs decreased between 1995 and 1999, and between 1999 and 2003. In 1995, the share of regular illicit drug users was 1.3%, in 1999 it was 4.8% and in 2003 6.6%. A great majority of children participating in the survey in all ESPAD countries who used any illicit drug used marihuana or hashish. Compared with the surveys in 1995, 1999 and 2003, the most notable increase was in the use of marijuana/hashish in the category of regular users of marijuana at any point in their life: they amounted to 1.3% in 1995, to 4.5% in 1999 and to 6.3% in 2003. In comparison with 1995, more surveyed persons replied that they had used ecstasy (all categories of use) in 1999 and 2003. Between 1995 and 1999, initiations of the use of ecstasy significantly increased (from 1.3% to 4.1%), while between 1999 and 2003, initiations decreased (from 4.1% to 3.3%), but frequent use increased (10 times and more often: by 0.1%, 0.3% and 0.7% respectively). A total of 15% of surveyed persons had used inhalants, while 5.4% of surveyed persons used inhalants in 1995, 7% in 1999 and 6.6% in 2003. Most surveyed persons who used any illegal drugs used marihuana.

Alcohol

Policy and Legislation in the Field of Restricting the Use of Alcohol

Policy in the field of restricting the use of alcohol, especially the Act Restricting the Use of Alcohol from 2003 (Ur. l. RS, No. 15/2003), observes the provisions of the European Charter on Alcohol (WHO) of 1995 and the European Alcohol Action Plan for the 2000–2005 period. Slovenia follows the guidelines of the Framework Alcohol Policy in the WHO European Region, the European WHO office strategy adopted in 2005 to control alcohol-related harm. It represents strategic guidelines and policy options for actions on alcohol control in the European region.

The policy on restricting the consumption of alcohol in Slovenia is also based on various commitments adopted by the EU Council, for example ″Council Recommendation on the drinking of alcohol by young people, in particular children and adolescents″ of 2001 and the "EU strategy to support Member States in reducing alcohol-related harm". The strategy sets five priority topics and corresponding good practices: (1) protect young people, children and unborn children; (2) reduce injuries and death from alcohol-related road accidents; (3) prevent alcohol-related harm among adults and reduce the negative impact on the workplace; (4) inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns; and (5) develop and maintain a common evidence base. The report foresees three levels of measures: (1) measures introduced by the European Commission; (2) measures implemented by the Member States at national

and local levels; and (3) harmonisation of measures at the EU level (establishment of an Alcohol and Health Forum, drink-driving and commercial communication).

In accordance with the above-mentioned documents, the national strategic and regulatory framework and in particular the EU Strategy to support the Member States in reducing alcohol-related harm, the Ministry of Health prepared an action plan on alcohol for the period 2009–2010, which is expected to be adopted by autumn 2008. The action plan will be based particularly on data on consumption of alcohol in Slovenia collected by the Institute of Public Health of the Republic of Slovenia on the basis of ESPAD and HBSC surveys and analytically processed data of other institutions and organisations. In the area of drink-driving, the Ministry of Health will build on the Resolution on the National Programme on Road Traffic Safety for the period 2007–2011 "Together for better safety", which aims at halving the number of victims in traffic compared to 2001. As part of the annual periodic plans, the Ministry of Health and other competent institutions (in particular, inspectorates) carry out a number of campaigns and enhanced measures to reduce drunk driving, which is accompanied by activities implemented by the Institute of Public Health and regional institutes for health care (for example, "Young drivers - safer on the road without alcohol") and non-governmental organisations (in particular the Z glavo na zabavo (Party with your Head) Foundation and the Varna pot (Safe Route) Institute).

6. Epidemic Control

Tasks in the field of protection from communicable diseases in the Republic of Slovenia are implemented by the Ministry of Health, the Institute of Public Health of the Republic of Slovenia and regional institutes of public health in cooperation with other institutions. The legislative basis for the implementation of tasks is the Contagious Diseases Act (CDA), Ur. l. RS No. 69/95, the Rules on Reporting Infectious Diseases (RPID) and Special Measures for their Prevention and Controlling, Ur. l. RS No. 16/99, and EU regulations, especially the Decision of the European Parliament and Council No. 2119/98/EC setting up a network for the epidemiological surveillance and control of communicable diseases in the Community. In accordance with the CDA, the reporting of 75 contagious diseases is still obligatory, with the regime of reporting being stipulated by the RPID. The reporting of outbreaks of contagious diseases is obligatory as well.

The Contagious Diseases Centre at the Institute of Public Health of the Republic of Slovenia is the national contact point for:

- the EWRS (*early warning and response system*), providing 24-hour/7-day stand-by of an epidemiologist monitoring messages from the network and forwarding them when necessary;
- implementation of the provisions of the IHR (*International Health Regulation*), for which a working group for IHR implementation was established.

7. Up-to-date Information on Immunisation Coverage

Table 15: Compulsory immunisation of children 2003–2007

	2003	**2004**	**2005**	**2006**	**2007**
OMR 1st dose	93.60%	94.10%	94.30%	96.10%	95.60%
OMR 2nd dose*	/	98.80%	98.40%	99%	98.4%**
DTP-HiB-IPV	95.30%	94.50%	95.40%	96.80%	97.70%
HBV			96.4%	97.8%	
* academic years; e.g. the data for 2007 apply to the academic year 2006/2007					
** the data apply only to four regions (CE, KP, KR, MS)					

Legend:
OMR – vaccination against measles, mumps and rubella
DTP-HiB-IPV – vaccination against diphtheria, tetanus, whooping cough, haemophilus influenzae type B, polio (inactivated vaccine)
HBV – vaccination against hepatitis B
Children in Slovenia undergo compulsory vaccinations against diphtheria, tetanus, whooping cough, haemophilus influenzae type B, polio, measles, mumps, rubella and hepatitis B. The annual vaccination programme is issued by the Ministry of Health of the RS following the proposal of the Contagious Diseases Centre at the Institute of Public Health of the Republic of Slovenia. The programme of immunoprophylaxis and chemoprophylaxis is published in Ur. l. RS, No. 22/2007.

8. Measures for the Prevention of Accidents on the Road, at Home, at School, in Free Time and Accidents Caused by Animals

Traffic accidents

The year 2006 saw the adoption of the Resolution on National Programme on Road Traffic Safety for the period 2007–2011 "Together for Better Safety", whose main intention is to halve the number of traffic casualties compared to 2001. The National Programme contains an analysis of the situation for the 2001–2005 period, during which the goal was met to a level of 81%, sets priority fields, measures in individual fields and their providers, and foresees the preparation of periodic action plans. For the purposes of achieving the goals of the National Programme, measures in four main areas are foreseen: human conduct, traffic environment, safety of vehicles and institutional activities.

Provided in the area of changing human conduct in traffic are individual measures to increase the use of safety belts and child seats, reduce the incidence of speeding, prevent the abuse of alcohol, illicit drugs and other psychoactive substances in traffic, ensure the safety of pedestrians, cyclists and bicycle riders, and ensure the safety of young drivers. Envisaged in the area of safe road infrastructure and security of vehicles are measures to eliminate dangerous points and sections of roads, measures to improve road safety (protective fences, lane, signalisation, crossings), measures to ensure traffic safety in settlements (crossings, bicycle paths, safe school routes, bus stops, traffic moderation, bypass roads), setting up a system of safety assessment and inspection of roads and their environment, ensuring security at level crossings of roads with the railway line, promoting the introduction of new technologies for passive protection in vehicles and increasing the safety of freight vehicles. Envisaged in the institutional field is the updating of legislation and its implementation, the development of an information system, inspection supervision, research and modernisation of the system of first aid and emergency medical aid. The year 2006 saw the adoption of the Road Safety Action Plan for 2007, which lists planned activities, measures and programmes and lays down the entities for their implementation (ministries, expert institutions, non-governmental organisations). Slovenia developed the programme "Young drivers - safer on the road without alcohol". The programme is implemented in schools in the form of a standard school lesson in which pre-qualified lecturers in the Road Transport Regulations programme present the topic of alcohol and driving to future young drivers with materials and methods prepared in advance (film, teamwork, presentations).

Home and free-time accidents

The year 2007 saw the adoption of the Protection against Drowning Act, which, together with other implementing regulations, lays down security measures in the area of protection against drowning at bathing sites (the size of bathing sites, the number of bathers allowed, the organisation of rescuers from water, the training of rescuers, equipment and resources for

rescuing, bathing signs, supervision), the safety of traffic by the water and on the water (equipment of boats with life jackets), measures for safe diving (training, conditions for obtaining a licence), measures for safety at work where there is a danger of drowning, and the training of the population. Swimming courses are financed by the Ministry of Education (Organization and Financing of Education Act, 2007) and are part of the curriculum in kindergartens (swimming course for children aged 4 to 5) and primary schools (20-hour swimming course in the second or third grade). The Rules on minimum technical conditions for the construction of apartment buildings and apartments adopted in 2003 set out measures for the construction of apartment buildings to prevent falls from a height (railings on stairways, balconies, the width of openings in a fence, the height of parapet windows, etc.). In 2004, it was followed by the Rules on fire safety in buildings. The Fire Protection Act of 2007 regulates the system of protection against fire and provides for the preparation of the national fire protection programme and the annual plan of activities, regulates education and training in primary, secondary and higher education, planning and implementation of measures against fires in buildings, transport and the natural environment, financing and control of measures, as well as the establishment of an information system.

The Chemicals Act adopted in 2003 lays down the conditions for placing new substances, especially biocides, on the market; the Act regulates the classification, packaging and labelling of chemicals (e.g. that certain chemicals must be properly labelled with warnings and equipped with special sealing preventing children from opening them), obligations in the production, use and transport of chemicals, and establishes measures to protect human health and the environment (restrictions of traffic and use of chemicals hazardous to health). The year 2006 saw the adoption of the Resolution on the National Programme on Chemical Safety with action plans for priority fields in the 2006–2010 period. The main activities are planned in the area of replacing hazardous chemicals with less hazardous ones, strengthening inspection control, the systematic introduction of toxicological knowledge in existing graduate and post-graduate studies, the establishment of an informal network of scientific experts, the strengthening of the centres of chemical safety and the Poison Control Centre, the improvement of technical possibilities in enterprises to raise the level of chemical safety, and raised awareness and improved communication with the public and stakeholders. The implementation of individual measures was assigned to different entities (ministries, expert institutions, non-governmental organisations).

Kindergarten and school accidents

The Regulations on Norms and Minimal Technical Conditions for Place and Equipment in Kindergartens, in force since 2000, determine the manner of construction and equipment of accommodation space of kindergartens and playgrounds guaranteeing a safe environment for children, and lay down the implementation of supervision. The Ministry of Education, acting in cooperation with experts, is preparing recommendations for action in kindergartens in the event of emergencies, which will determine the training of teaching staff in first aid and other conditions, and the equipment to be used in the case of injuries, poisoning or other emergencies.

Accidents caused by animals

The Animal Protection Act adopted in 2007 determines that a person responsible for animals must provide training and other measures ensuring that the animals are not dangerous to its environment; in a public place, a dog must be physically secured on a lead. It is specially determined how to provide physical protection and training of dangerous animals (i.e. animals having bitten a person or another animal). This Act prohibits poking, hitting and pushing

animals, exposing them to petards, intentional permanent or temporary abandoning of animals and similar. In the event of damage to humans because of a dog bite, a physician must refer an injured person to an anti-rabies clinic in accordance with the regulations governing the protection of the population against contagious diseases. A competent veterinary organisation must carry out a rabies examination on the dog and enter information on the bite in the central register of dogs.

Prevention of injuries in free time – Swimming

Safe head-diving (this content has been included in the draft document "Health Education for Children and Adolescents" prepared in January 2007) is part of the renewed programme prepared in 2006 and tested in the academic year 2006/07. It was prepared for implementation in the open-air school programme and is carried out in the course of head-diving practice. Before diving, children and their teacher consider everything that can be found in the water: bicycles, historical remains, etc. Then they explore what really is in the water and how deep it is, and only then can head-diving be practiced (head-diving training is already part of the school curriculum). Children learn a lot through play and interesting content. Such methods are of great help for teachers as well, because they can integrate very different topics, such as safe jumping in the water and water protection, the history of the place, etc. The programme is foreseen to be upgraded by targeting first aid content and included in the regular school curriculum.

Article 12: The right to social security

12/1 Social Security System

Information required by the European Committee of Social Rights (Conclusions 2006, pages 825–827):

Table 16: CHILD BENEFITS

year	*beneficiaries*	*benefits paid (in 1000 SIT/EUR)*
1996	342,443	21,104,101
1997	408,536	25,117,458
1998	410,864	26,705,104
1999	405,040	35,939,307
2000	411,397	44,904,004
2001	412,495	48,066,533
2002	408,051	51,461,986
2003	401,549	55,216,832
2004	392,538	56,061,446
January 2006	378,339	4,792,666
February 2006	381,561	4,824,057
March 2006	383,270	4,850,957
April 2006	383,349	4,848,179
May 2006	380,378	4,846,481
June 2006	384,315	4,897,773
July 2006	385,686	4,907,557
August 2006	381,718	4,846,545
September 2006	379,779	4,808,937
October 2006	372,999	4,740,512
November 2006	376,211	4,788,952
December 2006	379,462	4,818,787
January 2007	379,462	EUR 20,108,441
February 2007	381,229	EUR 20,715,734
March 2007	373,340	EUR 20,103,212
April 2007	376,772	EUR 20,280,688
May 2007	379,402	EUR 20,427,864
June 2007	378,382	EUR 20,552,243
July 2007	381,877	EUR 20,715,107
August 2007	382,962	EUR 20,759,572
September 2007	384,613	EUR 20,822,399
October 2007	383,166	EUR 20,773,599
November 2007	372,942	EUR 20,308,067
December 2007	375,150	EUR 20,445,169
January 2008	377,708	EUR 20,544,191
February 2008	379,694	EUR 23,232,233
March 2008	374,464	EUR 22,697,866
April 2008	371,495	EUR 22,392,688

Table 17: PARENTAL COMPENSATION

year	*beneficiaries*	*benefits paid (in 1000 SIT/EUR)*
1996	17,080	18,892,133
1997	16,916	21,202,239
1998	16,374	22,569,824
1999	16,181	24,541,501
2000	16,343	27,729,576
2001	16,617	31,645,974
2002	15,944	32,917,715
2003	17,443	35,219,875
2004	16,972	37,358,080
January 2006	17,714	3,661,366
February 2006	17,580	3,639,868
March 2006	17,752	3,650,343
April 2006	17,309	3,643,294
May 2006	17,951	3,715,920
June 2006	18,153	3,750,875
July 2006	18,168	3,818,910
August 2006	20,446	3,952,666
September 2006	18,667	3,961,637
October 2006	19,279	3,999,495
November 2006	18,636	4,017,305
December	18,404	3,989,891

2006		
January 2007	18,404	EUR 16,644,531
February 2007	18,870	EUR 17,076,471
March 2007	18,768	EUR 17,231,894
April 2007	18,905	EUR 17,438,643
May 2007	18,876	EUR 17,417,169
June 2007	19,301	EUR 17,643,281
July 2007	19,335	EUR 17,873,092
August 2007	19,748	EUR 18,137,437
September 2007	19,904	EUR 18,141,515
October 2007	19,706	EUR 18,224,864
November 2007	19,677	EUR 18,209,868
December 2007	19,626	EUR 18,395,172
January 2008	19,567	EUR 18,466,767
February 2008	20,357	EUR 19,706,884
March 2008	20,288	EUR 19,726,971
April 2008	20,331	EUR 19,858,708

Table 18: PARENTAL ALLOWANCE

year	***beneficiaries***	**benefits paid (in 1000 SIT/EUR)**
1996	2,822	556,237
1997	2,734	566,334
1998	2,616	573,746
1999	2,563	602,862
2000	2,452	608,000
2001	2,317	622,434
2002	2,175	781,603
2003	2,498	1,128,213
2004	2,808	1,281,932
January 2006	2,931	117,191
February 2006	2,918	116,358
March 2006	2,960	117,624
April 2006	2,934	117,657
May 2006	3,027	121,037
June 2006	2,992	118,277
July 2006	2,993	119,848
August 2006	3,056	121,681
September 2006	3,094	123,654
October 2006	3,085	122,630
November 2006	3,096	122,243
December 2006	3,041	121,475
January 2007	3,041	EUR 506,906
February 2007	3,056	EUR 518,153
March 2007	3,065	EUR 522,682
April 2007	3,063	EUR 514,958
May 2007	3,020	EUR 510,611
June 2007	3,072	EUR 518,193
July 2007	3,009	EUR 506,452
August 2007	3,006	EUR 507,024
September 2007	3,001	EUR 499,392
October 2007	2,976	EUR 500,813
November 2007	2,987	EUR 500,503
December 2007	3,001	EUR 510,084
January 2008	2,897	EUR 493,211
February 2008	2,963	EUR 519,334
March 2008	2,987	EUR 520,790
April 2008	2,984	EUR 525,130

Table 19: CHILDBIRTH ALLOWANCE

year	***beneficiaries***	**benefits paid (in 1000 SIT/*EUR*)**
1996	18,420	398,861
1997	17,916	433,342
1998	17,637	428,986
1999	17,295	452,382
2000	18,083	531,273
2001	17,295	508,637
2002	18,308	921,221
2003	16,746	902,179
2004	17,811	1,023,253
January 2006	1,606	95,664
February	1,344	79,749

2006		
March 2006	1,632	96,483
April 2006	1,401	83,026
May 2006	1,933	114,914
June 2006	1,641	97,536
July 2006	1,576	93,148
August 2006	1,741	102,919
September 2006	1,649	98,043
October 2006	1,669	89,228
November 2006	1,506	89,520
December 2006	1,390	82,617
January 2007	1,390	EUR 344,754
February 2007	1,709	EUR 433,444
March 2007	1,473	EUR 373,626
April 2007	1,610	EUR 408,675
May 2007	1,588	EUR 403,669
June 2007	2,048	EUR 522,042
July 2007	1,434	EUR 392,157
August 2007	1,666	EUR 453,471
September 2007	1,680	EUR 452,971
October 2007	1,632	EUR 440,682
November 2007	1,524	EUR 387,653
December 2007	1,762	EUR 450,468
January 2008	1,367	EUR 346,860
February 2008	1,860	EUR 491,850
March 2008	1,755	EUR 460,723
April 2008	1,599	EUR 419,499

Table 20: BENEFIT FOR CHILD CARE

year	*children*	*benefits paid (in 1000 SIT/EUR)*
1997	3,705	511,194
1998	4,132	567,601
1999	4,424	640,682
2000	4,731	722,598
2001	4,963	828,762
2002	5,219	1,175,399
2003	5,263	1,397,645
2004	5,325	1,410,766
January 2006	5,444	126,509
February 2006	5,471	127,484
March 2006	5,516	128,587
April 2006	5,510	126,768
May 2006	5,546	129,041
June 2006	5,596	130,616
July 2006	5,638	131,805
August 2006	5,598	128,770
September 2006	5,618	131,801
October 2006	5,578	130,253
November 2006	5,556	130,040
December 2006	5,541	128,583
January 2007	5,541	EUR 536,567
February 2007	5,596	EUR 567,339
March 2007	5,630	EUR 568,406
April 2007	5,666	EUR 565,802
May 2007	5,668	EUR 561,478
June 2007	5,733	EUR 573,713
July 2007	5,744	EUR 578,387
August 2007	5,721	EUR 573,424
September 2007	5,722	EUR 574,054
October 2007	5,748	EUR 583,891
November 2007	5,686	EUR 571,928
December 2007	5,735	EUR 576,787
January 2008	5,794	EUR 585,007
February 2008	5,839	EUR 610,312
March 2008	5,840	EUR 605,239
April 2008	5,896	EUR 617,506

Table 21: LARGE FAMILY SUPPLEMENT

year	*beneficiaries*	benefits paid (in 1000 SIT)
2002	23,946	598,650
2003	24,363	1,306,017
2004	24,419	1,915,495
January 2006	8	640
February 2006	1	80
March 2006	2	160
April 2006	1	80
May 2006	3	240
June 2006	3	240
July 2006	24,620	2,089,170
August 2006	810	66,226
September 2006	262	19,744
October 2006	460	32,478
November 2006	401	29,818
December 2005	208	15,180
January 2007	208	EUR 63,345
February 2007	7,016	EUR 2,536,134
March 2007	14,772	EUR 5,359,889
April 2007	2,819	EUR 1,007,713
May 2007	523	EUR 175,417
June 2007	450	EUR 147,072
July 2007	385	EUR 129,154
August 2007	542	EUR 179,685
September 2007	336	EUR 111,139
October 2007	269	EUR 85,647
November 2007	338	EUR 109,684
December 2007	474	EUR 149,095
January 2008	326	EUR 101,575
February 2008	306	EUR 98,446
March 2008	24,471	EUR 9,208,809
April 2008	679	EUR 243,373

Table 22: PARTIAL PAYMENT FOR LOSS OF INCOME

year	*beneficiaries*	benefits paid (in 1000 SIT/*EUR*)
2003	164	194,825
2004	322	335,672
January 2006	345	39,537
February 2006	352	40,678
March 2006	357	40,736
April 2006	360	41,065
May 2006	365	41,531
June 2006	369	42,995
July 2006	377	43,903
August 2006	385	43,961
September 2006	397	45,124
October 2006	405	48,026
November 2006	406	46,817
December 2006	406	46,776
January 2007	406	EUR 194,192
February 2007	411	EUR 198,361
March 2007	418	EUR 205,769
April 2007	422	EUR 202,148
May 2007	430	EUR 210,517
June 2007	422	EUR 212,695
July 2007	445	EUR 222,982
August 2007	445	EUR 212,458
September 2007	449	EUR 218,692
October 2007	457	EUR 221,860
November 2007	459	EUR 220,837
December 2007	470	EUR 224,672
January 2008	471	EUR 223,781
February 2008	473	EUR 233,713
March 2008	478	EUR 240,017
April 2008	478	EUR 237,401

Table 23: PATERNITY LEAVE (PL)

year	*number of fathers*	
	PL up to 15 days	*PL more than 15 days*
2004	12,667	/
2005	11,308	/
2006	14,098	1,441
2007	15,289	1,943
2008	5,650 *(until April)*	951 *(until April)*

Table 24: CONTRIBUTIONS FOR PART-TIME WORK

year	*beneficiaries*	**benefits paid (in 1000 SIT/*EUR*)**
2002	463	40,690
2003	828	167,541
2004	1,665	19,004
January 2006	2,495	40,084
February 2006	2,526	41,238
March 2006	2,600	42,579
April 2006	2,599	41,519
May 2006	2,630	41,689
June 2006	2,730	44,061
July 2006	2,810	44,728
August 2006	2,964	45,147
September 2006	2,975	45,281
October 2006	3,570	47,438
November 2006	3,446	51,736
December 2006		
January 2007	3,470	EUR 273,435
February 2007	3,740	EUR 293,035
March 2007	3,981	EUR 200,000
April 2007	4,254	EUR 164,861
May 2007	4,518	EUR 363,881
June 2007	4,650	EUR 373,361
July 2007	4,262	EUR 385,010
August 2007	4,316	EUR 398,866
September 2007	4,528	EUR 421,716
October 2007	4,527	EUR 432,695
November 2007	5,533	EUR 463,627
December 2007	5,862	EUR 479,662
January 2008	5,834	EUR 485,408
February 2008	6,023	EUR 198,817
March 2008	6,219	EUR 510,401
April 2008	6,425	EUR 556,457

Table 25: CHILD CARE LEAVE (CCL)

year	*number of fathers taking CCL*
2006	921
2007	1,008
2008	554 *(until April)*

12/2 European Code of Social Security

Information required by the European Committee of Social Rights (Conclusions 2006, p. 827):

This year, the Republic of Slovenia submitted its 3rd report on implementation of the European Code of Social Security.

12/3 Development of the Social Security System

Information required by the European Committee of Social Rights (Conclusions 2006, p. 828):

Adjustment of Social Transfers

Provided by the Act Regulating Adjustments of Transfers to Individuals and Households (Ur-l. RS, No. 114/2006) in force as at 1 January 2007:

"Article 3

Transfers to individuals and households, determined by legal provisions to be adjusted to the achieved or forecast growth of consumer prices or to be adjusted to the growth of the average gross wage of all employees in the Republic of Slovenia, to the growth of the average net wage, the guaranteed wage, the minimum wage, the basic wage for non-commercial activities or the average wage under the collective agreement for industry sectors, shall be adjusted in January of each year with the growth of consumer prices in the period from January to December of the previous year in comparison with the same period of the year before according to data from the Statistical Office of the Republic of Slovenia.
(2) The following types of transfers to individuals and households shall be adjusted in the manner and within the time limit stated in the preceding paragraph:
1. transfers paid from the state budget:
- child benefit in accordance with Article 65 of the Parental Protection and Family Benefits Act (Uradni list RS, No. 110/06 – official consolidated text)
- benefit for child care in accordance with Article 80 of the Parental Protection and Family Benefits Act
- partial payment for loss of earnings in accordance with Article 84 of the Parental Protection and Family Benefits Act
- large family supplement in accordance with Article 76 of the Parental Protection and Family Benefits Act
- assistance on childbirth in accordance with Article 63 of the Parental Protection and Family Benefits Act
- parental allowance in accordance with Article 58 of the Parental Protection and Family Benefits Act
- foster care payments in accordance with Articles 50, 51 and 53 of the Act Concerning the Pursuit of Foster Care (Uradni list RS, Nos. 110/02 and 56/06 – Constitutional Court Decision)
- financial social assistance in accordance with Article 19 of the Social Protection Act (Uradni list RS, Nos. 36/04 – official consolidated text, 69/05 – Constitutional Court Decision, 21/06 – Constitutional Court Decision)
- unemployment benefit in accordance with Article 18 of the Employment and Insurance Against Unemployment Act (Uradni list RS, No. 107/06 – official consolidated text)
- parental supplements in accordance with Articles 38, 39 and 40 of the Parental Protection and Family Benefits Act
- resources for the care of mentally and physically disabled – disability benefit, allowance for care and attendance by other persons in accordance with Articles 7, 8 and 9 of the Act Concerning Social Care for Mentally and Physically Handicapped Persons (Uradni list SRS, No. 41/83)
- invalidity allowance in accordance with Article 20 of the War Disabled Act (Uradni list RS, No. 63/95, 2/97 – Constitutional Court Decision, 19/97, 21/97 – corr., 75/97, 11/06 – Constitutional Court Decision and 61/06 – ZDru-1)
- supplement for special disability in accordance with Article 21 of the War Disabled Act
- attendance allowance in accordance with Article 22 of the War Disabled Act
- care allowance in accordance with Article 35 of the War Disabled Act
- disability allowance in accordance with Article 41 of the War Disabled Act
- family invalidity allowance in accordance with Article 57 of the War Disabled Act
- family allowance in accordance with Article 67 of the War Disabled Act

- attendance allowance in accordance with Article 125 of the War Disabled Act
- annuity in accordance with Article 2 of the Act on Special Rights of the Victims of the War for Slovenia in 1991 (Uradni list RS, No. 49/97)
- scholarship in accordance with Article 2 of the Act on Special Rights of the Victims of the War for Slovenia in 1991
- veteran's benefit in accordance with Article 8 of the War Disabled Act (Uradni list RS, No. 59/06 – official consolidated text, and 61/06 – ZDru-1)
- attendance allowance in accordance with Article 13 of the War Veterans Act
- lifelong monthly annuity in accordance with Article 16 of the 18/03 – official consolidated text, 54/04 – ZDoh-1, 68/05 – Constitutional Court Decision and 61/06 – ZDru-1)
- cash annuity in accordance with Article 16 of the
- national scholarships in accordance with Article 55 of the Employment and Insurance Against Unemployment Act
- Zois scholarships in accordance with Article 55 of the Employment and Insurance Against Unemployment Act
- scholarships for the unemployed in accordance with Article 53b of the Employment and Insurance Against Unemployment Act
- company scholarships in accordance with Article 55 of the Employment and Insurance Against Unemployment Act
2. transfers paid from municipal budgets:
- company scholarships
- partial payment for loss of earnings paid in accordance with social protection provisions to a home care assistant under Article 18i of the Social Protection Act
3. transfers paid by the Pension and Disability Insurance Institute of the Republic of Slovenia:
- annual supplement in accordance with Article 136b of the Pension and Disability Insurance Act (Uradni list RS, No. 109/06 – official consolidated text)
- attendance allowance in accordance with Article 137 of the Pension and Disability Insurance Act
- invalidity allowance in accordance with Article 143 of the Pension and Disability Insurance Act
- income support in accordance with Article 132 of the Pension and Disability Insurance Act
- cash allowance to beneficiaries on the basis of the remaining working capability implemented under provisions in force since the date determined in paragraph 1 of Article 446 of the Pension and Disability Insurance Act
- pension supplements granted under Article 1 of the Act Providing Social Security to Slovenian Citizens Eligible to Pensions from the Republics of the Former SFRY (Uradni list RS, Nos. 45/92, 45/99 – Constitutional Court Decision and 18/01)
- maintenance allowance in accordance with Article 3 of the Act Concerning the Provision of Maintenance to Farmers (Uradni list SRS, Nos. 1/79 and 1/86)

Article 4

(1) The manner and the time limit stated in paragraph 1 of the preceding Article also apply to the adjustment of the basis for the salary refund serving as the basis for the calculation of compensation during temporary restraint from work paid by the Health Insurance Institute of Slovenia and chargeable to compulsory health insurance on the basis of Article 28 of the Health Care and Health Insurance Act (Uradni list RS, No. 72/06 – official consolidated text).

(2) The basis of the salary refund shall be adjusted in the manner and the time limit referred to in paragraph 1 of the preceding Article only where an insured person has the basis from at least the year preceding the previous calendar year in respect to the restraint period.

Article 5

The manner and the time limit stated in paragraph 1 of Article 3 of this Act shall also apply to the adjustment of the following:

- basic amount of minimum income referred to in Article 22 of the Social Protection Act

- exemption from the payment of social services in cases when these are not adjusted in accordance with Articles 35 and 36, respectively, of the Decree on criteria for determining exemptions from the payment of social services (Uradni list RS, Nos. 110/04 and 124/04)

- base for assessment of supplementary rights referred to in Article 4 of the Pension and Disability Insurance Act

- base for assessment of supplement under Articles 2 and 4a of the Act Concerning the Provision of Social Security to Slovenian Nationals Entitled to Pensions from the Republics of the Former SFRY

- base for assessment under Article 20 of the War Disabled Act

- base for assessment of annuity under Article 3 of the Act on Special Rights of the Victims of the War for Slovenia in 1991

Article 6

Each year the Minister shall publish in the Official Gazette of the Republic of Slovenia (Uradni list Republike Slovenije) a decision on adjusted amounts of the transfers determined in nominal sums, and the percentage of adjustment of other transfers."

12/4 Social Security of Persons Moving Among Signatory States

Information required by the European Committee of Social Rights (Conclusions 2006, pp. 828–830):

Ensuring equal treatment to citizens of all ESL member states which are not EU Member States and with which Slovenia has not concluded bilateral agreements (Albania, Andorra, Armenia, Azerbaijan, Georgia, Moldova, Romania and Turkey) on social security:

The Republic of Slovenia shall conclude bilateral agreements in the field of social security on the initiative of an interested state and upon the finding that there is an actual need for such agreement due to the regularisation of the position of citizens of other states.

The need to conclude bilateral agreements on social security was thus demonstrated in the case of states from the area of the former SFRY – these have priority and are in the process of adoption, while we have not received any initiatives to conclude such agreements from the mentioned states, so we conclude, along with the assessment of the factual situation, that their conclusion for Slovenia is not a priority.

Slovenia is prepared to conclude agreements with all signatory states with bilateral interests, governing the field unilaterally at the same time.

Health care of citizens of ESL signatory states

As stated in our previous reports, we wish to reiterate for clarity the basic principle that all aliens, insofar as they fulfil the conditions of compulsory health insurance in Slovenia, shall be treated equally as citizens of the Republic of Slovenia in accordance with the legislation in force, and that bilateral agreements with particular countries apply only to particular categories of insured persons.

Insured aliens and their family members holding temporary residence permits are, as regards rights and obligations derived from compulsory health insurance, on an equal basis with insured persons and their family members holding permanent residence permits. Therefore, they shall have a right to equal medical treatment to the same extent and standard. The only exception is the condition of preliminary insurance to exercise the rights to orthopaedic, orthotic, eye, ear, orthodontic and other aids, with the exception of the rights referred to in the first point of paragraph 1 of Article 23 of the Health Care and Health Insurance Act providing that certain persons (e.g. children, school pupils, students, women as regards family planning and pregnancy) are provided health care in full, and that certain medical services are fully provided (e.g. compulsory vaccinations, treatment and rehabilitation of malignancies or other grave chronic illnesses, treatment of professional illnesses and work injuries, home treatment, etc.).

Information on Parental Supplement and Partial Payment for Loss of Earnings (Conclusions 2006, p. 829)

We inform the European Committee for Social Rights that unfortunately no amendments have been made regarding eligibility to the mentioned family benefits.

Information on the Access to Pension and Disability Insurance (Conclusions 2006, p. 829)

By law, pension and disability insurance in the Republic of Slovenia is compulsory and independent of the will of an individual. The insurance relationship is established under the law itself by the establishment of a legal relationship, which is the basis of compulsory insurance. The establishment of such legal relationship must be communicated to the Institute by an employer or other legally determined liable person by an application for compulsory insurance.

The consequence of inclusion in compulsory insurance is the possibility to acquire all legally provided rights when the insured person meets the conditions required for acquisition. Insured persons acquire rights from compulsory insurance exclusively by paying contributions, unless legally provided otherwise for individual cases.

In certain cases provided by law, a person may decide to enter into compulsory insurance voluntarily. Voluntary admission to compulsory insurance is subject not only to the will of the person to be insured, but also to his or her status at the time of exercising his or her right to such form of insurance and for the period of its duration. The scope of rights under compulsory insurance depends on the amount of the selected insurance basis, from which contributions are calculated in the period of the duration of such insurance.

Unlike insured persons included in compulsory insurance under the law itself, who cannot freely choose the scope of insurance, those persons entering insurance voluntarily may choose between insurance for the full scope of rights and insurance for a restricted scope of rights.

VOLUNTARY ADMISSION TO COMPULSORY INSURANCE

Compulsory insurance may be entered into voluntarily by a citizen of the Republic of Slovenia who has reached the age of 15, while it may only be acquired by an alien where provided by an international agreement and during the time of:

- being on unpaid leave;
- suspension of an employment contract;
- graduate or post-graduate studies;
- serving military service, performing the tasks of substitute civil service or training for reserve police units;
- caring for a child under the age of seven or for a disabled person incapable of independent life and work, or for a beneficiary of an attendance allowance;
- practising independent farming and not meeting the prescribed cadastral or other income resulting in compulsory insurance;
- being registered as an unemployed person at the Employment Service;
- staying abroad as a spouse or cohabiting partner of an insured person posted abroad to work or study;
- working in a sheltered workshop as a disabled person;
- being on an advanced or specialised course after the expiration of voluntary insurance;
- being in part-time employment, but only for the difference to full employment.

Persons who are in the course of graduate or post-graduate studies, entered in a register at the Employment Service or working as disabled persons in sheltered workshops, may also voluntarily enter into compulsory insurance at the time of receiving a survivor pension.
An unemployed citizen of the Republic of Slovenia who had been covered by compulsory insurance at least for five years in the last ten years before becoming unemployed may enter into compulsory insurance voluntarily even when he or she is not entered in any register of the Employment Service if he or she decides to do so within six months following the expiration of compulsory insurance.
The Employment Service may require that a person wishing to voluntarily enter into compulsory insurance undergo a medical examination establishing whether he or she is capable of work under the employment provisions. The costs of such examination are charged to the Employment Service.
Persons who may voluntarily enter into compulsory insurance are free to determine the amount of the insurance base from which they pay contributions for compulsory insurance. The Act provides only the lowest possible insurance bases which provide insurance for the full scope of rights and a minimum insurance amount for insurance for a restricted scope of rights.
The period in which the person was voluntarily included in compulsory insurance is considered a part of the insurance period regardless of the extent of rights under the insurance. Such period is also considered part of the years of service.

INSURANCE FOR THE FULL SCOPE OF RIGHTS
All persons who may be voluntarily included in compulsory insurance are guaranteed the full scope of rights under this insurance scheme with contributions from the insurance basis at least equal to the gross amount of the minimum pension basis (the minimum pension basis increased by an average rate of taxes and contributions calculated on wages).
Persons entering into compulsory insurance at the time of caring for a child under the age of seven, for a disabled person incapable of independent life and work or for a beneficiary of an attendance allowance, of practising independent farming, of being entered in a register at the Employment Service, of working in sheltered workshops as disabled persons or for the time equalling the difference to full time, are also guaranteed the full scope of rights when paying contributions from the insurance basis equalling at least half of the gross amount of the minimum pension rating base.

INSURANCE FOR A RESTRICTED SCOPE OF RIGHTS
Insurance for a restricted scope of rights covers the right to an old-age, disability, survivor or family pension for a blind person or a person whose mobility is restricted by at least 70%, as well as the right to an attendance allowance.
Such form of insurance may be taken by all persons allowed to voluntarily enter into compulsory insurance. The minimum insurance base equals the amount of guaranteed pay at the time.

EFFECT OF INSURANCE FOR A RESTRICTED SCOPE OF RIGHTS
An insured person or a recipient of a pension has a right conferred by compulsory health insurance regarding the prevalence of the individual of the potential forms of compulsory insurance. If he or she was covered by insurance for the full scope of rights for most of the period spent in compulsory insurance, he or she enjoys all rights under compulsory insurance, while in the opposite case he or she enjoys only the rights under a restricted scope of insurance.

The selected insurance base from which an insured person has paid contributions for compulsory insurance is of the same character as wages, and thus it may directly influence the amount of the pension base from which an insured person is assessed an appropriate pension or allowance under disability insurance. The effect may be positive as well as negative, depending on the amount.
It should be underlined that an insured person who was covered by insurance for a restricted scope of rights for most of the period of being included in compulsory insurance does not have either the right for the assessment of a pension on the minimum pension rating base or the right to an attendance allowance.

PROCEDURE FOR VOLUNTARY INCLUSION IN COMPULSORY INSURANCE
A person wishing to voluntarily enter into compulsory insurance establishes this by filing an insurance registration form (Form M1) with the registration office of the Health Insurance Institute of Slovenia in the area of residence.
Upon filing an insurance registration form, the person must also submit appropriate supporting documents on meeting the conditions for voluntarily entering into compulsory insurance, which are the following:

- for the time of unpaid leave – certificate of approval by the employer
- for the time of a suspended employment contract – employer's decision on suspension
- for the time of graduate or postgraduate studies – certificate of an educational institution on such education
- for the time of serving military service, performing the tasks of substitute civil service or training for reserve police units – corresponding certificate of a competent authority of an administrative unit;
- for the time of caring for a child under 7 – birth certificate of the child
- for the time of caring for a disabled person – certificate of disability of this person
- for the time of caring for a beneficiary of an attendance allowance – certificate that the person in his or her care is a recipient of an attendance allowance
- for the time of performing agricultural activity – certificate of the competent tax authority on the cadastral income or a decision on the assessment of tax on profits from agricultural activity, and a medical certificate of an occupational medicine service on health capacity to perform such activity
- for the time of unemployment – a certificate of the Employment Service on being entered in a register of unemployed persons, or proof of termination of compulsory insurance and, where no official data are available, proof of having been covered by compulsory insurance for at least five out of the last ten years
- for the time of staying abroad as a spouse or cohabiting partner of an insured person posted abroad to work – certificate of the employer on the posting abroad of his or her partner, a marriage certificate or proof of common law marriage, and proof of termination of compulsory insurance
- for the time of working in a sheltered workshop as a disabled person – appropriate certificate of the workshop
- for the time of expert studies or specialisation – proof of termination of compulsory insurance and proof of the institution providing expert studies or specialisation, or a certificate of the employer who sent the person for expert education or specialisation
- for the time equalling the difference to full time – certificate of the employer on the length of working time at the workplace at which the person is already insured, and on the number of hours of full working time

A person wishing to voluntarily enter into compulsory insurance must demonstrate his or her Slovenian citizenship with an identity card issued after 1 January 1992, a passport or a certificate of the competent administrative unit.
The proof of meeting the status conditions for voluntarily entering into compulsory insurance also refers to aliens, who must also cite an international agreement enabling such insurance.

PAYMENT OF CONTRIBUTIONS

A person voluntarily entering into compulsory insurance pays both employer and employee contributions under applicable rates. Exempted from this is a person voluntarily entering into compulsory insurance for the time of performing independent agricultural activity, who is not liable to pay the employer contribution.
The tax office in the place of residence of the insured person is competent for the collection of contributions. Contributions must be paid by 15th day of the month for the preceding month.
Each change in the amount of the insurance base must be reported to the competent tax administration by the 15th day of the month for the month then current.

TERMINATION OF INSURANCE

The termination of status conditions or the decision of an insured person to end his or her voluntary inclusion in compulsory insurance results in the termination of insurance. In either case, the insured person must file an application for termination of insurance (Form M2) with the registration service of the Health Insurance Institute of the Republic of Slovenia.
The application for termination of insurance must be filed within 8 days after the termination of status conditions for voluntary inclusion in compulsory insurance. If the conditions have not terminated, compulsory insurance is terminated on the day of filing the application.

Article 13: The right to social and medical assistance

The Republic of Slovenia has ratified only the second and third paragraphs of Article 13 of the European Social Charter (Article 13/2 ESC and Article 13/3 ESC).
The European Committee of Social Rights focused on the mentioned Article in its Conclusions 2006 (pp: 831–832) and established that the situation in Slovenia meets the ESL provisions.

In view of the fact that there were no significant legislative innovations in the reference period, we provide certain data referring to the implementation of Article 13/3 ESL.

13/3 Assistance of Public and Private Services to Prevent, Remove, or Alleviate Personal or Family Want

Immediate tasks under the Social Security Act are performed by public social security institutes covering:

- 62 centres of social work,
- 55 residential homes for the elderly,
- 7 special institutions for adults,
- 5 social security institutes for the training of children and youth with severe or serious mental development disorders,
- 40 occupational activity centres, and
- 8 crisis centres for children and adolescents.

Chapter II of the Social Security Act provides for several types of *social security services* which must be available *for assistance to individuals, families and groups in resolving personal distress* in the *provision of care, protection, education and training.* Social security services are provided in order to:

- prevent social distress and difficulties, and
- alleviate social distress and difficulties.

The Social Security Act provides for the *prevention of social distress and difficulties* through *social prevention services* which include activities and self-help support for individuals, families and population groups.

To alleviate existing distress and difficulties, the Act (Articles 11 to 18) provides several types of services, including:

- *individual counselling*, which is the right of each person in need of assistance in Slovenia;
- *family assistance*;
- *institutional care* consisting of all forms of assistance provided by institutions, other families or other organised forms. The purpose of such care is to substitute for or complement the functions of home and family, in particular accommodation, meals, care and social care, for an adult or child needing attendance; institutional care is provided in public social care institutes and in other social care institutes;
- *organised care for adult persons with physical or mental handicaps offering guidance and employment under special conditions* is provided in occupational activity centres with the status of public social care institute;
- *help to workers* employed in undertakings, institutions and other employers in solving personal problems relating to work or upon the termination of the employment relationship, as well as help with exercising their rights from health, pension and disability insurance, and child and family protection.

The Social Security Act stipulates that *services have the nature of a right*, which implies that an individual in need of certain services can exercise his/her right pursuant to the envisaged procedure. Entitlement to services is asserted according to the principles of equal accessibility and free choice of forms for all entitled persons under the conditions set forth by the Act and according to the principles of social justice.
In the field of social security, an individual also has the right to exercise the *right to choose a family assistant*, which may be exercised by adult persons in need of assistance in all basic daily activities.

Article 41b of the Social Security Act provides that *social security services may be performed by legal and natural persons* if they fulfil the conditions established by this Act and the regulations adopted on its basis. Services determined by this Act as public services are provided within the *network of public services under the same conditions by public social welfare institutions* and by other legal and natural persons who are *granted a concession* following an open invitation to tender. Social security services *outside the network of public services* shall be provided by legal and physical persons who *obtain a work permit*, granted and rescinded by the ministry responsible for social security. Paragraph 1 of Article 65 of the same Act provides that social security services may be provided by a *private provider fulfilling the following conditions*:

- having an appropriate professional education according to Articles 69 and 70 of the Act;
- having passed the professional examination and obtained the opinion of the social chamber;
- having at least three years of work experience in the field in which they are to perform private work, if they do the work for which at least a post-secondary degree of education is required;
- not being employed;
- there is no final decision of the court prohibiting them from performing their profession;
- they have provided premises, equipment and staff if the nature of work so requires.

Article 14: The right to benefit from social welfare services

14/1 Provision of Services Contributing to Welfare

Information required by the European Committee of Social Rights (Conclusions 2005, p. 645):

Effective and equal access to social security services

Under Article 4 of the Social Security Act (Ur. l. RS, No. 3/07 – official consolidated text, 23/07 – corr., 41/07 – corr. and 114/06 – ZUTPG, hereinafter: ZSV), all rights to social security services shall be implemented by the principles of equal access and free choice of forms for all participants under the conditions provided by law. In accordance with this information, persons eligible for social security services may access all social security services under the same conditions.

14/2 Inclusion and Participation of Non-Governmental Organisations in Social Security Services

Information required by the European Committee of Social Rights (Conclusions 2005, p. 647):

The government is aware of ***the importance of professional and efficient operation of NGOs***, and thus in various ways seeks to strengthen the fundamental and other conditions for their rapid and efficient development. In establishing cooperation, the government will continue to work *openly and transparently* and adhere to the principle of *independence of non-governmental organisations* in setting their own goals. In view of the fact that non-governmental organisations provide *very important, socially beneficial work* in different fields of operation, the government will *support the future transfer of public functions and powers* to the non-governmental sector in cases where non-governmental organisations may be more efficient and effective.

Similar to many countries, Slovenia is undergoing a *transfer of different services to the private sector*, and a part of these services may be provided by *non-governmental organisations*, which frequently offer the initiative for the provision of certain services often co-financed by the government in light of the established public interest. It is precisely in the *area of social security* that such effectiveness and efficiency is revealed in a special form, since it can create *high-quality and user-friendly programmes*.

One of the objectives set by the Ministry of Labour, Family and Social Affairs in the field of social security is the *creation of new approaches to deal with social distress*. An *important role* in this field has been played by *non-governmental organisations*, which continuously develop *new programmes adapted to users*. Together with public service providers they are tasked with *developing a uniform system of social security at the national level*. Such programmes are to be *provided* mostly by *non-governmental organisations* whose part in civil society facilitates the articulation of specific needs of individuals and population groups.

In relation to non-governmental organisations, the *Ministry* of Labour, Family and Social Affairs acts as a *stimulator of development*, regulates the legal options for their operation, cares for the determination of the operative position of the non-governmental sector in the implementation of social welfare activities, provides and redistributes resources for their operation and implements calls for the co-financing of programmes, awards work permits and sees to the quality provision of activities.

The Ministry has co-financed non-governmental organisations *by co-financing social security programmes ever since 1993*. Special emphasis and greater stability of financing of supplementary social security programmes were determined by the National Social Security Programme. Most of these programmes are implemented by non-governmental organisations; some applications are also made by public institutions, which do not, however, implement these programmes as a part of public service.

In the coming years, the Ministry will *continue to stimulate non-governmental organisations* through *public tenders* as well as through other forms of cooperation. The implementation of the National Social Security Programme must focus especially on the *extension of a network* for programmes where a network has not yet been established.

The expert approach must be enhanced in the implementation of individual programmes and certain programmes must be adapted to the individual needs of users. The development of the non-governmental sector must stress the greater *role of voluntarism* and thus recognise voluntary work in the society. And last but not least, this field must enhance the *role of local communities*, for this is the only way to enable the development of programmes whose needs arise from the environment of individual local communities.

Article 23: The right of elderly persons to social security

Information required by the European Committee of Social Rights (Conclusions 2005, p. 661):

Legislation on non-discrimination of the elderly

Article 14 of the Constitution of the Republic of Slovenia (Equality before the Law) provides that everyone in Slovenia is guaranteed equal human rights and fundamental freedoms irrespective of national origin, race, sex, language, religion, political or other conviction, material standing, birth, education, social status, disability or any other personal circumstance (old age). All are equal before the law. Even where an elderly person cannot exercise his or her own rights and interests due to health or other reasons, this may not mean that he or she should be discriminated against in being provided any social security service or assistance. In this case he or she can be appointed a custodian for a special case or a legal representative representing his or her interests or exercising rights on his or her behalf.

Information required by the European Committee of Social Rights (Conclusions 2005, p. 661):

Table 26: Information on old-age pensions and attendance allowance

		in SIT				in EUR
		December 03	December 04	December 05	December 06	December 07
Old-age pension						
Minimum old-age pension	*Minimum pension for 15 years of pensionable service*	33,459.67	34,668.50	36,573.41	37,751.80	166.79
Maximum old-age pension	*Highest pension paid*	340,394.79	356,590.29	389,611.05	406,639.39	1,821.01
Average old-age pension	*Average old-age pension with income support (IS) – net amount*	115,066.00	118,413.00	124,105.00	127,135.00	558.98
Pension rating base						
Lowest pension rating base		95,599.06	99,052.86	104,495.45	107,862.29	476.54
Highest pension rating base		382,396.24	396,211.44	417,98,80	431,449.16	1,906.16
Base for assessment of supplementary rights		79,876.73	82,281.33	86,288.26	88,545.56	369.49
Attendance allowance						
Beneficiaries suffering from severe impairment		79,876.73	82,281.33	86,288.26	88,545.56	369.49
Higher amount		55,913.71	57,596.93	60,401.78	61,981.89	258.65
Lower amount		27,956.85	28,798.46	30,200.89	30,990.94	129.32

Information required by the European Committee of Social Rights (Conclusions 2005, p. 662):

What is the minimum amount making an elderly person eligible for municipal assistance in payment of social security services (minimum income determined by the ZSV as the minimum means of subsistence)?

Pursuant to Article 100 of the ZSV, entitled persons and other persons liable for payment shall be obliged to pay for all provided services according to this Act, except social prevention, first social help and institutional care in social welfare institutions for training, which is free for entitled persons. On the basis of the Decree on criteria for determining exemption from the payment of social services (*Ur. l. RS,* Nos. 110/04 and 124/04, hereinafter: Decree), the services of personal assistance, home assistance to families and guidance, assistance and employment under special conditions shall be provided free of charge to any eligible person upon concluding an agreement on the provision of service pursuant to the law. In accordance with the above, exemption from payment may be claimed for home assistance to families and institutional care under paragraph 1 of Article 16 of the ZSV where an eligible person cannot pay for the full value of the service.

Pursuant to the Decree, eligible persons and persons liable can claim the right to be exempt if they cannot pay the full price of the service, in the following order:

- service is paid by an eligible person;
- an eligible person has the right to be exempt from payment where the payment exceeds his or her ability to pay;
- the amount of the exemption granted to an eligible person is covered by persons liable for maintenance, except where there are no liable persons;
- an eligible person, who is a natural person, has the right to be exempt from payment where the payment exceeds his or her ability to pay, and in other cases determined by this Decree.

In the case of exemption of an eligible person or a person liable, the difference to the full value of a service shall be covered by the municipality.

Exemption from payment for a social security service depends on the following criteria: value of the service provided, amount of established income, social security threshold, ability to pay and contribution to the payment for services. Social security threshold is defined as the subsistence amount at the disposal of a beneficiary and her/his family members after the payment of a contribution for service provided. The social security threshold of an unmarried person is determined as the sum of his or her minimum income and 30% of his or her established income, but cannot be lower than 1.5 times the minimum income (EUR 329.55). The social security threshold of a person in full-day institutional care amounts to 10% of his or her established income, but equal to at least 0.2 times the minimum income (EUR 42.59). The social security threshold for families is determined as the sum of the minimum family income and 30% of the established income of the family. Where no member of the family is placed in institutional care, the social security threshold cannot be lower than 1.5 times the minimum family income, while the social security threshold of a family with members placed in institutional care cannot be lower than the sum of its minimum income and 1.5 times the minimum income of family members not placed in institutional care.

The eligible person's ability to pay is the surplus of the established income over the social security threshold, and the person is able to contribute to the payment of a social security

service up to this amount. The same criteria apply to persons liable to pay for his or her maintenance, and if the sum of the contribution of the eligible person and the persons liable to pay for his or her maintenance, if any, does not suffice to cover a social security service, the difference is covered by the competent municipality.

Information required by the European Committee of Social Rights (Conclusions 2005, p. 662):

What is the practical operation of the integral system enabling supervision over the number of persons receiving relief and the amount of such relief?

With regard to decisions on exemptions from payment of social security services, the Information System of Centres of Social Work (IS CSW) was established with the intention of providing information support to expert workers in decisions on exemptions from payment of social security services (conduct of procedure and issuing decisions on exemption) and the possibility of obtaining statistical data for analysis of all parameters involved in these procedures. Therefore, the IS CSW may serve as the basis for determining each individual person eligible for a social security service partly or fully exempted from the payment of such service, the amount of his or her exemption and contribution, and the amount contributed to the payment of his or her service by persons liable to pay for his or her maintenance or by the municipality. In addition, it is possible to determine at the municipal level how much individual municipalities contribute to the payment of social security services for their residents, and how many eligible persons are covered by their contributions.

Information required by the European Committee of Social Rights (Conclusions 2005, p. 663):

What is the maximum amount paid by an individual eligible for the service of home assistance (in view of the fact that a part is contributed by the municipality, a part by the state, and the difference is covered by individuals)?

Pursuant to Article 99 of the ZSV, home assistance is covered from the municipal budget at least at the level of 50% as a subsidy of the price of service and at the level for which the entitled person or other person liable for payment is partially or entirely exempt from payment. According to the above, the person entitled to home assistance is obliged to pay the mentioned service to the maximum amount of 50% of the service price, which, however, differs from municipality to municipality and currently amounts to EUR 0.40/hour of assistance to EUR 11.20/hour of assistance, depending on the additional subsidy of individual municipalities.

Information required by the European Committee of Social Rights (Conclusions 2005, p. 664):

Information on the number of appeals in the social security field, and the results of these appeals (with regard to the means of appeal listed in our 4th report)

Information on appeals against administrative decisions of social security institutes resolved by the MoLFSA as a second instance authority in matters of exercising social security services:

- No. of appeals in 2005: **185**; No. of rejected appeals: **129**; No. of granted appeals: **41**
- No. of appeals in 2006: **200**; No. of rejected appeals: **150**; No. of granted appeals: **43**

- No. of appeals in 2007: **157**; No. of rejected appeals: **100**; No. of granted appeals: **53**

Information on initiatives for extraordinary inspections with regard to implementation of social security services:
No. of initiatives for extraordinary inspections in the period from 1 January 2005 to 31 December 2007 for institutional care: **41**, with **11 inspections** implemented, **15** cases of unfounded objections, and **15** cases of the content of the initiatives not falling within the competence of social inspections.
No. of initiatives for extraordinary inspections in the period from 1 January 2005 to 31 December 2007 for home assistance: **27**, with **7 inspections** implemented and **20** cases of unfounded objections.
All implemented inspections had established irregularities on the part of providers, which were rectified in all cases.

Information on objections against the provision of social security services by private providers addressed to the Social Chamber:
No. of objections in 2005: **0**
No. of objections in 2006: **37**, **10** of which were **granted**, with the Social Chamber advising the principals or expert leaders on how to act in case of appeal, how to regulate the means of appeal and how to improve the quality of work.
No. of objections in 2007: **29**, **12** of which were **granted**, with the Social Chamber advising the principals or expert leaders on how to act in case of appeal, how to regulate the means of appeal and how to improve the quality of work.

Article 30: The right to protection against poverty and social exclusion

In view of the information required by the European Committee of Social Rights (Conclusions 2005, pp. 676–679) and the reference period of the report, we enclose the **National Report on the Strategies of Social Protection and Social Inclusion 2006–2008** adopted by the Government of the RS on 21 September 2006.