LJUBLJANA

Health in the Municipality 2018 is an overview of key health indicators in municipalities, compared to the Slovene and regional average.

The environment in which we live and work has a strong influence on our health. By demonstrating the health status, we wish to motivate key parties on a local level, especially decision-makers, and their activities to promote and strengthen the health of the population.

You can find data for all Slovene municipalities, additional graphic displays and indicator definitions at http://obcine.nijz.si.

More health-related information is available at https://podatki.nijz.si.

A COUPLE OF FACTS ON HEALTH IN THE MUNICIPALITY

Health status and mortality

- Sick leave of active working population lasted 12.4 calendar days per year on average, 14.4 days in Slovenia.
- The percentage of persons who receive medication for increased blood pressure was lower than the Slovene average; the same goes for diabetes.
- The number of people treated in hospital for heart attacks was 1.4 per 1,000 residents, aged 35–74; the rate in Slovenia was 2.1.
- The rate of hospital care for older municipal residents for hip fractures was 6.8 per 1,000 residents; 6.2 in Slovenia.
- The percentage of home support users was close to the Slovene average.
- The mortality rate due to suicide was 14 per 100,000 residents, 20 in Slovenia.

Risk factors for health and preventive measures

- The physical fitness of children was close to the Slovene average.
- The number of people treated in hospital for transport accident injuries was 1.7 in 1,000 residents, 1.6 in Slovenia.
- The percentage of traffic accidents caused by intoxicated persons was lower than the Slovene average.
- Responsiveness to the Svit Programme - screening and early detection of colorectal cancer was 63.2% and 64.3% in Slovenia.
- Responsiveness to the Zora Programme - screening for cervical cancer was 70.4% and 71.8% in Slovenia.

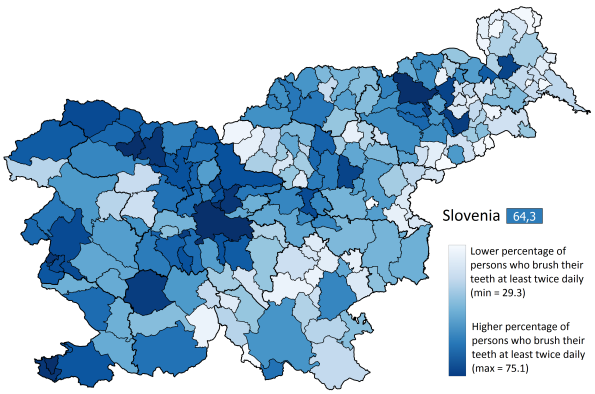

Figure 1: Percentage of inhabitants, who brush their teeth at least 2x daily, aged 25–74, CINDI, 2016.

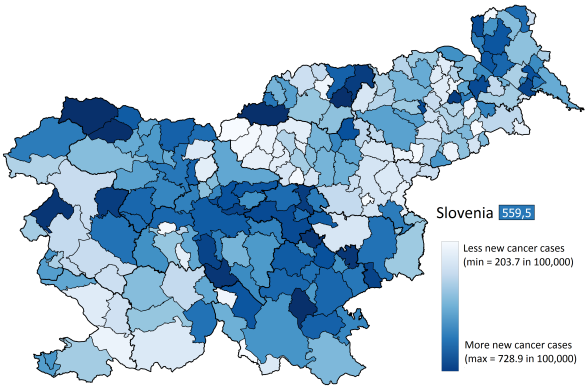

Figure 2: New cases of cancer by municipalities in 100,000 residents – rate standardised by age, average 2010–14.

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NIJZ Nacionalni inštitut za javno zdravje

INEQUALITIES IN HEALTH

Inequalities in health are a consequence of several factors. We are not able to influence certain factors but can influence socio-economic factors from a social point of view. Firstly, we need to systematically recognise inequalities in health so we can take appropriate action.

Inequalities in health among countries are great
We monitor the status of inequalities in health in a certain country and compare it with other EU Member States. We determined in 2014 that Slovenia is mostly average in comparison with other EU Member States according to certain health indicators. Slovenia is above the EU average when it comes to infant mortality and below average for suicide mortality.

Inequalities in health due to the socio-economic status of a person
In Slovenia, inequalities in health are present in most of the monitored indicators regardless of the level of education.

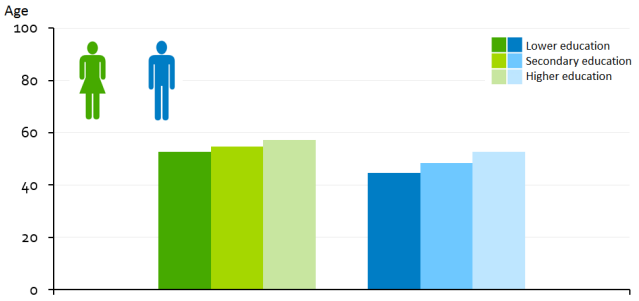

Figure 3: The anticipated life expectancy of men and women in Slovenia at age 30 by education, derived from the data average on deaths and education of population during 2012–2014

People with a lower level of education have poorer health and a lower life expectancy, but gender also plays an important role. This means that highly educated men aged 30 can expect roughly the same life expectancy as 30-year-old women with basic or lower education. However, a 30-year-old person, male or female, with a lower level of education will have fewer healthy years of life without greater limitations than a highly educated person.

Inequalities in health are present in all periods of life and are often permanent because the weaker starting position is maintained and intensified throughout life.

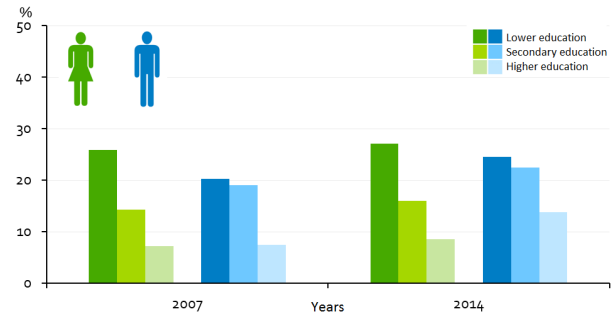

Figure 4: Percentage of overweight persons (BMI ≥ 30) by gender and education, Slovenia, comparison of 2007 and 2014

For example, pregnant women with a lower level of education attend the "school for parents" less often. The majority of mothers who gave birth to premature infants had a lower level of education. The youth who estimated that they live in a family with a low level of prosperity smoke and consume alcohol more often. They also assess their health, satisfaction with life and body weight as poorer and are more often mistreated.

The health and behaviour of adults varies clearly according to level of education. Persons with a lower level of education receive medication for mental disorders such as depression and anxiety more often (we considered all persons who received at least one prescription in 2014 for an anxiolytic or antidepressant) and also evaluate their health as being poorer more often.

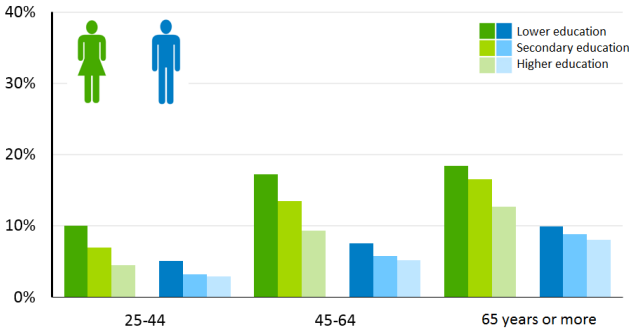

Figure 5: The percentage of people who received at least one antidepressant prescription by gender, age and education, Slovenia, 2015

The percentage of people who received at least one antidepressant prescription by gender, age and education, Slovenia, 2015

Crisis and inequalities

The economic crisis influences several segments of the society. However, its influences are not the same for everyone and some are not even affected by it. Some are very severely affected while the situation of others might even improve. Looking at numerous socio-economic changes in the time of crisis, we are expecting the gap between privileged and less privileged residents to increase. The monitored inequalities in health in Slovenia show that the economic crisis did not substantially worsen health or increase inequalities. Nevertheless, we remain cautious since the majority of influences on health are long-term.

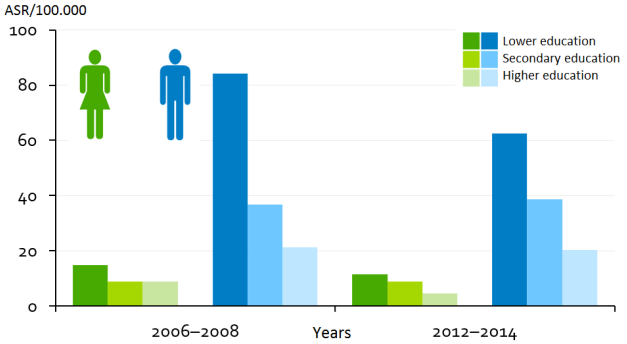

Figure 6: Mortality rate due to suicide by education and gender, comparison between the periods 2006–2008 and 2012–2014, Slovenia

In some countries the suicide rate increased in the time of crisis but in Slovenia there was no change in the difference in rates between people with a lower level of education compared to highly educated people. Inequality in mortality due to unintentional accidents and due to falls among senior citizens even decreased in the time of crisis.

Financial accessibility of the public healthcare system did not decrease in the time of crisis. From the viewpoint of expenditure for health in the form of self-funded healthcare, differences between the poorer and wealthier households have increased significantly in the last 15 years in Slovenia.

The unemployed are the largest, but not the only vulnerable group in the time of crisis

The number of unemployed increased greatly in the time of the last economic crisis. The unemployed used healthcare and health-related services less than the employed.

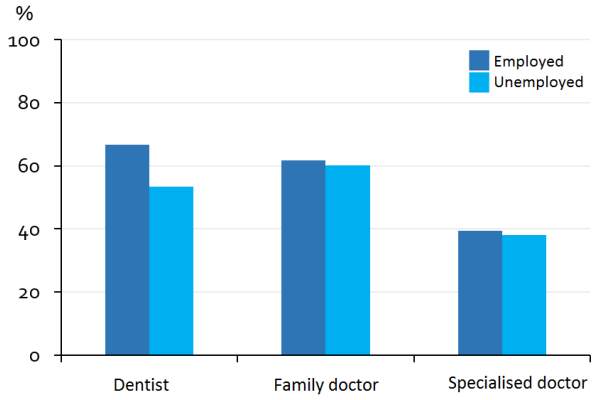

Figure 7: Percentage of people who visited a dentist, family doctor or specialist in the last 12 months at least once, employed and unemployed, Slovenia, 2014

Controlling inequalities in health

Shaping and executing measures that contribute to lowering inequalities is an important objective of public healthcare and includes measures in local communities. The promotion of fruit and vegetable consumption in schools turned out most effective in pupils with a weaker social status. Choosing suitable approaches and messages that also reach people with lower levels of education is fundamental for encouraging people to take care of their own health and participate in preventive and screening programmes. While recognising and treating vulnerable groups, we must collaborate with several parties on a local and national level.

Sensitivity for inequalities must be present in all sectors and segments of society. We should create possibilities for the socially weaker so they can make use of their potential, which is why we must invest in the youth and children. At the same time, we need to integrate approaches which will lower and not increase inequalities with every measure to improve behaviour, health, early detection and treatment of diseases.

ORAL HEALTHCARE

Oral healthcare is an important and integral part of general health and greatly influences quality of life. The interconnection between oral and general health has been proven particularly in the field of cardiovascular diseases, complications during pregnancy and metabolic diseases. The prevalent oral diseases are caries and periodontal disease which are especially a consequence of inadequate oral care.

Proper oral healthcare means:

- Brushing teeth at least twice a day using toothpastes with the required fluoride concentration,
- Using accessories, such as dental floss or an interdental brush to clean interdental spaces,
- A healthy diet, giving up snacks during main meals, drinking primarily water to quench thirst,
- No smoking and alcohol,
- Preventive dental check-ups at least once yearly,
- Passing on good habits to children by our own examples and promotion.

Caring for our bodies is the most important way of maintaining and strengthening oral health. We can only evaluate oral healthcare indirectly based on survey data. Proper oral care (brushing teeth at least twice daily and visiting the dentist at least once a year) is maintained by just 47% of residents in the age group 25–74 which includes more women than men. The percentage of persons with unsuitable oral care and insufficient visits to the dentist is 13%; men prevailing over women. (Figure 1)

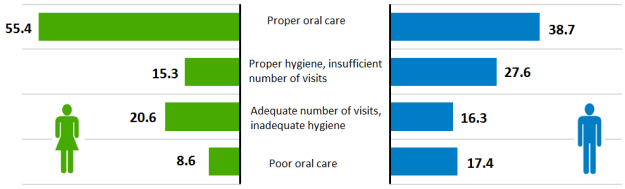

Figure 8: Oral healthcare, 25-74 years of age, Slovenia, 2016

Oral healthcare is an important part of a healthy lifestyle. By taking proper care, we maintain and strengthen oral health but also provide benefits to our general health and quality of life which should be an additional motivation in daily care.

Parents have the most important role in helping children acquire good habits, but the promotion of oral healthcare in educational institutions also makes an important contribution. Habits from one's childhood are easier to maintain in later stages of life. Accessibility of preventive dental care brings results particularly in the childhood phase but quickly worsens if care is reduced.

Health indicators in the municipality: Ljubljana

The set of health indicators in the table show how the municipality compares with the administrative unit (AU), statistical region and national average. Comparisons of municipal and national levels are graphically displayed. The indicators are tested for statistical significance. Higher variations of indicator values are expected between particular years in smaller municipalities due to a smaller number of occurrences. Definitions, additional data and graphic images are available at ▸.

● ▲ ■ ▼ Position of municipality value in relation to Slovenian average (|) and in relation to the range of values of all Slovenian municipalities (▬). In cases, where there is no mark next to the indicator, there was no occurrence of the event in the presented period ([n]).

The meaning of colours and shapes of markings:
▲ Green – the municipality is in a statistically significantly better position than the average in Slovenia.
■ Blue – the municipality is in a statistically significantly different position than the average in Slovenia. It was not possible to determine the direction of the indicator.
▼ Red – the municipality is in a statistically significantly worse position than the average in Slovenia.
● Yellow – the municipality does not statistically significantly differ from the Slovenian average.
○ White – value of chosen indicator is not reliable due to the small size of the observed population and thus small number of cases.

	Indicator	Municip.	AU	Region	SLO	Unit	Below average / Above average
Residents and community	1.1 Level of development of the municipality	**1.3**	/	/	**1.0**	index	
	1.2 Population growth	**2.1**	4.1	4.9	**0.8**	‰	
	1.3 Older population (above 80 years of age)	**5.3**	5.2	4.9	**5.0**	%	
	1.4 Adults with no more than primary school education	**12.7**	12.4	13.1	**16.1**	%	
	1.5 Level of labour participation	**59.2**	60.1	61.4	**59.5**	%	
	1.6 Labour migrations	**185**	85	87	**100**	index	
Risk factors	2.1 Physical fitness of children	**50.7**	50.8	50.7	**50.1**	index	
	2.2 Obesity of children	**19.9**	20.3	21.2	**24.8**	%	
	2.5 Injuries in road accidents	**1.7**	1.7	1.8	**1.6**	ASR/1000	
	2.6 Road accidents caused by intoxicated persons	**6.9**	7.3	7.8	**9.0**	%	
	2.8 Brushing of teeth	**71**[m]	70	69	**64**	%	
Prevention	3.1 Responsiveness to the Svit Programme	**63.2**	63.9	65.4	**64.3**	%	
	3.2 Screening in the Zora Programme	**70.4**	70.8	71.6	**71.8**	%	
	3.3 Microbiological quality of drinking water	**100**	/	/	**91**	%	
Health status	4.2 Sick leave	**12.4**	12.4	12.8	**14.4**	days	
	4.3 Asthma in children and adolescents (0-19 years of age)	**1.4**	1.4	1.2	**1.2**	ASR/1000	
	4.4 Diseases, directly attributable to alcohol (at least 15 years of age)	**2.0**	2.0	2.0	**2.0**	ASR/1000	
	4.5 Receiving medication for diabetes	**4.6**	4.6	4.8	**5.1**	ASR/100	
	4.6 Receiving medication for increased blood pressure	**20.7**	20.9	21.5	**23.4**	ASR/100	
	4.7 Receiving medication against blood clotting	**11.1**	11.1	11.1	**11.8**	ASR/100	
	4.8 Heart attack (35-74 years of age)	**1.4**	1.4	1.5	**2.1**	ASR/1000	
	4.9 Stroke (35-84 years of age)	**2.0**	2.0	2.1	**2.6**	ASR/1000	
	4.10 New cases of cancer	**616**	610	600	**559**	ASR/100.000	
	4.15 New cases of colorectal cancer	**73**	73	76	**77**	ASR/100.000	
	4.16 New cases of lung cancer	**76**	73	70	**64**	ASR/100.000	
	4.17 New cases of breast cancer	**147**	143	138	**118**	ASR/100.000	
	4.11 Hip fractures in older residents (at least 65 years of age)	**6.8**	6.7	6.7	**6.2**	ASR/1000	
	4.12 Receiving medication for mental disorders	**14.6**	14.2	13.9	**15.1**	ASR/100	
	4.13 Home support	**1.6**	1.6	1.4	**1.7**	%	
	4.14 Tick-borne encephalitis	**5**	7	10	**10**	ASR/100.000	
Mortality	5.1 General mortality	**758**	778	818	**943**	ASR/100.000	
	5.2 Mortality due to cardiovascular diseases (0-74 years of age)	**58**	60	64	**83**	ASR/100.000	
	5.3 Mortality due to all types of cancer (0-74 years of age)	**154**	152	153	**165**	ASR/100.000	
	5.7 Mortality due to suicide	**14**	15	17	**20**	ASR/100.000	

Legend: /: indicator is not available for this administrative level; ASR: age standardized rate per 100, 1,000 or 100,000 population standardized to Slovenian population on 1 July 2014.
[m]: Data is based on a statistical model. Municip.: Municipality. AU: Administrative unit.

Indicator explanation:
Population and community: 1.1: year 2016; **1.2**: year 2016; **1.3**: year 2016, 80 years or older, **1.4**: year 2016, aged 25–64 years; **1.5**: year 2016, aged 15–64 years; **1.6**: year 2016; **Risk factors: 2.1**: year 2016, children and adolescents, aged 6–14 years; **2.2**: year 2016, children and adolescents, aged 6–14 years; **2.5**: 2012–2016 average; **2.6**: 2012–2016 average; **2.8**: year 2016; **Prevention: 3.1**: year 2016; **3.2**: 1.7.2013 –30.6.2016, women, aged 20–64 years; **3.3**: year 2013–2017, national monitoring; **Health status: 4.2**: year 2016, employed population; **4.3**: 2012–2016 average, hospital treatments, aged 0–19 years; **4.4**: 2012–2016 average, hospital treatments, older than 15 years; **4.5**: year 2016; **4.6**: year 2016; **4.7**: year 2016; **4.8**: 2012–2016 average, hospital treatments, aged 35–74 years; **4.9**: 2012–2016 average, hospital treatments, aged 35–84 years; **4.10**: 2010–2014 average, newly discovered cancers except non-melanoma; **4.11**: 2012–2016 average, hospital treatments, aged 65 or more; **4.12**: year 2016; **4.13**: year 2016, aged 65 or more; **4.14**: 2008–2016; **4.15**: 2010–2014 average; **4.16**: 2010–2014 average; **4.17**: 2010–2014 average; **Mortality: 5.1**: 2012–2016 average; **5.2**: 2012–2016 average, aged 0–74 years; **5.3**: 2012–2016 average, aged 0–74 years; **5.7**: 2012–2016 average.
Data sources: National Institute of Public Health, Statistical Office of the Republic of Slovenia, Ministry of Finance, Slovenian Traffic Safety Agency, Faculty of Sports (UL), Cancer Registry, Social Protection Institute of the Republic of Slovenia.