Long-term care – the problem of sustainable financing (Ljubljana, 18-19 November 2014)

Slovenian Reform of the Long-term Care System[1]

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Introduction

Slovenia ranks in the upper third of the EU Members with the highest share of the population over the age of 65. This trend will continue to increase and the population over the age of 80 will grow particularly fast.

Ensuring a quality, active and healthy ageing in Slovenian society will require adaptations of the existing social protection systems as well as development of patterns of actual intergenerational cooperation and solidarity in the society. Well-functioning social protection systems, which are adjusted in a consensual manner and based on intergenerational cooperation and solidarity, are of key importance for the well-being of the entire population.

The needs and expectations of elderly are related to maintaining or strengthening of the acquired social rights as well as personal and generational dignity. In this context, the most important for them are a stable pension policy, the availability and quality of health care and long-term care services and a comprehensive employment policy for elderly. Rising life expectancy should not be perceived and addressed as a social burden but as an important social development potential.

Description of the current state of LTC provisions

Currently, there is no uniform system of long-term care (LTC) in Slovenia. Different forms of LTC services and benefits are provided within the health care system, social and parental protection system, pension and disability system and the system of care for the disabled, and are regulated by the different acts covering these areas.

LTC in Slovenia includes benefits in kind (health care and social care services in the form of residential/institutional care, community and home care) and cash benefits (attendance allowance according to the pension and disability regulations, attendance allowance to the minimum income beneficiaries, assistance and aid

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allowance for severely disabled people, attendance allowance according to the regulations on war-disabled persons and war veterans, special child care allowance for LTC, partial payments for loss of income of a household member providing care).

Cash benefits are provided according to different acts and are paid directly to the person in need of care (to the parent in the case of children). There is no uniform correlation between the level of need of recipients and the amount granted. The amounts are granted according to different acts and are set in different sums and depend on the status of the recipient. Still, a person is entitled to only one cash benefit (even if it is entitled to it under various acts).

The providers of LTC services can be public or private entities. Private providers are selected through public tenders, granted concession with limited duration and have to fulfil the same conditions as public providers. In the area of institutional LTC slightly less than 40% of providers are private ones (with concessions). The standards for provision of LTC services are quite strict (regarding the number of staff, qualifications, procedures, technical equipment and premises) and are defined by the state in the case of social care services (both institutional and home care), and by the Health Insurance Institute in the case of health care (institutional and home) services. Standards of care for comparable needs can differ because of different legislative bases for different types of users.

There is no unified entry point or a standard model of LTC needs assessment. The eligibility for a service is linked to the service in question and is made by a team of experts (GP, nurse, social worker) in the case of institutional care or by individual expert – in the case of home care a social worker. Cash benefits are granted upon application and approval of the expert team led by GPs.

Four modes of LTC provision can be distinguished in the current Slovenian system of LTC, as seen in Table 1.

Inpatient LTC (institutional care) is organised by homes for elderly, special social institutions, centres for training, occupation and care and centres for education of children with special needs. Persons staying in residential care are provided with integrated health and social care services. The costs of accommodation are also part of institutional LTC service. At the end of 2011 inpatient LTC was provided for 5.0% of population aged 65 years and over.

At the end of 2011 there were less than 400 users of organised **day care**, which accounts to 0.1% of population aged 65 years and over. They were mainly included in day care organised by homes for elderly.

More than 20,000 people received **home – based LTC services** at the end of 2011; 4.7% of population aged 65 years and over; mostly community nursing care and home help. Home-based LTC is organised by community nursing care, home help, family assistant, personal assistance and housing groups.

In 2011 there were in total 41,832 recipients of **cash benefits** related to LTC (Attendance and Allowance Supplement based on 6 different acts), of which 60.5% were aged 65 years and over. However, if the overlap between cash benefits and services in kind is taken into account, there were only 18,334 recipients of cash benefits who only received cash benefit and were not included in any other LTC service. Only the cash benefit was received by 2.1% of population aged 65 years and over.

Table 1: LTC provision in Slovenia, 31. 12. 2011

	Recipients	***Recipients aged 65 years and over***	***% of population aged 65 years and over***
Inpatient LTC (in institutions)	21,093	17,088	5.0
Day cases of LTC	377	214	0.1
Home-based LTC	20,991	16,199	4.7
LTC cash benefits	18,334	7,106	2.1
Sum	60,795	40,607	11.9

Source: Nagode M. et al, 2014.

It is estimated that there were altogether 60,795 recipients of formal LTC at the end of 2011; this accounts to 11.9% of population aged 65 years and over. Inpatient LTC (in institutions) is very well developed and spread in Slovenia. It has a long tradition. On the other hand, home-based LTC started to develop approx. 20 years ago. It is not well spread and developed. Even though, as seen in the Table 1, the number of people receiving home-based LTC at home is relatively high, such care is not so intense and comprehensive as in the case of institutional treatment.

Funding for LTC comes from several sources: compulsory pension and disability insurance, compulsory and complementary health insurance, the national budget and the budgets of municipalities (plus out-of-the-pocket contributions of users). Health care benefits in kind (services) are financed from the compulsory and the complementary health care insurance. Social care services are partly financed from state and municipal budgets, and partly paid by the users (recipients and their family). Out-of-the-pocket payments for social care LTC services depend on the financial situation of a person in need. In case a person has insufficient financial means, the relatives and/or the municipality cover expenses of residential or home care services. Health and social care LTC services for disabled children and disabled youth in full-time education are entirely (in the case of youngsters in full-time tertiary education only partially) covered by the health care insurance and the state budget.

Total expenditure on LTC in 2012 amounted to 1.35% of GDP (2011: 1.30%), of which public expenditure was 0.98% and private expenditure 0.37% of GDP. As seen from Table 2, the expenditure for LTC system is increasing over the years, mainly due to increased number of users. In relative terms, the private expenditure increased most (see Graph 1) especially private expenditure on long-term social care services (out-of-the-pocket payments of users). These mainly involve co-payments for accommodation and food in residential homes for the elderly, which raised mainly due to an increase in capacity (new homes for the elderly), and a higher, and hence more expensive standard of care in new, mostly private homes run on a concession basis. Private expenditure has been increasing much faster than public expenditure for a number of years. Therefore, in terms of financing sources, the share of total LTC accounted for by private expenditure increased in the period 2005-2012 from 22% to 27%, respectively. While in terms of functions of care (health or social care), the share of long-term social care in total LTC increased from 27% to 32%[2] (IMAD, 2014 a).

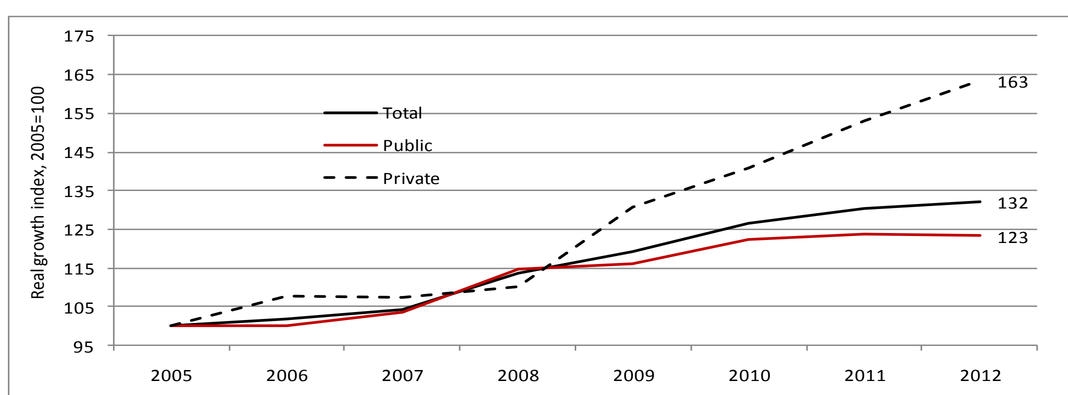
[2] In June 2014 the Statistical Office published the data on LTC expenditure for the period 2003-2012 which are revised according to the methodology of the SHA 2011, therefore the structure of LTC by function (health vs. social care) has been changed in favour of LTC health expenditure (HC.3).

Table 2: Expenditure on LTC by source of financing and by function, 2005-2012

						Nominal growth index	Average annual real growth rate, in %
	2005	2007	2009	2011	2012	2012/2005	2012/2005
Expenditure on LTC by source of financing (in million EUR)							
Total	314	349	429	469	477	152	4.1
Public	245	269	325	347	347	142	3.0
Private	70	80	104	122	131	188	7.3
Share in GDP (in %)							
Total	1.09	1.01	1.21	1.30	1.35		
Public	0.85	0.78	0.92	0.96	0.98		
Private	0.24	0.23	0.29	0.34	0.37		
Structure (in %)							
Public	77,8	77,2	75,7	74,0	72,6		
Private	22,2	22,8	24,3	26,0	27,4		
Expenditure on LTC by function (in million EUR)						Nominal growth index	Average annual real growth rate, in %
Total	314	349	429	469	477	152	4.1
Health care	230	256	303	321	324	141	2.9
Social care	84	93	126	148	153	182	6.8
Structure (in %)							
Health care	73.3	73.3	70.7	68.5	67.9		
Social care	26.7	26.7	29.3	31.5	32.1		

Source: SORS, July 2014; calculations by IMAD. Note: Data are based on the OECD, Eurostat, WHO System of Health Accounts methodology, 2011.

Graph 1: Expenditure on long-term care in Slovenia, 2005-2012

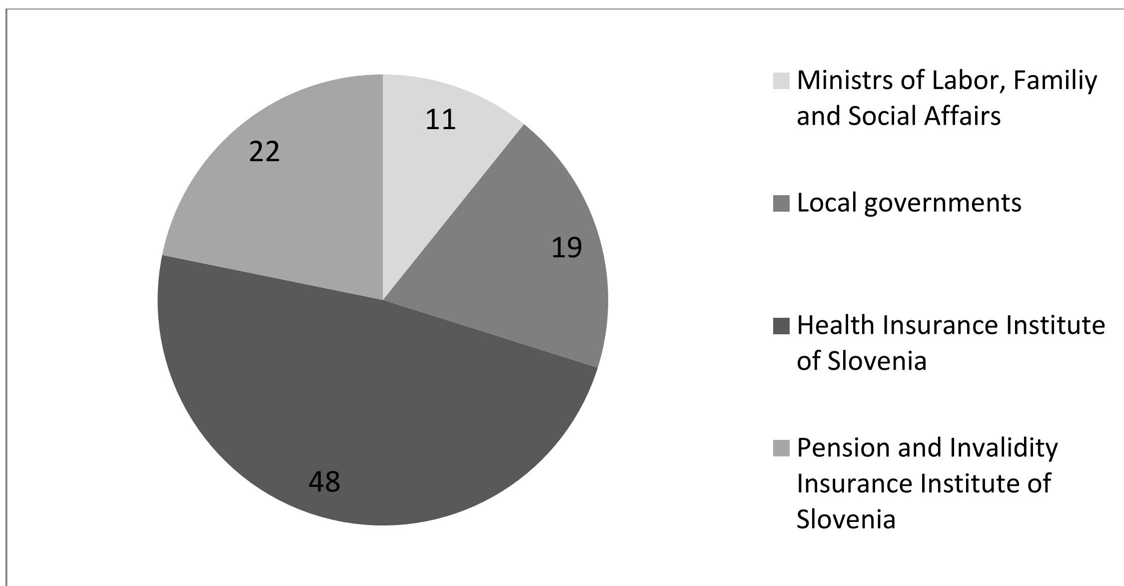


Source: SORS, 2014; calculations by IMAD. Note: Data are based on the OECD, Eurostat, WHO System of Health Accounts 2011 methodology.

In the **structure of public expenditure** on LTC almost half is financed by compulsory health insurance (Health Insurance Institute of Slovenia - HIIS). These funds are intended for health care in institutions for elderly, disabled adults and

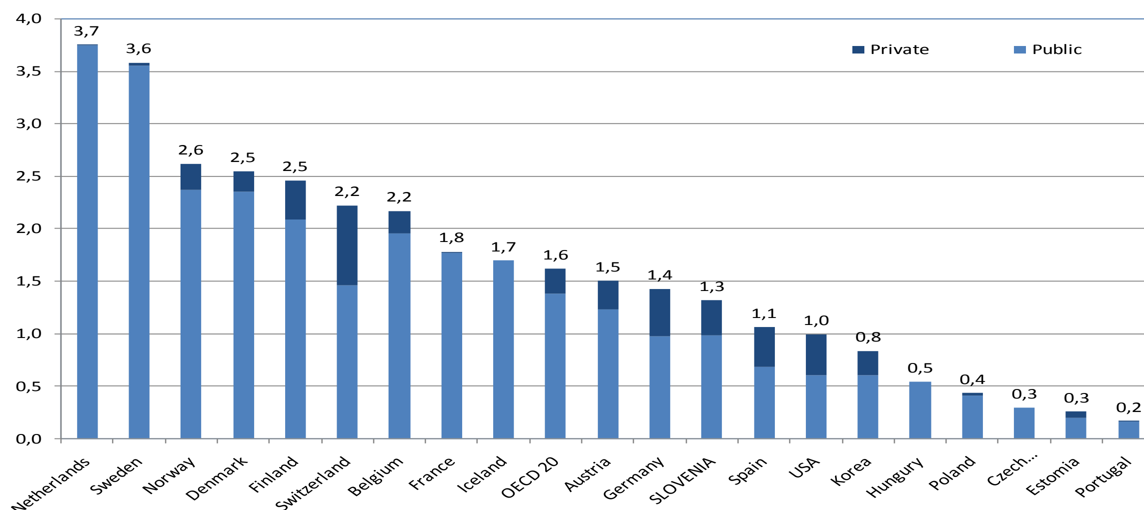
severely disabled children, hospital in-patient LTC and part of community nursing care. Pension and Invalidity Insurance Institute of Slovenia (PDII) contributes 20% of all public expenditure on LTC, namely expenditure on care allowances. Care allowances are partly covered also by the Ministry of Labour, Family, Social Affairs and Equal Opportunities (MLFSA) with 10% of public expenditure on LTC. These funds of the HII, the PDII and the MLFSA (together 80% of public expenditure) are used to finance long-term health care. The remaining 20% of public expenditure is intended for long-term social care, which is mostly financed by local government budgets and to some extent by the state budget (particularly the MLFSA).

Graph 2: The structure of public expenditure on LTC by source of financing, Slovenia, 2012



Source: SORS, 2014; calculations by IMAD. Note: Data are based on the OECD, Eurostat, WHO System of Health Accounts 2011 methodology.

Graph 3: Total expenditure on LTC as % of GDP, Slovenia and OECD countries, 2011



Source: OECD Stat 2013.

The social and economic reasons justifying the reform in the field of LTC

The existing LTC arrangements in Slovenia are rather un-coordinated, fragmented and non-transparent. The discussions (expert and political) on the need for changes and unification of the LTC system, and indicative plans for the reform started already 10 years ago. In 2004, the Government of the time adopted the starting points of the LTC system reform, emphasising that in the circumstances of an ageing society the need for LTC is a social risk that must be recognised and insured for, as it is in the case of health insurance, unemployment insurance, disability insurance, insurance for retirement, etc. This statement remained the main starting point of all discussions around the reform of LTC system in Slovenia.

Besides the systemic reasons for a reform of the LTC system, there are also important demographic, fiscal, economic and social reasons for a reform.

In March 2014 the Eurostat released new population projections[3] indicating that Slovenia is among the EU countries projected to witness the above-average increases in the number of elderly and the old-age dependency ratio by 2060. The number of persons over 65 years is projected to more than double relative to the working-age population (20-64) by 2060[4]. The number of the persons in the oldest age group (over 85), which rose rapidly over the last 13 years[5], will continue to increase (their share will increase from 2% to 7% of the population). The projections suggest that the share of the elderly will grow rapidly already in the period 2020–2030. This will step up the pressure on age-related expenditure, as the demand for pensions, health care and LTC will increase, whereas the share of the working-age population will contract, creating problems in securing revenue (IMAD, 2014 b). It is estimated that about 15% of the population aged 65+ will need some form of LTC. While currently in Slovenia there are around 50,000 people over 65 in need of LTC, by 2020 their number is expected to increase to 60,000 and by 2030 to 75,000 people.

Table 3: Shares of population Slovenia in different age groups for the period 2013 to 2060

	Population aged 0-14 (%)	Population aged 15-64 (%)	Population aged 65 or more (%)	Population aged 80 or more (%)	Old-age dependency ratio (%)
2013	14.5	68.4	17.1	4.5	25.0
2020	15.4	64.3	20.4	5.4	31.7
2030	14.0	61.1	24.8	6.7	40.6
2040	13.6	58.7	27.8	9.5	47.4
2050	14.8	55.3	29.8	11.1	53.9
2060	14.7	55.8	29.5	12.3	52.8

Source: EUROPOP 2013

[3] See also IMAD, Slovenian Economic Mirror, April 2014, Selected topic – EUROPOP2013 population projections.

[4] At the beginning of 2013 there were 26.9 over 65-year-olds dependent on 100 working-age people; by 2060 the figure will rise to 58.3 (EUROPOP2010: 63.4).

[5] At the beginning of 2016 the number of such in Slovenia had increased by 60% compared to 2000.

The relatively fast demographic ageing of Slovenia has many consequences in different areas. It increases pressures on social protection systems notably the pension, health care and LTC systems. It raises the need for different LTC services, especially for the home and community based ones, as well as for other services that are at the moment underdeveloped (for example, dementia related services).

Ageing affects also the fiscal sustainability of LTC systems. Long-term projections prepared by Ageing Working Group (European Commission, 2012) show that in Slovenia, public expenditure for LTC, as a share of GDP, will already by 2020 increase by 0.3–0.8 p.p. of GDP and by 1.4–4.2 p.p. of GDP by 2060. The growth projection in percentage points is similar to the EU average. In 2013 the OECD formulated two scenarios of LTC expenditure growth: (i) a cost-containment scenario, assuming that LTC policy will manage pressure on expenditure growth with appropriate measures, and (ii) a cost pressure scenario assuming that current policies will continue. OECD projections assume that public expenditure on LTC would more than double by 2060 under the cost containment scenario[6] and triple in the absence of policy change[7] (Maisonneuve C. and Martins O., 2013).

From the social point of view, it is important to note that at-risk-of-poverty rates among elderly people are over the EU average and the average monthly pensions are relatively low (565 EUR monthly in 2013).[8] Elderly people in Slovenia typically have low current income (pensions) but, on the other hand, often have accumulated other assets.

In the context of low pensions the increase in the out-of-the-pocket contributions of users of LTC can be problematic and can lead to social problems in the future as it puts substantial number of elderly people with the need of LTC and their close relatives in a situation when they can't afford formal care. In the situation of a lasting economic crisis the problem of out-of-the-pocket payments already became visible in decreasing scope of formal LTC, especially institutional (decreasing number of older people in care institutions). The unemployed people and families with low income more often than in the past decide to keep their elderly relatives, who need LTC, at home and to provide them with informal care instead of sending them to institutions. It was estimated by Association of Social Institutions of Slovenia that in 2013 alone, around 3% of institutional care users left institutional care for their homes or to live with their relatives. This is not necessary problematic. But there is no monitoring of or control over whether the domestic informal care is actually appropriate for the person in need, and there is no support and training for domestic carers.

Information on the envisaged reform

Future demographic changes that are greater in Slovenia than in the average of the EU28 present additional pressures to the fiscal sustainability of the pension, health care and social protection systems. Moreover, demographic changes have highlighted the interdependence of pension, health care and LTC systems. It is becoming clear that all three systems will have to be reformed in a correlated and coordinated way. The reform of pension system has been high on the political agenda and was already carried out in 2012, while the health care and LTC systems are still at the beginning of reform efforts.

[6] Assuming that expenditure per beneficiary increases at half the rate of labour productivity growth.
[7] Assuming that future expenditure per beneficiary grows in line with aggregate labour productivity.
[8] Monthly amount of poverty threshold for a single person household in 2013 amounted to 606 EUR.

The need for a reform of the LTC system and plans for it have become part of strategic documents, such as the main national development strategy in the area of social protection in Slovenia - the Resolution on the National Programme of Social Protection for the period 2013-2020 (passed in the parliament in April 2013). Besides the plan for a LTC reform the Resolution emphasises the development of community based services and unification of health and social home care services. In the draft Operational programme for the use of structural EU funds in the new financial perspective, the emphasis is also on de-institutionalisation and support for the development of community based services (such as day centres, smaller residential units, etc.).

Since 2012, the LTC reform has been high on the political agenda again. A working group for the methodological and statistical issues regarding LTC was established in 2012[9]. The group decided to follow the OECD definition of LTC and collect data based on the structure of services and rights according to SHA (System of Health Accounts) methodology (OECD, Eurostat, WHO, 2011). The first set of data on expenditure and recipients were already collected and published, including the data related to LTC system that were missing before (on users of different services, on financing and similar). A comprehensive group report was published in June 2014 (Nagode et al. 2014).

At the end of 2013, the Government of Slovenia adopted the starting points of the reform of LTC system, including the calendar for the reform. It was agreed that the first step of the reform will be the preparation and adoption of new legislation covering the whole LTC system and thus unifying it. A working group for the preparation of the new legislative Act was established, composed by representatives of three ministries (covering areas of health, social affairs and finances), different associations of users, different associations of service providers, the institutes of Health Insurance, Pension Insurance, and Macroeconomic Analysis and Development. The awareness of the fact that the reforms of health care system, health insurance and LTC should be connected has increased. However, due to different reasons (also collision of interests and lack of political agreement) the health care reform of previous government was stopped as there was no consensus on its direction (again, especially in terms of financing and fiscal sustainability of the system). The question whether it will be possible to make a reform of LTC without an accompanying reform of the health care system and the health care insurance remains open.

From September 2014, Slovenia has a new government, which has defined the introduction of health care reform and regulation of LTC system among the highest priorities. Views of the new government basically correspond to the starting point for the reform of LTC from 2013, however, an important difference is the belief that LTC reform should be linked to the reform of the health care system.

One of the key proposals related to health care reform is the abolishment of complementary health care insurance[10] and its replacement by levy tax. Hence,

[9] Appointed by Statistical Office of the Republic of Slovenia and led by Social Protection Institute of the Republic of Slovenia. The working group includes representatives of all main actors providing data on long-term care (in addition to already mentioned institutions, the Institute of Macroeconomic Analysis and Development, the Ministry of Labour, Family Social Affairs and Equal Opportunities, the Ministry of Health, the Slovenian Community of Social Institutions, the National Institute of Public Health, the Pension an Disability Insurance Institute, the Institute for Economic Research and the Health Insurance Institute of Slovenia).

[10] Currently more than 95% of insured by compulsory health insurance in Slovenia is also included in voluntary complementary health insurance. The main reason for so high coverage of the population by voluntary complementary health insurance is that the

public health care would be financed with more solidarity and would provide fairer distribution of financial burden among population. In addition to health care contribution rate, which is the current financial source for compulsory health insurance, health care levy would be calculated progressively in a specific share of insured's income (in %). Instead of charging voluntary complementary health insurance flat rate premium, the reform would introduce surcharge in form of health (and if agreed also LTC levy). The rate of levy would depend on individual's income.

It is planned that health care reform will also include the redefinition of the basic benefit basket, where certain so called 'low value' health services would be delisted. Therefore it can be expected that some new additional private resources will be used for financing health care, and consequently, one could expect that there will be some room left to finance LTC services from available public resources in compulsory health insurance or new compulsory levy which will replace current system of voluntary health insurance.

The new LTC act will be titled Act on long-term care, personal assistance and long-term care insurance, and will regulate both the LTC content (services) and the stable financing of the system. Thus the Act will regulate:

- LTC insurance and financing of activities;
- the definition of beneficiaries and rights (services);
- the procedure of claiming the rights (including needs assessment);
- the provision of LTC services;
- the providers of LTC services and the provider of LTC insurance.

The Act will also regulate the area of personal assistance to disabled persons, who fully depend on assistance of another person (as a form of community care), including:

- the definition of personal assistance (definition of the beneficiaries, services that are financed, relation to other LTC services);
- the providers of personal assistance;
- the particularities of financing the personal assistance;
- the procedure of claiming the personal assistance in relation to procedures for claiming other LTC services;
- the provision of personal assistance in relation to provision of other LTC services.

The draft Act is based on the agreement that the need for LTC is a new social risk for which the residents of Republic of Slovenia have to be insured within the system of public social insurances.

Currently, the regulation of obligatory social insurances in Slovenia is made in a way that contributions are paid by both employers and employees (including self-employed). Inactive persons (e.g. children and youngsters in full-time education) are insured either through their active close relatives or the reduced contributions for them are paid from the state and municipal budgets (the unemployed,

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extent of rights to health care services in compulsory health insurance is defined in a percent share of the total service costs. This means that the compulsory health insurance covers the majority of health related risks, however, not necessarily all of them and neither in full. Co-payments for some key health services and medicines is very high, therefore nearly all population takes out also a complementary insurance with private health insurance company to cover the balance. The problem and the main reason for the abolishment of this system is that the premiums are flat and too high for some groups of population with low income, hence there is no income solidarity in the system.

beneficiaries of minimum income). For example, in Slovenia there are more than 600,000 pensioners, and they do not pay directly any public social insurance contributions (part of compulsory health insurance for them is covered from the state budget), while they are nearly 100% included in the voluntary complementary health insurance. While currently only the active (working) population is burdened by compulsory public insurance contributions, the premiums for complementary health insurance are paid also by inactive population (with the exception of children until the age of 18 and students who are fully covered by compulsory health insurance). It is planned that the new public source for LTC will burden the entire adult population (active as well as inactive).

According to the new draft Act, in the future the provision of LTC services and rights will be financed from:

- a compulsory public insurance, based on the merged parts of the existing health and pension insurance intended for LTC expenses;
- tax based financing with the introduction of special private contribution (levy/tax) for LTC provision;
- out of the pocket payment with an optional voluntary private LTC insurance.

The new Act will also deal with new arrangements of LTC provision in a way that the users will have the access to quality integrated services, mainly in the local environment (community and home based services) or cash benefits or a combination of both.

The draft Act envisages a single entry point (one stop shop) and a uniform expert procedure for LTC needs assessment, based on 15 criteria related to managing basic and supportive life activities. The person in need will take part in the needs assessment procedure and will at the end decide for the type of care and support needed and preferred (services or cash-benefit or a combination of both or technical aid including the possibility of adaptation of the place of residence). If the person in need decides for cash-benefit to be used for informal domestic care, the informal carer has the right to appropriate training and advice; and the supervision of the domestic care is also envisaged.

The proposed minimum threshold to enter the LTC system is the need of ADL and IADL services for at least 3.5 hours per week over a minimum of 3 months. The final decision on the threshold, the scope and the content of the rights and provisions will be decided upon after the findings of a project on a micro-simulation model carried out by the Institute for Economic Research are available.

The estimated effects of the planned reform

With the new legislation, Slovenia is planning to introduce financing of LTC based on principles of social-risk insurance. The main aim of the LTC reform is to ensure fiscal sustainability of the LTC system, on one hand, and to increase social security and the quality of life of persons dependent on care and assistance, on the other hand. The new (reformed) system should provide access to quality LTC services that will enable care and support to individuals in need, especially in home and local community environments. The reformed LTC system should also have a positive effect on the reduction of poverty among elderly people (which is above average now). As the average pensions in Slovenia are relatively low, and the extent of out-of-the-pocket payments of people in need has been increasing, this currently means a strong pressure on the budgets of elderly and their families. With the planned system of financing the LTC, the out-of-pocket contributions will be reduced and for some categories of users these will not be necessary any more.

It is envisaged the new system would also encourage a more responsible health behaviour of individuals (through differentiated insurance payments), and enable the introduction of systematic prevention, development of rehabilitation services and the use of ICT in the delivery of LTC.

The merging of the different sources of LTC financing should provide more transparency and effectiveness in this area.

Individual planning, participation of users in the process of preparation of personal care plans and the responsibility of providers for realisation of individual care plans are the planned mechanisms that should also ensure more effective use of funds.

The reorientation from the presently prevailing institutional (residential) care to more community and home based care should also have some positive financial effects on the budget (less new investments for institutional infrastructure and redirection of funds to new jobs in community and home based services).

In the context of planned Slovenian reform we would like to discuss Member States' experiences specifically related to the following questions:

1. Due to the expected rapid growth in demand it is important to provide some flexibility in future LTC funding. We would like to discuss different models of financing the LTC:
    a. What are the advantages of different models of LTC financing (based on the general taxes, insurance contributions or mixed models)? Presentation of the differences in the systems of financing of long-term care and the pros and cons of the various approaches;
    b. To what extent should one and how can one best integrate (direct/indirect) private resources in funding of LTC?
2. Possible answers to the fact that on the long run the active part of the population alone would not be able to bear the whole financial burden of the financing of pensions, health and long-term care (sharing the burden of funding between all age groups, including young people); cf.: EU-long-term projections of age-related spending (pensions, health care, LTC), putting the sustainability of existing public funding systems into question;
3. The question of the necessity of simultaneously and in a coordinated manner reforming the health care and the long-term care systems while also taking into account changes in pension schemes;
4. How to reduce the need for LTC services and thus limit expenditure growth, including by:
    a. Improving the health of people older than 65 (how to raise the number healthy live years?);
    b. Strengthening the primary health care -treatment of chronic patients;
    c. Ensuring sufficient emphasis in social protection against LTC dependency on prevention and early rehabilitation?
    d. Using ICT to increase the capacity for independent living and raise the efficiency of care delivery?

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