World Health Organization

REGIONAL OFFICE FOR Europe

Participatory approaches to reaching the Sustainable Development Goals: SLOVENIA

Integrating population and individual services to reduce health inequalities at the community level through health-promotion centres

Key messages

In Slovenia, the following actions have facilitated progress towards reaching the Sustainable Development Goals (SDGs).

- **The introduction of a collaborative approach in the health system, particularly between the primary health care (PHC) and public health services, has proven to be a powerful vehicle for reaching vulnerable groups.**
  Slovenia has chosen this integrated approach to reducing health inequalities in order to reach those most in need in their communities.
- **Community-based approaches, using formal and non-formal types of care and a mix of population- and individual-based interventions, increase social cohesion.**
  The adoption of such community-based approaches, enabling a prompt and structured response to the needs of the population, allows for developing and implementing programmes to reach those in need. They also go beyond the institutional boundaries of health and social care.
- **The creation of health-promotion centres (HPCs) in primary-health-care (PMC) centres have proven to be an important component in linking stakeholders within the Slovenian health system.**
  Reaching out to and linking different stakeholders in the local communities regarding the needs of vulnerable groups helps to ensure that those most in need have equitable access to the health services (including preventive services).

Summary

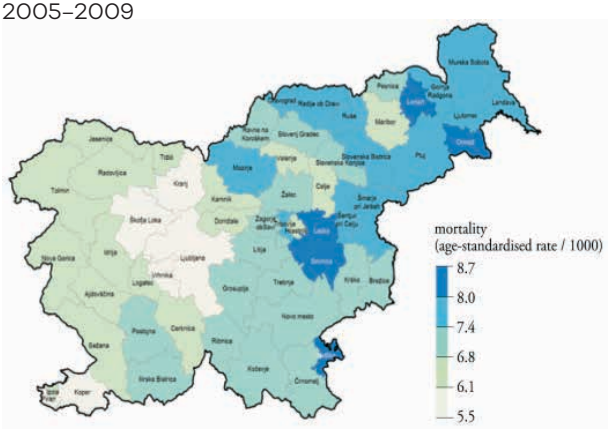
In 2002, HPCs were created in all 61 PHC centres across Slovenia. Their major role was to provide lifestyle interventions against the key risk factors for noncommunicable diseases (NCDs) through a combination of population- and individual-based approaches. These centres integrated activities, which had previously been dispersed among the PHC centres, including community nursing. To better focus on vulnerable groups, between 2013 and 2016, HPC centres piloted a new approach to integrating the different services, targeting vulnerable groups at the community level. This entailed their reaching out to and involving key stakeholders with an impact on community health to ensure that vulnerable groups were not left behind. Partnerships were created with different stakeholders, including social services and nongovernmental organizations (NGOs). This resulted in the adoption of local health-promotion strategies and action plans aimed at addressing the needs of the different population groups by identifying and reducing health inequalities. Slovenia's experience shows how they are working towards reaching SDGs 3 and 10 in order to achieve good health and well-being and leave no one behind.

The HPCs contribute directly to achieving SDG 3 (good health and well-being) and SDG 10 (reduced inequalities) *(1)*, and the five interdependent strategic aims of the WHO *Roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy for health and well-being*:

- advancing governance and leadership for health and well-being;
- leaving no one behind;
- preventing disease and addressing health determinants by promoting multi- and intersectoral policies throughout the life-course;
- establishing healthy places, settings and resilient communities; and
- strengthening health systems for universal health coverage *(2)*.

Motivation

Fig 1. Mortality by Slovenian administrative units, 2005–2009



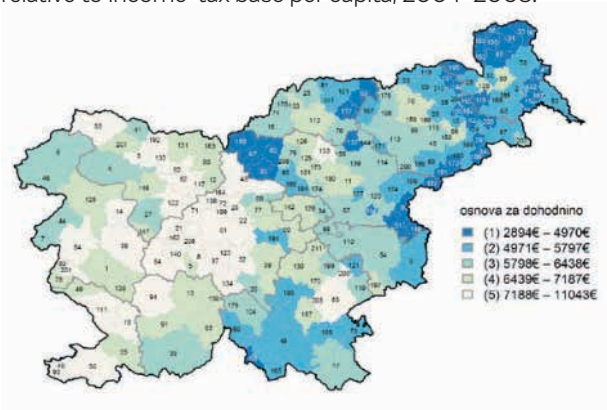
Source: National Institute of Public Health Mortality Database 2005–2009; Surveying and Mapping Authority of the Republic of Slovenia 2010.

The Slovenian health-care system provides access to universal and comprehensive health care for all Slovenian citizens, regardless of income. While the health of the population has improved over the last few decades despite socioeconomic transition, life expectancy and morbidity and mortality data show that inequalities among the regions in Slovenia still exist (Fig. 1). The western and central parts of the country are much better off than those in the eastern and north-eastern regions, reflecting differences in levels of development and poverty *(3)*.

It is recognized that disparities among the regions exist regarding not only health but also health-system response to the needs of the different population groups *(4)*. Health illiteracy, poverty and unemployment among vulnerable groups can make it difficult for them to access health services. This is particularly true for preventive services. Inequalities also exist between the genders regarding health status and access to and the use of medical services. According to the Health Behaviour in School-aged Children (HBSC) study for 2009–2010, health inequalities among schoolchildren are increasing, particularly among those from the lower socioeconomic groups (5). As in many other European countries, years of economic and financial crisis have also exacerbated health inequalities in Slovenia *(6)*.

Publication of the report, *Health inequalities in Slovenia* (2011) *(7)*, and a thorough analysis of the health system in Slovenia in 2015 *(8)* resulted in a parliamentary decision to find better ways of

Fig 2. Distribution of Slovenian municipalities into quintiles relative to income-tax base per capita, 2004–2008.



Note: osnova za dohodnino = income-tax base.

Source: Tax Administration of the Republic of Slovenia, 2004–2008 (recalculations by the Institute of Macroeconomic Analysis); Surveying and Mapping Authority of the Republic of Slovenia, 2010.

addressing the needs of vulnerable populations and to reduce inequalities by strengthening PHC capacities (9). Investments in strengthening the HPCs included integrating them in PHC to enable them to collaborate with other sectors, assuring an integrated community approach with a focus on health determinants, health promotion and the prevention of NCDs at the community level.

Strengthening PHC to reduce health inequalities at the community level: HPCs

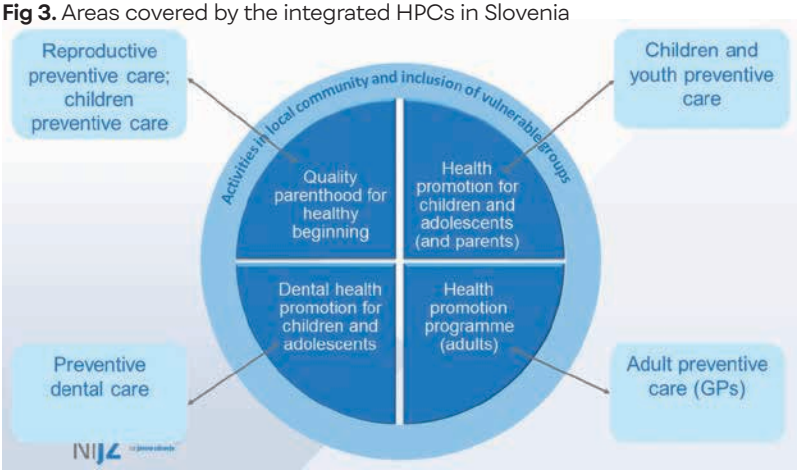
Slovenia has a long tradition in PHC, which represents the first point of patient contact. It has a strong gatekeeping role and involves the provision of care from a wide range of health professionals (general practitioners (GPs), paediatricians, gynaecologists, community nurses, midwives, dentists, pharmacists, physical therapists, psychologists, among others). The HPCs were built on the existing strong PHC system, offering both curative and preventive services.

HPCs were introduced as part of the National Programme on the Prevention of Cardiovascular Diseases, which was launched in 2002. In this context, GPs provided preventive check-ups and referred at-risk patients to HPCs where they could participate in lifestyle intervention programmes free-of-charge. Funding was provided in full by the national health insurance fund. Financial incentives were introduced to encourage GP practices to reach the targets for preventive check-ups. HPCs also stimulated the local economy by providing additional employment opportunities for nurses and other health-promotion professionals.

The implementation of measures to upgrade the HPCs started a few years ago with the aim of addressing the widening health-inequalities gap in the country. Population-needs assessments were carried out, according to which the HPCs adapted their practices to the specific requirements of vulnerable groups and provided them easier access to preventive services. This was also facilitated through the development of community health-promotion structures. Fig. 3 shows how the HPCs work in

In Slovenia, health-promotion centres became the corner stone and driver of the move to assure the most vulnerable groups access to health care.

Fig 3. Areas covered by the integrated HPCs in Slovenia



Source: NIPH, Slovenia.

local communities to ensure the inclusion of vulnerable groups and the achievement of SDGs 3 and 10 *(1)*.

The HPCs integrated different structures, professionals and programmes within the PHC centres and the community. Today, HPCs feature multidisciplinary teams of nurses, physiotherapists, psychologists, dieticians and kinesiologists. Patients attend individual and group interventions on healthy lifestyle in relation to nutrition, physical activity, mental health, smoking and alcohol consumption, obesity and diabetes. HPCs operate at the local-community level through local groups for health promotion, which have been established according to the community approach. The partners involved in these groups comprise municipalities, health-care and social-care institutions, educational institutions, the "Project learning for young adults" training programme, adult education centres, and various NGOs. The community approach enables response to the needs of the local population, overcoming perceived obstacles in a coordinated and integrated way. It also facilitates the development of support networks and self-help groups and assures better access to preventive services and treatment. Partners in the local groups for health promotion set common goals for the local environment in the areas of prevention, health promotion and health inequality, and plan and implement measures to reach them.

Impact

The initial scepticism of GPs and other health professionals about the contents, target values and funding of the National Programme on the Prevention of Cardiovascular Diseases gradually shifted to enthusiasm as health outcomes improved.

Over the last 16 years, the Programme has screened more than half of the adult population for lifestyle and risk factors. Every year, almost 50 000 patients take part in lifestyle interventions run by the HPCs. Trends in (premature) mortality continue to decline. There are, however, still disparities among the regions and among income categories *(11)*. In collaboration with NIPH, the PHC centres have extended their role to include conducting public health interventions at the community level.

Implications for policy

The development of HPCs within PHC centres is an innovative approach to scaling up health promotion and the prevention of NCDs. It also contributes to assuring hard-to-reach populations equal access to preventive services close to where they live. In the National Health Care Plan 2016–2025, equal rights and access to health services are defined as core values for the development of Slovenia's health system. The substantial financial investments made in piloting the HPCs and strengthening them in terms of their ability to reach vulnerable populations will only pay off if the concept is implemented in all 58 PHC centres and funding provided within the compulsory health insurance scheme. At present, this is case for only 25 of the PHC centres.

In Slovenia, reducing health inequalities and guaranteeing that the process will continue despite political changes is one of the main goals of health-system reform.

In Slovenia, health development at the national and local levels is on the political agenda. The first goal of the Slovenian Development Strategy 2030 is to improve the health of the Slovenian population and increase healthy life expectancy for all (*12*). Implementation of the Strategy will require strong political leadership as well as the constant support of empowered PHC and public health services.

Lessons learnt

HPCs seek to strengthen the capacities and competencies of the health sector by working with social-care services, NGOs and other stakeholders at the local-community level. To sustain this cooperation, it should be supported by incentives for both the health sector and other stakeholders.

The role of public health in further developing, monitoring and evaluating health-promotion and disease-prevention programmes in PHC, with a focus on health equity, will need to be better defined and promoted. This could be achieved through the two strategies foreseen in the National Health Care Plan 2016–2015, namely, the Strategy for the Development of Primary Health Care and the Strategy for the Development of Public Health.

In Slovenia, PHC has been proven capable of delivering preventive services and public health programmes with a focus on vulnerable groups. Nonetheless, coordination structures and a competent workforce are crucial to the successful performance of these functions and to assuring the integration of the different services involved. HPCs with multidisciplinary teams have the broad spectrum of competencies and skills necessary to establish health-promotion and disease-prevention programmes. They successfully link PHC centres and local communities. Slovenia's pilot experience in the use of HPCs illustrates the enormous potential of action at the local level in mobilizing individuals and organizations to build healthy communities.

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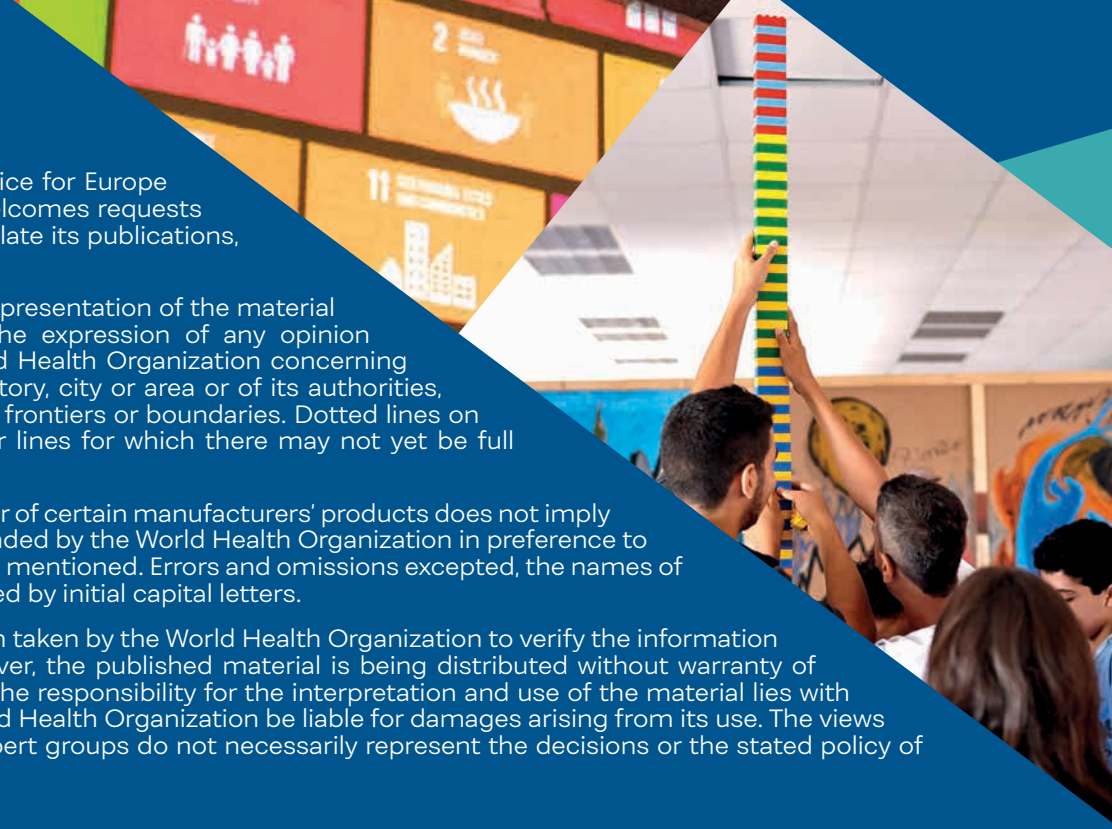

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