World Health Organization
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SITUATION ANALYSIS ON EVIDENCE-INFORMED POLICY-MAKING

Slovenia

EVIPNet Europe Series, N°1

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EVIPNet
EVIDENCE-INFORMED POLICY NETWORK

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FOREWORD

Slovenia was one of the first Member States of the WHO European Region to demonstrate commitment to the principles of strengthening evidence-informed health policy-making by joining the WHO Regional Office for Europe's Evidence-informed Policy Network (EVIPNet Europe). In 2014, the initiative was launched at a high-level stakeholder workshop and its assistance and capacity-building activities were warmly welcomed by the Ministry of Health, which at the time faced economic constraints leading to reduced spending, as well as embarking in 2015 on new health reform processes.

As a first step, a local team comprising researchers, decision-makers and other stakeholders was formed and trained by EVIPNet Europe in knowledge translation methodologies. An evidence brief for policy on the payment model for general practitioners was developed, and tailored to the local context. This brief informed the Slovene Government in implementing its National Health Care Plan.

In addition to capacity-building efforts, one of the key needs identified by the Ministry of Health in Slovenia was to build an evidence-informed policy infrastructure that functions well – a neutral, independent unit, which supports the transfer of evidence into policy and which decision-makers can refer to whenever evidence is in demand. The proposed unit would respond to policy priorities, and develop up-to-date, rigorous and unbiased evidence on key health issues, contextualized to local circumstances and thus facilitating decision-makers' day-to-day work. Such a unit would also ensure that the worlds of research and policy grow closer together, interact and create mutual understanding of each other's aims and cultures – one of the key predictors of evidence use in policy.

To identify a suitable structure and remit of such a unit, Slovenia has conducted a situation analysis which provides a deeper understanding of the national evidence-informed policy context (its actors, processes, facilitators, barriers) as well as the major factors influencing the establishment of a neutral evidence-informed policy unit and a knowledge translation platform. The situation analysis provides the basis for this document. In the meantime, both the need for situation analyses and establishing knowledge translation platforms have gained regional political traction since being featured in WHO's ***Action plan to strengthen the use of evidence, information and research for policy-making in the WHO European Region***, adopted by all 53 Member States of the Region in September 2016.

I would like to thank and congratulate the Slovene EVIPNet Europe team led by Mr Mircha Poldrugovac – the EVIPNet champion and Public Health Specialist from Slovenia's National Institute of Public Health – for undertaking the analysis. Conducting a situation analysis is a comprehensive undertaking, requiring good technical understanding, analytical thinking, participatory approaches and the engagement of various stakeholders, as well as full support from central authorities. We are delighted to now be in a position to present this, through this report.

Both the Ministry of Health and experts from the field have made clear their appetite for a knowledge translation platform as well as a Slovene knowledge translation strategy. The next step will be for these to be developed, with the WHO European Regional Office on hand to provide support at all levels wherever required.

Darina Sedláková

WHO Representative in Slovenia

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The authors of this situation analysis would like to thank those who contributed to its publication. Particular thanks are due to Tanja Kuchenmüller (coordinating EVIPNet Europe on behalf of the WHO Regional Office for Europe) for her technical guidance and support; Marijan Ivanuša (former Head of the WHO Country Office in Slovenia); Mark Leys of Vrije Universiteit Brussel (chair of the EVIPNet Europe Steering Group); Marija Andjelković (Administrative Assistant of the WHO Country Office in Slovenia); and other members of the (EVIPNet Europe) WHO Secretariat – in particular Janine Bröder and Olivia Biermann (WHO Regional Office for Europe).

The Evidence-informed Policy Network: EVIPNet Europe

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CONTRIBUTORS

This report was prepared as part of the biennial collaborative agreements (BCAs) covering 2014–2016 and 2016–2017 between the Ministry of Health of Slovenia and the WHO Regional Office for Europe, relating to the work of EVIPNet Europe.

Authors

Mircha Poldrugovac
Polonca Truden

Peer reviewers

Vesna Kerstin Petrič (Ministry of Health, Slovenia)
Tit Albreht (National Institute of Public Health, Slovenia)
Ivan Eržen (National Institute of Public Health, Slovenia)
Darina Sedláková (WHO Representative in Slovenia)
Patricia Tidmarsh (Consultant, WHO Regional Office for Europe)
Tina Dannemann Purnat (WHO Regional Office for Europe)
Govin Permanand (WHO Regional Office for Europe)

Editorial team

Mark Leys
Tanja Kuchenmüller

LIST OF ABBREVIATIONS

ARRS	Slovene Research Agency
DESA	Department of Economic and Social Affairs
DPADM	Division for Public Administration and Development Management
EBP(s)	evidence brief(s) for policy
ECDC	European Centre for Disease Prevention and Control
EIP	evidence-informed (health) policy-making
EU	European Union
EU15	Member States belonging to the EU until 1 May 2004
EU28	all 28 Member States of the EU (as at October 2017)
EVIPNet	Evidence-informed Policy Network
GDP	gross domestic product
HTA	health technology assessment
KTP	Knowledge Translation Platform
NIPH	National Institute of Public Health (Republic of Slovenia)
OECD	Organisation for Economic Co-operation and Development
PHIRE	Public Health Innovation and Research in Europe
SDG	Sustainable Development Goal
SURS	Statistical Office of the Republic of Slovenia
WHO	World Health Organization

EXECUTIVE SUMMARY

The Evidence-informed Policy Network (EVIPNet) is an initiative established by WHO to support capacity development in the use of evidence in a systematic and transparent manner in health policy-making. The ultimate ambition of evidence-informed policy-making (EIP) is in developing stronger health systems and outcomes, as well as reducing inequalities globally (Travis et al., 2004). EVIPNet promotes the use of knowledge translation tools: among which the evidence brief for policy (EBP) and the policy dialogue. WHO Regional Office for Europe supports the establishment of EVIPNet Europe country teams in the form of a knowledge translation platform (KTP), to bring together the countries' key stakeholders in health policy-making. According to the EVIPNet concept of the KTP, such a platform institutionalizes the bridge between the research community and the policy-makers (at different levels). For sustainability and effectiveness, KTPs should be adapted to the relevant political, social and scientific characteristics, as well as the specific institutional system and decision-making mechanisms (EVIPNet Europe, 2014).

One of the first activities undertaken when Slovenia became a member of EVIPNet Europe was to engage in a situation analysis, which is an advanced study of the country's policy context, the research context and the interaction between both of these realms. The aim of this situation analysis was to map and assess the context in which EIP takes shape, and to reflect on opportunities to establish a KTP.

The analysis was guided by a preliminary version of the EVIPNet Europe Situation Analysis Manual (WHO Regional office for Europe, 2017a). Information was gathered from publicly available documents, national laws and regulations in the health sector, papers and reports, and three workshops organized between 2014 and 2015.

The analysis was built on these information sources and structured into four areas:

1. general country context
2. the health system
3. national health research system
4. EIP processes.

General country context

Slovenia has been an independent country since former Yugoslavia dissolved in 1991. It became a member of the European Union (EU) in 2004 and adopted the euro in 2007 (Government Communication Office, 2011). Its gross domestic product (GDP) per capita was US$ 24 002 in 2014 (WHO Regional Office for Europe, 2017c). Slovenia was hit hard by the recession, which led to a drop in real GDP of 7.1% in 2009 alone (WHO Regional Office for Europe, 2017b), with a major impact on the resources available for health policy-making processes in the years that followed.

Demographically, Slovenia's population pyramid is typical of industrialized countries, meaning that the country faces challenges including an ageing population and an increasing burden of chronic noncommunicable conditions.

The health system

Slovenia's health care system is based on the Bismarck model, with a single health fund financing health services: the Health Insurance Institute of Slovenia (HIIS). Co-payments (which may be high in some situations) are covered by voluntary health insurance, in which the overwhelming majority of eligible residents are enrolled. Long-term financial sustainability of the health system is a significant concern in Slovenia. Several cost-reduction policies have been introduced. The Ministry of Health is the major driver of health policy, but policy-making is undertaken through dialogue and is influenced

by many stakeholders (professional groups, health insurance agencies, industry, patient groups, etc.) through both formal and informal mechanisms. The Committee on Health of the National Assembly is another prominent actor, which represents the legislative branch of government.

Accountability relationships between the various stakeholders are sometimes unclear, leaving room for improvement in the area of governance and leadership. The major long-term planning document in the area of health is the recently adopted National Health Care Plan for 2016–2025 (Ministry of Health, 2016). It identifies priorities for action, which also take into account the strategic objectives of the Health 2020 strategy of the WHO European Region (WHO Regional Office for Europe, 2013).

National health research system

No specific research strategy exists in the area of public health or health systems/services. However, the more general Resolution on the National Research and Development Programme 2011–2020 (2011) is used as framework by the Slovene Research Agency to issue grants, resulting partly from direct consultation with the Ministry of Health and taking into account the needs of the Ministry. In 2012 approximately €24.5 million was spent on research in the area of medical and health sciences (SURS, 2017). It is not known how much money was spent on health system or health services research in the country.

Most research institutions in the area of public health are publicly operated and funded. The biggest of these is the National Institute of Public Health (NIPH). All three universities in Slovenia are also active in this research area, particularly within their faculties of medicine, health sciences and economics. Other independent research institutions include the Jožef Stefan Institute, the Institute for Economic Research and the Angela Boškin Faculty of Health Care Jesenice.

EIP processes

The policy-making process in Slovenia is regulated by several legal documents. Most importantly, the Resolution on legislative regulation was adopted in 2009, requiring government bodies to present policy and regulation proposals that are backed by high-quality rationale and ex-ante impact assessments. The proposals are required to undergo extensive stakeholder discussion before being presented for adoption. However, the requirements of the 2009 resolution are not fully implemented, demonstrating the gap between intentions and actual practices.

Monitoring and evaluation of policies and regulation in Slovenia deserve more attention. Building capacity in monitoring and evaluation could strengthen accountability at all levels, including accountability of those responsible for the policy-making process. This could be an incentive to better adhere to the aforementioned 2009 resolution. In the health sector, in addition to the Ministry of Health, major actors include the HIIS, professional organizations (such as the Medical Chamber of Slovenia) and patient associations. The NIPH is the country's principal public health institution, and an important advisory role to the Ministry of Health is provided by its Health Council and by expert bodies called general expert collegia.

Several recent examples of an evidence-informed health policy-making process have been identified, including research commissioned by the Ministry of Health in order to prepare policy proposals, a working group engaged in knowledge translation activities, and evidence summarized through a collaboration of policy-makers and researchers in various policy briefs. However, the country still also relies on ad-hoc policy examples. Moreover, a system has not yet been established for systematic and regular comparison and fine tuning of research and policy priorities, which should include a broad range of stakeholders. Institutionalized capacity in the area of knowledge translation is currently lacking.

EIP institutionalization considerations

The situation analysis showed that there are opportunities and challenges involved in institutionalizing a KTP in Slovenia. At this stage the country has no infrastructure or platform to bridge the gap between policy-making and research in a systematic, sustainable manner. Regulatory frameworks

have been put in place that offer a basis for institutionally developing EIP, but currently capacity is lacking to introduce evidence effectively and consistently at the political level, as well as at the level of central public administration. No matter the organizational form of the platform, it would need to provide an environment conducive to respectful communication among all stakeholders.

Conclusions and next steps

Concrete recommendations have been made based on the situation analysis. A KTP is considered as an important infrastructure, needed to enhance a regular structural dialogue between stakeholders, policy-makers and the research community in order to share evidence and research priorities, public health needs and stakeholders' perspectives on health-related issues. The KTP should be neutral, independent and support the transfer of evidence into policy. It should be an infrastructure that decision-makers can refer to whenever evidence is in demand. It was concluded that the organizational model for the KTP should follow the BRIDGE criteria (Lavis, Jessani, Permanand et al., 2013), which put forward independence, transparency and the use of rigorous methods of analysis (see Chapter 7).

Different organization forms were suggested, in which a dedicated unit or organization should be established. If the platform were not established as a stand-alone organization, but rather as a standing committee, one or more organizations should be trusted to coordinate its day-to-day operations.

In any case, establishing a KTP would need human and financial resources to pursue its mission, which are not necessarily available at short notice. Eventually, stable funding would be needed to institutionalize, which means ensuring that human and financial resources are made available beyond the seed capital provided so far. At the very least, for a progressive approach towards a KTP infrastructure, Slovenia needs continuous capacity development in the field of EIP and knowledge translation, requiring further support from EVIPNet Europe. In order to engage in concrete EIP activities, it was recommended that the platform should build momentum by piloting the preparation of an EBP and a policy dialogue.

1. INTRODUCTION

1.1 EVIPNet Europe and EIP

EIP aims to ensure that the best available evidence is used to formulate policies to improve the health of individuals and populations. The mandate of EIP is enshrined in the role of WHO and reflected in its six core public health functions. These include: shaping the research agenda; stimulating the generation, translation and dissemination of valuable knowledge; and articulating ethical and evidence-based policy options (WHO, 2006). Since 2004, calls for action specifically aimed at bridging the "gap between knowing what to do and actually doing it" (WHO, 2006:20) have featured in WHO resolutions, such as the Mexico Statement on Health Research in November 2004 (WHO, 2004a), the Fifty-eighth World Health Assembly resolution in May 2005 (WHO, 2005) and the ***Bamako call to action on research for health*** in November 2008 (WHO, 2008b).

As a result, in 2005 WHO established the EVIPNet to support capacity development in the use of evidence in a systematic and transparent manner in health policy-making. The ultimate ambition of EIP is to develop stronger health systems and outcomes, as well as to reduce inequalities globally (WHO, 2008a).

EVIPNet is structured across three levels: country, regional and global.

- At the country level, key stakeholders, such as researchers, policy-makers and civil society, are brought together to form a KTP, mandated to strengthen EIP. This body plans, coordinates and manages the implementation of national activities promoting the use of the best available evidence in any health policy discussion, such as evidence briefs for policy (EBPs) and policy dialogues.
- Regionally, EVIPNet supports the country-level platforms, by encouraging networking among countries with similar features, exchange of experiences and capacity-building.
- At the global level, innovative knowledge translation mechanisms are being developed and/or assessed by international experts and institutions (Panisset, Campbell & Lavis, 2012).

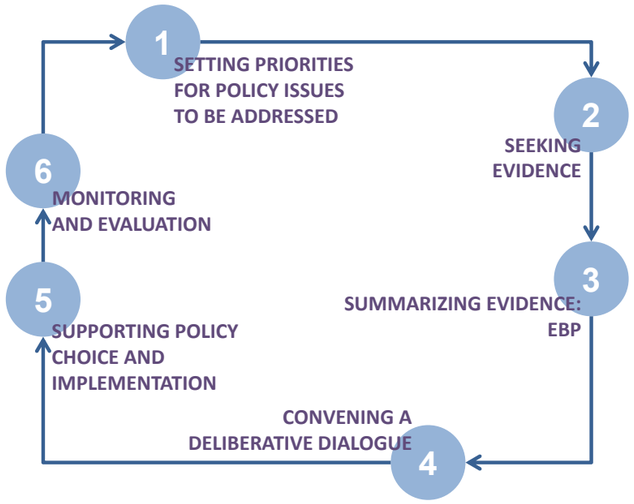
The WHO Regional Office for Europe established EVIPNet Europe in October 2012. EVIPNet Europe is instrumental to achieving the European policy framework, Health 2020 (WHO Regional Office for Europe, 2013) – a key implementation pillar of the European Health Information Initiative (WHO Regional Office for Europe, 2015a) and central to the goals of the ***Action plan to strengthen the use of evidence, information and research for policy-making in the WHO European Region*** (WHO Regional Office for Europe, 2016), as well as the United Nations' Sustainable Development Goals (SDGs) (in particular, SDG 3 on good health and well-being (United Nations, 2015)). EVIPNet Europe aims to (WHO Regional Office for Europe, 2015b:ix):

- be a network of communities of practice, supporting […] EIP in the region;
- promote and apply two of the core Health 2020 principles: 'whole-of-society' and 'whole-of-government';
- increase country capacity to develop evidence-informed policies on health system priorities that are in line with the Health 2020 priorities;
- function as a cross-society, multistakeholder partnership between health policy-makers, researchers and civil society;
- enhance countries' abilities to develop a transparent and responsive public sector in order to be better prepared to respond to citizens holding their governments accountable for governmental decision-making;
- routinely draw upon the best practices and lessons learnt of other EVIPNet regional networks around the world; and

» work directly with funders of health research – and seek to influence them through its network of [...] KTPs – so that they might better respond to on-the-ground needs and realities.

In order to apply EIP to strengthen health systems, EVIPNet promotes the use of two key knowledge translation tools: the EBP and the policy dialogue (Fig. 1.1).

Fig. 1.1 The EVIPNet action cycle



Source: WHO Regional Office for Europe, 2015b.

An EBP is a user-friendly evidence synthesis about a priority health policy issue, written in plain language and presented in a user-friendly three-tiered format: a page of key messages, followed by three pages of executive summary, and complemented by the full report, including a reference list and any relevant annexes. An EBP underpinned by a systematic and transparent method for collecting the available evidence on the issue: (a) the policy issue at hand is framed; (b) options addressing the policy issue are identified; and (c) implementation challenges of the policy options are outlined. To be relevant to policy-makers, the evidence used in the brief is contextualized by complementing systematic reviews and global research findings with the best available local evidence.

Information from the EBP is used in policy dialogues, whereby key stakeholders have the opportunity to present their views, concerns and experiences regarding the findings and policy options included in the brief. Policy dialogues allow: additional evidence to be identified, particularly tacit knowledge from the participants which may not be published or otherwise publicly available; knowledge gaps found in the EBP to be filled; buy-in by local stakeholders of the policy issue to be increased; and policy options to be presented.

Box 1.1 presents some key EIP-related definitions.

Box 1.1 Key concepts in EIP

EIP
EIP can be defined as (Oxman et al., 2006:4):

> ... an approach to policy decisions that is intended to ensure that decision making is well-informed by the best available research evidence. How this is done may vary and will depend on the type of decisions being made and their context. Nonetheless, evidence-informed policymaking is characterised by the fact that access and appraisal of evidence as an input into the policymaking process is both systematic and transparent.

Box 1.1 Contd.

Knowledge translation
WHO (2004b:140) defines knowledge translation as:

> ... the exchange, synthesis, and effective communication of reliable and relevant research results. The focus is on promoting interaction among the producers and users of research, removing the barriers to research use, and tailoring information to different target audiences so that effective interventions are used more widely.

KTPs
In general, a KTP can be defined as (Kasonde & Campbell, 2012:2):

> ... a national- or state-level entity designed to create and nurture links among researchers, policy-makers and other research-users; these links draw the research and policy communities closer together to ultimately create cycles of policy-informed evidence and evidence-informed policy. KTPs are ideally led by trustworthy, highly connected and credible experts, intermediaries who excel in various different fields, including evidence gathering, critical appraisal, facilitation, communication and networking. They almost certainly require experience–and command respect–in the worlds of both research and policy.

1.2 Why is EIP relevant in Slovenia?

Strengthening EIP in Slovenia is particularly valuable in the context of the impact of the recent economic recession, which threatened the sustainability of the health care system and is expected to have an impact on the health of the population. Slovenia also faces an ageing population, rising risk factors attributable to lifestyle in the young and active population, and an epidemic of long-term conditions, such as diabetes (Ministry of Health, 2016).

Slovenia believes the partnership with EVIPNet Europe will be beneficial in terms of mobilizing scarce human resources to enhance EIP and support the health reforms necessary to tackle the challenges outlined above. Policy developments highlight the relevance of EIP and in particular the need for further action in this area. The country aims to empower the health sector to influence other sectoral policies that inevitably in turn influence the health of the population. Moreover, the country is seeking ways to both strengthen participatory policy-making and increase stakeholders' involvement in the policy process, as well as ensuring that policy-making anticipates the consequences of any policy proposal. In terms of the latter, recent legislation requires high-quality ex-ante impact assessment (Resolution on legislative regulation, 2009).

Further testimony of the increasing importance attributed to the use of evidence in decision-making is a health system review commissioned in 2015 by the Slovene Ministry of Health. The review was undertaken by the WHO Regional Office for Europe and the European Observatory on Health Systems and Policies. It provided crucial input to the National Health Care Plan, the overarching long-term policy document in health (Kolar Celarc, 2016). International organizations were commissioned by the Ministry of Health to carry out the review, partly owing to limited capacities nationally in interpreting data and packaging the information in a user-friendly way.

1.3 Preparing the establishment of a KTP

In order to strengthen and institutionalize EIP, and prepare and establish a KTP, EVIPNet Europe encourages a country situation analysis. The aim of the analysis is to provide a snapshot of the health (systems) research and health (systems) policy-making context to identify "the organizational and operational niche of the future EVIPNet knowledge translation platform" (WHO Regional Office for Europe, 2017a:1).

The situation analysis is undertaken locally (at the country level), and is coordinated by an EVIPNet country team. The EVIPNet country team typically includes representatives of the WHO country office and EVIPNet Europe champions, as they are known; these are individuals selected by the

ministries of health as official focal points to facilitate and implement EVIPNet country activities. The investigators collecting and analysing data are supported by the WHO country office, as well as the WHO Secretariat of EVIPNet Europe at the WHO Regional Office for Europe.

1.3.1 Methods

The development of the situation analysis was guided by the first draft of the EVIPNet Europe Situation Analysis Manual (WHO Regional Office for Europe, 2017a), which is being revised. The manual organizes the information in four chapters:

1) general country context
2) the health system
3) national health research system
4) EIP processes.

Information was gathered from publicly available policy documents, applicable laws and regulations in the health sector, papers and reports, including some unpublished documents available to the authors. An unpublished report prepared by the Ministry of Health on research projects carried out during the period 2001–2012, and the country report for Slovenia relating to the European project Public Health Innovation and Research in Europe (PHIRE) (Poldrugovac et al., 2012) are two other notable sources of information.

In order to take into account stakeholder reflections and perspectives, investigators drew on the conclusions of three workshops: the first one took place at the launch event in March 2014, attended by representatives of the Ministry of Health, the NIPH and the Medical Chamber of Slovenia; the second one, in December 2014, featured discussions on EIP among professionals at the NIPH; the third workshop in February 2015 was a meeting with a broad range of stakeholders. Participants included (among others) representatives from institutions who participated in the launch event in March 2014, representatives from the HIIS, the Nurses and Midwives Association of Slovenia, the Slovene WHO Collaborating Centre for Cross Sectoral Approaches to Health and Development, the Centre for Health and Development Murska Sobota, the Faculty of Medicine and the Faculty of Economics of the University of Ljubljana, and several nongovernmental organizations (NGOs), including patient organizations. Comments on the draft situation analysis were encouraged.

The conclusions of the situation analysis stem from the investigators' interpretations, using all information sources. The risk of bias inherent in interpretations was at least partly mitigated by conducting the stakeholder consultations described above, to verify the results.

1.4 Structure of the report

The report is structured as follows.

- Section 2 on the national context offers a general understanding of the country's major political, social, public health, socioeconomic, and cultural characteristics beyond health and health system-related infrastructures and processes.
- Section 3 on the health system and policy-making outlines the characteristics of stakeholders, structures, decision-making processes, and key issues in public health and the health system.
- Section 4 on the country's health research system describes key stakeholders, available structures, overall processes and funding mechanisms, as well as key health research areas.
- Section 5 on evidence-informed policy processes presents an overview of current EIP efforts and how the health system and the health research system interface in these.

In several sections, summary boxes were added to outline the key challenges and opportunities to be considered in the reflection on how to establish a KTP in Slovenia.

2. GENERAL COUNTRY CONTEXT

» *This section on the Slovene national context offers a general understanding of the country's major political, social, public health, socioeconomic, and cultural features beyond the health and health system-related infrastructures and processes.*

The policy-making processes in democratic societies share many generally accepted principles. At the same time, many aspects are country specific, partly depending on the political structure of the country, which in Slovenia's case is described in this chapter. Socioeconomic conditions are also likely to play an important role, as they may give a general idea of the resources that can be expected to be mobilized for EIP. This chapter also looks at the process of national policy-making, taking into account key players and established practices, thus providing a broad context for EIP in health.

2.1 Political structure and socioeconomic conditions

Slovenia is a small central European country, with borders with Italy to the west, Austria to the north, Hungary to the north-east and with Croatia through its eastern and southern borders. It also has 46.6 km of coastline on the Adriatic Sea (Government of the Republic of Slovenia, 2015b) and a population of about 2 million. The capital is Ljubljana, which has approximately 280 000 inhabitants (SURS, 2017).

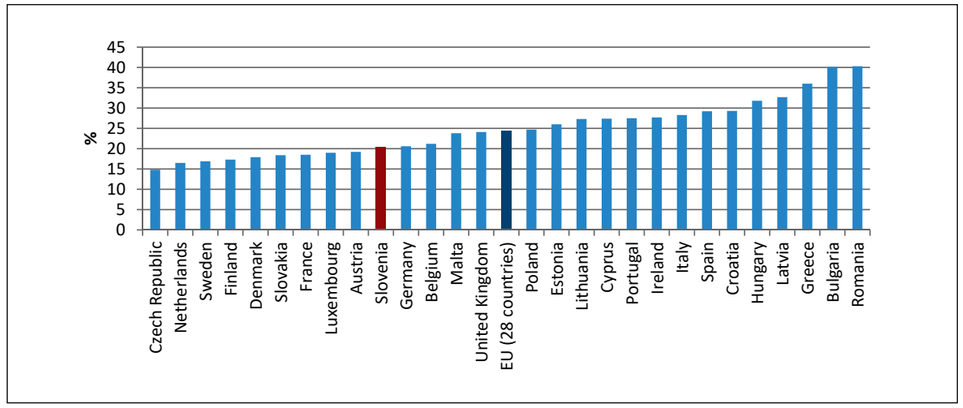
Slovenia is a democratic republic, with a unitary government, based on the principle of separation of legislative, executive and judicial powers. The highest legislative authority rests with the National Assembly, which has 90 deputies. The last parliamentary elections took place in 2014 and led to the formation of the current government, which is supported by a coalition of three parties (the Party of Modern Centre, the Democratic Party of Pensioners of Slovenia and the Social Democrats) (Government Communication Office, 2011; Government of the Republic of Slovenia, 2015a, 2015b). Some authority is given to municipalities (United Nations DPADM & United Nations DESA, 2004), of which there are over 200.

Slovenia has been an independent country since former Yugoslavia collapsed in 1991. The country became a member of the EU in 2004, adopted the euro as its currency in 2007 (Government Communication Office, 2011), and its GDP per capita was 24 002 US$ in 2014 (WHO European Health for All database, 2014).

The economic crisis, which started in 2008, had a significant impact on Slovenia, which recorded a drop in real GDP of 7.1% in 2009. It took until 2014 for the real GDP figure to reach the previous (2008) value (WHO Regional Office for Europe, 2017b). Between 2008 and 2014 the general government debt increased from 22% of GDP (€4.06 per capita) to 81% of GDP (€14.62 per capita) (SURS, 2017).

Not surprisingly, official unemployment data reflected the state of the economy, rising from 4.4% in 2008 to over 9.7% in 2014 (WHO Regional Office for Europe, 2017d). In the same period, the percentage of people at risk of poverty or social exclusion increased from 18.5% to 20.4% according to Eurostat (Eurostat, 2016). However, in 2014 this figure was still below the EU average (see Fig. 2.1). The GINI coefficient, which indicates inequality of income distribution in the country, is very low in Slovenia at 25.04 in 2014 according to the Health for All database which is lower than Germany (30.70), Italy (32.70) or Denmark (27.50) (Eurostat, 2016).

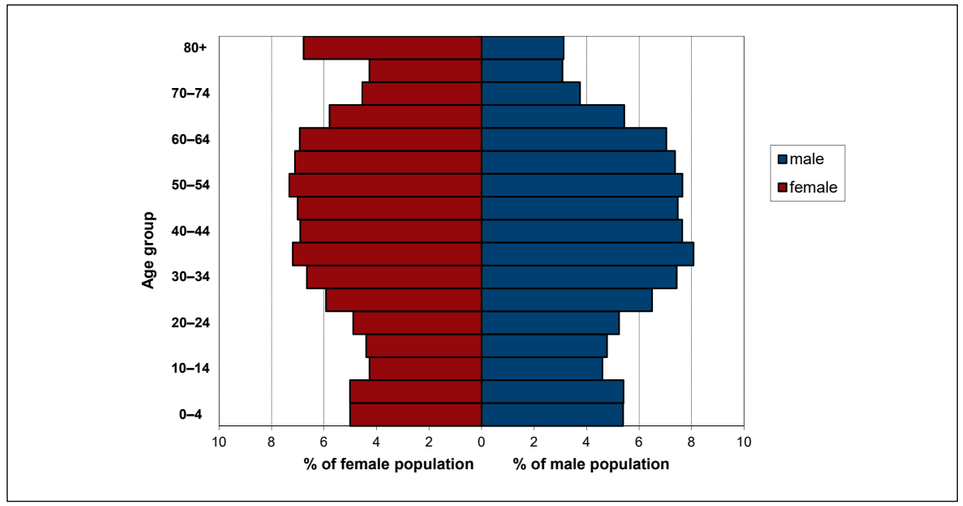
Fig. 2.1 Percentage of people at risk of poverty in 2014



Source: Eurostat (2016).

The population pyramid (see Fig 2.2) shows the typical structure of an industrialized country, implying an ageing population, which impacts both the social conditions in the country and the needs that the health system has to satisfy. Life expectancy at birth exceeds 80 years of age and is one year above the average for all 28 Member States of the EU (EU28), but still below the average for the Member States belonging to the EU until May 2004 (EU15) (Ministry of Health, 2016). Taking this into account, it is important to note that currently Slovenia has the lowest retirement age among Organisation for Economic Co-operation and Development (OECD) countries (OECD, 2017).

Fig. 2.2 Population pyramid for the Slovene population, 1 January 2016



Source: SURS (2017).

2.2 Policy stakeholders and the policy-making process

Recent Slovene governments have shown a particular interest in improving the policy-making processes in the country. In 2009, the Slovene Parliament passed the Resolution on legislative regulation (Resolution on legislative regulation, 2009), which outlines the process for preparing regulatory proposals. The Resolution is complemented by a more detailed manual on how to perform ex-ante impact assessments, which are supposed to be part of any policy or regulatory proposal (Ministry of Public Administration, 2011). Both documents stress the importance of evaluating policies and regulations and discussing openly new policy or regulation initiatives with all stakeholders. These documents strongly support the need for more rigorous policy analysis and participatory processes.

The Slovene Government also passed the Decree on the documents of development planning bases and procedures for the preparation of the central government budget (2007). The Decree recognizes the Slovene Development Strategy (Šušteršič, Rojec & Korenika, 2005) as the central long-term development document. A new draft Slovene Development Strategy has recently been made public by the Government, and its first stated objective is "Healthy and active life" (SVRK, 2017). Since October 2017 it is undergoing public debate.

The Decree on the documents of development planning bases and procedures for the preparation of the central government budget (2007) also determines how documents for development planning should be prepared. These are required to be coherent and consistent with the Slovene Development Strategy and the National programme of developmental priorities and investments. The Decree also determines that the Government Office for Development and European Cohesion Policy must keep a current record of all documents for development planning; however, this record – if indeed it is kept – is not publicly available.

2.2.1 The role of civil society

The basic civil liberties necessary for open discussion of policy issues are well-established. The independent watchdog Freedom House rated Slovenia as free in 2013, giving it its best rating (of 1) in the categories of freedom, civil liberties, and political rights (Freedom house, 2017). Nonetheless, according to the 2004 and 2011 CIVICUS civil society index, many areas require improvement to enhance civil participation (Rakar et al., 2011). In 2011 the EU-funded ASPEN project (The ASPEN Project Group, 2011) recommended to improve civil participation in mental health. These recommendations seem applicable to the entire health sector and possibly to other sectors as well. The key opportunities and challenges for a future KTP considering the general country context are summarized in Box 2.1.

Box 2.1 Summary of key opportunities and challenges for a future KTP considering the general country context

Opportunities provided by a KTP

- A KTP can support the process of preparing policy proposals in line with the 2009 Resolution on legislative regulation.
- It can support policy development consistent with other development documents.
- It can encourage further development of the role of civil society and other stakeholders in policy decisions.

Challenges for a future KTP

- Implementing rigorous policy analysis can be difficult.

3. THE HEALTH SYSTEM

» *This section on the health system and policy-making describes the characteristics of stakeholders, structures, decision-making processes, and key issues in public health and the health system.*

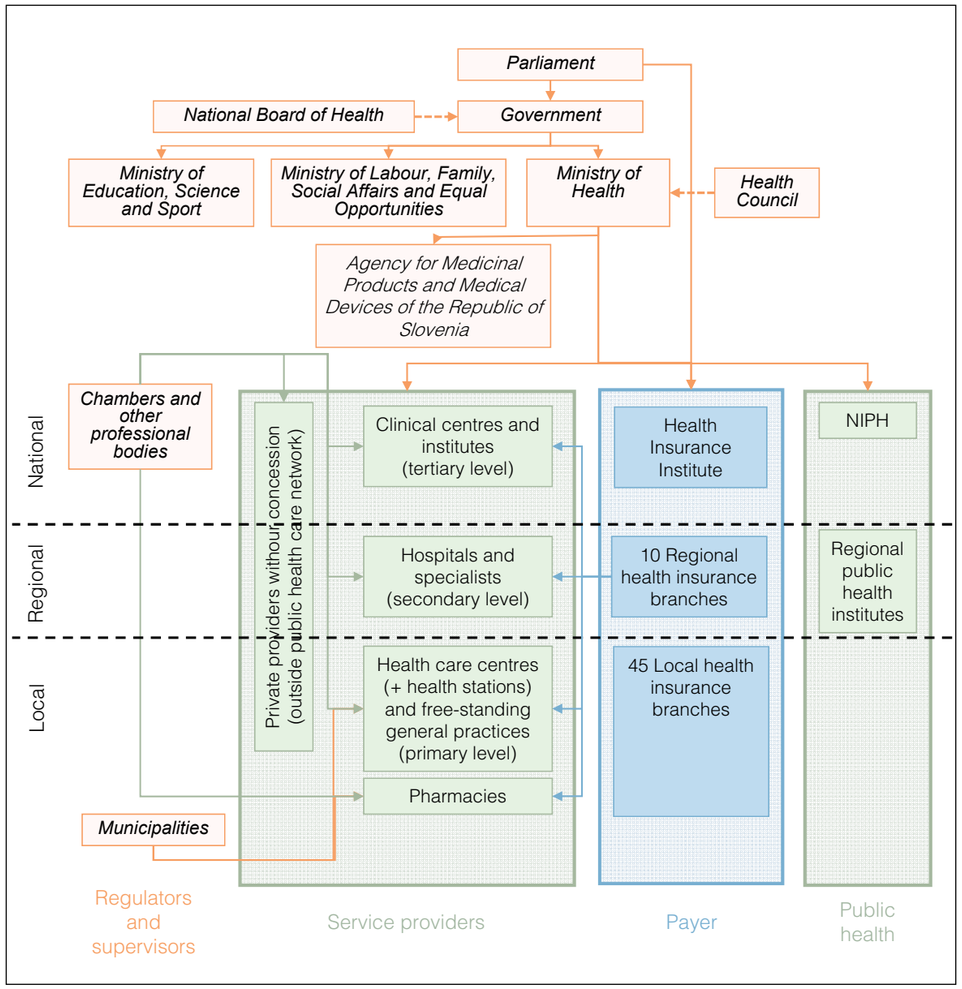
The initial subsection on organization and governance of the Slovene health system offers the opportunity to understand the roles and responsibilities of key stakeholders in health and their interactions. Looking into financing and service delivery in the country (subsections 3.2 and 3.3) seems to reveal additional challenges that policy-makers are tackling or need to tackle in the near future. Moreover, where major reforms are underway, or policy frameworks are already available, these clearly indicate the country's policy priorities and directions, and thus potential foci for EIP activities.

3.1 Organization and governance

The Slovene health care system is based on a Bismarck model (a health insurance system financed jointly by employers and employees through payroll deduction and executed by health insurers that are often called sickness funds) with modest additional financial input from the government budget. The system aims at universal and extensive health care access for all residents (Albreht et al., 2016). In practice, equality is a core value, and receives a lot of attention; for example, in the Resolution on the National Health Care Plan for 2016–2025 (Ministry of Health, 2016), in the report ***Health inequalities in Slovenia*** (Buzeti et al., 2011) and in the project "Together for health" focusing on equality in prevention programmes. Inequalities persist, such as observed differences in health status of the population according to socioeconomic status, and they need to be addressed (Buzeti et al., 2011).

The health policy-making process in Slovenia is formally structured in line with modern democratic practices (Rules of Procedure of the Government of the Republic of Slovenia, 2001). It includes a public debate phase for any policy or regulatory proposal and an ex-ante impact assessment of the proposal. However, day-to-day practice sometimes differs. Impact assessment in particular can be problematic as it requires serious and thorough analysis and research, carried out by experts, rather than just a formal filling of forms, as is often the case (Resolution on legislative regulation, 2009). In addition, stakeholders are sometimes not properly involved (Rakar et al, 2011; The ASPEN Project Group, 2011). Recommendations for improvement were formulated in the Resolution on legislative regulation (2009), and now the challenge remains to effectively implement those recommendations schematically presents the relationship between major stakeholders in the Slovene health system.

Fig. 3.1 Simplified organigram of the Slovene health care system.



Source: Albreht et al., 2016.

As shown in Fig. 3.1, health service delivery is arranged across three levels. Health care institutions are mostly publicly owned – by municipalities at the primary health care level and by the State at higher levels. Private providers can be included in the national public health care network, which means that the services they provide are covered within the public financing scheme (e.g. by the HIIS), or they can work independently and thus provide services based on out-of-pocket payments or according to substitute private health insurance schemes. All providers (public and private) operating in the public network have a contract with the HIIS as the single sickness fund in Slovenia; as such the HIIS has a high level of autonomy. There are also three providers of **complementary** health insurance, which is voluntary (and therefore not shown in the illustration). Public health is the domain of the NIPH, which has several regional offices. The Agency for Medicinal Products and Medical Devices is an independent government institution with delegated competencies from the Ministry of Health in the area of medicinal products and medical devices. The professional competence of health care professionals is assured by chambers and (self-governing) professional bodies, which often have the power to award professional licences to work (Albreht et al., 2016).

The Slovene health care system seems to struggle with governance and leadership. The responsibilities of various institutions are seldom clear and there is a lack of accountability. For instance,

clinical guidelines are drafted by various sections of the Slovene Medical Association (see Košnik & Marčun, 2015) and are supposed to be adopted by the general expert collegia, which are expert advisory bodies to the Ministry of Health (Rules on the composition and functioning of the General Expert Collegiums, 2002). However, the two expert bodies have no formal relationship, resulting in a situation with ambiguous accountability with regard to the design and use of the guidelines. As a side-effect, it is not clear who should initiate and encourage the preparation of such guidelines (Ministry of Health, 2016). Similarly, it remains vague who should tackle the unsustainable financial situations of many hospitals (Cylus, 2015), as hospital managers and the HIIS perceive each other as being responsible.

3.1.1 National strategic frameworks

The main policy document in the health sector is the National Health Care Plan. The draft Resolution on the National Health Care Plan for 2016–2025 (Ministry of Health, 2016) identifies four priority areas:

1. improving health and well-being and reducing health inequalities for the population of Slovenia;
2. implementing an accessible, effective and stable health care system, which effectively adapts to the needs of the population;
3. ensuring satisfied patients and providers;
4. increasing the contribution of health to Slovenia's development.

The first two priority areas reflect the strategic objectives of the WHO European Region's Health 2020 strategy (WHO Regional Office for Europe, 2013).

Four priority areas were set for the further development of the health system (Ministry of Health, 2016).

1. Focus should be placed on health promotion, health protection and disease prevention, addressing the entire population and various target groups.
2. Care should be optimized, whereby all levels of the care system provide individuals with the care they need, including preventive services and programmes, treatment, rehabilitation and reintegration.
3. Effectiveness of care should be increased to ensure the best possible outcomes, along with increased efficiency by improving leadership and management processes.
4. Financing of health care should be fair, solidarity driven and sustainable.

For each of these priority areas, more specific details have been elaborated. It is worth noting that one of the objectives in the first priority area is to establish health impact assessments for governmental policies and activities, tying in with the focus of this assessment. The key opportunities and challenges for a future KTP, considering the organization and governance of the health system are summarized in Box 3.1.

Box 3.1 Summary of the key opportunities and challenges for a future KTP considering the organization and governance of the health system

Opportunities provided by a KTP

- A KTP can be a forum for direct and open exchange of views among all stakeholders (including professional, patient, and health care organizations).
- A KTP can help set policy priorities to be studied and discussed among stakeholders

Challenges for a future KTP

- Unclear accountability relationships in the health care system can be a significant barrier to the drafting and implementation of solutions to prioritized issues.

3.2 Health financing

The HIIS is the single payer for health services, providing compulsory health insurance coverage. The compulsory health insurance scheme is complemented by a voluntary health insurance scheme which insures against co-payments. The overwhelming majority of the population in Slovenia is enrolled in this type of voluntary health insurance, which is tightly regulated (Albreht et al., 2016). Expenditure on health in the country represented 8.5% of GDP in 2014 (OECD, 2017). According to OECD data for the same year, approximately 71% of health expenditure was financed through public sources, including 68% through the HIIS. The share of private expenditure was about 29%, including 16% represented by voluntary health insurance and 13% represented by out-of-pocket payments (OECD, 2017).

Long-term financial sustainability of the health system is a significant concern in Slovenia. Several cost-reduction policies have been introduced (including, for instance, a cap on recognized costs of medications within a therapeutic group with similar pharmacologic effects). Action has been taken on the revenue side, broadening the range of eligible sources of income that require the payment of health insurance contributions. In the past few years, financing of hospitals has been significantly reduced, although the requirements in terms of volume of services have remained the same (Albreht et al., 2016; Cylus, 2015). Both the HIIS' and the Ministry of Health's activities have been significantly limited by austerity measures undertaken since the financial crisis that hit Slovenia in 2009.

Four key issues need special attention, as they have a significant impact on health financing in Slovenia (Thomas et al., 2015).

1. There is a heavy reliance on payroll taxes in terms of public spending, with a very low share of contribution from the government budget.
2. Insufficient counter-cyclical mechanisms exist to mitigate the effects of economic cycles, which have had a serious impact on revenues collected through the financial crisis which started in 2008.
3. A generally equitable and accessible health system is required.
4. A growing problem is that of long-term care, which will require increasingly more health system resources.

The National Health Care Plan for 2016–2025 calls for a revision of the contribution scheme for compulsory health insurance, to also include other types of income (such as income from capital). It also calls for earmarking part of the excise duty on alcohol and tobacco for health promotion and disease prevention, along with a remodelling of the complementary health insurance scheme to increase equity and fairness in the health system (Ministry of Health, 2016).

3.3 Delivery of health services

The health care system is characterized by a strong primary care network, acting as a gatekeeper to secondary health services (Kringos et al., 2013; Albreht et al., 2016). The number of hospital beds per capita in Slovenia is below the EU average. Slovenia faces challenges in the coordination of services, particularly between primary and secondary care and between providers of primary and secondary care on the one hand and providers of long long-term care on the other (Nolte et al., 2015).

There are far fewer physicians than the EU average (2.5 physicians per 1000 people in Slovenia compared to an average of 3.4 physicians per 1000 people in the EU in 2012) (Ministry of Health, 2016). The shortage is felt particularly with personal physicians;[1] this potentially impacts on the quality of care, as they are in charge of many patients. The Ministry of Health recently stated its commitment to reduce the average number of patients per personal physician (Delo, 2016).

Slovenia has one of the lowest neonatal mortality rates among OECD countries, and vaccination rates for diphtheria, tetanus and pertussis and measles, are about the same as the EU average (about 95%) (Ministry of Health, 2016). This can be taken as an indicator of a good disease prevention system.

The health care system is underdeveloped in terms of quality monitoring and assurance, as well as health technology assessment (Ministry of Health, 2016).

[1] Personal physicians are general practitioners or family medicine specialists, who are the most frequent primary contact for patients with the health care system, acting as gatekeepers.

4. NATIONAL HEALTH RESEARCH SYSTEM

» *This section on the health research system describes key stakeholders, structures, processes and funding mechanisms, as well as key research areas in health research.*

This chapter explores the organization of the health research system and looks at human resources, along with financing and producing research. The focus of the analysis is on public health research and more specifically on health system research, which is the area most often involved in health policy issues. Understanding the broader context for research – including the quality of research, as well as how research priorities are established and how they include the key decision-makers – allows research priorities to be better aligned with policy priorities the use of research in policy-making to be increased.

4.1 Infrastructure and stewardship of health research

As measured by number of publications, Slovenia has a well-developed research sector compared to other EU countries (Glavič Novak & Perdih, 2014). No specific research strategy in the area of health systems or health exists. However, a more general Resolution on the National Research and Development Programme 2011–2020 exists (since 2011), which also took into account the Slovene Development Strategy (relevant for the period 2005–2013) (Šušteršič, Rojec & Korenika, 2005). This resolution represents the framework for issuing grants by the Slovene Research Agency (ARRS). The ARRS also asks the Ministry of Health for recommendations on themes and research questions for a particular type of grants, related to applied research. In order to suggest themes, the Ministry of Health considers the research needs with a direct applicability in decision-making to professional/medical issues as well as legislation drafting. In addition, the Ministry "... sends informal queries about research proposals to key research institutions ..." (Poldrugovac et al., 2012:19).

This consultation phase mainly relates to immediate, short-term research proposals. The broad strategy does not indicate specific areas for health and health systems research, which highlights a gap between long-term strategy and actions taken. Stakeholders are experiencing the need for more transparent, open and regular discussion on priorities for both health policies and health research (see subsection 1.3). Moreover, the allocation by the ARRS of research grants for medical and health sciences is subject to competition between subdomains in the health sciences. It is also important to note that the Resolution on the National Research and Development Programme 2011–2020 states that Slovenia has (unfortunately) not yet developed a comprehensive system for the ex-post analysis of scientific results, which could be used to evaluate the impact of research funded by the state.

4.2 Human and financial resources for health research

According to the Statistical Office of the Republic of Slovenia (SURS), in 2012 over €928 million was spent on research and development. Approximately €578 million of those funds was provided by the private (business) sector and €703 million used for research and development by the same sector. No clear-cut data are available on expenditure and funding specifically of health systems research. It is only known that 2.64% of the €928 million (€24.5 million) was dedicated to medical and health sciences.

Grants by the ARRS are a major source of research funding. In 2013, 9% of its budget was dedicated to the area of medical and health sciences. Aside from funding, the ARRS also has a programme for infrastructure financing and a junior researchers' programme (Glavič Novak & Perdih, 2014). The ARRS monitors the "usefulness, innovation level, efficiency, quality competitiveness and professionalism of the work" (ARRS, 2005) that the Agency is financing.

Another important source of financing for health systems research is the European Commission, although co-financing by national institutions is often necessary. Higher education institutions have budgets which include some resources for research, however modest, in addition to those received from the ARRS and other external sources.

In the area of health systems research, the HIIS and voluntary health insurance companies, as financiers of tertiary institutions, partly finance the research activities of tertiary institutions. Tertiary institutions are providers of health care services and as such are often involved in research and education. Prominent examples of such institutions involved in education and research are the university medical centres in Ljubljana and Maribor, as well as the NIPH (HIIS, 2013).

Objective data are lacking on the number of researchers leaving the country. However, brain drain has been on the policy agenda for several years and was recognized in the strategy on economic migration of 2010 (Ministry of Labour, Family, Social Affairs and Equal Opportunities, 2010). Public research organizations have to remunerate their staff, including researchers, according to the regulation for public workers (Civil Servants Act, 2007). This regulation is rather rigid and does not offer much room for financial incentives and other benefits for successful researchers, which is sometimes mentioned as a possible reason for the field's brain drain. The junior researchers' programme financed by the ARRS has provided an incentive to the inclusion of young talents in established research groups (Perdih & Glavič Novak, 2013). These considerations are not specific to health systems research; however they do affect this field as much as any other.

4.3 Producing and using health research

Most research institutions in the area of public health – including health systems research – are public and so is their funding. Only some of these institutions are active in the area of public health research. Identifying the number of research organizations working in health systems research is a challenge, primarily since universities enjoy a high level of freedom in setting their research programmes, and the country lacks an official list or even classification of research initiatives undertaken by institutions, related to health systems research.

The biggest research institution in the area of public health is the NIPH. All three universities in Slovenia are also active in this research area, particularly within their faculties of medicine, health sciences and economics. Other independent research institutions that may provide research inputs include the Jožef Stefan Institute, the Institute for Economic Research and the Angela Boškin Faculty of Health Care Jesenice.

In order to better coordinate research activities, promote collaboration between researchers from different fields and more effectively steer decision-making on research areas that need priority financing, research organizations established a self-governing Council on Research in Public Health in the autumn of 2013; however, considering that it has not met since, it is unclear whether the initiative will be successful in realizing its purpose.

The autonomy of the research community in Slovenia is highly valued. The autonomy of public higher education institutions is determined in article 58 of the Slovene Constitution. On the other hand, possibly because of this high level of independence, researchers in health sciences often respond to public calls for proposals (which may have a very specific purpose) by submitting high-quality and methodologically sound projects; however, these often fail to adhere fully to the specific purpose of the call.

The role of researchers in shaping policy proposals was the subject of lively discussion at the EVPINet Europe stakeholder meeting which took place on 9 February 2015 in Ljubljana. Participants noted how experts invited to participate in the policy-making process often perform dual roles, as scientists but also as employees, representatives of professional or other organizations, which can lead to potential conflicts of interests. It is common for such experts to offer their opinions, without a clear reference to evidence. For these reasons, participants at the stakeholders meeting emphasized the need for those who participate in the policy-making process as experts to be rigorous about offering scientific knowledge instead of opinions. The key opportunities and challenges for a future KTP, considering the national health research system, are summarized in Box 4.1.

Box 4.1 Summary of key opportunities and challenges for a future KTP considering the national health research system

Opportunities provided by a KTP

- A KTP can enable a broader spectre of stakeholders (provider organizations, civil society) to be included in the prioritization of evidence production for policy-making.
- It can also improve cooperation between researchers, policy-makers and other stakeholders, so that evidence presentation is better suited to their needs.

Challenges for a future KTP

- Reducing the frequency with which legislation and policy proposals are prepared – without extensive stakeholder cooperation – can be difficult.

5. EIP PROCESSES

- *This section on EIP processes presents an overview of current EIP efforts and insight into how the health system and the health research system interface within these.*

This chapter analyses already established country practices concerning the use of evidence to inform health decisions or policies, specifically looking at key players and good practice examples. In general, knowledge translation entities are not established in countries that have recently signed up for EVIPNet membership and where systematic, transparent mechanisms for EIP are missing. However, the use of research knowledge and evidence can play a role in the policy-making process, for example through ad-hoc consultation of (research) experts, the occasional referencing of scientific papers in policy proposals or a tradition of preparing policy briefs. These types of efforts are a starting point on which to build further EIP efforts.

The decision of a country to engage in EVIPNet may be interpreted as an expression of willingness to further develop EIP. In particular, the Slovene decision to engage in EVIPNet is a clear indication of the intention to enhance capacity in EIP, with the binding Resolution on legislative regulation (2009) emphasizing the importance attributed to EIP. Yet, at the same time, policy decisions – which often need to be made at short notice – are not always supported by rigorous scientific input, demonstrating the gap between stated intentions and actual practice.

5.1 Major actors

The Ministry of Health plays a central role in preparing and implementing health policies and it coordinates the process through which those policies are defined. The Ministry also co-finances research projects it deems necessary for the development of policies for which it is responsible. Besides the Ministry of Health, many other stakeholders influence health policy decisions, such as the HIIS, the National Assembly, other ministries, professional associations, provider organizations and their representative bodies. For example, the strategy for the development and comprehensive governance in the areas of obstetrics and gynaecology (Ministry of Health, 2010b), supported by the Ministry of Health, was not approved by the Committee on Health of the National Assembly.

The NIPH is an independent public health institution. It is the major public health data collection and processing centre in Slovenia, providing expert advice on public health issues to the Ministry of Health (Health Care Act, 2005). It has a strategic plan (NIPH, 2010) but its relevance in policy-making depends mostly on whether the Ministry asks ad hoc for its input on specific issues or provides funding for research and policy briefs. The NIPH is often the de facto knowledge translation institution for public health issues, playing this knowledge translation role at times by "pushing" evidence on public health issues, through the organization of events and publications. On other occasions, such knowledge and evidence is "pulled" by the Ministry of Health, to synthesize and package evidence on issues on the Ministry's policy agenda.

The Ministry of Health is also supported by expert advisory councils. These advisory bodies have very limited direct decision-making authority (Rules on the composition and functioning of the General Expert Collegiums, 2002; Rules concerning the Health Council, 2001) and have no research agenda. The general expert collegia are composed of high-level experts, advising in different domains of medicine and health sciences. It is difficult to estimate the weight and credibility of general expert collegia. In 2012 the Slovene Medical Association set up a number of professional councils in response to a perceived increased bias of the general expert collegia. This bias was derived from the Ministry of Health taking a prevalent role in the appointment of collegia members (Zupanič, 2012). This could be interpreted as indicating a decreasing importance in terms of the role of general expert collegia. In contrast to these bodies, the Health Council is a general advisory body that

focuses more on health system issues in the country. The mandate of the Health Council is linked to the mandate of the Minister of Health. New approaches – strictly limited to the professional sphere of one specialty – are evaluated and approved nationally by the general expert collegia, while broader changes need to be approved by the Health Council (Rules concerning the Health Council, 2001; Rules on the composition and functioning of the General Expert Collegiums, 2002). The NIPH does not have a formal direct relationship with these professional bodies. It does, however, turn to them whenever their input is needed, according to applicable laws and regulations.

Professional organizations in health care (such as the Medical Chamber of Slovenia, among others) are well organized, well coordinated and influential in the policy-making process. Such organizations are rarely involved in research projects, but their recommendations (e.g. clinical guidelines) can have a huge impact on policies. The organizations are actively involved and can exert pressure on policy-making processes. For example, a meeting was jointly organized in December 2015 by the Medical Chamber and the Association for the health of the people, with participation by other organizations, such as the Trade Union of Doctors and Dentists and the Slovene Medical Association. At the meeting the organizers called for the Minister of Health to step down, based on a fundamental difference in opinion on the future development of the health care system (Košak, 2015).

As representatives of civil society, patient associations are very active in Slovenia. The umbrella organization for patient associations called Network NVO 25x25 is gaining in importance.

The HIIS is another influential actor. The Strategic Development Programme of the Health Insurance Institute of Slovenia for the period 2014 to 2019 reveals how policy decisions and financing of health care services are closely interrelated. Furthermore, international organizations (such as WHO, the OECD, the European Observatory on Health Systems and Policies, the European Commission, the European Council, the European Parliament and the European Centre for Disease Prevention and Control) influence policy-making priorities and processes through the support they provide.

5.2 Current country examples

Slovenia can provide examples of EIP in health. These examples represent promising but individual attempts at bridging the knowledge and/or policy gap and are not part of an effort to systematically implement knowledge translation.

- Between 2003 and 2006 the ARRS, in agreement with the Ministry of Health, financed a research programme in the area of nutrition to support the preparation of the national nutrition policy. A number of research projects were developed. The Ministry of Health makes reference to two projects in particular, which suggested a series of concrete actions in the area of nutrition policy.
- The 1980s were characterized by considerable opposition to the use of methadone therapy for heroin addiction. Despite increasing evidence about the effectiveness of substitution treatment, in 1991 psychiatrists' representative organizations were still recommending to abandon the use of methadone in the country. Nolimal & Nolimal (2014) describe how a working group – initially established to monitor the problem of illicit drug use – increasingly engaged in knowledge translation activities, using different approaches to present the evidence to decision-makers and the media. These efforts resulted in the reintroduction of methadone substitution treatment in 1994.
- Slovenia can provide good examples of the development and use of policy briefs, which aim to provide policy support by summarizing evidence, such as ***Health-related youth behaviour in Slovenia – challenges and answers*** (Koprivnikar et al., 2014), ***Alcohol policy in Slovenia. Opportunities for reducing harm and costs*** (NIPH, 2015a) and ***Tobacco free Slovenia – when***? (NIPH, 2015b). All three documents were prepared by the NIPH, often in close collaboration with the Ministry of Health. The publications seem to fulfil most of the BRIDGE criteria to assess a mechanism's capacity to package information (Lavis, Catallo, Permanand et al., 2013). The policy brief on tobacco was strongly supported by the Ministry of Health, and was used to convince other stakeholders in general terms of the necessity of a new bill on tobacco control, more than as a tool to decide on the best policy options to include in the bill.

- Information products to support policy-making are also produced by the National Diabetes Prevention and Care Development Programme 2010–2020 (Ministry of Health, 2010a).
- The major policy document in the health field is the National Health Care Plan, periodically adopted by the Slovene Parliament. It sets out the development strategy for health and must be based on the health status and the health needs of the population (Health Care and Health Insurance Act, 2006). Recently the Ministry of Health commissioned a large-scale health system review that was used to inform the National Health Care Plan for the period 2016–2025. The health system review was headed by the WHO Regional Office for Europe and the European Observatory on Health Systems and Policies, with the participation of several national experts and representatives of stakeholders' organizations. The review resulted in the publication of a series of reports analysing the Slovene health system, including papers on health system expenditure (Cylus, 2015), purchasing and payment (Quentin et al., 2016), optimizing service delivery (Nolte et al., 2015), evaluating health financing (Thomas, Evetovits & Thomson, 2015), making sense of complementary insurance (Thomas, Thomson & Evetovits, 2016) and long-term care (Normand, 2015). The findings of each of these reports provided an evidence-based starting point for discussions among stakeholders, which were taking place at the same time as the reports were being drafted. The collection of both published and tacit knowledge resulting from these activities led to the formulation of the National Health Care Plan that was passed by Parliament.

6. MAKING SENSE OF THE CURRENT EIP SITUATION

» *This section builds on chapters 2 to 5 and identifies key supporting factors and challenges to strengthening EIP.*

At this stage Slovenia does not have an infrastructure or platform to bridge the gap between policy-making and research in a systematic, sustainable manner. Currently, the country lacks capacity to effectively and consistently introduce evidence at the political level, as well as at the level of central public administration, thus missing out on opportunities to design successful policies, and to foster the efficient use of public and private resources through those policies. However, Slovenia has put in place regulatory frameworks that offer a basis to develop EIP, institutionally. The Resolution on legislative regulation (2009) and the Decree on the documents of development planning bases and procedures for the preparation of the central government budget (2007) offer a framework to enhance EIP in public health and health systems in Slovenia. Proposals should include an appraisal of the likely environmental, economic and social impacts, and an assessment of the monetary costs and consequences, particularly in terms of administrative costs of the proposed regulation. Such ex-ante impact assessments of policy proposals aim to improve the quality of new legislation, simplify it and consider the effectiveness of interventions, using evidence.

The Decree on the documents of development planning bases and procedures for the preparation of the central government budget (2007) also emphasizes strongly the importance of the coherence and consistency of any policy document with existing strategies and policies, particularly major national strategies, such as the Slovene Development Strategy (Šušteršič, Rojec & Korenika, 2005). All of these documents emphasize the importance of civil society participation in the policy-making process and set out relevant recommendations. However, in order to strengthen the coherence of various policy documents and the role of civil society in EIP and to avoid these regulations becoming merely symbolic, a few key challenges must be tackled. One key recommendation has already been formulated, with regard to the need to develop monitoring and evaluation capacity (including indicators) of policies and programmes in public administration (OECD, 2012). If we assume that monitoring and evaluation support accountability in the policy-making process, then it could also be an incentive to improve the adherence to the policy-making regulation of those in charge of the process.

A particular challenge for Slovenia is the coordination of policy and research priorities, including how and when to involve all relevant stakeholders. Currently, public health research activities are not always in line with policy priorities. In order to optimize the relevance of health research for the decision-making process, more dialogue and participation on emerging public health questions should be facilitated and short- and medium-term plans for policy and research priorities developed. The findings in previous sections show that several documents outline strategies in the area of research, but none provide specific research questions or fields related to public health or the health system. This limitation has already been recognized by representatives of research institutions in the Council on Research in Public Health.[1] In addition, the future engagement and research work of national institutes with regard to public health and health system development should be well coordinated to ensure a smooth reorientation of the research budget.

The challenge of enhancing EIP capacity is directly related to the question of setting medium- and long-term goals for public health research. The multidisciplinary nature of research in public health has important implications, as it often requires a particular skill set related to communication and collaboration between individuals and organizations with different backgrounds. For these reasons, capacity-building, increasing trust and collaboration among all stakeholders (including decision-makers), and acknowledging the multidisciplinary nature of public health have been strongly emphasized by participants throughout the stakeholders' consultations. It should also be remembered that international excellence of research is frequently measured solely by citations and papers, while social and economic relevance is often ignored (ERAC Policy Mix Expert Group, 2010). Strengthening the cooperation between the research community and policy-makers could therefore also become a criterion of scientific excellence.

[1] This recognition was officially recorded in the unpublished minutes of a meeting of research organizations active in the area of public health (19 April 2013).

7. EIP INSTITUTIONALIZATION CONSIDERATIONS

» *This section describes the reasons out of which the need to institutionalize EIP arises and outlines some of the features of an institutionalized EIP process in the country.*

Participants at the EVIPNet Europe workshops (December 2014, February 2015) emphasized the lack of a sustainable infrastructure to systematically engage stakeholders. They pleaded for the development of a KTP, which would enhance regular dialogue between researchers, policy-makers and other stakeholders, for example enabling evidence and research priorities to be shared, along with public health needs and stakeholders' perspectives on health-related issues. Moreover, a KTP would involve key individuals – possibly opinion leaders – to champion its cause (WHO Regional Office for Europe, 2015b). A KTP can thus become a catalyst for building trust among stakeholders, while being a trusted source of evidence itself. It can help bridge the gap between policy-making and research by tackling several issues, including:

- ensuring timely production of EBPs by establishing a standardized framework for commissioning and producing these briefs – such a framework would simplify the resource allocation process and create a more predictable environment for the planning processes of research institutions;
- commissioning relevant studies and analyses that directly address high-priority policy issues at hand;
- supporting capacity-building, particularly among researchers and policy-makers, on how to use push and pull efforts more effectively in order to foster change;
- ensuring that tacit knowledge is included in EBPs by conducting policy dialogues – the latter are important in supporting democratic decision-making processes and fostering a sense of ownership among participating stakeholders;
- building trust among researchers, policy-makers and other stakeholders by coordinating activities and facilitating open discussions;
- raising awareness about the importance of a transparent and systematic policy-making process that is informed by evidence and supported by stakeholders.

The main users of KTP products should be health decision-makers, such as the Ministry of Health, the HIIS and the Committee on Health of the National Assembly.

At the EVIPNet Europe workshop in December 2014, stakeholders also discussed the potential future location of the KTP. The Ministry of Health was seen as lacking the requisite human resources needed to run the KTP. Among the research institutions in public health, the NIPH covers the broadest range of themes, but does not have expertise in all the fields of public health (including health systems research). Professional organizations, in particular the Medical Chamber, have presented comprehensive reform proposals in the past (Medical Chamber of Slovenia, 2014). However, by representing individual stakeholder groups, professional organizations might be perceived as being biased.

The establishment of a steering group, similar to the coordination group for the implementation of the National Diabetes Prevention and Care Development Programme 2010–2020 (see subchapter 5.2), represents a possible approach – requiring leadership and enthusiasm among participants in order to be successful. The coordination group was formally appointed according to the established practices, ensuring that a wide variety of stakeholders are represented. One of the keys to the success of the coordination group seems to lie in strong engagement of leaders within the involved professions, as well as within the Ministry of Health, which keeps the implementation of the National Diabetes Prevention and Care Development Programme 2010–2020 high on the work agenda of most stakeholders.

Similarly to the Ministry of Health, the HIIS needs evidence, specifically in order to make decisions in health care financing and health services provision. It does not have the required characteristics to undertake a knowledge translation role (HIIS, 2016). A discussion platform could be provided by the Council on Research in Public Health, in which most public health research organizations are represented. However, the Council has been inactive in the past few years and it is unclear whether it could gain sufficient momentum to set up a KTP. In addition, the Council on Research in Public Health has neither the staff, nor the financial resources for the institutionalization of the KTP.

The KTP would need to take into account evidence, including stakeholders' tacit knowledge (through stakeholder consultations). It is expected that the KTP findings would therefore be carefully considered by decision-makers. The organizational model for the KTP should follow the BRIDGE criteria (see Table 7.1). As emphasized by these criteria, it is important that a KTP is guided by principles and values such as independence, transparency and the use of rigorous methods of analysis (of the evidence and of policies). The objectives that the KTP will pursue should include (Lavis, Jessani, Permanand, et al., 2013:8–9):

- inform[ing] policy-making in an objective manner using the best health systems information that can be prepared and packaged given time and resource constraints;
- inform[ing] the production, packaging and sharing of health systems information in an objective manner and based on current and emerging policy-making priorities; and
- employ[ing] and continuously improve[ing] information-packaging and interactive knowledge-sharing mechanisms that are based on a solid understanding of all aspects of the national policy-making context, operate in an objective manner, and complement other national, European and global mechanisms.

Table 7.1 BRIDGE criteria to assess an organizational model for knowledge translation

How the KTP model is governed	
1.	The organizational model should give policy-makers, stakeholders and researchers an explicit role in its governance and ensure they exercise their role with transparency and objectivity.
2.	It should encompass and enforce rules that ensure independence in how health systems information is produced, packaged and shared, as well as addressing conflicts of interest.
How it's managed and staffed	
3.	The model should grant the director the authority needed to ensure the accountability of the entire organization to its knowledge translation mandate.
4.	It should ensure an appropriate size, mix and capacity of staff with knowledge translation responsibilities.
How the KTPs resources are obtained and allocated	
5.	The organizational model should ensure an appropriate size of budget and mix of funding sources for knowledge translation activities (e.g. contributions from regional and national policy-making authorities, competitively tendered awards, and an appropriate endowment).
6.	An explicit approach should be outlined for prioritizing knowledge translation activities and accepting commissions or requests from policy-makers and stakeholders.

Table 7.1 Contd.

How it collaborates	
7.	The KTP should be located within another organization or network that supports its activities.
8.	It should collaborate with other knowledge translation organizations.
9.	It should establish functional linkages with policy-making and stakeholder organizations (e.g. rapid-response functions, exchange programmes and other mechanisms to support responsive relations).

Source: adapted from Lavis, Jessani, Permanand et al., 2013.

A further step in the development of policies is the design, piloting and implementation of a more radical approach to health issues, known as breakthrough solutions. Participants in the EVIPNet Europe workshop in December 2014 found that such developments are typically more complex and labour-intensive than the usual policy upgrades, which seek to only optimize the use of existing structures and maximize the efficiency of existing processes in order to achieve better health for the population. More complex changes require authority to modify not only professional guidelines, but also rules and regulations, investments, health workers' training, and so on.

On the one hand, the global financial crisis had a strong impact in Slovenia (The Economist, 2013) and despite recent improvement in GDP figures (SURS, 2017), the need for stabilization of public finances is still pressing (Jenko, 2014; STA, 2014). This is an obstacle to new projects requiring additional funding, and a source of political instability. In addition, the current austerity climate is a considerable barrier to allocating new (human) resources to these activities, and the Fiscal Balance Act (2012) introduced also several barriers to new employment in the public sector. A more optimistic observation is that in the past, WHO has been very helpful in the capacity-building process, including through the activities of EVIPNet Europe.

8. NEXT STEPS

Concrete recommendations to implement EIP and knowledge translation in Slovenia have been formulated. A neutral, independent KTP is considered to be important infrastructure to structure and enhance regular dialogue between stakeholders, policy-makers and the research community in order to share evidence and research priorities, public health needs and stakeholders' perspectives on health-related issues. Some actions have been put forward based on the situation analysis, promoting the institutionalization of knowledge translation and EIP.

The recommendations of the 2009 Resolution on legislative regulation imply high expectations about the quality of policy and legislative proposals. As the main source of policy and legislative proposals, the Ministry of Health has the opportunity to serve as the main promoter of knowledge translation: commissioning, endorsing and publishing EBPs, as well as catalysing their use.

Strong political commitment, a clearly defined strategic direction, as well as human and financial resources will be paramount for the KTP's success and operational sustainability. At the same time, training and capacity development in the country needs to be enhanced, as it is becoming increasingly clear that some aspects of EIP require a specific skill set in knowledge translation. A limited number of individuals within the NIPH have already been trained in knowledge translation, but these activities will need to be expanded and consolidated. Knowledge and skills of both research producers and users need to be strengthened throughout the country to ensure that a culture for EIP is being formed and knowledge translation activities – such as identifying, accessing, appraising, synthesizing and using the best available research evidence in health policy-making – will become routine processes. For such purposes, EVIPNet knowledge translation tools (e.g. for developing EBPs) need to be adapted to the Slovene context and made available to a variety of local stakeholders.

In the meantime, for as long as a KTP is not institutionalized, health policy issues can be supported by engaging policy and research partners in the development of KTP outputs, such as EBPs and policy dialogues. From its launch, the KTP needs to plan and implement concrete knowledge translation activities (including the aforementioned EBPs and policy dialogues) in order to shape expectations and develop tangible results. Part of the future KTP will be to coordinate and facilitate exactly these types of mechanisms, including their promotion among a broad stakeholder audience. It will be essential to ensure the KTP's visibility and increase awareness of the need and usefulness of knowledge translation activities. Eventually an official mandate (by law or regulations) of the KTP needs to be developed.

The KTP will need to engage from the start with international stakeholders and the international knowledge translation community, including EVIPNet Europe. The Network's support for capacity-building activities, along with its technical support, will be instrumental, particularly in the initial years of the KTP's operationalization.

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World Health Organization Regional Office for Europe
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
E-mail: contact@euro.who.int