COUNTRY REPORT

SLOVENIA

MIPEX HEALTH STRAND

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MIGRANT INTEGRATION POLICY INDEX

HEALTH STRAND

Country Report Slovenia

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READER'S GUIDE TO THE REPORT

This report was produced within the framework of the IOM's EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at http://bit.ly/2g0GlRd. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5–8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

0 no policies to achieve equity
50 policies at a specified intermediate level of equity
100 equitable or near-equitable policies.

'Equity' between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country's ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1-4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.

Section	Key indicators	Text
1. Country data	Eurostat	CIA World Factbooks, BBC News (http://news.bbc.co.uk), national sources
2. Migration background	Eurostat, Eurobarometer (http://bit.ly/2grTjIF)	Eurostat, national sources
3. Health system	WHO Global Health Expenditure Database[1] (http://bit.ly/1zZWnuN)	Health in Transition (HiT) country reports (http://bit.ly/2ePh3VJ), WHO Global Health Expenditure database
4. Use of detention		National sources, Global Detention Project (http://bit.ly/29lXgf0), Asylum Information Database (http://bit.ly/1EpevVN)

These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three 'neighbour' countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

[1] For the definition of these indicators please see p. 21 of the WHO document *General statistical procedures* at http://bit.ly/2lXd8JS

1. COUNTRY DATA

KEY INDICATORS		RANKING
Population (2014)	2.061.085	●●○○○
GDP per capita (2014) [EU mean = 100]	83	●●●○○
Accession to the European Union	2004	

Geography: Slovenia is a country of 20.273 km^2 located in South-Central Europe between Austria, Croatia, Hungary, and Italy. The terrain consists of a short south-western coastal strip on the Adriatic, an alpine mountain region in the north, mixed mountains and valleys with numerous rivers to the east. The largest city is the capital Ljubljana (279.000) and 49,6% of the population lives in urban settings, which is relatively few compared to the EU average of 75%.[2]

Historical background: The Slovene lands were part of the Austro-Hungarian Empire until its dissolution at the end of World War I. In 1918, the Slovenes joined the Serbs and Croats in forming a new multinational state, which was named Yugoslavia in 1929. In 1991, Slovenia became independent.

Government: Slovenia is a parliamentary republic divided in 200 municipalities. The country joined the EU in 2004 and the Eurozone in 2007.

Economy: Slovenia's GDP per capita in 2014 was more than double the average of other former Yugoslav republics. Almost two-thirds of the work force is employed in services, and over one-third in industry and construction. The country benefits from an excellent infrastructure, a well-educated work force, and a strategic location. After the economic crisis of 2008 Slovenia experienced a double-dip recession, with GDP reaching lows in 2009 and 2013;[3] however, between 2014 and 2017 annual growth stabilised at 2-3%. The unemployment rate rose from 7,4% in January 2008 to 14,2% in the same month of 2014, declining thereafter to 11,2% in 2017.[4] Slovenia's economic prospects are forecast to be favourable in the coming two years.[5]

[2] European Environment Agency http://www.eea.europa.eu/themes/urban
[3] https://ieconomics.com/slovenia-gdp-annual-growth-rate#
[4] https://ieconomics.com/slovenia-unemployment-rate
[5] https://ec.europa.eu/info/sites/info/files/ecfin_forecast_winter_1317_sl_en.pdf

2. MIGRATION BACKGROUND

KEY INDICATORS (2014)		RANKING
Foreign-born population as percentage of total population	11,4	●●●○○
Percentage non-EU/EFTA migrants among foreign-born population	70	●●●●○
Foreigners as percentage of total population	4,7	●●○○○
Non-EU/EFTA citizens as percentage of non-national population	83	●●●●●
Inhabitants per asylum applicant (more = lower ranking)	5.353	●●○○○
Percentage of positive asylum decisions at first instance	47	●●●○○
Positive attitude towards immigration of people from outside the EU (Question QA11.2, Eurobarometer)	41	●●●○○
Average MIPEX score for other strands (MIPEX, 2015)	48	●●●○○

Immigration in Slovenia started in the 1950s and increased in the 1990s, the main source of migration being other republics of the former Yugoslavia.[6]

From the 1950s until the 1970s, Slovenia was both a country of origin and a country of destination for migrants: Slovenes emigrated mainly as 'guest workers' to Austria and Germany, while people from the other Yugoslav Republics came to Slovenia principally in search of better job opportunities. The mid- to late 1970s saw an increasing number of Bosnians, Croats, and Serbs arrive in Slovenia.

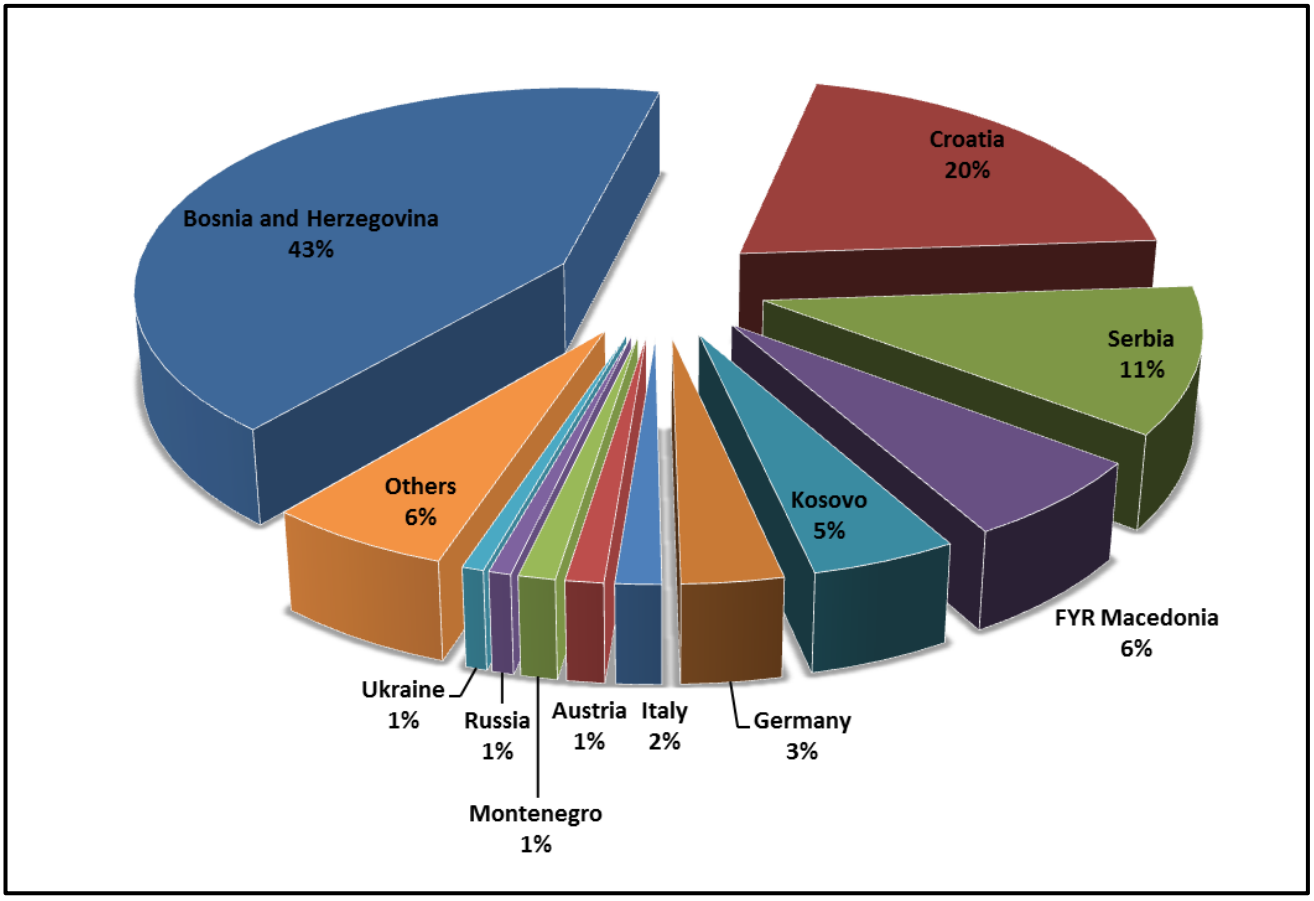
Slovenia gained its independence in 1991. Following independence, many migrants born in other ex-Yugoslavian republics obtained Slovenian citizenship. However, a significant minority (the 'erased' people) were unlawfully removed from Slovenia's registry of permanent residents.

The early 1990s war on the territory of the former Yugoslavia spurred major migration movements: first from Croatia and then from Bosnia-Herzegovina. The late 1990s witnessed the arrival of Kosovar refugees in Slovenia with the outbreak of conflict in Kosovo (Thomson 2006). In 2014, people born in, or having citizenship of, other (ex-) Yugoslav republics (particularly Bosnia & Herzegovina) formed the great majority - 87% - of migrants in Slovenia.

At the beginning of 2014, foreign-born residents amounted to 11,4% percent of the total population, but those with foreign nationality were only 4,7%. This is because a considerable number of the foreign-born have acquired Slovenian nationality. As noted above, many of these people were born in other former Yugoslav republics and became naturalized after independence in 1991. Figure 1 shows the main countries of birth of migrants in Slovenia.

[6] http://migrationtothecentre.migrationonline.cz/en/an-overview-of-the-migration-policies-and-trends-slovenia

Figure 1. Foreign-born population in 2014 by country of birth (Eurostat)



Asylum seekers: Until 2015, Slovenia received only a few hundred asylum applications a year, mostly from irregular migrants apprehended while in transit to other EU countries. During the 'refugee crisis' of 2015 and 2016, however, when almost 2,5 million asylum applications were received in the EU, Hungary closed its borders on October 16th 2015. The number of refugees entering Slovenia increased substantially. As a result, the authorities did not apply the regular procedure of denying entry to all except asylum applicants. Instead, the migrants were allowed to travel on towards Austria.[7] Until January 2016, 419.205 migrants traversed Slovenia through an informal 'humanitarian corridor'. In 2015, only 275 of them applied for asylum, of whom about 40 were accepted. In 2016, these figures were 1.308 and 170 respectively. Numbers of people passing through Slovenia declined steadily from about 8.000 in October 2015 to 2.000 in January 2016. In March 2016 the government closed the 'corridor', at the same time announcing that it would relocate 567 people from Italy and Greece and resettle 20 persons from third countries.[8] On 26th January 2017 the government passed new laws which, according to Amnesty International, "allow for special emergency measures that would deny entry to people arriving at the borders and automatically expel migrants and refugees who have entered Slovenia irregularly, without properly assessing their asylum claims or the risks to which they would be exposed upon return".[9]

Undocumented migrants: The overall number of undocumented migrants living in Slovenia is thought to be low, probably because it is hard to make a living without being registered (Björngren Cuadra 2010).

[7] https://osf.to/1VPwNmy
[8] http://www.vlada.si/en/helping_refugees/
[9] http://bit.ly/2nLyrhA

3. HEALTH SYSTEM

KEY INDICATORS (2013)		RANKING
Total health expenditure per person (adjusted for purchasing power, in euros)	1.756	●●●○○
Health expenditure as percentage of GDP	9,3	●●●○○
Percentage of health financing from government National health system (NHS) / social health insurance (SHI)	7	SHI
Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)	12	●●●●●
Score on Euro Health Consumer Index (ECHI, 2014)	-	N/A
Overall score on MIPEX Health strand (2015)	18	●○○○○

Compulsory social health insurance, financed mainly by payroll taxes, is obligatory for Slovene citizens with permanent residence in Slovenia, but does not cover all the costs of treatment. Only a certain percentage of the price for the service is covered. Full coverage is ensured only for minors, regularly enrolled students under 26, and for certain diseases and conditions. Compulsory health insurance is provided by ZZZS (Health Insurance Institute of Slovenia), which is a public institution. Complementary private health insurance is taken out by 95% of people liable for co-payments, to cover the difference between the full price of health services and the percentage covered by compulsory health insurance. The premium is approximately €30 per month; policies are offered by three insurance companies. Compulsory insurance premiums are income-adjusted but complementary premiums are not, which disadvantages poorer people.

Persons without complementary health insurance have to pay an out-of-pocket sum for the majority of medical services (the basket of services, covered fully by compulsory health insurance, is quite limited). To be able to acquire complementary health insurance, an individual needs to have compulsory health insurance. Therefore, migrants who do not have access to the national healthcare system have no access to complementary health insurance either.

Slovenia is not covered by the Euro Health Consumer Index (ECHI), but the WHO Health System Review (Albreht et al. 2016:xx) states that “According to EU-SILC data, Slovenia consistently has had one of the lowest reported levels of unmet healthcare needs in Europe for all income groups. However, since 2013, waiting times have been increasing, which is likely to have a more severe effect on poorer households. Nevertheless, satisfaction with health care provision is high”. The report also notes, however, that “marginalized population groups (e.g. undocumented migrants, Roma) exist without health insurance coverage” (ibid.:xxi).

4. USE OF DETENTION

Immigration detention in Slovenia is regulated by the **2011 Aliens Act (ZTuj-2)**, which transposes the EU Returns Directive, and by the **2007 International Protection Act (ZMZ),** which includes the criteria set in the EU Reception Conditions Directive.[10] In accordance with the above-mentioned acts, non-citizens for whom a return decision has been issued, or for whom there is a risk of absconding, may be detained in order to ensure the deportation. In addition, authorities can detain migrants when their identity cannot be established.

The Aliens Act provides that a foreigner may be detained prior to removal for an initial period of six months, which may be extended by a further six months.

The International Protection Act also establishes the grounds for detention of **asylum seekers**, who may be detained in the following cases: to verify their identity; in case of a suspicion that the person will mislead or abuse the procedures; to prevent a threat to another person's life or property; if there is a risk of absconding to avoid the transfer to a 'safe third country'; in case of asylum applicants subject to Dublin proceedings; in case of applicants in possession of visa or residence permit of another member state and have unlawfully crossed the border; in case of applicants who have received a decision that Slovenia will not consider their application.

Detention for asylum seekers can last up to three months. If after three months the grounds for detention are still valid, detention may be extended by another month.

Detention at the border is allowed for a maximum of 48 hours when a person intends to unlawfully cross the border, has already done so, or there is a reasonable suspicion that they did so. In cases where the person has been refused entry into Slovenia because they did not fulfil entry conditions, they cannot be immediately returned.

Detention facilities

The **Centre for Foreigners** is the only immigration detention centre operating in Slovenia. Open since 2000, it is located in Postojna and is managed by the Slovenian Police, under the supervision of the Ministry of Interior. The Postojna centre hosts men, women, families, and unaccompanied minors (who are accommodated in separate sections).

Slovenia also operates the **Brink Airport Holding Centre,** which is used to accommodate for a maximum of 48 hours up to 18 persons to whom entry has been refused and who are awaiting expulsion. The Holding Centre has separate spaces for men and women.

Conditions of detention

The Postojna Centre has been regularly visited by the Legal Centre for the Protection of Human Rights and Environment (PIC) and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), as well as other NGOs. Reports are generally positive:

[10] Amendments to these Acts were adopted in 2017 and 2016, after the reference date of this report (31st December 2014).

facilities are clean, the light is adequate and rooms are furnished and ventilated. Detainees can use phones and have limited access to internet, they have free access to the common areas and can use the outdoor yard once a day. Visits are allowed every afternoon, though legal representatives may visit detainees outside visiting hours. However, CPT expressed concerns about the lack of recreational activities (the only activity available was watching TV) and the strictness of police supervision.

Staff working at the centre consist of police officers, social workers, administrative and logistic personnel, as well as a medical team. In relation to **health care**, the centre employs a general physician and four nurses are present (who also provide weekend coverage). A psychiatrist is available upon request.

In Slovenia, **children**, **unaccompanied children** and **families with children** may be detained. The Aliens Act requires they be accommodated in specific places designed for children but in practice, due to the lack of adequate facilities, unaccompanied minors and families are systematically placed in detention (separate from other detainees). Children have access to education, games, and recreational activities.

In September 2016, the government issued a decree according to which all unaccompanied children, whether they apply for asylum or not, shall not be placed in detention but rather accommodated in dormitories in Postojna and Novao Ggorica.

5. ENTITLEMENT TO HEALTH SERVICES

Score 36 **Ranking** ●○○○○

A. Legal migrants

Inclusion in health system and services covered

Legal migrants' entitlement to health services depends on the details of their legal status. The majority of legal migrants are covered by the same health care system as nationals. Who exactly can be insured and on which grounds is defined in the articles 15 and 20 of the Health Care and Health Insurance Act (ZZVZZ). For legal migrants, this means fulfilling certain additional requirements.

Migrants with permanent residence status are covered by the same system as nationals. They are insured on the basis of the different points in article 15 of the ZZVZZ. Migrants with a permanent residence status also have a right to be insured as persons receiving welfare on the basis of article 30 of the Exercise of Rights to Public Funds Act (ZUJPS-C).

Dependents of migrants with permanent residence status can be insured on the basis of article 20 of the ZZVZZ either as a close family member (this includes children born in and out of wedlock, adopted children, children who have been placed into a family by the decision of the responsible authority, with the aim of adoption) or as a member of the wider family (stepchildren, grandchildren, brothers, sisters or other children without parents – here, a child with parents who are completely and permanently unable to work or who cannot take care of their child, is also counted as a child without parents).

Close family members of migrants with permanent residence status can be insured on this basis only after they obtain temporary residence status in Slovenia for at least three months, while legal migrants' wider family members can be insured only after obtaining permanent residence status. It is important to stress that apprioriate health insurance is a requirement for obtaining temporary residence status in the first place (article 22 and 23 of Aliens Act). Therefore, it is a common practice that migrants pay for private insurance for the first three months.

Migrants with temporary residence status can be covered by the same system as nationals, if they are employed on the basis of a regular contract (either permanent or temporary). In this case they are insured in accordance with the same category described in article 15 of ZZVZZ, valid for employed Slovene citizens. In this case, the health insurance preiums are divided between the employee and employer. However, employers frequently evade payment of health insurance for migrant workers, which results in obstacles to accessing health care. Some changes were made by the authorities in the past three years to prevent arbitrary deregistering of migrant workers from health insurance by their employers, but this issue needs continued monitoring (Lipovec Čebron 2010; Delavci migranti v primežu politike 2011).

Dependents of migrants with temporary residence status who are also employed on the basis of a regular contract can be covered by the same system as nationals. However, they are able to acquire the same coverage as nationals only after three months of regular status. Besides, NGO reports (e.g. safe

house for women, victims of violence in Celje) stress that in cases of (formal or informal) divorce, some holders of family insurance deregister their ex-spouses and children with temporary residence from health insurance, thus leaving them uninsured. In such cases, the ex-spouse's only option is to pay for private insurance, which they often cannot afford due to lack of income. This should also be closely monitored and a policy needs to be proposed to rectify this issue, particularly in cases of family violence, where victims are clearly in a precarious and vulnerable position.

Foreign students who do not hold a European Health Card or are not subject to bilateral agreements can be insured on the basis of the 14th point of article 15 of the ZZVZZ. However, the field is under-researched so it is not clear if in practice this enables full coverage and access to health care for foreign students, citizens of non-EU states.

Migrants who are not included in the health insurance system have the right to emergency health care services, the payment for which is provided in accordance with European legal order or international agreements. The right to emergency health care is by law a universal right of all living in Slovenia or passing through its territory. It is defined in article 7 of ZZVZZ, which states that the state budget (Ministry of Health) covers emergency care of persons of an unknown residency and of some other categories of uninsured persons. The range of emergency care (i.e. the situations in which the treatment is regarded as emergency care) is further defined in article 25 of ZZVZZ and article 103 of the Rules on Compulsory Health Insurance.

Special exemptions

Antenatal, perinatal, and postnatal care: A special internal provision of the Ministry of Health recently declared that all preventive care in general is part of emergency care and therefore accessible for everybody, regardless of insurance or legal status.[11] However, this provision is not implemented in any official legal regulation, so it is unclear how and to what extent it is transferred to practice. Research and experiences of the NGO sector confirm that this provision is generally not known, recognised or respected in practice (migrant women report they need to pay for childbirth, abortion, ante- and post-natal care; obligatory vaccination for children, etc.).

Minors: Minors have special protection regarding access to health care system. National legislation (point 24 of article 15 of the ZZVZZ) extends the right to health care to all minors enrolled in school, even if they do not have any health insurance, citizenship, or permanent residency status. Moreover, underage asylum seekers have the same access to health care system as nationals.

However, research and experiences of the NGO sector show that implementation of this legal provision is not always successful in practice, since a special procedure is required in order to obtain health insurance on this legal basis (NIPH 2015). Obstacles are present, especially in the case of undocumented minors due to documents (personal documents, tax number, proof that the minor is not insured in the country of origin, etc.) they need to provide in certain municipalities in order to be able to arrange health insurance on this basis. An additional problem is the fact that these procedures are usually initiated by an institution rather than by an individual, therefore this is a serious obstacle for people who are not enrolled in formal procedures and/or in contact with various institutions.

[11] Source: correspondence with the Health Insurance Institute of Slovenia, project *Skupaj za zdravje*, http://www.skupajzazdravje.si/projekt

Victims of human trafficking: Victims of human trafficking are defined by Slovenian legislation as a vulnerable group with special entitlements. Article 50 of the Aliens Act defines the rights of victims of human trafficking and illegal employment. When these persons are found to live in Slovenia without residence status, police can issue a permission to stay (*dovoljenje za zadrževanje*) for 90 days (with the possibility of an additional 90 days), during which time the person needs to decide if they will cooperate with the criminal investigation. In this period they have the same rights as other persons with permission to stay. If they decide to cooperate, they can be issued temporary residence status, but they still have access only to emergency health care.

Barriers to obtaining entitlement

Analysis of legislation and policies shows that the universal right to emergency health care services is violated by different administrative and structural obstacles preventing the possibility of exercising this right (Bofulin and Bešter 2010; Lipovec Čebron 2007, 2009, 2011; NIPH 2014). Administrative discretion also creates many barriers to access.

B. Asylum seekers

Inclusion in health system and services covered

According to Article 86 of the International Protection Act (ZMZ),[12] asylum seekers have the right to 'emergency health care'. This is defined as:

1. emergency care and emergency rescue transportation, as well as emergency dental treatment;
2. emergency treatment following the doctor's decision, which includes:
    - maintaining vital functions, stopping serious bleeding or preventing bleeding to death,
    - prevention of sudden deterioration of the health condition that could cause permanent damage to individual organs or life functions,
    - treatment of shock,
    - treatment of chronic diseases and conditions, the neglect of which would directly and within a short period of time cause invalidity, other permanent damage to health, or death,
    - treatment of high temperature conditions and preventing the spread of infection that could lead to a septic condition,
    - treating and preventing poisoning,
    - treatment of broken bones or sprains and other damages that require urgent medical attendance,
    - medicines from the positive list in accordance with the list of mutually replaceable medication prescribed for the treatment of certain diseases or conditions.
3. women's health: contraception, termination of pregnancy, and health care during pregnancy and childbirth.

[12] Numbering as in the current version, available at http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZAKO7103

Paragraph 3 of article 86 equates the rights of **underage asylum seekers** and of **unaccompanied minors** to those of nationals.

In practice, asylum seekers have access to more than just emergency care, if they are housed in one of the centres for asylum seekers. Indeed, most asylum seekers in Slovenia are accommodated in one of the two reception centres for asylum seekers in Ljubljana ('Asylum Home' Vič and Kotnikova). However, the health provisions available in the centres for asylum seekers are not part of the system of health care coverage.

In the case of Asylum Home Vič – which since its opening in 2004 and until recently used to be the only centre for asylum seekers in Slovenia – the health provisions that have been documented are as follows. A nurse treats non-urgent medical conditions, examining and distributing basic medicine. When the asylum seekers are first accommodated in the centre, they undergo a medical examination by a medical doctor, who is also available on call when necessary. In the event of sickness, the asylum seeker may receive treatment in the nearest health centre (*Zdravstveni dom Vič*) on presenting a valid asylum-seeker identity card. However, research shows (Palaić and Jazbinšek 2009; Lipovec Čebron 2009; T-Share 2011) that access to health care depends on the nurse's arbitrary decision about when and to whom treatment should be given. When the health condition of an asylum seeker requires specialist treatment (optician, psychiatrist, etc.), a special committee (organized by the Ministry of Interior Affairs) can authorize access to certain healthcare institutions.

Regarding psychotherapy, the centre for asylum seekers employs a psychosocial service, including a psychologist, on a permanent basis. However, therapies targeted at traumatised asylum seekers and refugees are not available. There is also no contract with any provider of specialist psychiatric care. Experience has shown that Slovenia does not really have any psychiatrists specialised in treating traumatised asylum seekers. We can therefore conclude that access to therapy by a specialist is not effectively ensured.

Special exemptions

The definition of 'emergency health care' (see previous section) is fairly elaborate and broad, and includes a number of conditions for which exemption from restrictions is often given on public health or humanitarian grounds. The right to health care of vulnerable asylum seekers – defined in paragraph 2 of article 86 as 'vulnerable persons with special needs' – and in exceptional cases other asylum seekers - is extended to cover a wider range of health services, including psychotherapeutic care. The application of this paragraph is subject to the decisions of the special committee mentioned above.

Barriers to obtaining entitlement

Analysis of legislation and policies shows that the universal right to emergency health care services is violated by different administrative and structural obstacles preventing the possibility of exercising this right (Bofulin and Bešter 2010; Lipovec Čebron 2007, 2009, 2011; NIPH 2014). Administrative discretion also creates many barriers to access.

C. Undocumented migrants (UDMs)

Inclusion in health system and services covered

According to Slovenian law, UDMs are only entitled to emergency medical care, because they are not entitled to health care insurance on the basis of article 15 of ZZVZZ, which defines categories of insured subjects in the national health insurance system. Theoretically, they have the possibility of paying for private insurance, but this is costly and only provides a narrow range of services.

Since the majority of UDMs are uninsured, they can seek medical assistance in health care centres for people without health insurance in Ljubljana, Maribor, and Koper. These centres are based on voluntary work by medical staff and donated medicines, and do not provide the same quality and range of health care as other public health centres – they are thus not a systematic solution.

UDMs held in the Postojna detention centre have access to a nurse, who treats non-urgent medical conditions, examining and distributing basic medicine. When a UDM waiting to be deported is first registered at the centre, he or she undergoes a medical examination by a doctor, who is also available on call when necessary.

A special UDM category is the so-called *'dovolitev zadrževanja'* (permission to stay), on the basis of article 73 of the Aliens Act.[13] This category contains persons whose removal from Slovenia has been ordered, but whose deportation is not possible due to various reasons (e.g. because the deportation is not allowed, a person does not have valid personal documents, or due to their health condition or the death of a family member, etc.) Article 75 of the Aliens Act gives them the right to emergency care, but since they are usually accommodated outside the detention centre, they encounter various obstacles when exercising this right in health care institutions. This provision should be regarded as unsatisfactory, since the permission to stay can be prolonged to many months or even years.

Special exemptions

See above under 'legal migrants' for exemptions applying to uninsured persons.

Barriers to obtaining entitlement

Even though emergency care is supposed to be given to anyone in need, without additional requirements, UDMs often need to provide additional documentation. It is a common practice in various health institutions to ask UDMs to present a health card (which only those with health insurance have) and/or personal documents. If they do not have such documents, they may be denied treatment, even in urgent cases. The decision as to whether they will receive treatment depends on a clinical judgement by health workers about the criteria for what constitutes 'urgent'. In cases where treatment of an emergency case subsequently turns out to be non-urgent, the institution providing health services is expected to assume the costs, which is likely to influence decisions of medical staff. Besides, since the emergency care is covered by the Ministry of Health budget, medical staff need to provide a range of different documents justifying the costs for services provided, e.g. a police statement in case of UDMs, confirmation by the NGO Helsinki Monitor in case of Roma, non-citizens, etc.[14] Emergency care is

[13] http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZAKO5761

[14] These requirements of the medical staff are documented in the document from Ministry of Health, 2010, entitled *Navodilo za sprejem pacientov v zdravstveno obravnavo v ambulantah nujne medicinske pomoči oziroma v sprejemnih*

therefore presented as a universal right, but in practice it is impeded by different administrative demands and depends on arbitrary decisions of medical staff. In case treatment is regarded as non-urgent, UDMs have to pay for the service out of pocket.

ambulantah v bolnišnicah ter za obračun opravljenega dela [Directive for the reception of patients in health care treatment, in the clinics for emergency medical care, or in reception clinics in hospitals, and for dealing with the costs of the service offered], available in Slovenian here: www.mz.gov.si/fileadmin/mz.gov.si/pageuploads/pravilniki/2010/VELJAVNO_NAVODILO_2.8.2010.doc

6. POLICIES TO FACILITATE ACCESS

Score 25 Ranking ●○○○○

Information for service providers about migrants' entitlements

Information about migrants' entitlements is not made available to service providers.

Information for migrants concerning entitlements and use of health services

There is no systematic dissemination of information concerning entitlements and use of health service for the migrant population. However, there are a few project-based initiatives and ad hoc published brochures translated in different languages. These are disseminated over different websites[15] and provide information about access to health care for migrants. Information can in theory be accessed by all groups of migrants mentioned above. However, since the information is difficult to find, access to it depends on personal initiative and motivation.

In addition, certain sub-categories of migrants are targeted in specific contexts. Thus, for example, asylum seekers tend to be better informed, due to their accommodation in a reception centre where information is centralized and provided by employees and various NGOs. They are informed about their entitlements upon reception in the centre for asylum seekers. The brochure explaining their basic rights is posted in front of the infirmary, and in the office where their asylum claim is submitted. The brochure is provided in Arabic, Turkish, Albanian, Serbian, English and Russian.

Health education and health promotion for migrants

Migrants with at least compulsory health insurance (this includes mostly legal migrants, if they meet the additional requirements, and certain groups of vulnerable asylum seekers, as well as all minors) have the same access to health education and health promotion as nationals. However, there are no special programmes adapted to the migrant population. Such programs would be necessary for the migrants to be truly included in the health care system, as migrant groups are sometimes linguistically, and often socially, excluded and as a consequence often do not have enough information about health promotion and prevention. This impedes their uptake of these programmes. A good example is SVIT (a national programme for the screening and early detection of precancerous changes and colorectal cancer) that provides an invitation in three languages (Slovenian, Italian, and Hungarian) but not in other languages spoken by migrants (Bosnian, Albanian, etc.). Health education and health promotion programmes in general do not take into account special needs and circumstances characteristic of the migrant population.

Provision of 'cultural mediators' or 'patient navigators' to facilitate access for migrants

Cultural mediators are not routinely provided in the national health care system. This would be necessary and is reported to be of vital importance for the improvement of migrant health care (NIPH 2014). Cultural mediation or advocacy is frequently exercised in practice, but only on an informal or ad hoc basis, and is therefore insufficient. Two NGOs in Ljubljana and Maribor (*Slovenska filantropija* and

[15] e.g. http://www.infotujci.si ; http://www.ess.gov.si/_files/5164/Smerokaz.pdf

Društvo Odnos) that have various services for migrants (mainly legal help) were providing cultural mediators for migrants in healthcare institutions in recent years, but these initiatives are temporary, project-based and not continuous or structural. They cannot be regarded as being a part of national or regional health policies.

Is there an obligation to report undocumented migrants?

Article 92 of the Aliens Act requires state and other organs and organizations to report to the police immediately any person residing illegally. The requirement is general and addressed to all institutions, and could be interpreted as a requirement for health care institutions. No such cases were reported, but the situation should be closely monitored since this article technically provides a legal obligation to report UDMs.

Are there any sanctions against helping undocumented migrants?

There are no legal sanctions against helping UDMs, but pressure exists to deter professionals from helping migrants who cannot pay. In particular, there are pressures to justify the costs of emergency health care, and in cases where it subsequently emerges that medical staff provided emergency care in non-urgent cases, the institution can be stuck with unpaid bills. This can act as a deterrent to treating migrants.

7. RESPONSIVE HEALTH SERVICES

Score 4 **Ranking** ●●○○○

Interpretation services

Even though the Patient Rights Act (ZpacP)[16] includes the patient's right to understand the procedure, to be informed and not to be discriminated against, in practice there is a great lack of systematic solutions (national or regional policy) regarding the availability of interpretation services. However, as the need definitely exists for the provision of interpretation services, some medical institutions find partial and ad hoc solutions for their patients. For example, the University Medical Centre in Ljubljana (UKCL) deals with this obstacle in the following manner: they usually try to communicate in English (which most medical staff speak) or another language such as German or Serbo-Croatian. If this does not work, they try to locate a staff member who speaks the required language. In 2013, the UKCL education officer did a survey among its employees regarding the languages they speak and on this basis a list of persons was compiled of employees who act as 'community translators'. This list is informal and is used only internally in cases when no other solution is possible: while it does cover some languages (e.g. Albanian), more 'exotic' ones are still left out.[17]

Requirement for 'culturally competent' or 'diversity-sensitive' services

As the majority of migrants in Slovenia are from ex-Yugoslavia, they are not regarded as culturally different to the extent that they would need a specially adapted and culturally sensitive health care. This is not necessarily true, as there are residents of the ex-Yugoslavia with significant cultural differences (for example Albanians from Kosovo or Macedonia). Besides, this view leaves out significant differences in cultural practices regarding health and disease, which exist in some of the other less represented migrant communities.

The lack of attention to culturally sensitive service provision is seen across the health care system. There are very few practices (in particular within secondary care, in hospitals) that take into account the variety of religious beliefs or cultural practices (e.g. regarding food), and these are not institutionalised at the national level.

Training and education of health service staff

In general, there is currently no staff training in provision of migrant-sensitive services. Furthermore, the prevalent view is that cultural competence and sensitivity to the cultural specificities of patients are irrelevant, and that all that matters is purely technical medical expertise. However, there are few exceptions to this: for example, the nurses' association recently held a short training programme on cultural competency. In the project *Skupaj za Zdravje* (NIPH 2014), funded by the Norwegian Financial Mechanism, an interdisciplinary team developed a pilot training programme on cultural competence for healthcare workers in three public healthcare centres (Sevnica, Vrhnika, Celje) from February 2015 to March 2016.

[16] *Zakon o Pacientovih Pravicah*: https://zakonodaja.com/zakon/zpacp
[17] Source: interview with the UKCL Public Relations department, January 2015.

Involvement of migrants

There are no policies concerning the involvement of migrants in information provision and service design or delivery.

Encouraging diversity in the health service workforce

No measures are taken to encourage diversity in the health service workforce.

Development of capacity and methods

There is no adaptation of diagnostic procedures and treatment methods to take more account of variations in the sociocultural background of patients.

Both in the strategies of employment and in medical work, the exclusive focus on biomedical standards remain unchallenged; policies are exclusively focused on standardising diagnostic procedures and treatment methods. There is no development of treatments for health problems specific to certain migrant groups, no adaptation of standard treatments for routine health problems in order to better serve migrant communities, and no use of complementary and alternative 'non-Western' treatments for physical and mental health problems.

8. MEASURES TO ACHIEVE CHANGE

Score 8 **Ranking** ●○○○○

Data collection

No information is systematically collected about the health of migrants and their healthcare consumption. According Bofulin and Bešter (2010), the Healthcare Databases Act (zzPPz)[18] does not require health providers to collect data on the nationality or the country of origin of the patient. Thus, it is not possible to get information from available data about migrants' use of health services in Slovenia in order to improve access and quality.

Support for research

There is no systematic research that could be used to inform national or regional policies with the aim of improving migrant access to health care. There are a few research projects, but they tend to be sporadic or focused on other populations (such as those who are uninsured and thus excluded from access to health care) which may incidentally include migrants. Given that compulsory health insurance is obligatory in Slovenia for permanent residents, there has lately been more focus on would-be patients (including migrants) facing obstacles in access to healthcare. Some recent research projects include:

- 'Access of migrants to the rights of social and health care: policies and practices', conducted by the Institute for Ethnic Studies.[19]
- 'Interpreting for the needs of the health care system in Slovenia', joint project by the Faculty of Arts of the University of Ljubljana, the University Medical Centre Ljubljana and the University Psychiatric Hospital.[20]
- 'Together for Health' *(Skupaj za zdravje),* a project of the National Institute for Public Health (NIPH 2014).
- Public tender for co-funding of programs of help, counselling and treatment for persons without health insurance in 2013 and 2014, Ministry of Health.[21]

'Health in all policies' approach

No consideration is given to the impact on migrant or ethnic minority health of policies in sectors other than health.

Whole organisation approach

No systematic attention is paid to migrant or ethnic minority health in any part of the health system. Indeed, measures to achieve change in this area are virtually non-existent. In general, the importance of sensitivity to cultural differences is entirely overlooked, and an unassailable conviction of the objectivity and neutrality of service providers prevails instead.

[18] *Zakon o Zbirkah Podatkov s Področja Zdravstvenega Varstva,* https://zakonodaja.com/zakon/zzppz
[19] http://www.inv.si/Dokumenti/dokumenti.aspx?iddoc=806&idmenu1=313&lang=slo
[20] http://bit.ly/1K8OZjB
[21] http://bit.ly/2oz4Fd2

Leadership by government

Improvement of health services for migrants is not on the policy agenda of the national government.

Involvement of stakeholders

There is no policy to involve stakeholders in the design of (national or regional) migrant health policies.

Migrants' contribution to health policymaking

Migrant organisations are not explicitly consulted on health policy.

CONCLUSIONS

Slovenia's scores on the MIPEX Health strand show many similarities with those of other formerly communist countries that joined the EU in 2004 or later. Most of these countries had experienced severe economic and political turbulence after the breakup of the Soviet Union or Yugoslavia, after which the economic benefits of joining the EU were undermined by the damaging effects of the 2008 financial crisis. Low wages and high unemployment levels attracted few labour migrants. In Slovenia, the percentage of migrants is inflated by the presence of many residents who were born before 1991 in other former Yugoslav republics, who acquired the status of migrants when the country became independent. (Like many ethnic Russians in Estonia, some then found themselves unable to acquire any citizenship at all.) In 2014, 87% of migrants in Slovenia were born in (former) Yugoslav republics. Although attitudes towards immigration of people from outside the EU appear to be average for the EU/EFTA (see Section 2), this finding is deceptive; for Slovenes, the question refers primarily to migrants from the Western Balkan region, not from developing countries.

In this situation, few of the incentives that have encouraged many other EU/EFTA countries to adapt their health systems to the presence of migrants. In Slovenia, indifference to the special needs of migrants was reinforced by the assumption – not always justified – that since most of them came from former Yugoslav republics, they would experience few linguistic or cultural barriers. Pressure for change has mostly come from NGOs campaigning for improvement of human-rights standards. (According to statistics from the European Court of Human Rights, Slovenia ranks first among the 47 members of the Council of Europe, including Russia, for the number of violations per capita of the European Convention on Human Rights).[22]

Although most legal migrants are included in the country's social health insurance system, the burden of additional complementary private insurance to cover co-payments and supplement the basket of services falls disproportionately on those on low wages – which is the situation of most migrants. Little is done to reduce the gap between health services and migrant users, either by adapting the services or signposting the way to them more clearly. As far as measures to achieve change are concerned, migrant health does not appear to be on the government's agenda, although academics and NGOs are active in this field.

[22] https://rightsinfo.org/infographics/human-rights-uncovered/

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