NATIONAL DIABETES PREVENTION AND CARE PROGRAMME 2020–2030 DEVELOPMENT STRATEGY

Summary

The objectives of the National Diabetes Prevention and Care Programme 2010–2020 (hereinafter: the 2010–2020 NDPCP) were to reduce the incidence of type-2 diabetes, prevent or delay type 2 diabetes in persons at high risk, increase the opportunities for early detection of diabetes, and reduce complications and mortality due to diabetes.

The activities carried out by the partners of the 2010–2020 NDPCP in accordance with the two-year action plans were designed and carried out to implement a common vision: to reduce the incidence of diabetes through measures at the population-wide level and among individuals at high risk of type 2 diabetes and to empower people with diabetes to obtain the necessary knowledge, understanding and skills related to their type of diabetes and to be able to make healthy lifestyle and quality-of-life decisions about things that matter to them, to receive care coordinated at all levels of healthcare and within the healthcare team, and to live in an active society that is aware of the diabetes burden for each individual, their family and loved ones, the community and society as a whole and in a society that recognises the importance of a healthy lifestyle for reducing the incidence of type 2 diabetes and for those who already suffer from this disease.

Over the 2010–2020 period the participating partners have, for example, strengthened access to diabetes education, especially at the primary level, by upgrading family medicine teams with registered nurses and by upgrading health promotion centres with new diabetes prevention and care programmes. The performance of family medicine teams has been improved through comprehensive care coordinated among all healthcare levels in terms of implementation of uniform and regularly updated clinical guidelines and in the field of diabetes education also through setting up mentoring networks between the primary and secondary/tertiary levels. Good access to modern medicines and medical devices has been maintained in spite of the recession. The availability of key data and information required to monitor diabetes prevention and care has also been improved. Activities complementary to the 2010–2020 NDPCP were implemented within the framework of the Resolution on the National Programme on Nutrition and Physical Activity for Health 2015–2025 (hereinafter: ReNPPTDZ 2015–2025), by way of which the state wishes to improve the nutritional and physical activity habits of the population from early years until old age, halt the rise in obesity in the population, and help reduce the incidence of related chronic diseases, including type 2 diabetes. Despite the unfavourable lifestyle, some positive shifts can be seen in healthy eating and physical activity.

The gaps that still exist in 2020 also include systemic gaps and the Ministry of Health of the Republic of Slovenia (hereinafter: the Ministry of Health) will propose to the Government of the Republic of Slovenia to adopt the National Diabetes Prevention and Care Programme 2020–2030 (hereinafter: the 2020–2030 NDPCP), which will serve as a development strategy for this 10-year period and bring together all key partners in the health sector. The current period is characterised by significant health inequalities between the regions in Slovenia, a high prevalence rate of diabetes and a sharp increase in the incidence rate in some regions, and significant differences in incidence rates between the regions. This situation highlights the greater healthcare needs of the local populations in certain regions, the need for public health

measures to improve lifestyle and health system factors in these regions, and the need for measures outside the healthcare sector where the causes for health inequalities can be found. Healthcare, which often requires the involvement of many profiles and is fragmented in this regard, can only be at a high quality level if it is coordinated and integrated, whereby the circumstances vary greatly from one region in Slovenia to the other. In addition to differences in access to care at the primary level, there are also marked differences in diabetes teams at the secondary level, which leads to important differences in the access to care at the secondary level provided by diabetes teams.

The changes refer, inter alia, to the following areas: since the quality of life of a person with diabetes is not only determined by the disease alone, the representatives of associations of people with diabetes express their need and wish to participate in the planning and implementation of care (therefore the term "patient" should be replaced by the terms "person, individual", while the term "patient-centred care" should be expanded descriptively to include the active participation of the individual, who is not only the recipient of decisions taken by others); a life-long approach is needed to empower individuals at all stages of life and to create conditions that provide everyone with a healthy diet and regular physical exercise, regardless of the circumstances in which they live; barriers to empowerment are not only on the part of the person with diabetes, but often also reflect a lack of resources and competences of healthcare teams in this area; healthcare must not only be coordinated but also integrated, in which regard the circumstances in individual regions in Slovenia vary considerably; the environment in which a person lives also has the capacity to co-create health (community approach to health); the healthcare sector is not the only and indeed often not the key partner in ensuring good health, so joint action between different sectors is needed, with horizontal and vertical integration and coordination to maximise joint impacts. Investment in health is an investment in the development of society.

In 2020, COVID-19 disrupted healthcare both for the chronically ill and for persons with acute conditions (not caused by COVID-19), first as a pandemic and later through persistence in the population, and caused the discontinuation of the implementation of health promotion programmes and preventive medical examinations for early detection of chronic diseases, which have been implemented in adapted forms even since their relaunch; in social terms, COVID-19 has worsened the health determinants of some segments of the population. Since persons with diabetes are at particular risk, the 2020–2030 NDPCP is a key development document, and, using diabetes as a model disease, it will support and introduce information-based action, disseminate knowledge and good practices, enhance the capacity to anticipate and manage unplanned and unpredicted events, strengthen and promote cooperation between various actors, establish socially acceptable measures and values, contribute to the protection of the mental health of the population and healthcare workers, introduce greater flexibility of healthcare capacities, and support the provision of measures aimed at health promotion, the prevention and early detection of diabetes, and continuing diabetes care along with effective control of COVID-19.

There are three overall objectives of the 2020–2030 NDPCP which have been substantially upgraded (the measures for the implementation of objective No 2 and objective No 3 of the 2010–2020 NDPCP are interconnected in the system):

- to strengthen the population health, with a special focus on diabetes;
- to delay or prevent type 2 diabetes in persons at increased risk and increase opportunities for early detection of diabetes; and
- to reduce complications and mortality caused by diabetes and increase quality of life, including long-term care.

The partners' common idea for the implementation of the 2020–2030 NDPCP is the following: to identify the population groups and individuals who are at a higher risk of developing type 2 diabetes, in particular individuals with impaired fasting glucose and impaired glucose tolerance, and to reduce the incidence of type 2 diabetes or delay it to a later stage of life by taking action proportionate to the risk, so that persons with diabetes are empowered, i.e. that they have the knowledge, understanding and skills to manage their diabetes and that the medical team where they receive treatment enable and support them to make healthy lifestyle and quality-of-life decisions about things that matter to them and provide them with coordinated and integrated care at all levels of healthcare and by the medical team, regardless of where the persons with diabetes live and what their personal circumstances are, and to help them live in an active society aware of the burden of diabetes on an individual, their family and loved ones, the community and society as a whole and in a society which co-creates a healthy lifestyle through inter-sectoral action aimed at improving the health of all and the development and well-being of society.

Approaches and tools to implement the partners' common idea include, for example, health literacy and support in the process of empowerment for successful self-management of diabetes and quality of life; having clinical guidelines, clinical pathways, cooperation protocols, a care plan, a discharge plan, a care coordinator and a case coordinator; a common approach to health at the level of municipalities; and a new coordination and integration structure or process at the area/regional levels and coordinated and integrated cross-sectoral measures at the area/regional levels and at the level of local communities.

Table of Contents

1. Introduction

The partners' common idea for the implementation of the 2020–2030 NDPCP is to provide conditions for life in a society that co-creates a healthy lifestyle through inter-sectoral measures aimed at improving the health of every individual and the development and well-being of all in an active society that is aware of the burden of diabetes on the individual and their family and loved ones, on the community, and on society as a whole; to reduce the incidence of type 2 diabetes and delay it to a later period in life by identifying population groups and individuals who are at a higher risk of developing type 2 diabetes, in particular individuals with impaired fasting glucose and impaired glucose tolerance, providing them with care by taking action proportionate to the risk, empowering them and providing them with a high level of health literacy, with special attention on individuals with adverse health determinants; to help individuals with diabetes to acquire a high level of health literacy and to be empowered, i.e. to have the knowledge, understanding and skills to manage their diabetes, and to be supported by the medical team where they receive treatment to make healthy lifestyle and quality-of-life decisions about things that matter to them, to be provided with coordinated and integrated care at all levels of healthcare and by the medical team, regardless of where they live and what their personal circumstances are.

Approaches and tools to implement the partners' common idea include coordinated and interconnected inter-sectoral measures at the area/regional levels and in local communities, a new coordination and integration structure or process at the regional level and a common approach to health at the level of municipalities; improvement of health literacy and support in the process of empowerment to strengthen health and quality of life for all and additionally also successful self-management of diabetes for persons suffering from it; and having clinical guidelines, clinical pathways, cooperation protocols, a care plan, a discharge plan, a care coordinator and a case coordinator.

The baselines have been prepared by the partners of the 2010–2020 NDPCP and are based on the reports on the implementation of the Diabetes Prevention and Care Action Plans 2010–2011, 2012–2013, 2014–2015, 2016–2017 and 2018, by way of which the 2010–2020 NDPCP was carried out, on debates at national diabetes conferences in November 2017 and November 2018, on seven short discussions of the 2010–2020 NDPCP Coordination Group in 2018 and on a full-day workshop of the members of the 2010–2020 NDPCP Coordination Group in February 2019, and taking into consideration the recent key analyses and reports in this area. From 15 February 2019 to 10 October 2019, all partners of the 2010–2020 NDPCP discussed the text and adapted the baselines so as to also make it the strategy of development of their institutions by 2030. The representatives of the partners submitted written comments and each partner presented their comments at one of the three Coordination Group meetings which were held in autumn 2019 and devoted to the closing discussion on the baselines. With regard to the agreement reached and on the basis of the results of the external evaluation of the 2010–2020 NDPCP implementation carried out by the Inštitut za multikulturne raziskave (Multicultural Research Institute) and on the basis of data on indicators for monitoring diabetes prevention and care in Slovenia during a longer period of time (by the National Institute of

Public Health (NIPH)), certain new activities and activities revised at the full-day workshop of the members of the 2010–2020 NDPCP Coordination Group held in January 2020, the revised objectives and values of the 2020–2030 NDPCP and an approach to management were included in the 2020–2021 Diabetes Control Action Plan.

On the basis of the finalised baselines prepared by the Coordination Group at the end of January 2020, the Ministry of Health prepared the text of the 2020–2030 NDPCP, including an update on COVID-19. The Ministry of Health organised a public debate on the basis of which the 2020–2030 NDPCP document was presented to the Health Council and approved by the Government of the Republic of Slovenia.

2. Formal framework

In Slovenia, several strategic documents have been adopted at the national level in the past to ensure a more comprehensive and joint approach to certain chronic diseases (Rules on the prevention of cardiovascular diseases, the National Cancer Control Programme 2017–2021, the 2010–2020 NDPCP, the National HIV Prevention and Control Strategy 2017–2025, etc.).

The analysis of the health system in Slovenia leads to the important conclusion that, like many other European countries, Slovenia is also tackling the challenges of an ageing population, which brings a higher burden due to chronic diseases, people's rising expectations, technological progress along with financial constraints, and the need to use resources more efficiently. An important formal legal framework for the preparation of the new 2020–2030 NDPCP is therefore the Resolution on the National Health Care Plan 2016–2025 "Together for a Healthy Society" (Official Gazette of the Republic of Slovenia [*Uradni list RS*], No 25/16), which, in addition to amending the legislation, updating the indicators and the system, and monitoring safety and quality, also defines the importance of a comprehensive approach to the management of chronic non-communicable diseases.

The Resolution on the National Programme on Nutrition and Physical Activity for Health 2015–2025 (Official Gazette of the Republic of Slovenia [*Uradni list RS*], No. 58/15), by way of which Slovenia aims to improve the nutritional and physical activity habits of the population from the earliest period of life to very old age, to stop the increase in obesity in the population and control the incidence of related chronic diseases, including type 2 diabetes, has also had a significant impact on the development of the new 2020–2030 NDPCP. Despite the unfavourable lifestyle there have been some positive developments in healthy eating and physical activity.

The legal bases for the preparation and adoption of the 2020–2030 NDPCP are:

a) the first and second indents of paragraph one of Article 4 of the Health Care and Health Insurance Act (Official Gazette of the Republic of Slovenia [*Uradni list RS*], Nos 72/06 – official consolidated version, 114/06 – ZUTPG, 91/07, 76/08, 62/10 – ZUPJS, 87/11, 40/12 – ZUJF, 21/13 – ZUTD-A, 91/13, 99/13 – ZUPJS-C, 99/13 – ZSVarPre-C, 111/13 – ZMEPIZ-1, 95/14 – ZUJF-C, 47/15 – ZZSDT, 61/17 – ZUPŠ, 64/17 – ZZDej-K and 36/19);
b) paragraph two of Article 2 of the Government of the Republic of Slovenia Act (Official Gazette of the Republic of Slovenia [*Uradni list RS*], Nos 109/08, 38/10 – ZUKN, 8/12, 21/13, 47/13 – ZDU-1G, 65/14 and 55/17);
c) Rules on carrying out preventive healthcare at the primary level (Official Gazette of the Republic of Slovenia [*Uradni list RS*], Nos 19/98, 47/98, 26/00, 67/01, 33/02, 37/03, 117/04, 31/05, 83/07, 22/09, 17/15, 47/18, 57/18 and57/18);
d) recommendations given by international diabetes organisations of which the Republic of Slovenia is a member (general positions of the International Diabetes

Federation and the results of the project on joint EU action JA-CHRODIS in the field of diabetes).

3. Situation analysis

The documents with information for the situation analysis that served as the basis for the 2020–2030 NDPCP are:

1. reports on the implementation of the Diabetes Prevention and Care Action Plans 2010–2011, 2012–2013, 2014–2015, 2016–2017 and 2018–2019;
2. key documents prepared by the 2010–2020 NDPCP Coordination Group from November 2018 to January 2020;
3. evaluation of the implementation of the NDPCP Development Strategy 2010–2020, Zavod Inštitut za multikulturne raziskave (Institute for Multicultural Research);
4. shortlist of indicators for monitoring diabetes prevention and care in Slovenia 2019, NIPH, available at https://www.nijz.si/sites/www.nijz.si/files/publikacije-datoteke/ozji_nabor_kazalnikov_obvladovanja_sb_2019.pdf.

The indicators of diabetes prevention and care in Slovenia show that the percentage of the population with risk factors for developing type 2 diabetes is increasing, that the number of people with type 2 diabetes (both new cases and cases with regard to longer life expectancy) and the number of children and adolescents with type 1 diabetes is rising sharply, and that there are significant differences between regions in health and morbidity and in the provision of certain services (for example access to care provided by diabetes teams at the secondary level). For more information, see the aforementioned document.

The recommendations from the external evaluation of the 2010–2020 NDPCP include:

National Diabetes Prevention and Care Programme 2020–2030: continue to implement the principles of complementarity with other policies and processes in healthcare and in the wider society; strengthen integration with various partners in the field of diabetes prevention and care; set priority programme tasks; connect programme activities with financial resources and define concrete, measurable and attainable goals and responsibilities for members and organisations.

Management and activities of the NDPCP Coordination Group: strengthen the power of the Coordination Group for a stronger impact on policies and actors in the healthcare sector by involving representatives from all Directorates of the Ministry of Health (Public Health Directorate, Health Care Directorate, Long-Term Care Directorate) and other ministries (Ministry of Education, Science and Sport etc.); strengthen programme management structures (for example by setting up working groups and communication channels with the Coordination Group and other relevant structures); establish the decision-making protocol of the Coordination Group; define criteria for membership and occasional involvement of other experts; strengthen mutual communication (providing information on the work of the various profiles, understanding diabetes and how to manage it); provide further support to Coordination Group members in communicating and implementing the programme activities in their own institutions; introduce an ethical code of conduct for the Coordination Group.

Evaluation of the NDPCP: define the methodology and time schedule for the monitoring of the 2020–2030 NDPCP implementation; strengthen the quantitative and qualitative evaluations of individual NDPCP activities.

Terminology upgrade: consider using certain terms in a more appropriate way or replace certain terms, such as diabetic/diabetes patient and lay adviser with more appropriate terms (such as person with diabetes).

Strengthening the role of primary prevention: improve the health literacy of the population and strategic communication with target audiences; emphasise life-long prevention and establish programmes for all population groups: strengthen inter-sectoral cooperation in this field (education and social services); tackle health inequalities; give greater focus to respecting different cultural practices, habits and beliefs; work in the community using the mode of a community-based approach to health.

Improvement of quality of care in the healthcare sector: upgrade the horizontal and vertical integration of care in the healthcare sector by strengthening partnership cooperation between all stakeholders in healthcare, developing patient care protocols to standardise procedures and to provide minimum standards for care, promoting information infrastructure development, and acquiring, exchanging and monitoring data; develop new expert profiles in the health sector (for example podologist/podiatrist, care coordinator) and formalise fields of specialisation in diabetology; identify and reduce disparities in care between regions; provide access to quality education at all levels; encourage discussions on new medicines and medical devices.

Empowerment and integration of the target population: integrate persons with diabetes and/or carers in decision-making processes; organise and implement activities in the local environment; support further efforts to provide mutual support and lay counselling; involve NGOs and civil society stakeholders in education on diabetes and in the promotion of healthy lifestyles.

As some of the identified gaps are systemic, the Ministry of Health also supports the preparation and implementation of the NDPCP after 2020.

4. Importance of the document, vision, mission, principles and approaches

Due to its high prevalence and severe consequences, diabetes is not only a health problem, but also a wider social, societal and economic challenge, and without additional effective measures the burden will continue to rise sharply over the next decade. The 2020–2030 NDPCP is Slovenia's response to the expected increase and the basis for the preparation, implementation, monitoring and evaluation of effective measures to manage the burden of diabetes.

The 2020–2030 NDPCP is also a strategic document aimed at strengthening and expanding cooperation between various partners in society to better provide diabetes prevention and care in the Republic of Slovenia. It is complementary to other health strategies in the country which broadly refer to health promotion, to the management of risk factors for chronic diseases, to the management of all chronic non-communicable diseases and the organisation and financing of healthcare to increase the accessibility and the quality of healthcare services, and also to the Resolution on the National Health Care Plan 2016–2025 (hereinafter: ReNHCP 2016–2025).

The 2020–2030 NDPCP is based on the results of and experience with the 2010–2020 NDPCP and includes the promotion of the health of the population, the prevention of the occurrence of type 2 diabetes and its delay to a later period in life, the early detection of diabetes, care for people with diabetes of any type, and the monitoring of diabetes prevention and care. It sets out the objectives Slovenia wishes to achieve in these areas, proposes changes, and, above all, facilitates better integration between various key partners involved in the fulfilment of the set objectives based on shared values.

In order to carry out the 2020–2030 NDPCP and to implement its objectives successfully, the Ministry of Health adopts two-year action plans in which the processes, measures and concrete activities of key partners are defined. The action plans facilitate better cooperation between partners and integration of activities, the monitoring of results regarding diabetes prevention and care, and reasonable upgrading of future action in this area.

PRINCIPLES AND APPROACHES ON WHICH THE 2020–2030 NDPCP IS BASED:

For the planning and implementation of activities which will contribute to the achievement of the key objectives, the following principles should be taken into consideration:

1. **Complementarity**

The 2020–2030 NDPCP is part of a broader effort to improve the health of the population in Slovenia and to tackle health inequalities. The programme complements, upgrades and relates to activities carried out in Slovenia to prevent and manage chronic non-communicable diseases.

2. Nurturing of partnerships

The development and implementation of effective approaches to prevent diabetes and treat persons with diabetes requires cooperation between different partners both in and outside the health sector. Cooperation is successful if it is based on common values and goals, trust, complementarity and the search for consensual solutions. It is also important that all partners involved recognise the results as their own. Diabetes associations and other civil society representatives play an important role and are a very important partner in the planning and implementation of all activities related to diabetes prevention and care. In communicating with the general public, especially the interested public, the role of the media is also important. Complementarity with other strategies and processes in Slovenia has proven to be one of the key values that further support the development and the nurturing of partnerships among the institutions involved.

3. Reducing health inequalities

All key development documents and strategies support the right of citizens to be provided with maximum health equity. This means, among other things, equal access to the same quality programmes of prevention, early detection and treatment of diabetes, regardless of socio-economic status, age, gender, level of education or place of residence. In this context, the different needs, opinions, beliefs and choices of individuals, groups at higher risk of diabetes and specific groups, such as pregnant women, children and adolescents, need to be taken into consideration in the planning of activities. Special attention should be paid to tackling health inequalities due to social inequalities and other unfavourable determinants of health. The health system should systematically implement tailored approaches to diabetes for disadvantaged and vulnerable groups.

Health inequalities exist between regions in Slovenia, and this is one of the key starting points for the planning of programmes and activities in the future. Environments with poorer health indicators and social determinants of health inequalities generally have higher healthcare needs.

4. Community approach

A community approach is a system whereby "the community approaches the health of its members". This means that the community identifies, provides and coordinates activities to maintain and promote health and reduce health inequalities among its members. In doing so, it preserves the creativity of the individual and their freedom to choose activities for promoting health and makes use of all scientific, technological and institutional development results. The local community approach to health thus means that all those involved in community development, i.e. local actors (local self-government, local civil society associations and the local economy) and representatives of social institutions at the local level (healthcare centres, schools, social services, employment service branch offices, social work centres, etc.)

contribute to improving the health of the population through their involvement in local healthcare strategies.

5. Empowerment and health literacy

Empowerment of persons with diabetes is a process that enables people to take better control of their lives and to strengthen their ability to take action on issues which they themselves identify as important. It can take place at the level of the individual, whereby a person works with healthcare professionals regarding their health and participates in the treatment. It can also take the form of community empowerment, which means that an individual or informed groups strengthen the conditions in their environment which promote health improvement. At the systemic, national level, empowerment means that representatives of organised groups of persons with diabetes are proactively involved in the preparation and implementation of systemic measures such as the NDPCP. In addition to people with diabetes, the empowerment process can also involve others, for example healthcare professionals and their institutions. Complementary to empowerment is health literacy, which means that an individual has the knowledge, motivation and ability (competences) to access, understand, evaluate and use health information to make an assessment and to take a decision on healthcare, disease prevention and health promotion in order to maintain and improve the quality of life in the given situation and in the future.

6. Comprehensive treatment in which a person with diabetes is actively and responsibly involved

A person with diabetes needs coordinated and continuous care in which the person is actively involved and which provides the best possible health outcome. Effective implementation of continuous care requires the cooperation of all those who care for the person in outpatient clinics and hospitals, the team that accompanies the person during outpatient treatment, and the person themselves and their families. The family doctor is key to providing comprehensive care. Persons who have other chronic diseases and conditions in addition to diabetes require special attention in order to be ensured comprehensive treatment. The best outcome for the person is only possible if they are actively and responsibly involved in this process.

7. Coordinated and integrated care

Care is coordinated when a person receives quality care, regardless of the level of health service at which individual elements of care are being carried out, whereby no duplication or omission of elements should occur and where the person receives coordinated information about their health. System-level healthcare integration (WHO definition) means strengthening people-centred healthcare systems by promoting comprehensive and quality care at all stages of life tailored to the different and numerous needs of the population and the individual and delivered by a coordinated multidisciplinary team of providers working in different settings and at different levels of care. Or as one person with diabetes said: "My care is planned, planned with people who work together in order to understand me and my loved ones, with people who

let me take control, who are coordinated and provide healthcare services to achieve an outcome that is best for me."

8. Quality, efficiency and safety

Everyone has the right to life-long quality, effective and safe care, which includes treatment for extremely high blood sugar, blood pressure and lipids and the consideration of other risk factors for chronic complications and mental health aspects and at the same time maximises the quality of life.

9. Diabetes from onset to old age

A person with diabetes is included in different environments at different stages of life. Children with diabetes attend kindergarten and school, and at that time their families are importantly involved in care. Children in this period may also be affected by diabetes if one of their parents or others who are close to them suffer from this disease. The increasing prevalence of type 2 diabetes among the working population also calls for workplace adaptations for persons suffering from diabetes to prevent diabetes and other chronic diseases and workplace adaptations to promote the health of healthy people. There are also an increasing number of women of reproductive age who suffer from diabetes or develop diabetes during pregnancy. During that time, diabetes has an impact on the woman, her family and also on her child. The quality of an individual's life in their domestic environment, in the family, within the wider social network and in the local community has a key impact on their lives, which is an additional challenge of providing diabetes prevention and care to maximise the quality of life. The third stage of life is often accompanied by the individual's re-evaluation of values and choices, but at the same time it also represents an increased risk of developing several chronic conditions and diseases. Diabetes, whether it is a long-time companion or a newly developed chronic disease, is therefore often just one condition, and the quality of life is increasingly dependent on the functional capacity of the individual and their social network.

10. Consideration of achievements in science and ensuring progress by investing in research and development of the profession

Diabetes prevention and care for persons with diabetes are based on achievements in science, professional guidelines, standards, clinical pathways and protocols of cooperation that need to be continuously updated in line with advances in the profession and monitored to ensure quality, efficiency and safe care. Progress in diabetes prevention and care requires ongoing professional development of physicians, nurses and other healthcare professionals, training of professionals from other branches who work in the health sector, and specially trained individuals with diabetes who provide organised support to other persons with diabetes (peer support). In addition to medical knowledge, other skills are also needed, for example skills to carry out health promotion activities, to promote functional integration between different professionals in health teams and for the planning of care. Independent research should be encouraged in all areas of diabetes prevention and care.

11. Monitoring the situation in the field of diabetes

The planning of activities to provide diabetes prevention and care, ranging from health promotion, the identification of persons at higher risk of type 2 diabetes and early detection of the disease to quality treatment of all types of diabetes requires a system of collecting data and their ongoing analysis. This information is the basis for assessing the situation, monitoring the effectiveness of measures being taken and their adjustment, and the planning of new activities. In this way, strategic decision-making and planning of activities are based on relevant information.

12. Monitoring the implementation of the National Diabetes Prevention and Care Programme

The 2010–2020 NDPCP was a development strategy of the Republic of Slovenia and all partners involved in it. It was implemented through two-year action plans prepared and coordinated by the Coordination Group at the Ministry of Health, which included representatives of all partners. This group was responsible for the reporting on the course of action, the obstacles encountered by the partners and the opportunities they perceived. Often, this group could also identify possible ways to resolve obstacles and make full use of the opportunities. The group monitored activities which were initially planned by the partners themselves, who then often invited other partners to work with them, thus extending the results beyond what they could have achieved on their own. In general, the group plans some activities in such a way that several partners are involved from the very beginning. Activities that bring together partners who trust each other work particularly well. Partners consider the NDPCP as part of a broader effort to improve the health of the population in Slovenia and to tackle health inequalities. This approach, upgraded by a steering committee, will also be used in the implementation of the 2020–2030 NDPCP.

5. Method of implementation of the NDPCP

The 2020–2030 NDPCP is based on the findings of the 2010–2020 NDPCP and draws on the decade of experience gained during its implementation. Implementation is based on the consensus of all partners engaged in the NDPCP, as shown in Enclosure 1. Below only a brief summary is given.

Type 2 diabetes can be prevented or delayed to a later stage of life

State of play in 2010: Health promotion activities appear to be insufficiently coordinated and interconnected. Investing in health for quality of life. Preventive medical examinations are primarily aimed at detecting diseases and intervening in the case of persons at high risk of cardiovascular disease and are carried out within a limited age group.

State of play in 2020: The ReNPPTDZ 2015–2025 is being implemented. Calculations show that investment in health is directly connected with the economic situation. Action is focused on proactive participation of the community by building on health promotion through a community-based approach along with the introduction of health promotion centres. Preventive medical examinations are designed to reduce the burden caused by key chronic diseases, including mental health problems, and are targeted at the entire population above the age of 30.

Development trends until 2030: Provision of coherent and inter-sectoral action at national/area/regional/municipal and local community levels after the period covered by the ReNPPTDZ 2015–2025. Investing in health is the basis for progress and the prosperity of society. A community-based approach provides innovative ideas and activities to promote health and reduce the burden of chronic diseases. Preventive medical examinations should be upgraded to ensure that measures are proportionate to the risk of chronic diseases and that the identification of persons at risk of chronic diseases is innovative and that it also includes individuals who have not undergone preventive medical examinations carried out in 2020.

Persons with impaired fasting glucose or impaired glucose tolerance need special treatment

State of play in 2010: Persons at high risk of type 2 diabetes are not precisely identified. The protocol for preventive screening of people with high blood sugar conditions is not precisely defined. However, at the expert level it is clearly stated that type 2 diabetes should be detected as soon as possible and immediately adequately treated.

State of play in 2020: Special emphasis is placed on the care of persons with impaired fasting glucose and impaired glucose tolerance and a diabetes education programme designed for these two target groups is carried out in all health education centres/health promotion centres. Women who had gestational diabetes are also exposed to a higher risk. Registered nurses take charge of preventive medical examinations and the coordination of care for the two groups, including early detection of suspected yet undiagnosed type 2 diabetes.

Trends until 2030: On the basis of properly conducted research activities more precise ways of determining the risk of developing chronic diseases (including type 2 diabetes) are developed and action is tailored to the level of risk. Family medicine services are

complemented by occupational, transport and sports medicine services and the services of pharmacists in pharmacies. Information technology supports decision-making in the healthcare sector, providing people with relevant and credible information and supporting them in lifestyle-related activities.

Type 2 diabetes is a very common disease and requires treatment related to blood sugar, blood pressure and blood lipids

State of play in 2010: Professional guidelines are in place. Education is recognised as the key element of good diabetes care, but it is mostly only carried out in diabetes teams. The population is being acquainted with the ways care can be appropriately organised. The division of tasks between the primary and secondary levels is not clear – it differs between regions and often depends on local circumstances. The activities of pharmacists in pharmacies are not coordinated with the activities of healthcare teams. A need for additional training in areas such as diabetes education, psychological support and teamwork is identified.

State of play in 2020: Medical guidelines are being developed in line with the development of the profession, whereby the preparation process is inclusive. Accessibility of diabetes education is extended to the primary healthcare level through the integration of registered nurses in family medicine teams and the upgrading of programmes in health promotion centres. Key tools for establishing coordinated and integrated care are identified, such as clinical pathways, cooperation protocols, care plans, discharge plans, care coordinators and case coordinators. Sharing and integration between teams at the primary and secondary levels are agreed and are being introduced. The services of pharmacists in pharmacies are extended so as to include the role of consultant pharmacists, but they are still not integrated in other activities. Training of professionals working in the healthcare sector which is related to new approaches and new forms of work is identified as essential and is being put in place, mostly through the process of education.

Development trends until 2030: Professional guidelines include efficiency and safety analysis and other aspects of health technology assessment and knowledge on how to organise care successfully and efficiently. Tools intended for more complex conditions include mind-lines that guide physicians to select the optimum treatment for each individual patient with regard to the patient's associated diseases, wishes and quality of life. Education is adapted to the needs of persons with diabetes and is performed in various ways, including through the use of information technology. Health promotion centres are located everywhere in Slovenia and co-create activities and measures in cooperation with the community. In all settings, care is provided in a coordinated and interconnected manner, including through well-established tools, such as clinical pathways, cooperation protocols, care plans, discharge plans, care coordinators and case coordinators and in other innovative ways. All healthcare professionals perform their tasks and roles in accordance with the agreed division of duties and work together to provide care in an integrated and coordinated manner, of which persons with diabetes are informed. The work of pharmacists in pharmacies is a coordinated part of diabetes care. Professionals who are already working in healthcare are trained for new roles and tasks, new profiles with new competences are developed, and competences are more flexible, especially with regard to the needs of chronic disease management.

Type 1 diabetes: a person with diabetes mimics the function of the pancreas

State of play in 2010: All insulins and medical devices proven to be useful are available, but education in this field is still very demanding. All persons with type 1 diabetes are provided with care by diabetics teams at the secondary level. The transition of treatment from adolescence to adulthood is not yet regulated systematically.

State of play in 2020: All insulins and medical devices proven to be useful are available and information technology significantly simplifies the work; however, education in this field is still very demanding. All persons with type 1 diabetes are provided with care by diabetes teams at the secondary level; however, the division of care with family medicine as regards other conditions is often unclear. The transition of treatment from adolescence to adulthood is gradually getting available to all.

Development trends until 2030: New insulins and other medicines and innovative medical devices relieve a significant burden on the person in terms of self-management. All persons with type 1 diabetes are provided with care by diabetes teams at the secondary level; the division of roles and duties with family medicine teams with regard to the general care for health is clearly defined. The transition of treatment from adolescence to adulthood is well organised for all persons with type 1 diabetes that developed in childhood or adolescence.

Chronic complications of diabetes: stroke, heart attack, kidney failure, blindness, amputation

State of play in 2010: The complexity of care in terms of prevention and early detection of chronic complications is identified. Care procedures for all chronic complications are described on the basis of professional guidelines, including mental healthcare. The importance of clinical pathways to ensure access to appropriate care is highlighted.

State of play in 2020: In addition to the content, the guidelines also set out standards for the organisation of care. Tools that provide quality care include clinical pathways, cooperation protocols, care plans, discharge plans, care coordinators and case coordinators. Emphasis is placed on the importance of support provided by a specially trained individual with diabetes if this activity is carried out in an organised way. Relevant data and information start to be collected to facilitate successful action planning. With regard to individual diseases the following was found: in the case of cardiovascular diseases, accessibility of tests and treatment methods should be ensured; in the case of kidney disease caused by diabetes, it is important to provide equal care for all; in the case of diabetic retinopathy, a network of diabetic retinopathy centres should be developed; for foot health, foot screening should be provided by all family medicine teams and all diabetes teams at the secondary level through timely access to diabetic foot clinics, as should be appropriate care in cases of higher risk of amputation. It is important that a person with diabetes has access to all information important for their health. Emphasis is also placed on raising awareness of mental healthcare and measures in place in health promotion centres and of appropriate oral hygiene and access to dental care.

Development trends until 2030: On the basis of the acquired data, care is organised so as to provide quality and safety and to adapt to the changing needs of persons with diabetes. Key data on the management of chronic complications are monitored annually and on their basis

relevant adjustments are made in the organisation and with regard to other elements of care. At every step of the care pathway, persons with diabetes receive information that they themselves consider relevant for their health and participation in the decision-making process regarding their care. Friendly and high-quality level care is also provided to persons who have multiple chronic diseases or conditions.

When health complications suddenly occur, timely treatment and a plan of how to move forward are required

State of play in 2010: The importance of transition from the chronic period to the period with sudden problems or treatment in hospital is not identified as one of the elements to be specifically highlighted and the 2010–2020 NDPCP does not contain a section related thereto.

State of play in 2020: For a person with diabetes, most of the care is provided on an outpatient basis; however, if they suffer from acute diseases, they are usually admitted to hospital and after being discharged must continue to undergo outpatient treatment. Possible tools are a discharge plan, a discharge coordinator and a case coordinator, in particular in more complex cases.

Development trends until 2030: Transition of coordination and integration of care is provided, although care is implemented by various health organisations.

To live a quality life, persons with diabetes need knowledge, understanding and skills and an environment in which they can participate in the decisions on the treatment of their disease

State of play in 2010: Emphasis is placed on knowledge obtained by the person with diabetes, their understanding and motivation and their responsibility for their own health, and on the role of the medical team in helping and encouraging them and providing them with psychological support.

State of play in 2020: The terms empowerment, self-management and health literacy and the ways how to influence them are defined more clearly; in addition to the responsibility and capacity of individuals with diabetes, importance is also placed on the responsibility and need to establish capacities to create an appropriate environment at the level of the healthcare team and the healthcare organisation. There is a better understanding of habit changes – inner motivation is complemented by support in planning attainable goals and their implementation, the recording of results, raising awareness of progress, and the management of failures.

Development trends until 2030: Conditions, sources and relevant capacities to provide health literacy and support regarding the empowerment for successful self-management of diabetes and a quality lifestyle are set up both on the part of persons with diabetes and on the part of healthcare professionals and organisations.

Diabetes and pregnancy: protecting the baby and the mother

State of play in 2010: Emphasis is placed on the extreme importance of this condition for both the mother and the child. The content of the section is based on expert guidelines.

State of play in 2020: Universal screening tests are required for all pregnant women who have not yet been diagnosed with diabetes. Along with the changed diagnostic criteria, care is extended beyond the diabetes teams at the secondary level, which provided care for pregnant women in the past. Clear clinical pathways and cooperation protocols need to be established. The health literacy of women with gestational diabetes needs to be strengthened, in terms both of taking care of their own health and of transferring these attitudes and skills to the family environment.

Development trends until 2030: After intensive treatment during pregnancy appropriately adjusted and structured care is required in the post-natal period and beyond to reduce the likelihood that the woman develops type 2 diabetes later in life and to increase health literacy in relation to healthy family life.

Management of diabetes in children and adolescents is an investment in the future society

State of play in 2010: Emphasis is placed on friendly and accessible type 1 diabetes care which involves parents and the school and kindergarten environment and on care for the nutritional and physical activity habits of children and adolescents in the light of the threatening incidence of type 2 diabetes.

State of play in 2020: The rapid development of technology has largely facilitated the management of type 1 diabetes. Strengthening the health of children and adolescents through the integration, coordination and upgrading of activities and the management of obesity in their living environment is one of the objectives of introducing health promotion centres, in particular taking into consideration a community-based approach. The measures and activities at inter-ministerial level are planned and supported through the implementation of the ReNPPTDZ 2015–2025.

Development trend until 2030: The accelerating development of medicines and medical devices should make the treatment of type 1 diabetes much easier. The community and the related and coordinated key actors in and outside the healthcare sector provide optimum conditions for a healthy lifestyle for children and adolescents.

Quality monitoring is the basis for continuous improvement of care

State of play in 2010: Quality monitoring is identified as key to action planning; there is, however, a lack of data, information and competences to respond to information.

State of play in 2020: A system to obtain key information and data is being put in place. Quality and safety management providers and the relevant sources and procedures are still not yet clearly defined, while the culture of quality and safety is not yet sufficiently recognised.

Development trends until 2030: The quality and safety management system is in place and it can be co-created as a model area; uniform quality criteria related to mechanisms for continuous improvement of care are set up.

Diabetes from birth to old age

State of play in 2010: The diversity of experience in living with diabetes at different stages of life and in different environments is not yet specifically emphasised.

State of play in 2020: Importance is placed on developing approaches for different stages of life and living environments with a focus on occupational health.

Development trends until 2030: Provision of occupational health and appropriate integration of persons with diabetes in work organisations that are aware of the importance of appropriate working conditions for better health of its employees and of reducing employment-related stigma and discrimination of persons with diabetes.

The organisation of care for people with diabetes involves all levels of healthcare and extends beyond the healthcare system

State of play in 2010: Expert contents provide expert guidelines; the tools planned include the introduction of clinical pathways and quality monitoring.

State of play in 2020: Expert guidelines are the basis for setting up standards for the organisation of care; the need for development and introduction of clinical pathways, cooperation protocols, care planning, discharge planning, care coordinators and case coordinators is identified.

Development trends until 2030: Establishment of a system of monitoring the impact of various organisational models which serves as the basis for the introduction of innovative forms of care organisation that take into consideration the increasing burden of chronic diseases and respond to the needs of sick people who co-create these forms.

Research on diabetes prevention and care extends to many areas which requires constant cooperation

State of play in 2010: Emphasis is placed in particular on basic research and the need for integration and coordination; attention is also given to neglected research areas and research as an important part of the working day of every healthcare professional.

State of play in 2020: Importance is placed on strengthening research in the field of epidemiology, prevention of type 2 diabetes and, above all, the identification of the importance of methods that include natural and social sciences.

Development trends until 2030: Development of basic research and research in science related to improving the organisation of healthcare, acquiring a fundamental understanding by integrating research approaches in natural and social sciences.

Education and training of healthcare professionals makes diabetes prevention and care more effective, while the support provided to people with diabetes by other people with diabetes appropriately trained for these purposes (peer support) makes life easier

State of play in 2010: Emphasis is placed on awareness-raising of healthcare professionals and education, primarily in traditional health professions, through the upgrading of skills in team work, diabetes education and psychological support. The role of specially trained and organised individuals suffering from diabetes (lay advisors) is recognised.

State of play in 2020: Emphasis is placed in particular on training (acquisition of knowledge and skills) for new tasks in healthcare, the establishment of flexible forms of training, in particular for education in diabetes, where also a mentoring network is being set up, and the integration of experts who are originally not healthcare professionals.

Development trends until 2030: Greater flexibility in the training of experts working in the healthcare sector in terms of additional training to acquire new competences, performance of tasks and roles required to reduce the burden of chronic diseases, adapted curricula of the existing educational institutions, and the introduction of new training methods, such as mentoring.

Diabetes associations and other non-governmental organisations take on an important role in diabetes prevention and care

State of play in 2010: For decades, societies and federations of societies have been carrying out activities to improve knowledge and understanding and, in some cases, to acquire skills for successful self-management; they are advocates for health promotion, including organising competitions in the knowledge of diabetes in primary and secondary schools.

State of play in 2020: Traditional activities are being implemented, mostly through traditional approaches, and there are no capacities for the training and organisation of activities for individuals with diabetes who are particularly interested in these activities.

Development trends until 2030: Strengthened, upgraded, modernised, professionally sound and innovative activities to support health literacy and the empowerment process for all persons with diabetes and the organisation of peer support to help other people with diabetes or to help them in other environments in order to make life with diabetes easier.

Managing, monitoring and coordinating the implementation of the national programme and its effectiveness

State of play in 2010: Identification of the need for a structural element – a coordination team to monitor and coordinate the implementation of the national programme through the implementation of two-year action plans with the purpose of implementing the objectives and to introduce long-term horizontal processes.

State of play in 2020: Additional identification of important elements with an impact on efficient strategy implementation, such as pressure from the environment, complementarity with other

policies, importance of participative leadership with key personnel who possess systems leadership characteristics, the culture of the coordination group, the importance of interconnection between groups of healthcare professionals and managers of the health system and policies, and integration of representatives of persons with diabetes if they are impartial advocates for a quality lifestyle of persons with diabetes.

Development trends until 2030: Upgrading the aforementioned elements, identification of windows of opportunity and qualifications to react quickly to them, and willingness to acquire new knowledge and skills and forms of leadership.

Partnership is based on trust and finding consensual solutions

State of play in 2010: Already during the preparation and launch of the national programme it is pointed out that partnership cannot be taken for granted but needs to be cultivated. Trust is built during the preparation of the joint text, but beyond that some mistrust still remains. Efforts are made to include representatives of persons with diabetes, in particular in the role of advocates.

State of play in 2020: In joint activities which have given important results, a high level of mutual trust is established between partners which results in joint planning and the implementation of further activities. The partners are joined by new partners, especially in specific areas of expertise (e.g. ophthalmology and the section of nurses specialised in family medicine); there are first attempts of joint cooperation with the Ministry of Education. Organised representatives of persons with diabetes are proactively involved in the co-creation of activity implementation.

Development trends for 2030: The key partners in the healthcare sector establish even closer ties and develop an even higher level of trust; new partners get involved, in particular those who are active in fields where breakthrough changes are required. The representatives of persons with diabetes have the capacities to initiate new activities and to co-shape the outcomes of all key activities and are successful advocates for diabetes prevention and care, including at the area/regional and local levels and in all settings where people with diabetes live, learn and work.

6. Objectives

The 2020–2030 NDPCP as the development strategy for the following decade is defined by three overall objectives:

1. to strengthen population health with a focus on diabetes through activities that are complementary to other programmes, plans and projects by:
   - providing conditions for a healthy lifestyle and health promotion in Slovenia with regard to type 2 diabetes risk factors;
   - raising public awareness of diabetes;
   - supporting communities (family, local community, work organisation, region, country) to actively co-create an environment in which better health is guaranteed to all, in particular to individuals with unfavourable health determinants;
   - supporting the empowerment of individuals for a healthy lifestyle and strengthening health literacy by ensuring accessibility of health programmes and other health promotion measures to all population groups and by reducing the burden of chronic diseases with a special focus on threatened and vulnerable groups;

2. to delay or prevent type 2 diabetes and increase the chances of early detection in individuals by ensuring early identification and structured care, with measures proportionate to the level of risk of developing type 2 diabetes, and to provide empowerment and a high level of health literacy specifically adapted to individuals with unfavourable health determinants, including:
   - persons with type 2 diabetes risk factors;
   - persons with impaired fasting glucose or impaired glucose tolerance;
   - children, adolescents and pregnant women;

3. to reduce complications and mortality attributable to diabetes and to improve quality of life, including long-term care:
   - through access to coordinated, integrated, holistic, continuous, life-long, effective, safe and quality care that actively involves persons with diabetes in the decision-making process and is based on an appropriate organisation of care and the monitoring of the quality thereof;
   - by providing conditions to strengthen health literacy and support the process of empowerment for successful diabetes self-management;
   - through continuous professional upgrading of the knowledge and skills of professionals working in the healthcare sector;
   - through training and an appropriate organisation of stakeholders outside the health system who can significantly contribute to the care of persons with diabetes.

On the basis of the 2020–2030 NDPCP as a strategic document and on the basis of diabetes prevention and care indicators and the impacts of other activities of the expiring action plan, the 2020–2030 NDPCP Coordination Group prepares, as a rule, two-year action plans for

diabetes prevention and care which include the following: a description of the situation, short-term and medium-term purposes and objectives, processes and strategies for the implementation of these processes, measures and activities for the implementation of strategies with the identified leading partners, a timeframe and specific sources, and a performance indicator related to the implementation of activities. The Diabetes Prevention and Care Action Plan 2020–2021 is attached as Enclosure 2.

7. Stakeholders and their role

We are facing various problems and gaps in individual areas of diabetes prevention and care. These are defined in detail in the NDPCP, which also includes guidelines until 2030. The identification of common courses of action improved the complementarity between institutions that had already been the leading partners in individual activities during the implementation of the 2010–2020 NDPCP. They include: the Diabetology Association of the Republic of Slovenia, the Chair of Family Medicine at the Faculty of Medicine of the University in Ljubljana, the Clinical Department for Endocrinology, Diabetes and Metabolic Diseases of Internal Medicine Clinics of the University Medical Centre Ljubljana, the Clinical Department of Endocrinology, Diabetes and Metabolic Diseases of the Paediatric Clinic of the University Medical Centre Ljubljana, the Chamber of Pharmacy of Slovenia, the Ministry of Health, the National Institute of Public Health, the Ophthalmology Clinic of the University Medical Centre Ljubljana, the Slovenian Diabetes Association, the Chamber of Nursing and Midwifery Services of Slovenia – The Nurses and Midwives Association of Slovenia – the Section of Nurses in Endocrinology, and the Health Insurance Institute of Slovenia. In the implementation of activities also the following partners participate: the Department of Endocrinology and Diabetology of the University Medical Centre Maribor, the Ministry of Education and Sport of the Republic of Slovenia, the Ophthalmology Clinic of the University Medical Centre Ljubljana, the World Health Organisation, the Chamber of Nursing and Midwifery Services of Slovenia – The Nurses and Midwives Association of Slovenia – the Section of Nurses in Family Medicine, and the Slovenian Endocrinology Association.

With regard to the guidelines until 2030, the already established partnerships between partners at all levels of healthcare, the key professional groups and the representatives of the association of persons with diabetes will be the cornerstone of the implementation of the 2020–2030 NDPCP, while integration and cooperation with other partners in the healthcare sector and beyond will be the basis for breakthrough actions necessary to ensure Slovenia's development and its prosperity with regard to the expected burden of diabetes and other chronic diseases.

Leadership, monitoring and coordination for successful implementation of the NDPCP and the nurturing of partnerships based on trust and the search for consensual solutions are of particular importance for the implementation of the NDPCP, and therefore two sections in Enclosure 1 are specifically devoted to these issues.

8. Quality indicators

No	Indicator	Time limit	Responsibility for implementation	Benchmark
1.1	Approval of the 2020–2030 NDPCP by the Government of the Republic of Slovenia	fourth quarter of 2020	MoH	Decision
1.2	Appointment of the 2020–2030 NDPCP Coordination Group	first quarter of 2021	MoH	decision
1.3	Appointment of the NDPCP Steering Committee	first quarter of 2021	MoH	decision
1.4	Assessment of the viability of the preparation of a strategic document on diabetes prevention and care after 2030 and decision to initiate the procedure for preparation	first quarter of 2028	MoH	note in the minutes of the Coordination Group
1.5	External evaluation of the 2020–2030 NDPCP implementation, period 2021–2028	2029	Outsourcer, sources to be provided by the Ministry of Health	Report
1.6	Publication of key indicators related to diabetes prevention and care	Annually	National Institute of Public Health	Report
1.7	Preparation/adjustment of activities on the basis of the reports on Indicators 1.5 and 1.6	Annually	CG	note in the relevant DPCAP
Implementation of NDPCP through two-year action plans				
2.1	Preparation of the DPCAP 2020–2021	first quarter of 2020	CG	Document
2.2	Preparation of the DPCAP 2020–2021 report	fourth quarter of 2021	CG	Document
2.3	Preparation of the DPCAP 2022–2023	first quarter of 2022	CG	Document
2.4	Preparation of the DPCAP 2022–2023 report	fourth quarter of 2023	CG	document
2.5	Preparation of the DPCAP 2024–2025	first quarter of 2024	CG	document
2.6	Preparation of the DPCAP 2024–2025 report	fourth quarter of 2025	CG	document
2.7	Preparation of the DPCAP 2026–2027	first quarter of 2026	CG	document
2.8	Preparation of the DPCAP 2026–2027 report	fourth quarter of 2027	CG	document
2.9	Preparation of the DPCAP 2028–2029	first quarter of 2028	CG	document

2.10	Preparation of the DPCAP 2028–2029 report	fourth quarter of 2029	CG	document
2.11	Preparation of the DPCAP 2030–2031	first quarter of 2030	CG	document
2.12	Preparation of the DPCAP 2030–2031 report	fourth quarter of 2031	CG	document
Participation of partners				
3.1	Share of NDPCP partners with planned activities within the DPCAP	during the preparation of each DPCAP	CG	100%
3.2	Share of partners actively participating in the CG meetings and actively involved in the preparation of the CG products	2020–2030	CG	100%

Abbreviations:

MoH – Ministry of Health, NDPCP – National Diabetes Prevention and Care Programme; DPCAP – Diabetes Prevention and Care Action Plan; CG – Coordination Group at the MoH

9. Timeline for action

Measure	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	
Approval of the 2020–2030 NDPCP by the Government of the Republic of Slovenia	X												
Appointment of the 2020–2030 NDPCP Coordination Group		X											
Appointment of the NDPCP Steering Committee		X											
Assessment of the viability of the preparation of a strategic document on diabetes prevention and care after 2030 and decision to initiate the procedure for preparation									X				
External evaluation of implementation of the 2020–2030 NDPCP, period 2021–2028										X			
Publication of key indicators related to diabetes prevention and care	X	X	X	X	X	X	X	X	X	X	X		
Preparation/adjustment of activities on the basis of the reports on Indicators 1.4 and 1.5	X	X	X	X	X	X	X	X	X	X	X		
Preparation of the DPCAP 2020–2021	X												
Preparation of the DPCAP 2020–2021 report		X											
Preparation of the DPCAP 2022–2023			X										
Preparation of the DPCAP 2022–2023 report				X									
Preparation of the DPCAP 2024–2025					X								
Preparation of the DPCAP 2024–2025 report						X							
Preparation of the DPCAP 2026–2027							X						
Preparation of the DPCAP 2026–2027 report								X					
Preparation of the DPCAP 2028–2029									X				
Preparation of the DPCAP 2028–2029 report										X			
Preparation of the DPCAP 2030–2031											X		
Preparation of the DPCAP 2030–2031 report												X	
All NDPCP partners have planned activities within the DPCAP	X		X		X		X		X		X		

All partners are actively participating in the CG meetings and are actively involved in the preparation of the CG products	X	X	X	X	X	X	X	X	X	X	X	X	

Abbreviations:

MoH – Ministry of Health, NDPCP – National Diabetes Prevention and Care Programme; DPCAP – Diabetes Prevention and Care Action Plan; CG – Coordination Group at the MoH

10. Financial evaluation

In order to achieve the 2020–2030 NDPCP goals, the Republic of Slovenia will continue to finance the activities from the resources of the Health Insurance Institute of Slovenia and the budgetary funds; in view of the current high financial burden in the healthcare sector due to COVID-19, more effort will be devoted to the drawing of European funds, to reforms and to effective system measures.

In the past, Slovenia was successful in drawing European funds for the JA CHRODIS and JA CHRODIS PLUS projects under the 2010–2020 NDPCP to provide diabetes prevention and care.

In the budget, funds in the amount of EUR 400,000.00 per year are provided for the management, monitoring and implementation of measures related to chronic non-communicable diseases under budget item 7083 – Protection of Health and Health Education Programmes, measure No 2711-18-0003 – Management of Chronic Non-Communicable Diseases. These funds are intended in their entirety for the co-financing of health protection and health education programmes and for measures to manage chronic non-communicable diseases, including diabetes.

In its document "Strategic Development Programme of the Health Insurance Institute of Slovenia (ZZZS) for the Period 2020–2025", Section 5.1, "Description of strategic activities of the ZZZS in the period 2020–2025", the Health Insurance Institute of Slovenia states that measures from the already adopted national programmes (prevention, cancer, diabetes and mental health) need to be taken into consideration. In this context, financing should be provided in the long term and as a priority with regard to the burden of individual chronic diseases, and diabetes is definitely one such. On the basis of the 2012 evaluation, direct medical costs of diabetes for 2019 were estimated at EUR 145 million. In 2012, the estimated share of costs for public health programmes amounted to 1.5% of the direct medical costs, while the share of costs for care at the primary level amounted to 4.5% thereof. Diabetes is also associated with high indirect costs, but no comprehensive estimate of these for Slovenia has been made so far.

For new technologies to be published in the guidelines (including medicines), uniform criteria for all branches of healthcare will need to be defined (not only diabetology), taking into consideration professionally developed and approved cost-effective mechanisms.

From the financing aspect, the objective of the 2020–2030 NDPCP is to invest into measures that substantially comply with the overall objective of the NDPCP and are cost-effective, which means that they reduce the burden of chronic complications of diabetes and hospitalisations that could have been prevented through effective outpatient treatment and also indirect costs, such as costs related to temporary absence from work and the loss of future earnings.

The share of investments in public health programmes, in treatment at the primary level and specialist outpatient treatment at the secondary and tertiary levels, in hospital treatment of

conditions that cannot be treated in outpatient clinics, and in rehabilitation should be increased and adequate supply of medicines and medical devices, including new ones, should be provided. For persons with diabetes and their families, efficient long-term care is also extremely important.

Taking into consideration the new situation caused by COVID-19, the 2020–2030 NDPCP provides a framework and bases for the planning and financing of programmes and activities related to the treatment of persons with diabetes within the framework of drawing European funds, the available national budget and the general agreement for the current contractual year being adopted by partners and approved by the Government of the Republic of Slovenia.

11. Glossary of Terms

Causes, risk factors and markers, and health determinants

Every disease and medical condition has its causes. Chronic diseases may be associated with genetic or biological characteristics and other causes, risk factors and markers, and health determinants. There are different types of causal factors. Cause is a generic term that refers to numerous and various factors (bacteria, behaviour, environmental circumstances, personal characteristics, etc.) without which a disease would not have developed. This means that without one single factor the disease would not have occurred. Causes are necessary for the development of the disease, but are rarely sufficient in themselves. In a common discussion, we usually look for the cause retrospectively: "Doctor, what caused my heart attack?" The term "risk factor" is, however, often used prospectively, in discussions about whether a disease can occur or not. Risk factors usually refer to factors that work at an individual level and increase the probability of disease development: these are factors that are neither necessary nor sufficient. The language of probability is appropriate, because there are only a few factors that definitely cause a disease. "Smoking is a risk factor for developing lung cancer" implies a causal influence, but it does not mean that every smoker will get lung cancer. Some other characteristics (for example age or ethnic origin) can be described as risk markers/indicators, which means that they are not actual causal factors but identify people who are more likely to develop the disease. Youth can be a risk marker for car accidents: not primarily because the person is young, but because the behaviour that leads to accidents seems to be more common in young people. The determinant is often described as "the cause of causes" – which means the basic factor that causes direct causal factors and provides an explanation for them. Determinants are often related to social characteristics, such as poverty, lack of a social safety net or inadequate legislation to prevent poor eating habits among young people. Determinants help to explain disease patterns and the incidence of the disease in a population. Determinants also explain the disease incidence rate in a population, while risk factors indicate who the individuals likely to get a disease are. There are many factors involved in the development of the disease, and it is therefore not reasonable to talk about a single "cause". For chronic diseases in particular, different people can develop the same disease, but this may be associated with different causal factors. For example, a disease may have a causal component that is itself insufficient (this factor alone will not cause the disease) but is a necessary component of a set of factors that are altogether necessary for a disease to develop (because a disease can develop through different causal pathways); if the whole set of factors is present at the same time, the disease can develop. This means that there are parallel but still independent sets of causal influences.

Behavioural, social and structural health determinants

The purpose of this explanation is to emphasise the mutual determinism of behavioural, environmental and biological determinants. There is no doubt that the behaviour of an individual is related to health and disease. In fact, individual responsibility and guilt have too often been over-emphasised and the cause of health problems has simply been attributed to

the individual's negligence, carelessness, ignorance, recklessness and selfish behaviour; instead, the solving of health problems should have been focused in particular on the individual's social and physical environments. No matter how the behaviour is related to the explanation of the development of a chronic disease from a moralistic aspect, the behaviour is an inevitable variance associated with the incidence of an individual's disease and the prevalence of the disease in the population. One purpose of public health is thus to strengthen individuals' behaviour associated with better health, to protect individuals from the behaviour of others, and to encourage the behaviour of groups to influence the social and physical environments in relation to health. The social health determinants are circumstances in which people are born, in which they grow, live, learn, work and age, and are shaped by a series of forces that exceed the control of the individual. These are intermediate health determinants, "the downstreams" of structural determinants. They include material conditions and psychosocial and behavioural characteristics. They also include people's living and working conditions, such as pay, access to housing and healthcare. Structural determinants are the "basic reasons" of health inequalities, because they shape the quality of social health determinants faced by people in their neighbourhoods and communities. Structural determinants include the governance process, economic and social policies that affect wages, working conditions, housing and education. Structural determinants also have an impact on the resources needed for health, i.e. whether they are equally distributed in society or are distributed unequally with regard to race, gender, social class, geographical location, gender identity or another defined social group.

Culture in healthcare

Culture is a buzzword and often an overused term. In this context, it means deep-rooted beliefs and values, officially adopted mindsets, and patterns of behaviour. In the healthcare system, culture still mostly refers to doctors and hospitals. The curricula for the education of professionals working in the health sector often do not focus sufficiently on the strengthening of knowledge, skills and competences to provide care that would actively involve the sick and take into consideration the expanded roles of other occupational groups. Each healthcare system consists of a complex set of many cultures. Action undertaken to change these cultures is often the key to improving the quality of care for persons with chronic diseases. The dialogue between directors or managers of healthcare organisations and healthcare workers is extremely important, while clinicians who object to changes can be a major obstacle on the path of improvement. Clinicians in key leadership positions can help understand the values of healthcare professionals and can encourage commitment to cooperation in planning and implementing changes. Changes at the level of changing culture require a lot of energy.

Health Literacy

Health literacy means that an individual has the knowledge, motivation and ability (competences) to access, understand, evaluate and use health information to make an assessment and take a decision on healthcare, disease prevention and health promotion in order to maintain and improve the quality of their life in the given situation and in the future.

Empowerment

Empowerment is a process that enables persons to increase their control over their lives and strengthens people's ability to take action on issues they themselves consider important.

Self-management

Chronic disease self-management includes tasks that people can carry out themselves or with the help of a healthcare professional to reduce the impact of the disease on their own health condition. This means that they need skills to monitor health problems and clinical markers of the chronic disease, to understand the consequences related thereto, and to adjust the use of medicines, treatment and behaviour accordingly. Diabetes self-management means taking action on the basis of the outcome of self-control; self-control primarily means that people measure their blood glucose level themselves, which can also include self-monitoring of urine glucose and ketones in blood or urine. In the broadest sense, care for health is described by the term "self-care", which includes not only successful self-management of glycaemia, but also the control of other risk factors for cardiovascular diseases, detection of chronic complications and care for one's general health condition.

Improved effectiveness of approaches in public health to reduce the burden of chronic diseases

Measures to improve effectiveness are understanding the theory of change and activities and actions that reach all actors in various sectors of society, the actors involved having the capacity to respond appropriately and the public health system having the competences needed to achieve health as one of the objectives of the development of society.

Life-course approach

Public health uses the life-course approach as a tool for understanding the connections between time, exposure to a factor or combination of factors, experience, and subsequent health-related results. A life-course approach can be helpful in identifying and understanding the health results in the population and the links between different life stages. By using this approach, actions can be put in place to create the conditions for optimal population health and well-being.

Provision of case coordination

There are several different models of providing case coordination. Model 1: in this system, the case manager is a professional who carries out the tasks of coordinating integrated care and is a member of one team; the advantage of this model is that a single member of the team possesses the entire expertise and that persons with the disease clearly understand who it is that provides them with integrated care; there is, however, the risk that other members of the team continue to provide "treatment as usual" and that there is no coordination in the wider team. Model 2: in this system, the case manager is a professional who works with different

medical teams at the primary level; the advantage of this model is that a single member of the team possesses the entire expertise; the risks, on the other hand, are that the person with the disease does not really know who is responsible for the coordination of care and that the manager has less understanding of the dynamics in each individual team and is not familiar with the expectations of the members of each team, while the number of tasks must be limited, because the acquisition of information on all circumstances is extremely complex but, of course, the coordinator must know all the key data. Model 3: in this system, there is a case coordinator, but he or she operates outside the team and is assigned to the team on a case-by-case basis. The advantage of this model is that all other members of the team must extend their services and their own competences to coordinate the case, while the person with the disease can participate in the selection of their case coordinator, which can have a positive impact on the confidence of the person with the disease, improve the quality of interaction, improve the satisfaction of team members and provide a greater variety of tasks for the case coordinator. There is, however, a risk that the case coordinator may not develop all the competences if there is no specific training and no interest on the part of other team members in such a manner of working.

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Enclosures:

Enclosure 1: Programme Implementation Methods and Guidelines until 2030

Enclosure 2: Diabetes Prevention and Care Action Plan 2020–2021