3 An inclusive, healthy, safe and responsible society

Social inclusion, participation in social life and gender equality have all improved in recent years, which indicates a society that is developing towards becoming inclusive. Although the material conditions have improved for the majority of social groups (broken down by gender, education, etc.), improving the social inclusion of the older population remains a challenge, with the risk of poverty particularly high among women. Considering the ageing of the population, it is particularly important to increase employment and social participation among the older population. To improve the socio-economic status of youths, meanwhile, it is necessary to increase participation in the labour market and in particular reduce labour market segmentation, which predominantly affects youths and may also influence their decision on whether or not to start a family or explore job prospects abroad. In the future, the capacity to provide decent living conditions will be significantly affected by demographic change, which will reduce the supply of labour and hence exert a drag on economic development; demographic change will also require adjustment of social protection systems as age-related expenditure rises. The overall health of the population is improving, although healthy life expectancy remains fairly low. Progress in this field will rely primarily on how the health care system performs in improving lifestyles, reducing inequalities in health and shortening waiting times.

3.1 A decent life for all

A decent life for all (development goal 3)

The aim is to provide for a decent life for all generations. To realise the goal, it is necessary to ensure appropriate income levels for a decent life by creating work opportunities and putting in place targeted social transfers which reduce the risk of social exclusion, by establishing sustainable social protection systems, by improving the quality of the living environment, by strengthening cooperation and solidarity, and by eliminating all forms of discrimination. Demographic change requires adaptation on the part of society and of the systems of social protection. Realisation of the decent life goal is contingent on the implementation of the development goals of a healthy and active life (development goal 1), a competitive and socially responsible business and research sector (development goal 6), an inclusive labour market and high-quality jobs (development goal 7), and sustainable natural resource management (development goal 9).

Performance indicators for development goal 3:

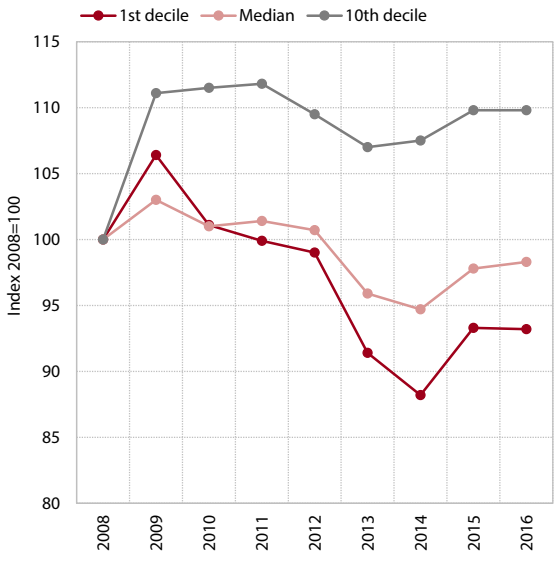
	Latest value		Target value for 2030
	Slovenia	EU average	
The risk of poverty or social exclusion, in %	18.4 (2016)	23.5 (2016)	< 16
Income inequality, quintile share ratio (80/20)	3.6 (2016)	5.1 (2016)	< 3.5
Personal experience of discrimination, in %	13 (2015)	21 (2015)	< 10

3.1.1 Impact of material conditions

The risk of poverty or social exclusion has been decreasing in recent years and in 2016 reached a similar level to that before the crisis. Among the three elements of social exclusion, two were still higher in 2016 than in 2008, the risk of poverty and the percentage of people living in households with low work intensity, whereas severe material deprivation was lower (see Indicator 3.1). In the last two years, the risk of social exclusion was reduced because of improvements on the labour market and the return of economic growth, the partial relaxation of austerity measures in social transfers, and the reintroduction of grants for underage pupils. Despite the improvements, however, 371,000 people were still at risk of social exclusion in 2016, with the high risk of poverty among older women particularly worrying.

Gross adjusted disposable income and actual individual consumption returned to growth in the last two years. This is attributable to improvements on the labour market as a result of more robust economic activity. The economic crisis reduced household incomes in lower income brackets more than in higher brackets, but when growth returned (after 2013), incomes in the lower brackets increased faster than those in higher brackets. We believe this is the result of activities that employ lower-skilled workers being affected more severely by the economic crisis. Between 2008 and 2013, the share of income of the first quintile dropped largely because of lower income from employment, as the crisis reduced employment the most among the lower-skilled and those on temporary contracts (low wages). Consequently, in the first quintile social benefits (effect of automatic stabilisers) and income from self-employment increased, including due to necessity-driven self-employment and the promotion of self-employment with active employment policy measures. Since 2013, on the other hand, the incomes of the bottom quintile have increased faster than those in other income brackets. We believe this trend has been driven largely by growing

Figure 16: Real growth in disposable income per household member in selected income brackets



Source: SI-STAT Data Portal, 2018; calculations by IMAD.
Note: Data for an individual year refer to the previous year's income.

Table 2: Share of types of income in 1st, 3rd and 5th quintiles in disposable income, Slovenia

In %	2008			2016		
	First quintile	Third quintile	Fifth quintile	First quintile	Third quintile	Fifth quintile
Income from employment	5.6	18.8	37.9	4.8	19.1	38.2
Income from self-employment	11.8	14.8	40.7	15.0	15.6	33.8
Pensions including bonuses	16.8	18.6	25.6	14.3	18.9	26.5
Family allowances	21.4	18.9	16.6	24.7	21.7	12.3
Social benefits	25.5	19.7	14.8	28.0	18.6	16.0
Other	8.9	19.7	35.1	5.6	12.7	58.0
Equivalent disposable income	10.0	18.6	33.5	9.5	18.7	34.0

Source: SURS, SILC.
Note: Other includes income from capital, difference between received and given transfers among households, children's income, property tax, and difference between income tax payments and refunds.

employment of the lower-skilled – i.e. those most likely to have been dismissed during the crisis. Consequently, the consumption of households with the lowest incomes has been growing faster than that of households with higher incomes. Gross adjusted disposable income per capita was 78.2% of the EU average in 2015 (the last year for which data are available), the gap to the EU average being wider than ten years ago. Similarly, actual individual consumption per capita (in PPS) reached 78.4% in 2016. However, the gap to the EU average in both indicators widened at a slower pace than the gap in per capita GDP (see Indicator 1.1).

Income inequality is very low, whereas wealth inequality is almost at the euro area average. Income inequality increased slightly in the last 15 years, but it remains among the lowest in the EU due to the strong impact of high progressivity of income taxation (see Indicator 3.2). ECB data show Slovenia slightly below the euro area average by gross wealth distribution in 2014. A similar picture emerges in the share of gross wealth of the wealthiest 20% of households, which amounts to 62.3% (euro area: 65.0%). The poorest fifth of households has 0.5% of total wealth.

Accessibility of health services, an indicator of quality of life, is undermined by longer waiting times. In the Slovenian health care financing system, direct payments are relatively low (see Indicator 3.20)[57] and significantly below the EU average, so that even households with the lowest incomes do not face catastrophic health expenditure.[58] However, differences in health expenditure increased markedly in the past decade, in particular during the crisis and from 2012 to 2015, when waiting times also increased rapidly. This may lead to health inequality, as those with higher income[59] are more likely to be able to afford out-of-pocket payments. That waiting periods are a major problem is also evident from the indicator of unmet needs for medical treatment, which are rarely associated with financial reasons but are most frequently a result of waiting periods.[60] Measures were therefore adopted in 2016 and 2017 to manage waiting periods.[61]

Providing long-term care is becoming increasingly challenging. The number of recipients of long-term care has been increasing for several years and exceeded 61,000 in 2015. Just over a third received institutional long-term care, the rest being in home care.[62] Measured by the participation of total population in long-term care, Slovenia exceeds the average of 23 OECD Member States,[63] but it is widening its gap in terms of participation of the population aged over 65 (2015: Slovenia: 11.6%, OECD 18: 13.0%). Home care is the least developed segment and the one in which Slovenia lags farthest behind as measured by the participation of persons over 65.[64] Inadequate long-term care is a burden on families and increases the demand for health care services. Systemic regulation is therefore needed as soon as possible.

Slovenia is no exception in that the income status of individuals across all age groups affects the

[57] According to WTO recommendations, out-of-pocket expenditure is acceptable until it reaches roughly 15% of health expenditure; in Slovenia is was 12.6% in 2016.
[58] Ministry of Health, WHO, European Observatory on Health Systems and Policies, 2015.
[59] Zver, E. and Srakar, A., 2018.
[60] According to the EHIS survey, in 2017 waiting periods were the reason for 19.6% of unmet needs related to health care among the total population, which approximately corresponds to the available data on the number of all patients on waiting lists. In 2017 the government adopted a special programme for the reduction of waiting periods, which continues in 2018. The number of all persons on waiting lists rose by 1.6% from 1 January 2017 to 1 January 2018 (from 229,814 to 233,475), of which the number of those waiting longer than admissible rose from 40,648 to 58,887 (National Institute of Public Health, 2018).
[61] To improve the accessibility in certain programmes, the government earmarked additional funds of EUR 7.9 million in 2016 in the framework of the One-Off Additional Programme; in 2017 and 2018 a special government project for the reduction of waiting periods and increased quality of health treatment was conducted.
[62] These persons receive home care (21,600) or just a cash allowance (16,600). The actual number of recipients of a cash allowance is significantly higher (over 41,000), but in the final tally of recipients the rule of double counting is used: a recipient receiving both the service and the cash allowance is only counted once.
[63] In 2015 it amounted to 3.0% (OECD: 2.5%) (OECD Stat, 2018). For Slovenia the number of recipients of long-term care includes recipients of community health nursing (more in Nagode et al, 2014).
[64] The share of those over 65 receiving home care was 58.8% in 2015 (OECD 16: 66.8%) (Health at a Glance, 2017).

accessibility of education, which is otherwise relatively good overall. Participation of children in pre-school is above the EU average, which contributes to a high share of women in full-time employment. Although participation of children is lower in lower income brackets than in higher ones, the difference is smaller than in the EU on average, which indicates that accessibility is relatively good. The situation is similar when it comes to participation in after-school classes and other forms of organised care. Those in lower income brackets are more likely to have difficulties paying for children's care than people at the same income level in the EU generally.[65] Pupils from families with a lower socio-economic status achieve poorer reading, mathematics and science scores (see Indicator 2.3) and are more likely to enrol in vocational programmes, which reduces their social mobility. Participation of the lower-skilled (lower income) in lifelong learning is significantly below that of persons with tertiary education (higher income), which further reduces their employability.

Cultural activity and physical activity are strongly correlated with income status. Persons with lower incomes are least likely to visit cultural events or engage in amateur cultural activities. They are also less likely to do sports or work out, activities which affect overall wellbeing and health,[66] in which regard the difference between the lowest and highest income brackets, which is wider than in the EU on average, did not decrease significantly between 2012 and 2016.

Exposure to various kinds of discrimination may affect decency of life; in Slovenia, it is relatively low. Discrimination constitutes a breach of the right to equal treatment of an individual or group due to nationality, race, skin colour, gender, sexual orientation, religion, age, disability, education, social status or other personal circumstance; it may occur in fields including employment, education and access to goods. Long-term exposure to discrimination has a negative impact on the discriminated persons and groups in that it may lead to social exclusion and produce negative economic outcomes.[67] The share of persons who experienced any form of discrimination dropped in 2008–2015 and is lower than in elsewhere in the EU (see Indicator 3.3), but age discrimination (of those over 55) increased in 2012–2015, which is particularly worrying given future population ageing trends. Violence against women may be considered an extreme form of discrimination as well, and according to a pan-European survey on violence against women, its incidence in Slovenia is below the EU average.

[65] In Slovenia (2016), 17% of households in the first quartile (EU: 11%) and 7% of households in the fourth quartile (EU: 3%) have problems settling these expenses and the costs of formal education (textbooks, books, school materials, etc.).

[66] 36% of persons in the first quartile and 59% of persons in the fourth quartile do sports and exercise.

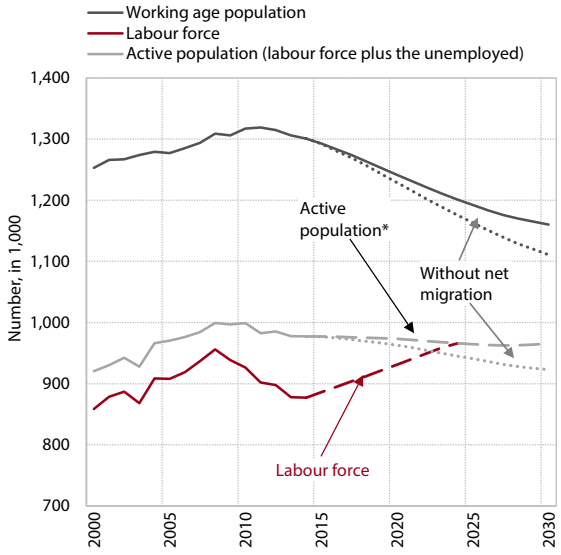
[67] Kogovšek, N. and Petković, B., 2007.

3.2.2 Impact of demographic change

In the future, the capacity to provide for a decent life for the population will be strongly affected by demographic change, which is very marked in Slovenia. Life expectancy is rising, the share of the older population is growing, the number of births is stagnating and net immigration is relatively low. Since 2011 the most active segment of the population (20–64 years) has been shrinking.[68] In the coming years, the pace of demographic change will only intensify. The latest population projections from 2015 forecast that the dependency ratio will rise by 20 pps by 2030 to 79.6%, which means that 80 children, youths and older persons will depend on 100 people aged 20–64.

Demographic change is reducing the supply of labour, which may become a drag on economic development in the future. As the demand for labour rises, employers increasingly face problems finding appropriately skilled workers, an issue that will only become more acute in the coming years. Assuming migrations remain modest, even higher employment of youths and the older population will not suffice to fully meet the demand for labour. And assuming labour market regulations and retirement conditions remain unchanged, the contraction of the population in the age group 20–64 will become a limiting factor to economic growth within the next ten years. Simulations of the

Figure 17: Scenarios of changes in the size of the working age population, labour force and active population



Source: Eurostat – ESSPOP2015; calculations by IMAD.
Note: *The simulation is based on the ESSPOP2015 population projections. The assumptions used for the labour force simulation are as follows: i) continued growth of the share of the highly educated, ii) equalisation of the (lower) employment rate of women with the (higher) employment rate of men by 2030, and iii) a 20-pps increase in the employment rate of the older population by 2030. For a detailed description of the methodology, see Peschner and Fotakis (2013, 2015).

[68] In 2016, their number was almost 40,000 lower than in 2011.

Table 3: Long-term projections of age-related public expenditure

	Share of GDP, in %							Change, in pps of GDP 2016–2070		
	2016	2020	2030	2040	2050	2060	2070	Slovenia	EU	EUs
Baseline AWG scenario[1]										
Total	21.9	22.1	23.9	26.6	28.8	28.8	28.3	6.3	1.7	2.1
Pensions	10.9	11.0	12.0	14.2	15.6	15.2	14.9	3.9	–0.2	0.2
Health care*	5.6	5.8	6.3	6.7	6.8	6.8	6.7	1.0	0.9	0.9
Long-term care**	0.9	1.0	1.1	1.4	1.7	1.8	1.8	0.9	1.2	1.1
Education	4.0	4.0	4.2	4.1	4.5	4.7	4.6	0.6	0.0	–0.1
Unemployment benefits	0.4	0.3	0.3	0.3	0.3	0.3	0.3	–0.1	–0.2	–0.2
Risk AWG scenario[2]										
Health	5.6	6.0	6.7	7.3	7.6	7.7	7.6	2.0	1.6	1.8
Long-term care	0.9	1.0	1.4	2.1	2.9	3.7	4.4	3.5	2.7	3.1

Source: The 2018 Ageing Report: Economic and Budgetary Projections for the EU Member States (EC), working version, March 2018.
Notes: [1] The baseline scenario for health expenditure accounts for the effects of ageing, the assumption that half of the additional years of life are spent healthy and, via an assumption about lower income elasticity of demand for health care services (1.1, which drops to 1.0 towards the end of the period), the effect of technological progress, albeit to a lesser extent. [2] The risk scenario for health expenditure accounts for the effects of ageing and assumes that half of additional years of life are spent in a healthy state. It also takes into account income elasticity of 1.4 (dropping towards 1.0 through the end of the period) and hence gives greater weight to the pressure of technological progress. Expenditure on long-term care accounts for demographic change as well as the assumption about the convergence of expenses and the increase in coverage of long-term care to the level of the EU average in 2070. EU – weighted average; EUs – simple average; *Public expenditure on health care according to SHA methodology but excluding expenditure on long-term care and including expenditure on investments according to COFOG methodology. **Total expenditure on long-term care according to SHA methodology (excluding expenditure on disability benefits, which had been included in previous AWG projections).

assumptions of demographic trends show that absent a net positive migration of foreign labour, the working age population, presently defined as the age group 20–64, would contract even if it were to be redefined as the age group 20–85.

Unless policies and systems change, population ageing will create significant problems in the provision of stable financing of social protection systems. Projections prepared by the European Commission in conjunction with Member States and released in February 2018 indicate that in the majority of Member States, age-related expenditure will rise even faster until 2060 than projections in 2015 suggested. For Slovenia, the forecast is similar to that in 2015 in that the country stands out in terms of a strong increase in overall age-related expenditure: by 6.9 pps of GDP by 2060 and by 6.3 pps by 2070. Long-term projections are thus a renewed warning that assuming a no-policy-change scenario, the effect of ageing on general government expenditure will be very strong and significantly above the EU average. The projected increase in pension expenditure is the area where Slovenia stands out the most, but it also exceeds the EU average in terms of growth in expenditure on health, education and unemployment. This is the result both of current systems and policies and of Slovenia's overall demography: until 2050 larger cohorts will retire and, given the increasing life expectancy, they will spend more years in retirement (assuming the current retirement conditions remain unchanged). At the same time, smaller cohorts will enter the labour market, severely worsening the ratio between pensioners and workers, which has been deteriorating since 2012 in any case. The long-term sustainability of public finances would come under even more pressure if public expenditure on health care and long-term care were to grow at a faster pace due to non-demographic factors (risk scenario).

Pension expenditure growth has been moderate over the last several years but ensuring the sustainability of financing and providing decent pensions remains a challenge. The new pension legislation (the ZPIZ-2), which entered into force in 2013, temporarily slowed down the increase in the number of old-age pensioners[69] and the number of other types of pensioners decreased as well. Temporary suspension of annual statutory pension indexation has also contributed to a moderation of growth in recent years. Yet despite several years of moderate growth, the transfer from the national budget to the ZPIZ remains high,[70] which indicates there are short-term problems with the financing of pensions. Long-term projections of pension expenditure indicate that spending as a share of GDP will start increasing again in a few years, reflecting a faster increase in the number of persons over 65 and a concurrent faster deterioration in the ratio of the active working population to pensioners. It is therefore of paramount importance that Slovenian residents be properly informed about the consequences of ageing and the rights stemming from mandatory insurance and

[69] We estimate that the rate of increase in the number of pensioners slowed down due to the effects of the adoption of the ZPIZ-2, as their number surged prior to adoption of the act and in the year after it was adopted. In the next few years the effect will gradually diminish, as those who had to defer retirement due to stricter conditions provided by the law start to retire. It is therefore expected that the retirement age of new retirees will gradually increase.

[70] The transfer from the national budget to the pension insurance fund amounted to EUR 1,163 million in 2017.

to promote saving for old age. Securing a decent level of pensions will become increasingly difficult. Although there is no uniform definition of a decent pension, OECD experts estimate it to be around 70% of pre-retirement income,[71] considering the minimum rights of low-income individuals. In Slovenia, the ratio for individuals with an average wage and 40 years of pensionable service is 58.8% for men and 65.4% for women.

[71] Antolin, P., 2011.

3.2 An inclusive labour market and high-quality jobs

An inclusive labour market and high-quality jobs (development goal 7)

The objective is to create an inclusive labour market that will provide high-quality jobs with high value added (see also goal 6). By implementing the concept of sustainable working lives and adapting jobs to demographic change, older workers will be able to work longer and their health will improve. An improving system of flexicurity and the promotion of employment of both sexes in professions atypical for their sex will enhance the participation of under-represented groups on the labour market.

Performance indicators for development goal 7:

	Zadnji podatek		Target value for 2030
	Slovenia	EU average	
Employment rate (20–64 age group), in %	70.1 (2016)	71.1 (2016)	> 75
In work at-risk-of-poverty rate, in %	6.1 (2016)	9.6 (2016)	< 5

After deteriorating sharply during the crisis, the situation on the labour market has improved in recent years, but participation of some groups remains only modest. The strong turnaround on the labour market was driven by an acceleration of the economic recovery and attendant job creation, in particular in activities with high value added. After 2013, the activity rate[72] increased as well, following several years of stagnation. As employment prospects improved, even persons who had been deterred from the labour market by a long period of low demand[73] returned to the workforce. The improvement is also evident from the employment rate, which in the second quarter of 2017 exceeded the EU average for the first time since the crisis (see Indicator 3.10). Despite the improved situation, however, participation of under-represented population groups such as older people and the low-skilled remains a challenge. Long-term unemployment is also persistent, with one in two unemployed out of work for over a year.

Participation of youths and older population on the labour market has increased in the last several years, this due both to economic activity and to demographic trends and policy measures. Youths were disproportionately affected by the crisis,[74] not only because of the generally low demand for labour but also because they were more likely to have temporary jobs (fixed-term employment and student work[75]). After 2013 the youth employment rate increased, which we believe was due to higher demand for student work, greater youth focus of active employment policy measures and demographic trends.[76] Since youths in Slovenia have above-average participation in upper secondary and tertiary education (see Section 2.1), the share of those who are neither employed nor studying is relatively low (see Indicator 3.13). The employment rate of the older population (55–64) increased rapidly after 2013 as well, driven by demographic trends and the pension reform adopted in 2013, which gradually increases the statutory retirement age. But even though it is increasing, the employment rate in this age group is among the lowest in the EU as a result of relatively early retirement, which undermined the long-term sustainability of the pension system.

Despite the adoption of certain measures, labour market segmentation remains a problem. In a segmented labour market, one tier of workers has regular, better-paid jobs and a second tier are in precarious,[77] non-standard, less-protected and low-paying jobs[78] and have poorer prospects of transitioning to safer forms of employment. Severe segmentation may increase inequality among workers, accentuate the volatility of hiring and firing, discourage companies from investing in workers, and undermine the motivation

[72] The activity rate in the age group 20–64, which shows the share of the employed and unemployed population, rose by 3.5 pps to 78.4% from the second quarter of 2013 to the second quarter of 2017.

[73] According to the Labour Force Survey, these are inactive persons who are willing to accept work but are not actively looking for work. In the first three quarters of 2017 their number declined by a third compared to the same period of 2013.

[74] In 2008–2013 they were the age group whose employment rate decreased the most and whose unemployment rate rose the most.

[75] The scope of student work contracted by 36.7% in 2008–2013. In addition to lower demand for work, this could also be due to the increase in the concession fee in mid-2012 and restrictions on student work in the public services sector. By the second quarter of 2017 the scope of student work had again increased and was up 39.1% on the same quarter in 2013.

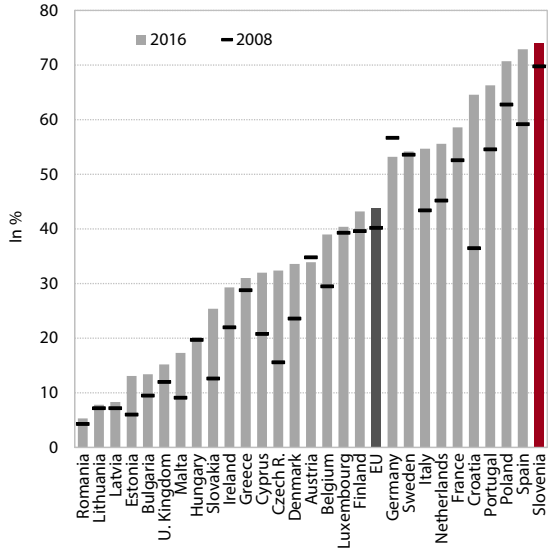
[76] Demographic trends are evident in the contraction of the number of youths (aged 15–24): Labour Force Survey data show it declined by 15,500 (7.1%) from the second quarter of 2013 to the second quarter of 2017. Coupled with higher employment (by 13,700 or 24.2% in the same period), this increased the employment rate in this age group (by 8.7 pps to 34.4%).

[77] The term "precarious forms of employment" does not have single definition. Eurostat and the European Commission define it as employment with lower pay (below two-thirds of median hourly wage) that is not full-time permanent employment.

[78] An EC analysis (2017) for Slovenia showed that excluding selected factors such as age, education, activity and profession, workers on temporary employment contracts have 10% lower wages than employees on permanent contracts.

for work. A segmented labour market is also more susceptible to shocks.[79] The prevalence of temporary forms of employment depends on factors such as the ease of using such forms of employment, rigidity of regulations governing firing and uncertainty of demand. Although legislative changes adopted in 2013 improved workers' prospects of getting permanent employment contracts,[80] the share of temporary employment remains high and above the EU average, in particular among youths, where it is the highest in the EU. A major driving force thereof is the existence of student work, the most flexible type of work in Slovenia. The share of precarious types of employment is also significantly above the EU average (see Indicator 3.14). The precarious status of youths, coupled with an unfavourable housing policy, may induce youths to emigrate[81] and affect their decisions on whether and when to start a family.

Figure 18: Share of temporary employment among youths (15–24)



Source: Eurostat Portal Page – Population and Social Conditions, 2018.

The employment prospects of the long-term unemployed have been improving and the long-term unemployment rate has dropped to the EU average. The long-term unemployed are at risk of their knowledge and skills becoming obsolete, which reduces their employment prospects. This may result in them transitioning into inactivity, which is not only unfavourable per se but also from the vantage point of Slovenia's demographic challenges. Long-term unemployment was exacerbated in 2009–2014 due to a long period of modest demand for labour. In the early stages of the economic recovery, the situation initially improved only for the short-term unemployed; in the last several years, however, high employment growth and certain active employment policy measures have reduced the number of the long-term unemployed. In the second quarter of 2017 the long-term unemployment rate was on a par with the EU average, having been above the average throughout the crisis (see Indicator 3.10). Nevertheless, the share of long-term unemployment in total employment remains high (51.3%), which calls for additional activation and training measures to improve the employability of the long-term unemployed. It is also necessary to develop and more frequently implement measures that prevent the transition to long-term unemployment.

Slovenia allocates relatively limited funds for active employment policy programmes, although such measures could improve the participation of vulnerable groups. To improve flexicurity, it is sensible to increase funding of active employment policy programmes and expand unemployment benefit coverage. However, in framing the system of flexicurity, it is necessary to place greater emphasis on creating appropriate incentives for work.[82] Slovenia is among the countries with a significant unemployment trap in the early stage of unemployment;[83] the trap increased in the past ten years and discourages individuals from seeking employment.

The available job quality indicators show a slight improvement in the last ten years. Job quality is a multi-faceted concept and how it is measured is gradually evolving (see Box 2). Eurofund,[84] for example, has found that the physical environment index and the working time quality index improved in the majority of the countries surveyed. In Slovenia a comparison between 2010 and 2015 also indicates a decrease in work intensity and a significant improvement in individual discretion and educational prospects. Eurofund's classification of profiles (cluster analysis) ranks Slovenia slightly above the EU average by share of lower-quality jobs and around the EU average by all other profiles in 2015. Measured with OECD quality benchmarks, Slovenia ranks around the average of the analysed countries.

Job quality may affect health, and hence the status of an individual on the labour market, and social protection systems. Jobs characterised as highly demanding (e.g. time pressure, physical risks to health), coupled with a lack of resources for the job (e.g. insufficient discretion and poor social support at work) pose a great health risk. Physical and mental

[79] Lepage-Sauicier, 2013.

[80] Vodopivec et al (2016), for example, found that immediately after the reform, the probability of transitioning from fixed-term employment to indefinite employment with the same employer rose by 28.2% for low-skilled men under 30.

[81] Precarious Youths and Emigration in Times of Crisis: Images, Reality, Growth, 2013.

[82] Combined with high taxation of income, unemployment benefits and social transfers may deter individuals from employment.

[83] The unemployment trap indicates the difference between the net income of a person when they transition from unemployment to employment; it occurs because of higher taxes and social contributions in employment and lower social transfers compared to income and higher social transfers during unemployment.

[84] Sixth European Working Conditions Survey (Eurofound), 2017.

Box 2: Job quality – Concepts and measurement

Job quality is a multidimensional concept. Ways of measuring it are evolving only gradually, which is why time series are not yet available. Below we present two multidimensional measuring concepts developed by the OECD and Eurofund which benchmark Slovenia against other countries and indicators developed by Eurostat.

The **OECD**[1] measures job quality with three dimensions of quality:

a) **Earnings quality**, which deals with two aspects: (i) level of earnings, which directly affects material wellbeing, and (ii) distribution of earnings, which is likewise important for quality (measured with the Gini coefficient).

b) **Labour market security**, captures aspects of economic security related to the risk of job loss and its economic cost for workers. These dimensions are measured with (i) probability of job loss (transition to unemployment) and duration of unemployment and (ii) public insurance for unemployment (coverage and amount of unemployment benefits).

c) **Quality of the working environment**, captures non-economic aspects of jobs, including the nature and content of the work performed, working-time arrangements, and workplace relationships. It is measured as incidence of job strain characterised as high job demands with low job resources.

In the Sixth European Working Conditions Survey, **Eurofund** measured job quality using seven indices: (i) physical environment, (ii) work intensity, (iii) working-time quality, (iv) social environment, (v) skills and discretion, (vi) prospects for education and promotion, and (vii) earnings.

Using cluster analysis of these dimensions, Eurofund has created the following job profiles:

a) **High-flying jobs**, which denotes complex and demanding jobs where individuals have high discretion and can set their own work methods and pace of work. Such workers also have good education, training and promotion prospects. The downsides of these jobs are poorer working-time quality and high work intensity.

b) **Smooth running jobs**, which are characterised by low work intensity, high quality of working time (often fewer than 48 hours per week) and good social environment at work. The level of earnings, skills and discretion at work is somewhat lower than in other profiles.

c) **Active manual jobs,** zwhich are characterised by more risk in the physical environment (noise, temperature, etc.). Working time quality is average, though atypical and shift work is more common; the social environment is good.

d) **Under pressure jobs**, where social environment stands out in negative terms due to a high incidence of abuse at work (frequent verbal abuse), work intensity is high, and the quality of the working environment is poor (frequent night, shift and/or weekend work). Earnings and the use of skills and discretion in these jobs are high.

e) **Poor quality jobs**, which are characterised by low earnings, promotion prospects, skills and discretion, average working time quality, and a work intensity that is slightly better than in under pressure jobs.

Eurostat measures job quality with indicators measuring a single dimension, for example weekend work, longer working hours in main job, weekly hours worked, share of employees working through employment agencies or share of precarious types of employment (the last is presented in Indicator 3.22).

[1] From OECD: How Good Is Your Job? Measuring and Assessing Job Quality, 2015.

health are also affected by poor working conditions and unemployment, which is an additional burden on health care and the welfare system. The employment rate among the older population, which is very low in Slovenia, is additionally dragged down by chronic illnesses, obesity, and other risk behaviours such as smoking and alcohol consumption. The result is a high rate of absenteeism, which has been growing in recent years (see Indicator 3.15) and lower participation on the labour market. Considering that 38% of respondents in Slovenia (EU: 25%) believe that work has adverse effects on health, and as many as 43%[85] think they will not be able to do their job until age 60, measures promoting a sustainable working life are particularly important against the backdrop of demographic challenges.

[85] The percentage in Slovenia is among the highest in the EU.

3.3 A healthy and active life

A healthy and active life (development goal 1)

The aim is to provide a high quality of life for all generations by promoting healthy and active lifestyles throughout the life cycle. Against the backdrop of profound demographic change, maintaining a high quality of life will require adapting social protection systems, promoting longer working lives, and making sure high-quality health care and long-term care services are accessible. It is also necessary to create opportunities for the transfer of knowledge between generations and to provide equal opportunities, including by facilitating a balance between work, care and leisure activities across the entire life cycle. To realise this goal, it is necessary to create conditions for a decent life for all generations, which is dealt with under development goal 3.

Performance indicators for development goal 1:

		Latest value		Target value for 2030
		Slovenia	EU average	
Healthy life years at birth, number of years	Men	58.5 (75.2% of life expectancy (2015)	62.6 (80.3% of life expectancy) (2015)	64.5 (80% of life expectancy)
	Women	57.7 (68.8% of life expectancy) (2015)	63.3 (76.0% of life expectancy) (2015)	64.5 (75% of life expectancy)
Gender equality index		68.4 (2015)	66.2 (2015)	> 75

The health of the population has improved in the last ten years, but measured by healthy life years, Slovenia is still far below the EU average. Basic health indicators improved across the EU due to advances in medicine, better quality of health care, and factors including growing incomes, higher educational attainment and better awareness. In Slovenia, life expectancy at birth improved more over the last decade than in the EU on average. The gap in healthy life years narrowed as well, but by 2015 the number of years a person could expect to live without disability was still significantly below the EU average (see Indicator 3.17). Self-assessment of health and dependence also improved, but they also remain below the EU average. Measured by preventable deaths, an indicator of the efficiency of the health system, Slovenia achieved the EU average (see Indicator 3.19), but it still ranks poorly in terms of premature mortality,[86] which is related to the high prevalence of unhealthy lifestyles.

Health inequalities have slightly reduced in the last ten years. The gap between the low-skilled and the high-skilled in terms of life expectancy at 30 and 65 narrowed in 2012–2014 compared to 2006–2008. It also narrowed more for men than for women, with life expectancy increasing in particular for low-skilled men. However, regional differences[87] in life expectancy for men remain wide. Measured by the educational gap, Slovenia places in the middle of the rankings of EU countries for which data are available (see Indicator 3.23). In healthy life expectancy the gap between the low-skilled and the high-skilled also narrowed in 2005–2014, with the narrowing for both sexes a result of a higher number of years without disability for the low-skilled and a lower number of years without disability for the high-skilled.[88] Reducing inequalities in health requires interdepartmental coordination focused on promoting healthy lifestyles in those with low socio-economic status and other most vulnerable groups. The low-skilled population in particular require additional attention and opportunities to leverage their potentials, actively contribute to society and enjoy a healthy old age. Continued reduction of inequalities in health would significantly contribute towards the mitigation of pressure on health expenditure growth and towards a reduction in absenteeism (see Indicator 3.15).

Despite lifestyle improvements in certain areas, the gap to the EU average has been widening. The share of overweight children, rising rapidly and already among the highest in the EU, is a key risk factor for adult obesity and obesity-related illnesses (see Indicator 3.22). Slovenia is also well below the EU average in terms of the share of youths who eat vegetables every day. The share of regular smokers has declined in the last ten years, but in the majority of other European countries it has been dropping at a faster pace. Slovenia also stands out in terms of per capita alcohol consumption, ranking fifth

[86] The premature mortality rate is an indicator of mortality before age 65 which is associated with unhealthy and/or risky lifestyles (death due to accident, especially traffic fatalities, and smoking- and alcohol-related deaths) or could be prevented by health care measures (early detection of risk factors, cancer screening tests).

[87] The biggest differences between regions were 4.3 years for men and 2.2 years for women.

[88] Kofol Bric,T., Zaletel, M., 2018.

among EU Member States; the gap to the EU average[89] continues to widen. Similarly, the poor ranking in cancer[90] mortality is largely associated with risk behaviour. To improve lifestyles, it is essential to strengthen preventive medicine and public health,[91] improve policies mitigating risk behaviour, and raise awareness about responsibility for own health. This would also contribute to higher labour market participation.

The incidence of mental health problems has increased in the last several years. The upward trend is characteristic of all developed countries, a consequence of fast-paced life, society's high expectations regarding individual performance, unhealthy lifestyles, growing inequalities, deprivation, and loneliness among the older population. Between 2008 and 2015 Slovenia recorded a significant increase in first doctor visits by children and youths due to mental and behavioural disorders. In those over 20, the number of prescriptions for antidepressants rose and mental health problems were the third most common cause of sick leave in this period.[92] The EHIS survey shows that in 2014 the share of the population reporting depression in the year before was above the EU average (Slovenia: 8.8%; EU26: 7.9%). The high suicide rate has fallen slightly in the last ten years, but it remains among the highest in the EU.[93] Only the prevalence of dementia is slightly below the EU average (Slovenia: 13.4 per 1,000 population; EU: 15.0), but projections suggest it will increase to 21 by 2035.[94] The Resolution on National Mental Health Programme 2018–2028 adopted in early 2018 calls for broader action by multiple sectors and policies to reduce the burden of mental illness and defines priority areas of action. The emphasis is on a transition from predominantly in-patient treatment to treatment of mental health conditions at the primary level and in the local environment.

In gender equality, an important element of an active society, Slovenia had made headway in the last ten years and is currently achieving good results. Slovenia has advanced very rapidly in terms of gender equality in the last ten years and scores above the EU average across all six analysed areas[95] (see Indicator 3.18). Significant progress was achieved in particular in women's participation in political life,[96] which is associated with changes in electoral law (introduction of gender quotas)[97] and the consequent improvement of the index in the power segment. Gender pay and employment gaps are narrow, largely due to good availability of pre-school education, appropriate regulation of parental leave, high educational attainment among women and a high share of women working full-time.[98] Overall, women are better educated than men, though they are under-represented in some of the best-paid professions and in leadership positions, while their average wages are lower. The index shows that much like in other countries, in the last ten years Slovenia did not record an improvement in the segment of time, which indirectly measures work–life balance and the division of household chores between men and women. Women do significantly more unpaid work than men, which has an adverse impact on their work–life balance.[99]

Participation in social life has increased in recent years and is relatively good, except among the older population. The share of the population regularly performing unpaid work exceeds the EU average and has risen in the last few years (see Indicator 3.24). As the demand for long-term care and social protection services rises, it makes sense to promote volunteering on the part of the older population in the provision of such services as this is the area in which the gap with the EU average is widest. More volunteering increases the participation of older persons in society, contributes to intergenerational cooperation and expansion of individuals' social networks and development of new knowledge and also helps to prevent loneliness. Political participation has also risen in the last few years, although it remains below the EU average. Compared to the EU as a whole, youths (18–24) are the least politically active. Older persons, on the other hand, are less likely than those in younger age groups to participate in cultural events or visit cultural or historical sites, though they do not lag behind in terms of participation in artistic activities. Considering that society is ageing and given that a major aim is to prevent dependence, the share of those over 50 who regularly do sports or exercise is too low, lagging behind the EU average.

[89] OECD Health at a Glance 2017, 2017.

[90] Slovenia ranks third among OECD countries by cancer mortality. In 2015 it recorded 243.3 deaths per 100,000 population, compared to the EU average of 203.7 (OECD Health at a Glance 2017, 2017).

[91] Contrary to recommendations by international institutions, expenditure on preventive medicine and public health decreased in the five years to 2015; in 2003–2010 it stood at 3.7% and by 2015 it had dropped to 2.7% of current health expenditure (OECD: 2.8%). Several studies (Sassi, F. et al, 2013; Cecchini, M. et al, 2015; OECD, 2015) have confirmed that anti-alcohol policies and measures to restrict tobacco use and consumption of unhealthy food have a positive impact on heath expectancy and life expectancy and reduce health expenditure (see Assessing the Effects of Some Structural Measures in Slovenia, IMAD, 2016).

[92] Resolution on a National Mental Health Programme 2018–2028 (Ministry of Health), 2018.

[93] Slovenia 2015: 18.1 suicides per 100,000 population; EU-28 2013: 21.1 (OECD Health at a Glance, 2017).

[94] OECD Health at a Glance, 2016.

[95] The gender equality index is calculated from 31 indicators across six segments: work, money, knowledge, time, power and health.

[96] In 2008, the share of women in the Slovenian parliament was 13.5%; in 2016 it was 35.6%.

[97] For more, see Bratuž-Ferk et al, 2017.

[98] For more, see Čelebič, T., et al, 2017.

[99] While on average women do five hours of paid work per week less than men, they spend 32 hours per week on care and unpaid household work compared to 15 hours for men.