HEALTH CARE SYSTEM AND NURSING IN SLOVENIA

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The authors describe the health system in Slovenia, a part of which is the place and priorities of nursing care, and at the same time they discuss education of nurses, the transformation of which took place after the change of the political system

INTRODUCTION

Slovenia faces dilemmas and uncertainty in the development of health care but these do not differ from those encountered in most European countries. They include how to preserve health and social security in the light of a situation that will be marked by the problems of an ageing population, a related increase in chronic degenerative diseases, and growing needs and requirements for health care services. The Slovenian health care system remains relatively centralized and the self-governing communities still have limited responsibility. Privatization of health care delivery is taking place gradually in health centres and homes for elderly people.

Very few private, for profit hospitals exist in Slovenia, with no more than 50 beds in total (Albrecht et al. 2002 a, b). The nurse education system is now adapting to the EU systems, and education has to be adjusted to the European Credit Transfer System agreed by the Bologna Declaration (European Commission 1998).

SLOVENIA

The Slovene lands were part of the Austrian Monarchy until 1918, when the Slovenes joined the Serbs and Croats in forming a new multinational state, renamed Yugoslavia in 1929. After World War II, Slovenia became a republic of the renewed Yugoslavia. The Slovenes succeeded in establishing their independence in 1991 after a short 10-day war. Historical ties to western Europe, a strong economy and a stable democracy have assisted in Slovenia's transformation into a modern state and it acceded to both NATO and the EU in the spring of 2004. Slovenia is now a small country in Central Europe, with the eastern Alps bordering the Adriatic Sea, between Austria and Croatia, consisting of 20273 km² and bordering Austria, Croatia, Italy and Hungary. It has a Mediterranean climate on the coast, and a continental climate with mild to hot summers and cold winters on the plateau and in the valleys to the

east. The total population is 2 011473 (July 2004 estimated) consisting of Slovenes (92%), and small minorities of Croats, Serbs, Hungarians, Bosnians, and others (1991). The religions practiced are Roman Catholic (Uniate 2%) 70.8%, Lutheran 1%, Muslim 1%, atheist 4.3%, and other 22% (Republic of Slovenia 2005).

POLITICAL SYSTEM AND ECONOMY

In accordance with its new constitution, Slovenia became a democratic country based on the principle of the division of power among the legislative, executive and judicial bodies. The supreme legislative body is the National Assembly (the parliament, with 90 deputies), which passes laws. The 40-member National Council has a consultative role. The country is governed as a parliamentary democratic republic. The government represents the executive branch of power and is answerable to parliament. The president is elected directly for a maximum of two five-year terms and is the commander in chief of the armed forces.

The first human rights ombudsman, who reports to parliament, was elected in September 1994.

Because of its historical ties to western Europe, Slovenia enjoys a per capita gross domestic product (GDP) substantially higher than that of the other transitioning economies of Central Europe. In March 2004, Slovenia became the first transitional country to graduate from borrower status to donor partner at the World Bank. Privatization of the economy proceeded at an accelerated pace in the period 2002-2003, and the budget deficit dropped from 3.0% of the GDP in 2002 to 1.6% in 2003. Despite the economic slowdown in Europe in 2001-2003, Slovenia maintained 3 % growth. Structural reforms to improve the business environment allow for greater foreign participation in Slovenia's economy and help to lower unemployment. Slovenia entered the EU on 1 May 2004 (Albrecht et al. 2002 a, Republic of Slovenia 2005).

Slovenia can develop successfully only if it has an open externally-orientated economy. The goal of Slovenia's foreign trade policy and strategy is to strengthen its position in the EU and expand to regain its share of the former Yugoslav markets, to expand substantially its presence in the USA, in the markets of the former Soviet Union and within the Central European Free Trade Agreement, and to gain access to other non-European markets. In terms of per capita GDP (forecast at USD10 832 for 1999) Slovenia can be compared with EU member states Greece and Portugal (Albrecht et al. 2002 a, Republic of Slovenu 2005).

In 1998 Slovenia's population of 2 million (of whom 871000 were economically active) generated a GDP of USD18.8 billion, giving a per capita GDP of USD9864. Over half of the employed population work in the service sector, about a third in industry and about 6% in agriculture.

HEALTH CARE SYSTEM

The health care system in Slovenia underwent few major reforms until 1991. After the country's independence, liquidity problems led to the introduction of legislation in 1992. During the 1970's and 1980's, Slovenians had high expectations for free and comprehensive health care, and this contributed to a progressive increase in health care staff and facilities. The reforms succeeded in securing an increasing proportion of the GDP for the health care sector, partly because of the introduction of compulsory insurance and partly because most of the population purchased voluntary insurance. After the 1992 health care reform legislation, the Health Insurance Institute was created as a public, not for profit entity strictly supervised by the State. Similar to most systems in Europe, the Slovene health care system has characteristics of both the integrated and the contract models. There is still conflict between the high inherited expectations of the population and the limited resources of the public system. Primary causes of dissatisfaction are waiting times and complicated administrative procedures. Overall patient satisfaction with private providers remains high. The priority is to implement health policy and the development of insurance for long-term nursing care for the ageing Slovene population (Albrecht et al. 2002a, b).

The Slovenian health system provides universal and comprehensive access for all Slovenian citizens, regardless of income. The health care reforms of 1992 were prompted mainly by the need to increase transparency in the financial aspects of the system to control escalating costs.

The health care delivery system is defined by the Health Services Act. Apart from public institutions, some private institutions are also part of the public health network. Capacity is structured at primary, secondary and tertiary levels. At the primary level, centres provide health care to the population of one or several communities. Both public and private providers deliver primary health care. Public providers comprise 64 health care centres and 69 health stations. Community nursing services are based in the health care centres and work simultaneously with general practitioners or family physicians in the self-governing communities. Their main tasks should be preventive measures and health education, but most of their work (80%) is still devoted to curative activities (Albrecht et al. 2002b).

Specialist care at secondary level is organized in regional general hospitals, specialist hospitals and specialist outpatient facilities organized within hospitals or health care centres, or as independent practices.

The tertiary level includes university hospitals and institutes providing highly specialized services, education, research, dissemination of knowledge and development. These services are usually organized at national level.

Specialist secondary care is provided in hospitals, polyclinics, spas and private health facilities. There are 26 hospitals, including five regional and three local general hospitals, and the main tertiary and teaching hospitals (the Clinical Centre) in Ljubljana. In addition, there are 12 specialized hospitals providing orthopaedic, pulmonary, gynaecological and psychiatric care. Apart from the Clinical Centre, there are two other national tertiary institutions, the Institute of Oncology and the Institute for Rehabilitation.

Average life expectancy for Slovene men is 71.65 years and for women it is 79.58 years. Diseases of the cardiovascular system are the most common cause of death, representing almost half of all deaths. These are followed by cancer, injuries, poisoning, respiratory diseases and diseases of the digestive system. This pattern is similar to that in most EU countries (Albrecht et al. 2002b).

THE NURSING PROFESSION

Nursing is a constituent part of health care and nurses and midwives need appropriate legislation for a clear definition of their profession, qualifications, status, role and functions, that show their competencies and the extent of their contribution to and their position within the health care system. According to EU directives the provisions of the Health Services Act define nurses and mid-

wives as special regulated professions. The Act also demands registration for both these professions, which has not yet been realized. A list exists at the Ministry of Health of those nurses who have completed their probationary period and the professional examination that is a requirement for independent professional work.

In general, the Health Services Act determines that health care workers who have undertaken suitable education, are professionally qualified to work without supervision and meet other conditions determined by the law and other regulations, may practice their profession. It also determines that all health care workers and associates may work independently after completion of the necessary probationary training period and passing a professional proficiency examination. The probationary period for nurses responsible for general care is nine months or 1560 hours. The professional proficiency examination is taken according to a procedure prescribed by the health minister and covers four areas: specific professional subjects, social medicine, first aid and basic legal matters concerning health care, health care activities and health insurance. The examination is taken at the Ministry of Health, from where the qualification certificate is issued.

Nurses and midwives have their own code of ethics, more serious violations of which can lead to exclusion from membership of the profession. The Court of Honour of the Nursing Chamber rules on violations of the code. Regional bodies rule on violations of the statute of the organization.

The work of nurses who are responsible for general care is subject to the penal provisions of the Health Services Act and its implementing regulations, the Penal Code (criminal responsibility), the Obligations Act (material responsibility), and internal regulations of the health care organizations (on disciplinary and material responsibility) (Filej and Kersnic 2001).

STATUS OF PRACTITIONERS IN PUBLIC HOSPITALS

Nurses are employed under a collective contract made between them and employers, under which job particulars and rights are agreed. An employment contract has to be made for work in both the public health service and the private sector. Nurses responsible for general care are mainly employed in public health institutions (public employees). Those who are employed by private physicians have separate employment contracts.

Nurses face moral problems in everyday practice; sometimes they feel moral distress at the

impossibility of making the right choice. Sources of such moral problems can be both external factors (physicians, legislation, reporting, bureaucratic procedures, politics) and internal factors (organizational structure, becoming used to obeying orders, feelings of powerlessness) (World Health Organization 2002, European Commission 2002).

Nurses and midwives are organized professionally by the Nurses Association of Slovenia, which constitutes the Nursing Chamber of Slovenia. It has 14 600 members; 3408 are registered nurses, 89 are midwives, and the remainder are health technicians and retired members. Membership is voluntary. Eleven regional organizations (European Commission 2002) comprise 30 professional sections representing individual professional areas (Filej and Kersnic 2001).

Nurses and midwives can voluntarily join the Trade Union of Nursing Staff that has over 8000 members and conducts negotiations on pay and other rights of nurses at work (leave, safety at work, education, etc.).

NURSE EDUCATION

Nurse education has been established for some decades on two educational levels, at secondary health schools and at tertiary level colleges at the three universities of Ljubljana, Maribor and Koper. Additional ongoing education and specialization is required for community nurses, those working in psychiatry, geriatric care, surgery and intensive care, and nurses involved in medical informatics. The universities take part in international exchange agreements for teachers and students. The new programme for nurses, that is harmonized with EU directives, started in October 2004. There are approximately 300 new students per year in the three colleges.

There are also nine secondary health schools for health technicians (nurse assistants). About 1000 pupils enter this programme every year.

The proportion of nursing personnel working in the public sector is 95% and in the private sector 5%. All work is full time. The average age of nurses is 42 years (Albrecht et al. 2002b, World Health Organization 2002).

INTERNATIONAL CO-OPERATION

Nurses are included in international activities through the Nurses Association of Slovenia, the Collaborative Centre for Primary Nursing Care, and individual professional sections organized within the Association. The Nurses Association of Slovenia became a member of ICN in 1993. It publishes the official journal *Obzornik zdravst-*

vene nege and a monthly bulletin Utrip as well as various leaflets and books on nursing and teaching materials. The journal publishes articles on nursing practice and research and the monthly bulletin aims to keep Slovenian nurses regularly informed of the most important and relevant activities of nurses in the country and abroad (Filej and Kersnic 2001).

PRIORITIES IN HEALTH AND NURSING SYSTEMS

- To develop nursing management for middle managers and clinical leadership in hospitals;
- To implement nurse education at all levels and to develop specialization, under-graduate, bachelor, master and doctoral studies according to Bologna Declaration criteria;
- To develop the bachelor education system according to European and WHO strategies for nursing and midwifery: criteria for admission, education of the deans, criteria for lecturers and mentors, course contents, role and the functions based on competencies, and accreditation of the institutions;
- To consider European and WHO directives;
- To develop total quality management to improve standards of nursing care;
- To redefine the roles of nurses with BSc and registered nurse qualifications, and health technicians; the division of work between doctors, nurses and health technicians; and staffing levels;
- To pass legislation on nursing care;
- To improve the pay and the working conditions of nurses;
- To implement the information systems of the International Classification of Nursing Practice;
- To promote evidence based nursing and international research projects (Bohinc et al. 1999).

Research has shown that nurses in Slovenia have knowledge about patients but they do not have enough power to use it owing to rigid organizational structures and their low level of professional autonomy (Bohinc and Gradisar 2003). Nurses do not collaborate enough with other professionals involved in the care of their patients. Nurse leaders struggle to implement visions for accountability and professional satisfaction, and to promote team work. The organizational structure is not able to support the development of an empowered, autonomous nursing workforce (Bohinc and Gradisar 2003).

This study, carried out in 13 hospitals, showed

that there is a significant difference in job satisfaction between registered nurses and health technicians. Registered nurses have more possibilities for professional growth and career advancement. Both groups are dissatisfied with pay, relationships in nursing teams, rewards for the quality and quantity of work done, recognition, collaboration with doctors, clinical decision making, and the autonomy of nursing services and their organization (Bohinc and Gradisar 2003).

CONCLUSIONS

Nursing in Slovenia faces challenges similar to those encountered in many other European countries. The first step to be taken has to be the development of university programmes for bachelor and master's level nurse education according to the Bologna Declaration, and continuing education and specialization based on the needs already recognized in practice: clinical leadership, clinical supervision and mentorship, and developing new roles as case managers and nurse practitioners. Nurse educators and researchers must improve the gaps between clinical practice, research, and evidence based nursing. Nurses in practice must focus more on working in interdisciplinary teams and in integrated health care delivery systems.

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