



**World Health
Organization**

REGIONAL OFFICE FOR
Europe

A large, stylized map of Europe is shown in white against a light blue background. The map is semi-circular at the top. A small area in the Balkans, representing Slovenia, is highlighted in a darker green color. A large, solid green circle is overlaid on the map, containing the title text.

Slovenia

Profile of Health
and Well-being



The World Health Organization was established in 1948 as the specialized agency of the United Nations serving as the directing and coordinating authority for international health matters and public health. One of WHO's constitutional functions is to provide objective and reliable information and advice in the field of human health. It fulfils this responsibility in part through its publications programmes, seeking to help countries make policies that benefit public health and address their most pressing public health concerns.

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Abstract

Country profiles on health and well-being give an overview of a country's health status, providing data on mortality, morbidity and exposure to key risk factors together with trends over time. They are developed in collaboration with WHO European Member States. When possible, each report also compares a country to a reference group, which in this report is the whole WHO European Region and the European Union member countries prior to 1 May 2004. To make the comparisons as valid as possible, data are as a rule taken from one source to ensure that they have been harmonized in a reasonably consistent way. The data in the report are drawn from the European Health for All database of the WHO Regional Office for Europe. These data are collected from Member States on an annual basis and include metadata that specify the original source of data for specific indicators.

Keywords

HEALTHY PEOPLE PROGRAMS – STATISTICS AND NUMERICAL DATA, HEALTH STATUS, HEALTH POLICY, SLOVENIA

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ISBN 978 92 890 5152 1

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Contents

Acknowledgements	iv
Abbreviations and acronyms	v
Summary of situation and trends in health and well-being in Slovenia	vi
References	viii
Introduction	1
Selected demographic and economic information	2
Health status and burden of disease	4
Life expectancy	4
Healthy life expectancy and disability-adjusted life-years	5
Morbidity	5
Infant and maternal mortality	7
Leading causes of death	8
Other major causes of death	9
Premature mortality	12
Risk factors and determinants of health	15
Alcohol consumption	15
Tobacco smoking	15
Diet, consumption of macronutrients and overweight	16
Comparative risk assessment	16
Health system	18
Health 2020	20
Reduce premature mortality by 2020	20
Increase life expectancy	22
Reduce inequalities in health	22
Enhance the well-being of the population	23
Ensure universal coverage and the right to the highest attainable level of health	24
Set national goals and targets related to health	24
Conclusions	25
References	27
Annex 1 ICD-10 codes for causes of death	29
Annex 2 Selected mortality data	30

Acknowledgements

The highlights on health and well-being and accompanying profiles of health and well-being are produced under the overall direction of Claudia Stein, Director, Division of Information, Evidence, Research and Innovation, WHO Regional Office for Europe.

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Abbreviations and acronyms

DALY disability-adjusted life-years

EU European Union

EU15 countries belonging to the EU before 1 May 2004

GDP gross domestic product

ICD International Classification of Diseases

Summary of situation and trends in health and well-being in Slovenia

The health status of the population in Slovenia has improved considerably in the past decade and a half. Nonetheless, while the improvements in life expectancy and mortality have been rapid since 2000, the most recent rates remain below the average of the countries belonging to the European Union (EU) before 1 May 2004 (EU15). Although Slovenia joined the EU on 1 May 2004, the EU15 were chosen as a comparator group at the explicit request of the Ministry of Health of Slovenia. In 2010, life expectancy at birth was 76.6 years for males and 83.2 years for females in Slovenia. A more salient indicator of gains, healthy life expectancy, had increased to 66 years for men and 72 years for women by 2013.

Declining infant and maternal mortality rates are driving these improvements in life expectancy, in conjunction with decreasing mortality rates from diseases of the circulatory system, infectious diseases, diseases of the respiratory system and diseases of the genitourinary system. Motor vehicle traffic accident deaths have also decreased rapidly in recent years. In contrast, slow progress has been observed concerning mortality from malignant neoplasms (cancers) and diseases of the digestive system, especially chronic liver disease and cirrhosis. For these causes, mortality in Slovenia is higher than the average for the WHO European Region. The incidence of cancer and the prevalence of cancer and diabetes have increased substantially in recent years, hindering progress in the reduction of mortality rates, and the mortality rate from external causes of injuries and poisoning has been above the EU15 average, especially regarding suicides. In general, the incidences of infectious diseases are low, but outbreaks of syphilis and pertussis have been reported. The rates of HIV infection and AIDS have increased during recent years although the incidences have remained below the average for EU15 countries.

Improved trends have been observed for 12 out of the 19 core indicators in the Health 2020¹ policy targets in Europe (see table on next page). Deteriorating trends have been noted for four indicators: alcohol consumption per capita, prevalence of overweight, the unemployment rate and private household out-of-pocket expenditure. Slovenia has documented that it is following the recommendations in the policy

¹ WHO's policy framework supporting action across government and society for health and well-being.

for introducing a process for target-setting as well as a national policy aligned with Health 2020, including an implementation plan and accountability mechanism.

Life satisfaction (a measure of subjective well-being) with a score of 6.1 is similar to the average for the Region but lower than the EU15

Core indicators for monitoring Health 2020 policy targets, Slovenia, most recent years available

Target	Indicator	Value			Year
		Male	Female	Total	
1. Reduce premature mortality^a	Premature mortality rate from cardiovascular disease, cancer, diabetes mellitus and chronic respiratory diseases among people aged 30 to under 70 years	392.2	189.5	289	2010
	Prevalence of tobacco use among adults aged 18 years and over ^b	22.2	15.9	19.2	2012
	Pure alcohol consumption per capita among people aged 15 years and over	–	–	10.3	2010
	Prevalence of overweight and obese (body mass index ≥ 25) adults aged 18 years and over (age-standardized estimate)	66.1	55.1	60.6	2014
	Mortality rate from external causes of injury and poisoning, all ages	87	28.7	56.3	2010
2. Increase life expectancy	Life expectancy at birth, in years	76.6	83.2	80	2010
3. Reduce inequities^c	Infant mortality rate per 1000 live births	2.1	3	2.5	2010
	Proportion of children of official primary school age not enrolled	3.2	2.2	2.7	2013
	Unemployment rate (1)	8.9	10.5	9.7	2014
	National policy addressing reduction of health inequities established and documented	NA	NA	Yes	2014
	Gini coefficient	–	–	25	2014
4. Enhance well-being^d	Life satisfaction among people aged 15 years and older (2)	–	–	6.1	2007–2012
	Availability of social support among adults aged 50 years and older (3)	–	–	88	2014
	Percentage of population with improved sanitation facilities	–	–	99.1	2015
5. Universal coverage and “right to health”	Private household out-of-pocket expenditure as proportion of total health expenditure	NA	NA	12.1	2013
	Percentage of children vaccinated against measles (one dose by second birthday)	–	–	95	2010
	Percentage of children vaccinated against poliomyelitis (three doses by first birthday)	–	–	96	2012
	Percentage of children vaccinated against rubella (one dose by second birthday)	–	–	95	2012
	Total health expenditure as a percentage of gross domestic product	NA	NA	9.2	2013
6. National targets	Establishment of process for target-setting documented	NA	NA	Yes	2014
	Evidence documenting:				
	(a) national health strategy aligned with Health 2020	NA	NA	Yes	2014
	(b) implementation plan	NA	NA	Yes	2014
(c) accountability mechanism	NA	NA	Yes	2014	

NA: not applicable.

^a Target 1 also includes the percentage of children vaccinated against measles, poliomyelitis and rubella.

^b Prevalence includes regular daily smokers among people aged 15 years or more.

^c Target 3 includes life expectancy at birth.

^d Target 4 includes Gini coefficient, the unemployment rate and the proportion of children not enrolled in primary school.

Source: WHO European Health for All database (4), unless otherwise specified.

average. Among objective well-being measures, 88% of people aged over 50 years in Slovenia reported that they had relatives or friends on whom they could count when in trouble, equal to the average for the EU15 and exceeding the 82% average for the Region.

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Introduction

In 2012, WHO European Member States adopted Health 2020 (1,2), a policy framework supporting action across government and society for health and well-being. With the accelerated implementation of Health 2020, the WHO Regional Office for Europe has introduced two new series, the country profiles of health and well-being and the highlights on health and well-being. These follow on from the highlights of health series, which ran from the early 1990s to the mid-2000s with the aim of addressing the need for analyses of the health situation and trends in newly emerging states in order to assist European countries with evidence-informed policy-making. The profiles provide comparative analyses of the situation and trends in health and well-being in countries, providing recent data on mortality, morbidity and exposure to key risk factors and giving special emphasis to all Health 2020 indicators (3), including well-being. They are developed in collaboration with Member States and do not constitute a formal statistical publication. The highlights of health and well-being form a separate series, with policy-makers as the target audience, highlighting the main findings from the longer profiles.

To make the comparisons as valid as possible, data are taken from a single source to ensure that they are harmonized consistently. Unless otherwise noted, data in the reports are drawn from the European Health for All database¹ of the Regional Office (4). These data are collected from Member States and other international sources on an annual basis and include metadata that specify the original source of data for specific indicators. Other data and information used in the report are referenced accordingly. The International Classification of Diseases, tenth edition (ICD-10) codes for causes of death are given in Annex 1. When possible, each report also compares a country to one or more reference groups of countries, which in this report are all the WHO European Member States and the countries belonging to the European Union (EU) before 1 May 2004 (EU15). Although Slovenia joined the EU on 1 May 2004, the EU15 was chosen as the comparator group at the explicit request of the Ministry of Health of Slovenia.

¹ The European Health for All database (4) covers data since 1970. Data on mortality for Slovenia are available from 1985 to 2010. The reference year is 2000.

Selected demographic and economic information

From a demographical perspective, Slovenia typifies the ageing population in the WHO European Region. These trends are, however, occurring more rapidly in Slovenia than in the Region as a whole or the EU15. In 2010, children aged 0–14 years made up 14.1% of the total population – a decrease of almost two percentage points since 2000 – compared to 15.8% for the EU15 and 17.7% for the Region (Table 1, Fig. 1). At the same time, the share of the population aged 65 years

Table 1. Selected demographic indicators in Slovenia, 2012 or latest available year

Indicators	Slovenia	WHO European Region	EU15
Population (in 1000s)	2 059	902 367	398 635
Percentage aged 0–14 years	14.1	16.8	15.8
Percentage aged 15–64 years	69.4	67.8	66
Percentage aged 65 years or more	16.6	15.3	18.2
Percentage urban	49.5	70.3	76.8
Crude birth rate (live births per 1000)	10.6	12	10.5
Crude death rate per 1000	9.1	10.5	9.3
Natural population growth per 1000 ^a	1.8	1.5	1.2

^a Birth rate minus death rate.

Fig. 1. Percentage of population aged 0–14 years, Slovenia, WHO European Region and EU15, latest available data

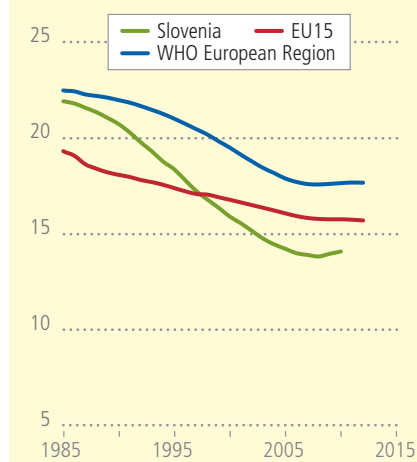
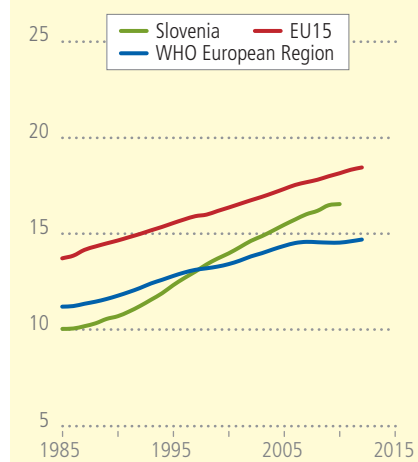


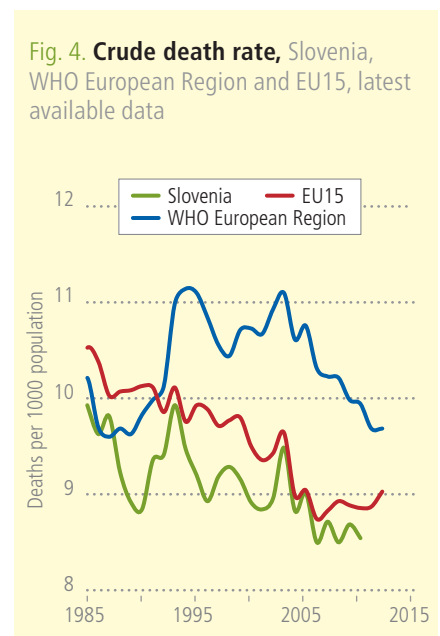
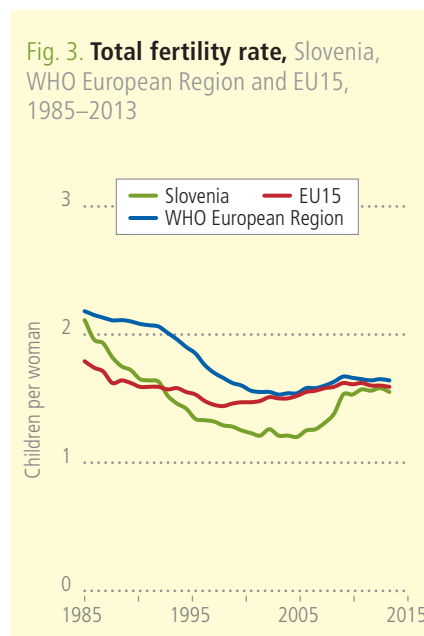
Fig. 2. Percentage of population aged ≥65 years, Slovenia, WHO European Region and EU15, latest available data



and over rose to a high of 16.6% in 2012, almost two percentage points higher than in the Region overall (Table 1, Fig. 2). While still lower than the figure for the EU15, the annual rate of increase in Slovenia was much higher, at 1.7% between 2000 and 2010.

Recent years have seen a positive increase (23% from 2000 to 2010) in the total fertility rate, which recovered from a low of 1.2 in the early 2000s and appeared to stabilize at around 1.5 in 2013, almost paralleling that of the Region and the EU15 (Fig. 3). This is, however, still far below the theoretical population replacement level of 2.1. Combined with a slowly decreasing crude death rate (Fig. 4), natural population growth² in Slovenia since 2005 appears to have recovered to positive numbers following a decade of growth hovering below zero.

While the unemployment rate has typically been lower than that in the Region and the EU15, the increase following the European debt crisis in 2009 was steeper in Slovenia than in the comparative regions: an annual increase of almost 18% compared to 1% in the Region and 6% in the EU15. As a result, the unemployment rate in Slovenia in 2014 was 9.7%, surpassing that of the Region. When disaggregated, it is apparent that the gap between the sexes increased after 2000. In 2014, the unemployment rate among females was 10.5%, almost two percentage points higher than that among males (5).

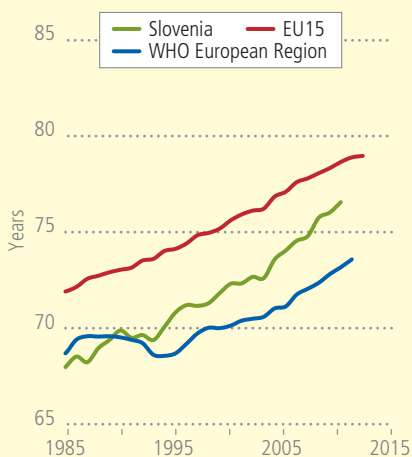


² Birth rate minus death rate.

Health status and burden of disease

Life expectancy

Fig. 5. Life expectancy at birth for males, Slovenia, WHO European Region and EU15, latest available data



Life expectancy at birth is defined as the average number of years that a newborn infant would live if prevailing patterns of mortality at the time of birth were to continue throughout his or her life. Life expectancy at birth has increased rapidly in Slovenia, by 4.3 years for males and by 3.2 years for females since 2000 (Fig. 5, 6). The figure for Slovenia remained below the EU15 average, by 2.1 years for males and by 0.8 years for females, in 2010. However, life expectancy (76.6 years for men and 83.2 years for women) was substantially higher than the averages for the Region (73.2 years and 80.3 years, respectively). The gap between the sexes in life expectancy at birth has decreased by one year since 2010.

Life expectancy at 65 years, defined as the average number of years a 65-year-old would expect to live based on prevailing mortality statistics, has followed the same trends as life expectancy at birth (Fig. 7, 8). The gap between male life expectancy in the EU15 and in Slovenia narrowed after 2000, so that in 2010, male life expectancy in Slovenia was one year below the average for the EU15. Life

Fig. 6. Life expectancy at birth for females, Slovenia, WHO European Region and EU15, latest available data

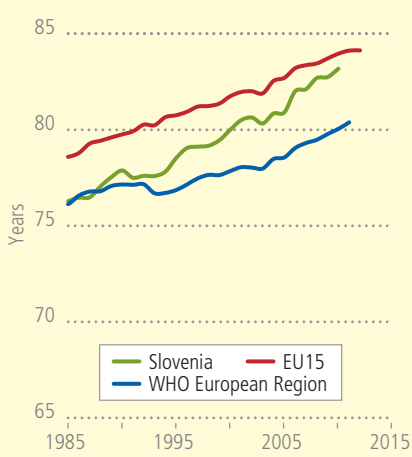


Fig. 7. Life expectancy at 65 years for males, Slovenia, WHO European Region and EU15, latest available data

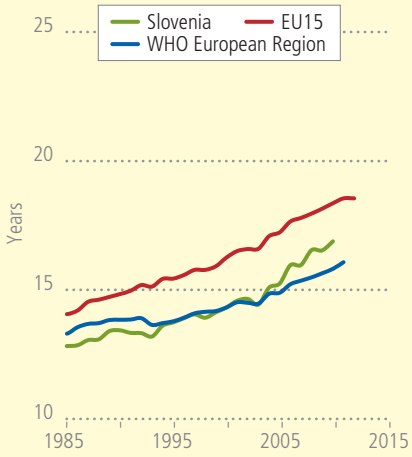
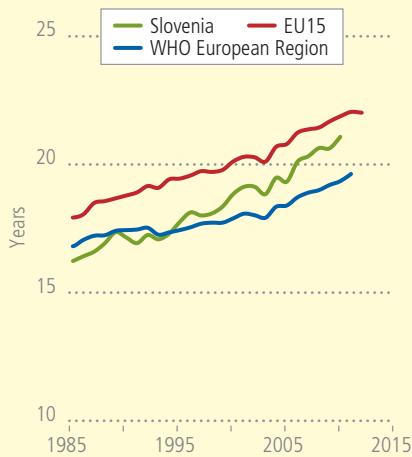


Fig. 8. Life expectancy at 65 years for females, Slovenia, WHO European Region and EU15, latest available data



expectancy for females increased at a similar rate after 2000, and by 2010 the difference in life expectancy for females between Slovenia and the EU15 was less than one year.

Healthy life expectancy and disability-adjusted life-years

Healthy life expectancy summarizes mortality and non-fatal outcomes in a single measure of average population health. It has been used to compare health between countries and to measure changes over time.

WHO estimates for Slovenia show that healthy life expectancy increased by three years to 66 years for males and 72 years for females between 2000 and 2013. These estimates were lower than the EU15 averages (68.5 years for males and 72.5 years for females) but two years higher than the estimates for the Region (64 years for males and 70 years for females). Only 86.1% of men's lives are considered healthy life-years, the second lowest percentage in the Region and 1.9 percentage points lower than the regional average. Equally for women, only 86.6% of a woman's life expectancy can be considered disability-free.

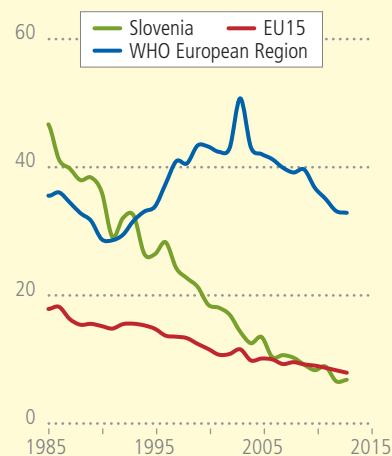
Morbidity

Comparable information on morbidity is more limited than for mortality. Data are, however, available on certain infectious diseases, cancers and mental disorders based on routine health reporting systems. The coverage, completeness and quality of these data vary between countries and over time, and comparisons should be interpreted with caution. Primary sources of data are diverse and include registries, surveillance systems and hospital data.

Infectious diseases and vaccinations

The incidence of tuberculosis decreased by 63% after 2000 to 6.8 per 100 000 population in 2013, when it was below the EU15 average of 7.9 per 100 000 (Fig. 9). The incidence of gonorrhoea decreased by two thirds after 2000 to 1.2 per 100 000 in 2011, when the rate was lower than the averages for the EU15 (9.4/100 000) and the Region (14/100 000). In contrast, the incidence of syphilis increased almost 10-fold after 2000 to 5.4 per 100 000 in 2011, above the EU15 average (3.7/100 000); this, however, was still only half the regional average (10.4/100 000).

Fig. 9. Tuberculosis incidence per 100 000 population, Slovenia, WHO European Region and EU15, 1985–2013



There have been no recent major outbreaks of measles, diphtheria, tetanus, acute poliomyelitis, rubella or mumps in Slovenia, but the incidence of pertussis increased significantly in the late 2000s, peaking in 2006–2007 and 2009–2010. In 2012, this rate (8.7/100 000) remained between the averages for the EU15 (10.8/100 000) and the Region (7.9/100 000).

The incidence of HIV infection increased 3.4-fold between 2000 and 2012 (Fig. 10a). Despite this increase, the incidence in 2012 (2.2/100 000) remained substantially below the averages for the EU15 (6.6/100 000) and the Region (10.6/100 000). In parallel to the rise in the incidence of HIV infection, the incidence of AIDS increased by over 50% between 2000 and 2012 (Fig. 10b), and the rate in 2012 (0.53/100 000) was below the averages for the EU15 (0.88/100 000) and the Region (1.25/100 000).

Overall, trends in vaccination rates are very high for measles (Fig. 11a), rubella and mumps (95% in 2012), diphtheria, tetanus, pertussis, invasive disease due to *Haemophilus influenzae* type b (96% in 2011–2012) and poliomyelitis (96% in 2012) (Fig. 11b). The rate for hepatitis B is somewhat lower (92% in 2011).

Other diseases

The incidence and prevalence of cancer have been increasing rapidly in Slovenia. The increase has been greater for prevalence (73% between

Fig. 10a. HIV infection incidence per 100 000 population, Slovenia, WHO European Region and EU15, 1985–2012

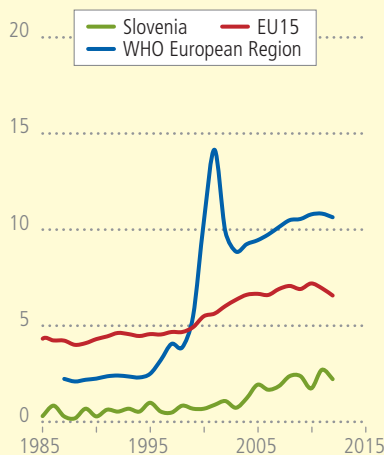


Fig. 10b. AIDS incidence per 100 000 population, Slovenia, WHO European Region and EU15, 1985–2012

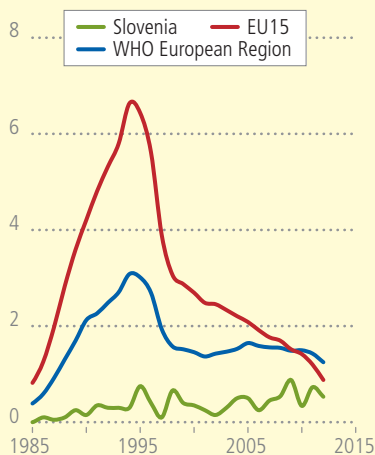
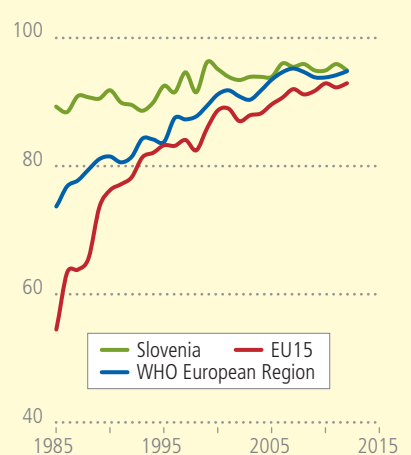


Fig. 11a. Percentage of children with measles vaccination, Slovenia, WHO European Region and EU15, 1985–2012



2000 and 2011) than for incidence (37%). The incidence of cancer (630/100 000 in 2011) is above the averages for the EU15 (565/100 000) and the Region (419/100 000). Likewise, the prevalence of cancer is greater in Slovenia (4.2% in 2011) than the averages for the EU15 (2.5% in 2008) and the Region (2.2% in 2011).

As elsewhere in Europe, the prevalence of diabetes has increased, from 3.5% to 4.9% between 2005 and 2013. The most recent rate (2013) equalled the average for the EU15 (5% in 2011) but was higher than the average for the Region (3.6% in 2012).

Information on mental disorders and alcohol psychosis is not available.

Infant and maternal mortality

The infant mortality rate per 1000 live births in Slovenia has declined rapidly. For a decade and a half it was below the EU15 average (Fig. 12), and in 2010 it was the second lowest in the Region after Finland.

The maternal mortality ratio has also decreased substantially in Slovenia (Fig. 13). For the three-year period 2009–2011, only one maternal death was reported. The three-year rolling average for the maternal mortality ratio for these years show that the rate in Slovenia

Fig. 11b. Percentage of infants with poliomyelitis vaccination, Slovenia, WHO European Region and EU15, 1985–2012

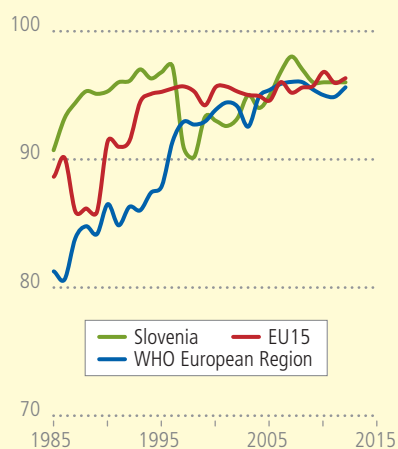


Fig. 12. Infant deaths per 1000 live births, Slovenia, WHO European Region and EU15, latest available data

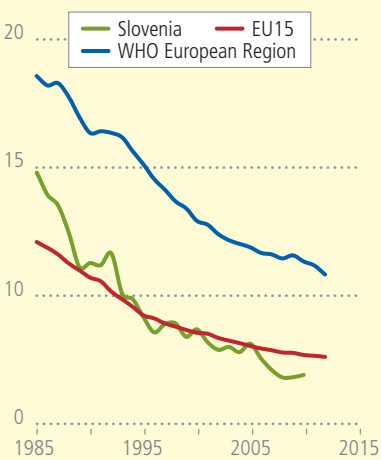
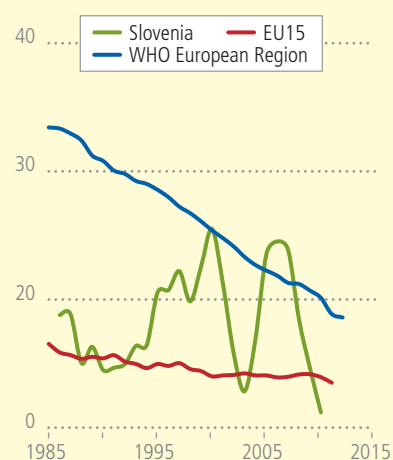


Fig. 13. Maternal deaths per 100 000 live births, Slovenia, WHO European Region and EU15, three-year rolling average



(1.5 per 100 000 live births) was one of the lowest in the Region, well below the averages for the EU15 (5.2 per 100 000) and the Region (13.5 per 100 000) for the same period.

Leading causes of death

A comparison of age-standardized mortality rates³ between countries highlights population differences in the most common causes of death, allowing easier identification of which deaths could be prevented. Deaths from diseases of the circulatory system, malignant neoplasms (cancers) and external causes of injury and poisoning (accidents, homicides and suicides) are the main killers in the Region: in 2012 they caused 73% of all deaths. In Slovenia, the share was higher, at 77% in 2010, while the share in the EU15 countries was much lower (67% in 2012).

Age- and sex-standardized mortality from all causes is higher in Slovenia than in the EU15 on average, explained by excess mortality from diseases of the circulatory system, malignant neoplasms (cancers), external causes of injuries and poisoning and diseases of the digestive system. Premature mortality before the age of 65 years is also higher than the EU15 average; indeed, in 2010 the relative excess

Fig. 14. Mortality profile from main causes of death, age-standardized death rate per 100 000 population, Slovenia, WHO European Region and EU15, latest available data

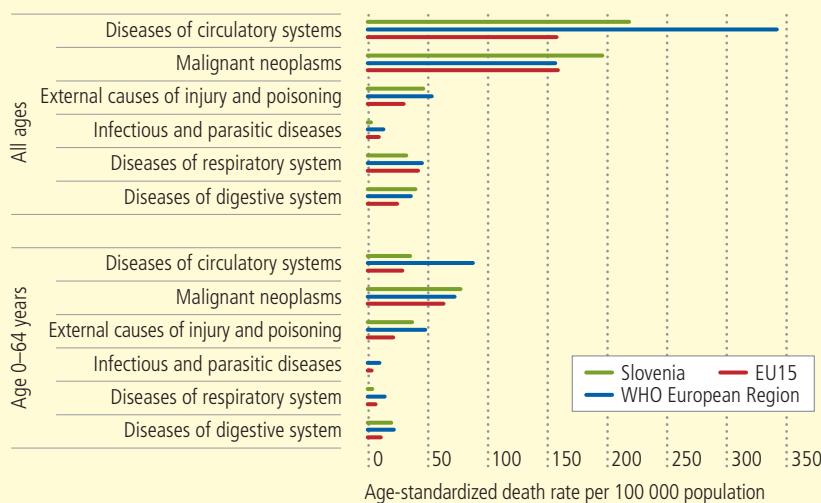
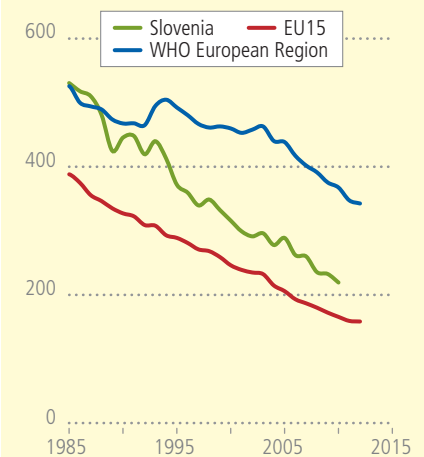
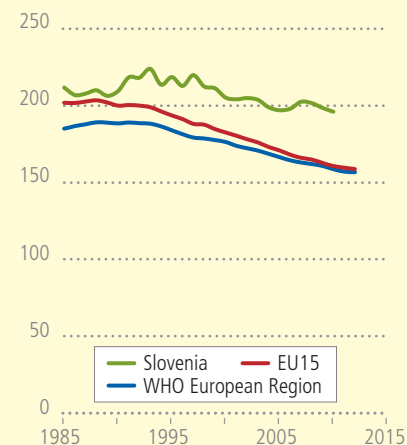


Fig. 15. Age-standardized death rate from diseases of the circulatory system, all ages per 100 000 population, Slovenia, WHO European Region and EU15, latest available data



³ Age-standardized death rates are calculated by the direct method: that is, they represent what the crude rates would have been if the population had the same age distribution as the standard European population.

Fig. 16. Age-standardized death rate from malignant neoplasms, all ages per 100 000 population, Slovenia, WHO European Region and EU15, latest available data



mortality was higher for premature mortality (18%) than for all ages (13%). The overall causes for the excess premature mortality are the same as for all ages (Fig. 14), and are specifically dominated by cancers of the trachea, bronchus and lung.

The trends in age-standardized death rates for diseases of the circulatory system, malignant neoplasms (cancers), external causes of injury and poisoning and diseases of the respiratory system are given for all ages and for both sexes combined in Fig. 15–18.

Other major causes of death

The age-standardized mortality rates from infectious diseases, diseases of the respiratory system and diseases of the genitourinary system for all ages have decreased and are below the averages for the EU15 and the Region.

The age-standardized mortality rate from diseases of the digestive system (Fig. 19) has also decreased (by 27% between 2000 and 2010), but the rate in 2010 (40/100 000) was still higher than the averages that year for the EU15 (26/100 000) and the Region (37/100 000).

Fig. 17. Age-standardized death rate from external causes of injury and poisoning, all ages per 100 000 population, Slovenia, WHO European Region and EU15, latest available data

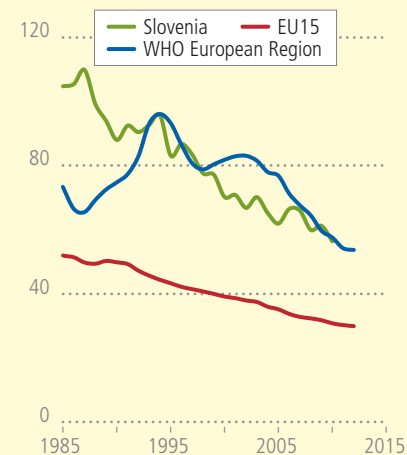


Fig. 18. Age-standardized death rate from diseases of the respiratory system, all ages per 100 000 population, Slovenia, WHO European Region and EU15, latest available data

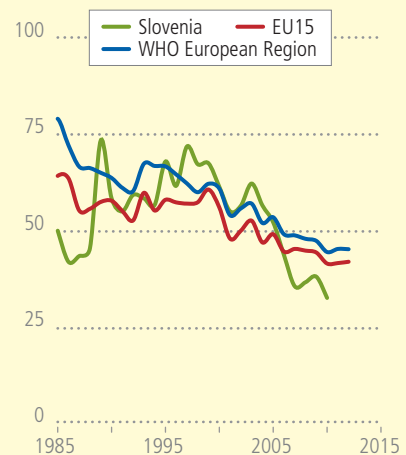
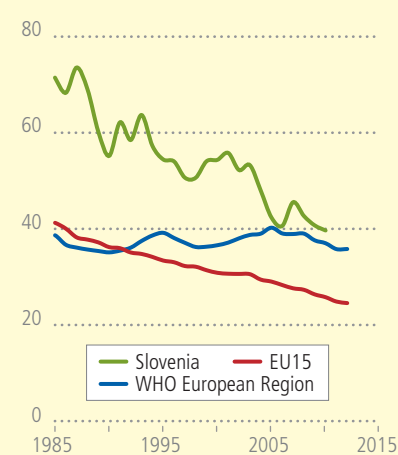


Fig. 19. Age-standardized death rate from diseases of the digestive system, all ages per 100 000 population, Slovenia, WHO European Region and EU15, latest available data



Excess mortality rates are observed especially for men aged 45 years or more and for women aged 60 years or more. This trend is similar for deaths from chronic liver disease and cirrhosis (Fig. 20), which together cause 43% of all deaths in this group in the Region and 38% in the EU15. At 60%, this share is much higher in Slovenia. This increase could be attributed not only to increased alcohol consumption but also to increased prevalence of hepatitis B and C. Indeed, the likelihood of dying from chronic liver disease and cirrhosis is higher in Slovenia compared to the Region on average for both men aged 30 years or more and for women aged 45 years or more.

Age-standardized mortality from external causes and poisonings has decreased by one fifth since 2000, but the most recent rate (2010) was 5% higher than the average for the Region. Even though this mortality rate was higher among men (85/100 000 in 2010) than women (25/100 000), the excess mortality in 2010 from external causes and poisonings in Slovenia compared to the Region was greater for women (14%) than for men (2%).

The age-standardized suicide mortality rate has decreased by one third since 2000, but the rate is still among the 10 highest in the Region, especially for males (Fig. 21, 22): at 29.3/100 000 for men it is almost fivefold the rate for women (6.1/100 000).

Fig. 20. Age-standardized death rate from chronic liver diseases and cirrhosis, all ages per 100 000 population, Slovenia, WHO European Region and EU15, latest available data

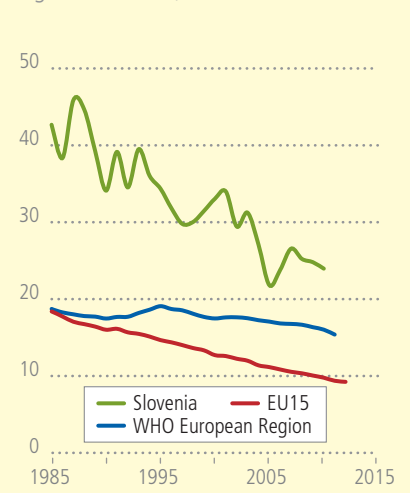


Fig. 21. Age-standardized death rate from suicide and self-inflicted injury, all ages per 100 000 population, males, Slovenia, WHO European Region and EU15, latest available data

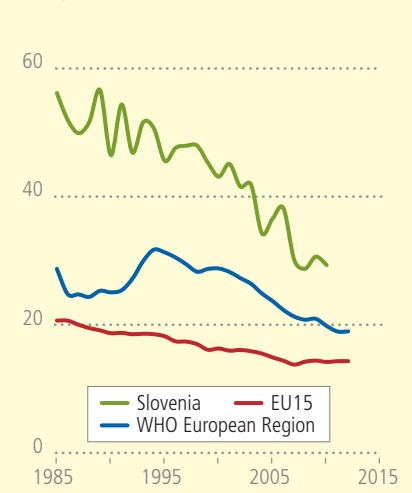


Fig. 22. Age-standardized death rate from suicide and self-inflicted injury, all ages per 100 000 population, females, Slovenia, WHO European Region and EU15, latest available data

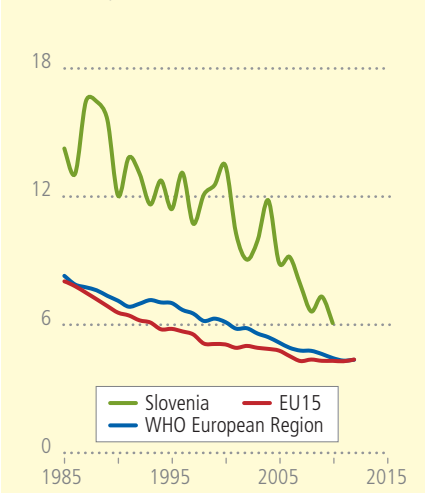
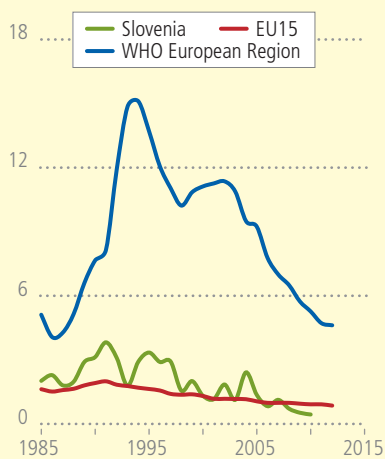


Fig. 23. Age-standardized death rate from homicide and intentional injury, all ages per 100 000 population, males, Slovenia, WHO European Region and EU15, latest available data



Age-standardized mortality from homicides and intentional injury decreased by more than 60% between 2000 and 2010. This decline was more pronounced for men than for women. In 2010, the rate was similar for males and females (0.4/100 000). While the rate for females that year equalled the EU15 average (0.4/100 000), the rate for males was one of the lowest in the Region (Fig. 23, 24).

Even though the age-standardized mortality rate from motor vehicle accidents halved in Slovenia between 2007 and 2010 (Fig. 25, 26), the most recent rate (in 2010) was still somewhat higher than the EU15 average. In 2010, the mortality rate for men (10.7/100 000) was more than fourfold the rate for women (2.4/100 000).

The mortality rate from accidental falls is particularly high in Slovenia. With 112 deaths per 100 000 people aged 65 years or older, it is the highest in the Region.

In addition to the trends highlighted in this section, selected causes of mortality are presented in Annex 2, in which the percentage changes from 2000 to the latest available year in Slovenia (2010) are compared with the averages for the Region (2012) and the EU15 (2012).

Fig. 24. Age-standardized death rate from homicide and intentional injury, all ages per 100 000 population, females, Slovenia, WHO European Region and EU15, latest available data

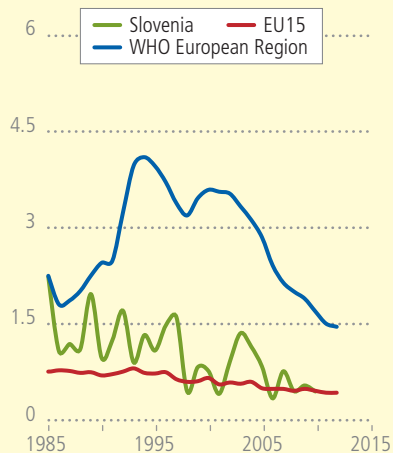


Fig. 25. Age-standardized death rate from motor vehicle accidents, all ages per 100 000 population, males, Slovenia, WHO European Region and EU15, latest available data

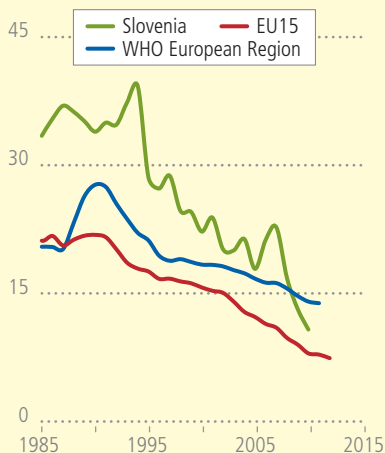
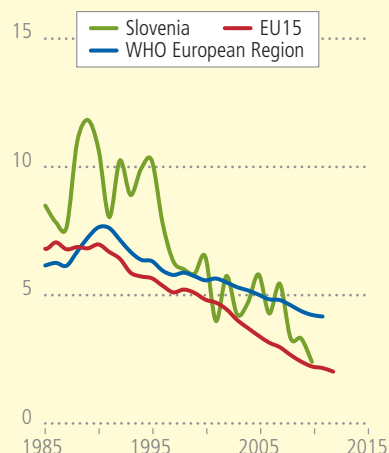


Fig. 26. Age-standardized death rate from motor vehicle accidents, all ages per 100 000 population, females, Slovenia, WHO European Region and EU15, latest available data



Premature mortality

Since a large share of premature deaths from cardiovascular diseases, cancer and accidents are influenced by health-related behaviour and habits, trend analyses of premature mortality between countries can confirm which, if any, treatments and health promotion and prevention measures have been successfully implemented.

Premature mortality from diseases of the circulatory system has decreased in most European countries in recent decades, and faster in Slovenia (–43%) than the EU15 average (–35%). In 2010, the rate for men in Slovenia was 54/100 000 (Fig. 27), one fourth higher than the EU15 average (45/100 000 in 2010), while the rates for women were similar between Slovenia and the EU15 at 16/100 000 in both cases (Fig. 28).

Even though mortality for premature deaths from ischaemic heart disease for males in Slovenia decreased by one third between 2000 and 2010 (Fig. 29), it was still higher in 2010 (27/100 000) than the EU15 rate (22/100 000). For women, the corresponding rate more than halved in the same period to 4 per 100 000 (Fig. 30), lower than the average rate for the EU15 (5/100 000).

The mortality rate for premature deaths from cerebrovascular diseases halved for men and decreased by one third for women between 2000 and

Fig. 27. Age-standardized death rate from diseases of circulatory system, males aged 0–64 years per 100 000 population, Slovenia, WHO European Region and EU15, latest available data

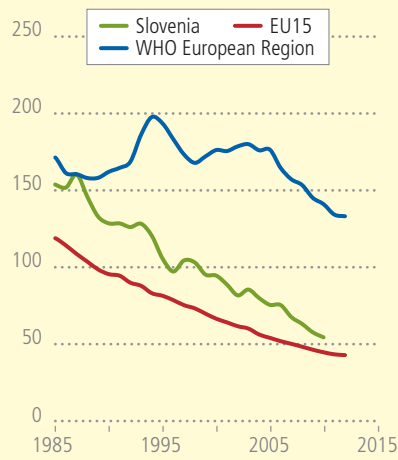


Fig. 28. Age-standardized death rate from diseases of the circulatory system, females aged 0–64 years per 100 000 population, Slovenia, WHO European Region and EU15, latest available data

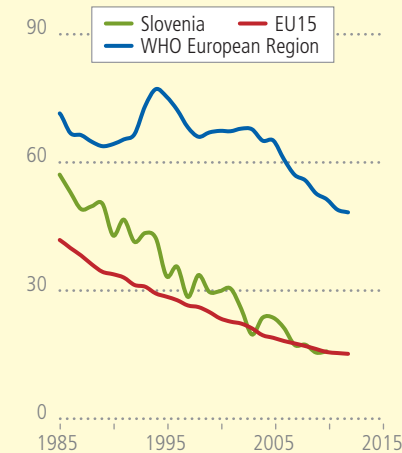


Fig. 29. Age-standardized death rate from ischaemic heart disease, males aged 0–64 years per 100 000 population, Slovenia, WHO European Region and EU15, latest available data

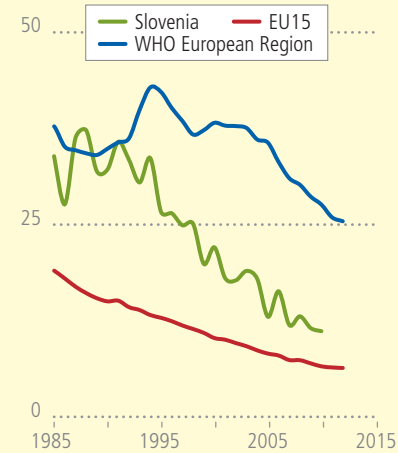
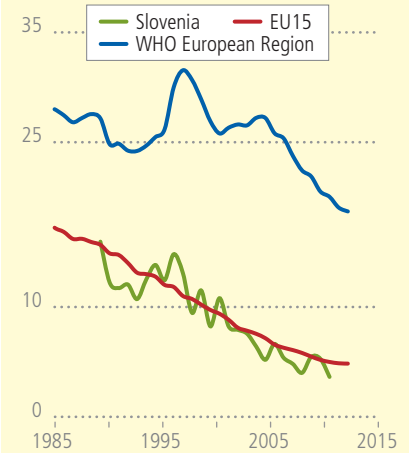
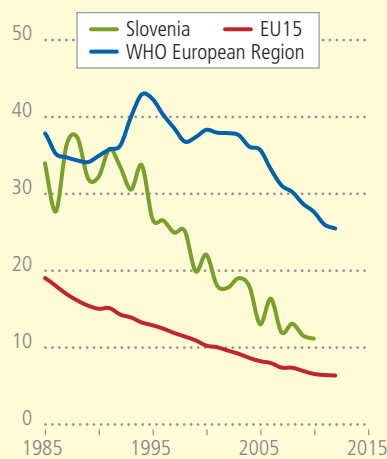


Fig. 30. Age-standardized death rate from ischaemic heart disease, females aged 0–64 years per 100 000 population, Slovenia, WHO European Region and EU15, latest available data



2010 (Fig. 31, 32). In 2010, the age-standardized mortality rates were still higher in Slovenia than in the EU15 on average, both for men (11/100 000 vs. 7/100 000) and for women (6/100 000 vs. 4/100 000).

Fig. 31. Age-standardized death rate from cerebrovascular diseases, males aged 0–64 years per 100 000 population, Slovenia, WHO European Region and EU15, latest available data



The mortality rate for premature deaths from malignant neoplasms decreased in Slovenia between 2000 and 2010, but the rates for males and females were still higher than those for the EU15 (Fig. 33, 34). For men, the rate (96/100 000) was one third higher than the EU15 average (73/100 000) and one tenth higher than the average for the Region (89/100 000). The differences in premature mortality for women are smaller, with a rate (59/100 000) similar to the regional average (58/100 000) but slightly higher than the average for the EU15 (54/100 000).

The premature mortality rate from cancers of the trachea, bronchus and lung for males decreased up to 2010 but remained higher in Slovenia that year (30/100 000) than the averages for the EU15 (21/100 000) and the Region (26/100 000) (Fig. 35). The corresponding rate for females increased over the same period, reflecting increased smoking rates among females, from eight to almost 11 per 100 000, which is higher than the averages for the EU15 (10/100 000) and the Region (8/100 000) (Fig. 36).

The premature mortality rate from malignant neoplasm of the female breast decreased after 2000 to 13/100 000 in 2010 (Fig. 37), slightly higher than the averages for the EU15 and the Region.

Fig. 32. Age-standardized death rate from cerebrovascular disease, females aged 0–64 years per 100 000 population, Slovenia, WHO European Region and EU15, latest available data

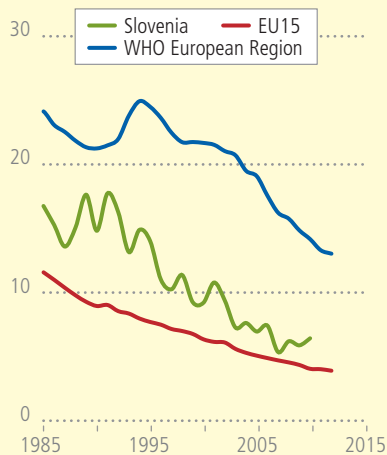


Fig. 33. Age-standardized death rate from malignant neoplasms, males aged 0–64 years per 100 000 population, Slovenia, WHO European Region and EU15, latest available data

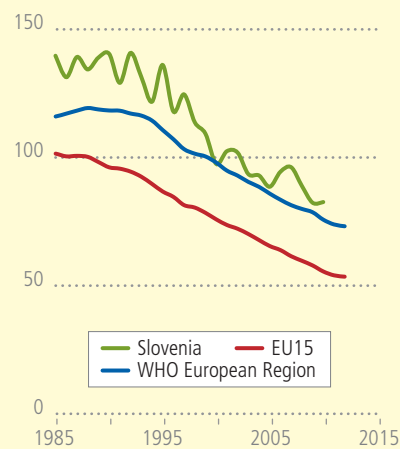
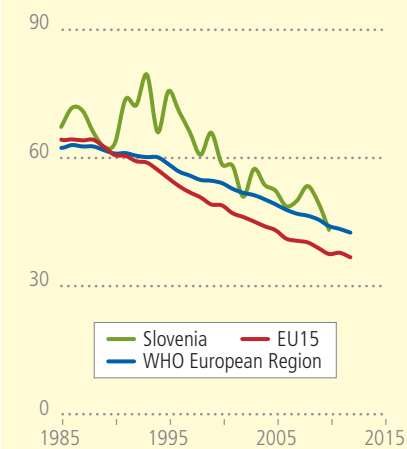


Fig. 34. Age-standardized death rate from malignant neoplasms, females aged 0–64 years per 100 000 population, Slovenia, WHO European Region and EU15, latest available data



The premature mortality rate from cancer of the cervix uteri increased to above the regional average in the mid-1990s, but has declined since then (Fig. 38). The most recent rate (2.3/100 000 in 2010) is between the low EU15 average (1.6/100 000) and the average for the Region (3.4/100 000).

Fig. 35. Age-standardized death rate from cancers of the trachea, bronchus and lung, males aged 0–64 years per 100 000 population, Slovenia, WHO European Region and EU15, latest available data

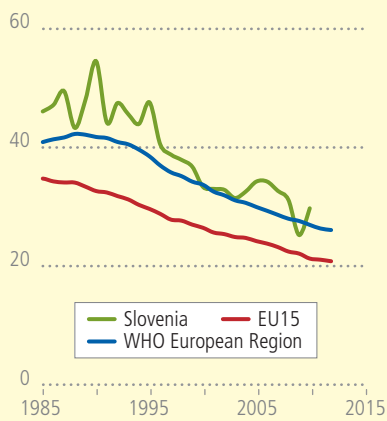


Fig. 36. Age-standardized death rate from cancers of the trachea, bronchus and lung, females aged 0–64 years per 100 000 population, Slovenia, WHO European Region and EU15, latest available data

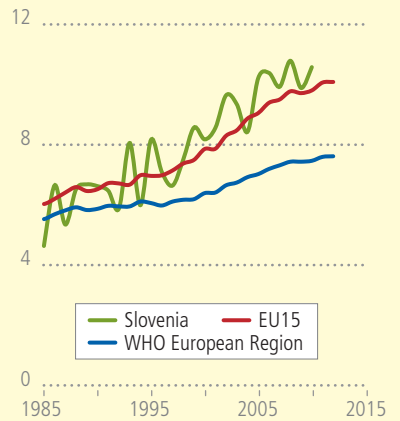


Fig. 37. Age-standardized death rate from breast cancer per 100 000 females aged 0–64 years, Slovenia, WHO European Region and EU15, latest available data

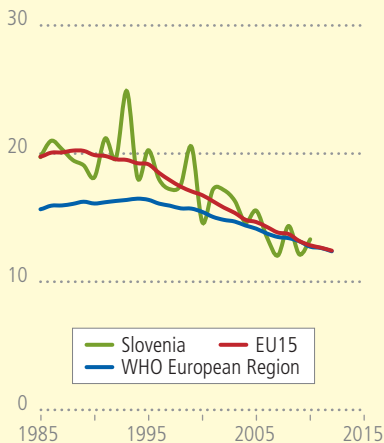
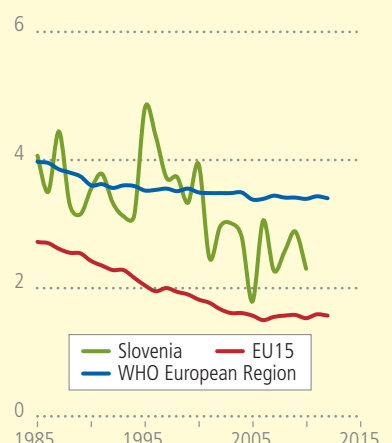


Fig. 38. Age-standardized death rate from cancer of the cervix uteri per 100 000 females aged 0–64 years, Slovenia, WHO European Region and EU15, latest available data



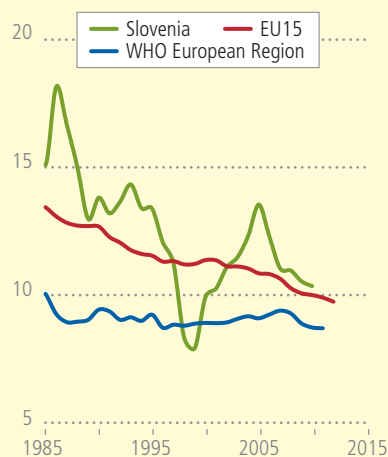
Risk factors and determinants of health

Several factors, including genetics and physical, social and cultural environments and health behaviour, affect the health and well-being of individuals and the population. Risk factors such as unhealthy diet, low levels of physical activity, smoking and harmful alcohol consumption are linked to elevated blood pressure, high serum cholesterol and overweight. These risk factors contribute to premature mortality from cardiovascular diseases and cancers in particular, the two main causes of death in the Region. Risk factors also contribute to a wide range of other chronic illnesses and thus affect the quality of life in general.

Alcohol consumption

The consumption of alcohol is measured as the recorded amount of alcohol consumed per adult aged 15 years or more over a calendar year in a country, expressed in litres of pure (100%) alcohol. The recorded alcohol consumption per capita for the adult population in Slovenia has historically been very high, exceeding 10 litres prior to 1998 and again after 2001. In 2010, the figure was 10.3 litres (Fig. 39), higher than the averages for the Region (8.7 litres in 2011) and the EU15 (9.7 litres in 2012). Although sales figures do not cover unrecorded consumption, the Global Health Observatory estimates that the unrecorded consumption of alcohol in Slovenia is low: one litre per capita (6).

Fig. 39. Pure alcohol consumption, recorded litres per capita in the population aged ≥15 years, Slovenia, WHO European Region and EU15, latest available data



Tobacco smoking

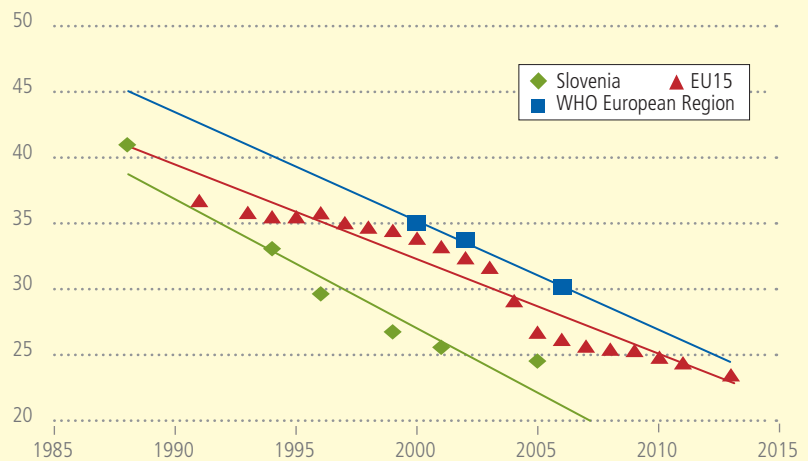
The percentage of regular daily smokers is measured among adults aged 15 years and older. In Slovenia, the prevalence of smoking has decreased for both sexes (Fig. 40). For men, the decrease was seven percentage points, from 29% in 1999–2001 to 22% in 2012; for women, the decrease was four percentage points, from 20% to 16%, respectively. These figures were lower than the averages for the EU15 (26% for males and 19% for females). According to Global Health Observatory data based on national survey data, 20% of girls and 14% of boys aged 13–15 years responded to surveys conducted in 2007 that they were current cigarette smokers (6).

Diet, consumption of macronutrients and overweight

Between 2000 and 2009, the average number of calories available per person per day in Slovenia increased by 7%. As of 2009, an average Slovene had 3275 kcal available per day, lower than the averages for both the EU15 (3484 kcal) and the Region (3488 kcal). In Slovenia, 35% of total energy came from fat, lower on average than in the EU15 (39%) but higher than in the Region (33%). The average number of fruits and vegetables available per person per year (225 kg) in 2009 was slightly lower than the averages for the EU15 (231 kg) and the Region (243 kg).

In 2014, the Global Health Observatory estimated that 66% of men and 55% of women in Slovenia were overweight (body mass index of 25 or more) with an increase of two percentage points since 2010. The prevalence of obesity (body mass index of 30 or more) had also increased by two percentage points. Women (26% in 2014) were more often obese than men (25%). The averages for the Region are higher for overweight (59%) and obesity (27%) in women but lower for overweight (65%) and obesity (23%) in men.

Fig. 40. Percentage of regular daily smokers in the population aged ≥15 years, Slovenia, WHO European Region and EU15, latest available data



Comparative risk assessment

Since the estimates produced by WHO for the number of disability-adjusted life-years (DALYs) attributable to selected risk factors apply only at regional and not country level, the estimates

produced by the Institute for Health Metrics and Evaluation, which are available at country level, are used in this publication (7). The Institute estimates that the highest burden of disease in Slovenia is caused by dietary risks, followed by high blood pressure. Estimates of the top 10 risk factors and the associated burden of disease measured in DALYs for Slovenia are given in Table 2, disaggregated by sex.

Table 2. Top 10 risk factors and the associated age-standardized burden of disease for Slovenia, by sex, 2013

Risk factor	DALYs (average rate per 100 000 population)
Females	
High body mass index	2869
High systolic blood pressure	2801
Dietary risks	2799
High fasting plasma glucose	1470
Tobacco smoke	1399
Alcohol and drug use	1070
Low glomerular filtration rate	929
Low bone mineral density	914
High total cholesterol	735
Low physical activity	619
Males	
Dietary risks	4295
Tobacco smoke	4152
Alcohol and drug use	3783
High systolic blood pressure	3143
High body mass index	2912
High fasting plasma glucose	1668
High total cholesterol	1089
Occupational risks	1023
Low glomerular filtration rate	897
Air pollution	780

Source: Institute for Health Metrics and Evaluation (7).

Health system

The key indicators for the health system in 2013 are shown in Table 3. The number of hospital beds fell between 2000 and 2013; in the latter year, the rate was 9% below the EU15 average and 20% lower than the average for the Region. As regards human health resources, the levels have been increasing for physicians, dentists, nurses and midwives since 2000. In 2013, the availability of physicians and midwives was substantially below the averages for the EU15 and the Region, while the numbers of dentists and nurses per capita were just below the EU15 average (–7% and –9%, respectively) but above the average for the Region.

The number of inpatient care discharges increased from 16.7 per 100 inhabitants in 2000 to 18.2 per 100 in 2013. This rate was higher than the average for the EU15 (17.1/100) but equalled the average for the Region (18.1/100). The average length of stay in all hospitals has been declining for decades. The most recent rate (2013) was 6.5 days, around two days shorter than the averages for the EU15 countries (8.2 days) and the Region (8.6 days).

The average number of outpatient contacts has remained unchanged since 2000. The most recent available number (2013) was, at 6.5, lower than those in the EU15 (6.8) and the Region (7.6).

Table 3. Key indicators for health resources, use of health services and health expenditure, Slovenia, 2013 or latest available

Indicator	Slovenia	Change since 2000	WHO European Region	EU15
Hospital beds per 100 000 population	455.4	-16%	566.7	498.1
Physicians per 100 000 population	263	22%	307.9	364.4
Dentists per 100 000 population	64.9	12%	53.3	70.1
Nurses per 100 000 population	833.4	–	728.9	912.4
Midwives per 100 000 population	6	–	40.2	30.4
Inpatient care discharges per 100 population	18.2	9%	18.1	17.1
Average length of stay, all hospitals	6.5	-24%	8.6	8.2
Outpatient contacts per person per year	6.5	–	7.6	6.8
Total health expenditure as percentage of GDP ^a	9.2	0.9 ^b	8.2	10.3
Total health expenditure, purchasing power parity \$ per capita ^a	2595	78%	2455	3871
Public sector health expenditure as percentage of total health expenditure ^a	71.6	-2.4 ^b	67.1	77.1
Out-of-pocket expenditure as percentage of total health expenditure	12.1	5.2%	26.4	14.2

^a Gross domestic product; WHO estimates.

^b Change in percentage points.

WHO's estimate for total health expenditure shows that its share of gross domestic product (GDP) increased from 8.3% in 2000 to 9.2% in 2013. This was higher than the average for the Region (8.2%) but lower than the EU15 average (10.3%). During this period, the average annual growth of total health expenditure was 4.6% per year, in line with the average annual growth rates of 4.8% and 4.5% in the Region and EU15, respectively. The level of spending in 2013 was just above the average for the Region (US\$ 2455) but one third lower than the EU15 average (US\$ 3871). The most recent WHO estimate of public sector health expenditure (2013) was 72%, five percentage points above the average for the Region (67%) but at the same time five percentage points below the EU15 average (77%). Out-of-pocket expenditure is very low. In 2013 it represented 12% of total health expenditure, one of the lowest values in the Region, half of the average for the EU15 and one third of the average for the Region.

A detailed description of the health system is given in *Slovenia: health system review (8)*.

As stated in the Introduction, Health 2020 is the health policy of the Region, which aims to support action across government and society to significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality (1). European Member States have agreed on a set of core indicators to monitor the progress on Health 2020 policy targets in Europe and in all Member States (3).

The newly revised highlights on health and well-being and accompanying profiles on health and well-being publications constitute a country-by-country means of reporting progress towards achieving the overarching targets of Health 2020. For Slovenia, the Health 2020 indicators are given in Table 4.

Reduce premature mortality by 2020

Slovenia has made considerable progress in reducing premature mortality.⁴ The age-standardized overall premature mortality rate combined for the four selected major noncommunicable diseases (cardiovascular diseases, cancer, diabetes mellitus and chronic respiratory diseases) declined annually by 2.8% between 2000 and 2010 for both sexes, surpassing the regional target of 1.5% per year. Despite this progress, premature mortality rates in Slovenia remain higher than those in the EU15, particularly with regard to malignant neoplasms, diseases of the circulatory system and diseases of the digestive system. Overall, progress in reducing premature mortality has been more pronounced for males than females, in accordance with the general pattern in the Region. This is probably a corollary of the earlier downward trend among males, with higher mortality rates than females, representing a narrowing of the gap between the sexes. In both sexes, however, reductions in premature mortality from cardiovascular diseases follow the pattern in the EU15 rather than the patterns typifying many other central and eastern European countries (4). Mortality from external causes of injuries and poisoning also decreased between 2000 and 2010, by one fifth. The decline was more pronounced for women (-25%) than for men (-18%), and the difference between the

⁴ Defined as mortality between 30 to under 70 years of age in the Health 2020 monitoring framework (2) in order to be aligned with the noncommunicable diseases monitoring framework (9).

sexes in the age-standardized mortality rate remained high: in 2010, the likelihood of a Slovenian man dying from external causes of injuries and poisoning was still three times that of his female counterparts.

When the risk factors contributing to the age-standardized burden of disease are considered (Table 2), it is apparent that dietary risks contribute to the greatest share of DALYs, confirming the role

Table 4. Core indicators for monitoring Health 2020 policy targets, Slovenia, most recent years available

Target	Indicator	Value			Year
		Male	Female	Total	
1. Reduce premature mortality^a	Premature mortality rate from cardiovascular disease, cancer, diabetes mellitus and chronic respiratory diseases among people aged 30 to under 70 years	392.2	189.5	289	2010
	Prevalence of tobacco use among adults aged 18 years and over ^b	22.2	15.9	19.2	2012
	Pure alcohol consumption per capita among people aged 15 years and over	–	–	10.3	2010
	Prevalence of overweight and obese (body mass index ≥ 25) adults aged 18 years and over (age-standardized estimate)	66.1	55.1	60.6	2014
	Mortality rate from external causes of injury and poisoning, all ages	87	28.7	56.3	2010
2. Increase life expectancy	Life expectancy at birth, in years	76.6	83.2	80	2010
3. Reduce inequities^c	Infant mortality rate per 1000 live births	2.1	3	2.5	2010
	Proportion of children of official primary school age not enrolled	3.2	2.2	2.7	2013
	Unemployment rate (5)	8.9	10.5	9.7	2014
	National policy addressing reduction of health inequities established and documented	NA	NA	Yes	2014
	Gini coefficient	–	–	25	2014
4. Enhance well-being^d	Life satisfaction among people aged 15 years and older (10)	–	–	6.1	2007–2012
	Availability of social support among adults aged 50 years and older (11)	–	–	88	2014
	Percentage of population with improved sanitation facilities	–	–	99.1	2015
5. Universal coverage and “right to health”	Private household out-of-pocket expenditure as proportion of total health expenditure	NA	NA	12.1	2013
	Percentage of children vaccinated against measles (one dose by second birthday)	–	–	95	2010
	Percentage of children vaccinated against poliomyelitis (three doses by first birthday)	–	–	96	2012
	Percentage of children vaccinated against rubella (one dose by second birthday)	–	–	95	2012
	Total health expenditure as a percentage of gross domestic product	NA	NA	9.2	2013
6. National targets	Establishment of process for target-setting documented	NA	NA	Yes	2014
	Evidence documenting:				
	(a) national health strategy aligned with Health 2020	NA	NA	Yes	2014
	(b) implementation plan	NA	NA	Yes	2014
(c) accountability mechanism	NA	NA	Yes	2014	

NA: not applicable.

^a Target 1 also includes the percentage of children vaccinated against measles, poliomyelitis and rubella.

^b Prevalence includes regular daily smokers among people aged 15 years or more.

^c Target 3 includes life expectancy at birth.

^d Target 4 includes Gini coefficient, the unemployment rate and the proportion of children not enrolled in primary school.

Source: WHO European HFA database (4), unless otherwise specified.

that poor diet plays in the lack of progress in reducing premature mortality. A further contribution to the levels of premature mortality from noncommunicable diseases is the increasingly “obesogenic” environment in Slovenia. In 2014, 55% of females were overweight or obese compared to 66%, or two thirds, of males (6). These figures represent the increased prevalence of overweight and obesity since 2010, highlighting the need for better health promotion and control measures.

Slovenia has made positive strides towards reducing the prevalence of regular tobacco use, but, by 2012 (the last year for which data are available in the Health for All database (4)), the rate of decrease appeared to be slowing and even going into reverse. In that year, 22% of men and 16% of women were regular daily smokers. For males, this placed Slovenia below the average for the EU15 and substantially below the average for the Region (38%). Progress for females was less pronounced, and the 2012 figure placed Slovenia below the average for the EU15 (19%). Likewise, total per capita alcohol consumption⁵ increased after 2000, and in 2010 was higher than the values for both the EU15 and the Region. While the degree to which alcohol consumption contributes to overall premature mortality from noncommunicable diseases remains to be quantified, it is clear that reducing alcohol consumption in Slovenia would spur greater progress in reducing premature mortality in general.

Increase life expectancy

Life expectancy at birth was 76.6 years for males and 83.2 years for females in 2010, representing an increase by 4.3 years for males and 3.2 years for females since 2000. Further data beyond 2010 are required to determine whether life expectancy in Slovenia is increasing at least at the current rates⁶ for both males and females, as per the Health 2020 target (3).

Reduce inequalities in health

With regard to children, Slovenia has made progress in closing gaps in health status associated with social determinants in line with the Health 2020 recommendations (3). In 2010, infant mortality

⁵ Based on sales figures among people aged 15 years and over in litres of pure alcohol.

⁶ The annual rate from 2006 to 2010.

rates were 2.1/1000 live births for boys and 3/1000 live births for girls, representing decreases of 62% for boys and 29% for girls since 2000. For both sexes, infant mortality rates were lower than the averages for the EU15 and the Region, especially for males. Similar gains were observed for maternal mortality, which fell from 21/100 000 live births in 1999–2001 to 2/100 000 live births in 2009–2011. The proportion of children of official primary school age not enrolled in education also dropped by 40% after 2000 to 3.2% for boys and 2.2% for girls in 2013.

Unemployment constitutes a priority area of the Health 2020 targets (1). As a consequence of the financial crisis, unemployment rates rose steeply in Slovenia: in 2014, they were 8.9% for males, an increase of 2.1 percentage points since 2000, and 10.5% for females, an increase of 3.4 percentage points in the same period (5). After 2013, however, the unemployment rate for both sexes dropped considerably. The Gini coefficient (a measure of income distribution) increased by 14% from 22 in 2000 to 25 in 2014. This was, however, still one fourth lower than the value for the Region and one fifth below the EU15 value.

Enhance the well-being of the population

Well-being, as monitored by a suite of indicators, is a relatively new construct and thus will require further country data before adequate trend analysis may be performed. Data from Gallup World polls for 2007–2012 obtained through the UNDP human development reports (10) give an overall life satisfaction index of 6.1 on a scale from 0 (least satisfied) to 10 (most satisfied) for Slovenia, lower than the average for the EU15 (6.7) and higher than the average value for the Region (6).

Of people aged 50 years or more, 88% reported in 2014 that they had relatives or friends on whom they could count when in trouble. This figure places Slovenia between the values of the EU15 (90%) and the Region (85%).

As of 2015, drinking-water was piped into 99% of homes, both rural and urban, and 99% of both rural and urban populations had access to a sewage system, septic tank or other hygienic means of sewage disposal, the same as in 1990.

Ensure universal coverage and the right to the highest attainable level of health

According to WHO estimates, the share of private household out-of-pocket payments as a proportion of total health expenditure is one of the lowest in the Region, outperforming many of the more advanced economies of the EU. While there was a slight increase from 11.5% to 12.1% between 2000 and 2013, the Slovenian health system provides excellent financial protection against the cost of ill health. According to EUROSTAT data, the self-reported unmet need for medical care (due to it being too expensive) is also one of the lowest in the EU, indicating that access to health services is not limited by financial barriers (11).

Set national goals and targets related to health

By 2014, Slovenia had documented a process for target-setting as well as a national policy aligned with Health 2020, including an implementation plan and accountability mechanism, in accordance with the recommendations of the policy (3).

Conclusions

The health status of the Slovenian population has improved rapidly since 2000 but is still lagging behind the average for the EU15. Life expectancy at birth has increased by three to four years but is still around one year below the EU15 average. Healthy life expectancy increased by three years to 66 years for men and 72 years for women between 2000 and 2013. These estimates remained lower than the EU15 average. The infant and maternal mortality rates have declined rapidly and in 2010 were among the lowest in the Region.

Premature mortality from noncommunicable diseases fell more quickly in the period 2000–2010 in Slovenia than the EU15 average, mostly due to large reductions in premature mortality from circulatory diseases, which decreased faster. The rate for females reached the EU15 average in 2010, while the rate for men was one fourth higher. The rates are similar for ischaemic heart disease, but for cerebrovascular diseases the age-standardized mortality rates are still higher in Slovenia than in the EU15. Although the premature mortality rate from malignant neoplasms has decreased, the rates were still higher in 2010 than the averages for the EU15 and the Region. The premature mortality rate from cancers of the trachea, bronchus and lung decreased after 2000 for males but increased for females, while the rates for malignant neoplasm of the female breast and cancer of the cervix decreased after 2000.

Particularly worrying are the rapid increases in the incidence and prevalence of cancer as well as the prevalence of diabetes.

Additionally, the age-standardized mortality rates from diseases of the digestive system and chronic liver disease and cirrhosis have decreased, but the current (2010) rates remain above the averages for the Region. The suicide rate is high but the mortality rate from homicides and intentional injury is low, while mortality from motor vehicle accidents halved between 2007 and 2010.

Mortality from infectious diseases, diseases of the respiratory system and diseases of the genitourinary system fell to below the averages for the EU15. The incidence of both tuberculosis and gonorrhoea decreased by two thirds after 2000. The incidence of pertussis increased significantly in the late 2000s, but the number of new cases

has fallen since then. The incidences of syphilis, HIV infection and AIDS have increased since 2000. Overall, rates are high or very high for most vaccinations.

The recorded consumption of alcohol per capita for the adult Slovene population has historically been high and in 2010 was above the averages for the Region and the EU15. The prevalence of smoking has been decreasing for both sexes and in 2012 was 22% for men and 16% for women. While this was below the EU15 average, several countries had even lower rates. WHO estimates suggest that the prevalence of both overweight and obesity increased by two percentage points between 2010 and 2014. In 2014, 66% of men and 55% of women were overweight with a body mass index of 25 or more, and 25% of men and 26% of women were obese with a body mass index of 30 or more.

WHO's estimate for health expenditure shows that the share of GDP increased to 9.2% in 2013. While out-of-pocket expenditure on health is remarkably low in Slovenia, this is mainly due to the high level of population coverage by complementary private insurance that covers co-payments for services. Public sector health expenditure is lower than the EU15 average: in 2013 it was 72% of total health expenditure. The number of hospital beds has decreased and is below the EU15 average. The availability of physicians, dentists, nurses and midwives has been increasing since 2000, although the availability of physicians and midwives is still substantially below the EU15 averages.

Health policies in Slovenia are aligned with Health 2020, and implementation plans and accountability mechanisms are in place. Objective indicators of well-being are in line with EU15 averages, but subjective well-being is still lagging behind. Although significant improvements in the health status of the population have been achieved in recent years, some indicators are still behind those of the EU15. High levels of selected risk factors and the increasing prevalence of noncommunicable diseases, combined with the lower availability of human resources for health and the increasing share of private health expenditure, could slow progress in the coming years: close monitoring is required of the health situation and trends.

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Annex 1. ICD-10 codes for causes of death

Cause of death	ICD-10 codes
Cancer of cervix uteri	C53
Cancer of female breast	C50
Cancer of trachea, bronchus and lung	C33–C34
Cerebrovascular diseases	I60–I69
Chronic liver disease and cirrhosis	K70, K73, K74, K76
Diseases of the circulatory system	I00–I99
Diseases of the digestive system	K00–K93
Diseases of the respiratory system	J00–J99
External causes of injury and poisoning	V00–V99, W00–W99, X00–X99, Y00–Y99
Homicide and intentional injury	X85–X99, Y00–Y09
Infectious and parasitic diseases	A00–A99, B00–B99
Ischaemic heart disease	I20–I25
Malignant neoplasms	C00–C97
Motor vehicle traffic accidents	V02–V04, V09, V12–V14, V20–V79, V82, V87, V89
Suicide and self-inflicted injury	X60–X84
Symptoms, signs and ill-defined conditions	R00–R53, R55–R99
Tuberculosis	A15–A19, B90

Annex 2. Selected mortality data

Standardized death rate per 100 000 population and percentage changes from 2000.

Cause of death	Sex	Slovenia (2010)		WHO European Region (2012)		EU15 (2012)	
		Rate	Change (%)	Rate	Change (%)	Rate	Change (%)
All causes	Both	599.7	-25.1	753.3	-20.6	519.5	-20.9
	M	800.1	-26.9	982.9	-21.8	650.3	-23.4
	F	448.4	-24.9	578.1	-19.7	412.4	-19.2
Infectious and parasitic diseases	M	3.7	-41.1	18	-18.3	11.1	-2.5
	F	2	-31.9	8.5	11.1	7.4	15.4
Malignant neoplasms	M	270	-8.5	211	-13.5	204.5	-16.6
	F	145.6	-3	119	-8.9	124.1	-10.2
Diseases of the circulatory system	M	269.2	-33.8	429.6	-25.1	193.3	-37.2
	F	178.1	-29.1	277	-26.6	127.2	-35.5
Diseases of the respiratory system	M	49.7	-47.9	66.8	-29.1	56.5	-29.7
	F	23	-46.3	30.5	-23.6	31.8	-22.5
Diseases of the digestive system	M	55.4	-25.8	47.6	-4	31.2	-21.5
	F	26.1	-31.3	26.1	-0.3	18.5	-20.4
Symptoms, signs and ill-defined conditions	M	14.1	-49.4	43.4	5.6	23.8	4.9
	F	4.6	-65.3	28.2	7.1	14.6	12.9
External causes of injury and poisoning	M	87	-18.3	85.1	-35.8	43.3	-24.3
	F	28.7	-24.5	25.1	-31.9	17.4	-22.1
Motor vehicle road traffic injuries	M	10.7	-51.8	–	–	7.4	-53
	F	2.4	-63.1	–	–	2	-58.2
Suicide and self-inflicted injuries	M	29.3	-32	19	-34.2	14.3	-12.2
	F	6.1	-54.9	4.4	-28.8	4.4	-13.9
Homicide and intentional injury	M	0.4	-68	4.6	-58.6	0.8	-35.2
	F	0.4	-42.1	1.5	-59.6	0.4	-35.4

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