ESPN Thematic Report on Challenges in long-term care

Slovenia

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Directorate-General for Employment, Social Affairs and Inclusion
Directorate C — Social Affairs
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European Social Policy Network (ESPN)

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

The ESPN is managed by the Luxembourg Institute of Socio-Economic Research (LISER) and APPLICA, together with the European Social Observatory (OSE).

For more information on the ESPN, see:
http:ec.europa.eusocialmain.jsp?catId=1135&langId=en

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Summary

There is no single, overarching legislative act in Slovenia that covers long-term care (LTC). Due to population ageing, the number of elderly needing LTC has been increasing. In 2015, there were 61,084 recipients of long-term care (SI-Stat Data Portal, 2017). The split between institutional and home care is 50/50. It was estimated (Majcen et al., 2016) that in 2015 there were 104,000 people receiving informal care in Slovenia, plus 35,500 persons with unmet needs. That same year, the expenditure on LTC amounted to EUR 489.4 million (1.27% of GDP). As much as 72.8% of total expenditure is public, and 66.9% is used for health care (SORS, 2017).

The affordability of long-term care (evaluated by comparing the incomes of the elderly and the price of care) has been worsening since 2007. Especially rural areas frequently do not provide sufficient institutional care or home care, while urban areas tend to offer a wide range of services. Quality of LTC is difficult to judge as, except for monitoring and minimum standards, there is no quality or safety assurance and no strategy at the national level. For institutional care, the employment data are not analysed at the national level, but there are data available on home care. The home care employment data show an increasing burden of care (each social worker cared for 7.8 users in 2016 and for 7.2 in 2015), but the forms of employment have shifted from irregular to regular: 96.2% of carers were in regular employment in 2016, compared to 61.8% in 2010.

The burden of informal care for dependent relatives remains mostly within the family – and falls mainly on women. Projections of financial sustainability show a deficit and indicate a need to increase contribution rates by 2060.

A draft Act on LTC was prepared at the end of 2017. It has been criticised by several stakeholders (e.g. Association of Social Institutions of Slovenia, Health Insurance Institute of Slovenia, Social Protection Institute of the Republic of Slovenia) for being vague on many points: financial sustainability was not presented for the medium or long term; the estimated resources were based on an unclear distribution of users; rights were not clearly defined; and the criteria for placing recipients in different care categories were not included in the draft Act. This made it difficult to understand the rights of individuals; there was confusion regarding public/private services provision and capacities, as well as over the education required for better long-term provision; quality of care was not tackled; and the draft Act is too medically oriented, not taking social issues into account sufficiently.

The recommendations to improve access, adequacy, quality and sustainability of the LTC system refer to external factors, such as inclusion of the elderly in the labour market, active and healthy ageing programmes, provision of a safe environment for the elderly, and social inclusion. Further recommendations introduce possible improvements that reflect current shortcomings within LTC, such as a lack of quality guidelines and indicators in all forms of care.

1. Description of the main features of the country's long-term care system(s)

Due to population ageing in Slovenia and the complexity of need arising from multiple chronic conditions among the elderly, the development of a delivery system that can ensure the proper interface of health and long-term care is essential.

At present, long-term care (LTC) is the responsibility of the Ministry of Health and is regulated under different sets of legislation, including pensions (Pension and Disability Insurance Act, War Veterans Act and War Disability Act), health care (Health Care and Health Insurance Act), as well as social and family care (Social Assistance Act, Social Assistance Benefits Act, Exercise of Rights to Public Funds Act, Parental Protection and Family Benefit Act, and Act on Social Care of Persons with Mental and Physical Impairments). As yet, there is no single, overarching legislative act specifically regulating long-term care (EU, 2014; Črnak Meglič et al., 2014). This means that, at present, LTC is provided through different routes across the health, social care, and pension and disability sectors, with different entry points and different procedures for the assessment of entitlement to supplements in support of long-term care needs (Nolte et al., 2015).

As Table 1 shows, at the end of 2015 there were 61,084 recipients of long-term care, or 334 more than in 2014 (SI-Stat Data Portal, 2017). Of these, 36.7% were in institutional long-term care and 35.4% were receiving home-based long-term care services; 27.2% received cash benefits and less than 1% used organised day care services. The data on their distribution across types of care show that the number of recipients of LTC services in institutional care approximately equalled the share of recipients of LTC services at home.

Table 1: Long-term care provision in Slovenia, 2012-2015

	2012	2013	2014	2015
Institutional care	20,974	21,902	22,173	22,415
Home-based care	20,446	20,744	20,995	21,612
Day care	444	485	434	487
Cash benefits	17,261	17,181	17,148	16,570
Total	59,125	60,312	60,750	61,084

Source: SI-Stat Data Portal (2017).

Institutional care is traditionally well developed in Slovenia. In 2015, there were 94 homes for the elderly (54 public and 40 private). Both the number of institutions and the number of residents have been increasing since 1990. During the last 15 years, there has been a trend towards privatisation.

Home care for the elderly consists of community nursing and home help. Community nursing is carried out by community nurses, on instructions from a family physician. It covers the medical care of a patient at home (or in a social institution), like wound care, injections, taking samples for laboratory examination, etc. Community nursing services are fully covered by compulsory health insurance. Community nurses are employed by healthcare centres that are geographically spread across Slovenia. Currently, there are 57 public healthcare centres at the primary level.

Persons entitled to home help are those whose psycho-physical capabilities enable them to function at home and keep in satisfactory mental and physical condition, with occasional organised help from another person(s). This group also includes persons over 65 who are – due to age or age-related factors – incapable of fully independent living. The person in need fills out a special request form for home help and submits it to the relevant local Centre for Social Work. Upon receipt of the application, a social worker visits the person in need to make an assessment of his/her situation, and then together

they define the services needed. Home help is financed from the user's own funds and municipality budgets. The user fees are income related, with 10 income brackets. The local Centre for Social Work may grant partial or full exemption from payment for long-term care services to users of institutional and community-based services. Full or partial exemption from payment is determined on the basis of a cap on spending and the ability of users (or their families) to pay for the services. Where the user payment does not cover the cost of the long-term care provided, the remaining amount is paid by the municipality or central government.

The only cash benefit relevant for the elderly (65+) is the assistance and attendance allowance. It is granted to, among others, retired residents of Slovenia who need assistance in meeting their basic needs. These needs are assessed by the Disability Committee of the Disability Insurance Institute of the Republic of Slovenia, to whom the request for assistance and attendance allowance is submitted by the general physician or the person in need himself/herself (Rules on the Organisation and Functioning of Expert Bodies of the Pension and Disability Insurance Institute of the Republic of Slovenia, 2013 and 2015). Beneficiaries must be residents of Slovenia. The allowance is not means tested; the scheme is financed by the Disability Insurance Institute of the Republic of Slovenia. There are three different rates of assistance and attendance allowance, ranging from EUR 292.11 to EUR 418.88 per month (Declaratory Decision on Assistance and Attendance Allowance Rate, 2013). There is no care leave system for long-term care of the elderly.

The number of people depending on others to carry out activities of daily living will increase significantly over the coming 50 years. Taking the 230,000 residents who lived with severe limitations due to health problems in 2013 as the baseline, an increase of 21.5% is envisaged up to 2060 (to around 282,000). Of these, 43,000 are projected to receive institutional care, 40,000 home care and 100,000 cash benefits (EC, 2015). A recent draft Act on Long-term Care raised the issue of potential informal care recipients of LTC (and particularly the number of them). Using the SHARE project data (5th wave) for Slovenia, Majcen et al. (2016) calculated that 104,000 people aged 50 and over were receiving informal care in 2013 (13% of the population of that age group) (Table 2). In terms of unmet needs, the same study estimated that 35,000 people aged 50 and over had at least one limitation in carrying out activities of daily life (ADL) but received no care (either formal or informal) in 2013. The estimated number would be higher if instrumental activities of daily life (IADL) were taken into account.

Table 2: Number of recipients of informal care and unmet need for LTC in Slovenia, 2013

	Number	%	Share of total population 50+
ALL (informal and unmet needs)	138,973	100	17
UNMET needs	35,307	25	4
INFORMAL CARE	103,666	75	13
ALL (informal care)	**103,666**	**100**	**13**
Almost every day	48,802	47	6
- no ADL limitations	31,283	30	4
- one or more ADL limitations	17,519	17	2
Occasional help	54,864	53	7

Source: Majcen et al. (2016).

In 2015 in Slovenia, total expenditure on LTC was EUR 489.4 million, or 1.27% of GDP (SORS, 2017). Almost three quarters (72.8%) of this expenditure was financed from public sources and the rest (EUR 133 million) was covered from private sources. The Health Insurance Institute of Slovenia (HIIS) spent EUR 163 million on LTC (45.8% of all

public expenditure on LTC). The spending under health insurance is mainly intended for the provision of health care in nursing homes, hospital inpatient LTC and community nursing. The Pension and Disability Insurance Institute of Slovenia (PDIIS) contributed EUR 79 million (for assistance and attendance allowance) – 22.2% of public expenditure on LTC. Expenditure is also partly covered by the Ministry of Labour, Family, Social Affairs and Equal Opportunities, which contributed a further EUR 35.3 million, or 9.9% of public funds. The municipal budgets contributed EUR 78.8 million (SORS, 2017; IMAD, 2017).

Considering LTC by function of care, expenditure on health care increased by 42% in absolute terms between 2005 and 2015 (from EUR 230 million to EUR 327 million), but fell from just over 73% to under 67% of total LTC expenditure in the same period (Table 3). The spending on social care increased by almost 93%: its share of total LTC expenditure increased from 27% to 33%. Within the health care function, about 72% of total expenditure was allocated to institutional LTC and 27% to home-based LTC. Most of the expenditure on the social care function of LTC is private (paid by the person receiving care) and is used to pay for accommodation and food in nursing homes and other forms of institutional care, as well as for household expenditure on home help. Based on the rules set by the Government (Decree on the criteria for defining exemptions in the payment of the services, 2004 and 2006), the competent local Centre for Social Work decides on partial or complete exemption of the user from the payment for services. The Decree defines the social security threshold, set as the amount of money that has to remain at the disposal of the user of the services after payment. Further on, the Decree defines the ability to pay – the maximum amount that the user is able to contribute to the cost of LTC services. If the amount paid by the user (and/or other liable person)[1] does not cover the service costs, the difference is made up from the local community or central government budget. In this case, the user must apply for exemption from payment of the total costs at the relevant Centre for Social Work.

The local communities can decide on additional exemptions from payment of the costs of home care services. If the user of the LTC service who is seeking exemption from payment owns real estate, the written order on exemption places a lien on that real estate, preventing it from being sold or mortgaged, so that the local community can recoup the amount paid for institutional care from the user's estate. If the user asks for exemption from payment for home care LTC services, the lien applies only to real estate that is not the user's permanent residence.

As regards informal care, the family is the main provider of care for older people in Slovenia. Most Slovenes (60%) consider it the children's responsibility to care for older people; this figure is higher than the EU average (48%) (EC, 2007). A Eurobarometer study has shown that almost two fifths of Slovenes see the solution to a family care-provision issue as cohabitation with an old, disabled family member (Hvalič Touzery, 2007). Traditionally, the family plays a very strong role in ensuring good living conditions – not only in terms of care and finances, but also with regard to the housing issue (Cirman, 2006). Hence, there is a very strong tradition of multigenerational households in Slovenia.

[1] Liable persons are a spouse and a long-term partner, or other persons in case of specific legal contracts.

Table 3: Long-term care expenditures by source of funds and purpose, Slovenia, 2005-2015

	2005	2010	2013	2014	2015
LTC expenditure (in million EUR)					
Total	314	450	471	487	489
- Public	245	339	342	356	356
- Private	70	111	130	131	133
Share in GDP (in %)					
Total	1.08	1.24	1.30	1.30	1.27
- Public	0.84	0.94	0.94	0.95	0.92
- Private	0.24	0.31	0.36	0.35	0.35
Structure (in %)					
- Public	77.8	75.3	72.5	73.1	72.8
- Private	22.2	24.7	27.5	26.9	27.2
Expenditure in GDP by function (in million EUR)					
Health care	230	315	314	328	327
- Institutional care	n.a	n.a	227	228	238
- Day care	n.a	n.a	0.9	1	1
- Home care	n.a	n.a	86	99	88
Social care	84	134	157	159	162

Source: SORS (2017).

2. Analysis of the main long-term care challenges in the country and the way in which they are tackled

Access and adequacy challenge

The LTC health services financed by the HIIS are free of charge and are covered through contributions collected under the compulsory health insurance system. Conversely, social LTC services are only partially subsidised by the state or municipality. Access to publicly subsidised long-term care services is means tested. If the amount paid by the user (and/or other liable person) does not cover the service costs, the difference is made up from the local community or central government budget. If the user of the LTC service who seeks exemption from payment owns real estate, the written order on exemption places a bar on the sale or mortgaging of that real estate, so that the local community can recoup the amount paid for institutional care from the user's estate. If the user seeks exemption from payment for home care LTC services, the bar applies only to real estate that is not the user's permanent residence (Decree on the criteria for defining exemptions in the payment of social assistance services, 2004 and 2006).

In 2015, institutional care covered 4.86% of the population aged 65 years and over; this proportion has been decreasing since 2012 (see Figure A1 in Appendix). Institutional care is running at full capacity, and the occupancy coefficient (Figure A2) has been almost 100% since 2010. Municipalities vary in their ability to provide adequate community-based long-term care services for older people; in particular, there are differences between urban and rural areas (Hlebec et al., 2014). Available evidence suggests that especially rural areas frequently do not provide adequate institutional care and home care, while urban areas tend to offer a wide range of services (SSZS, 2016).

Affordability is getting worse for the elderly in institutional care: the shortfall between the average pension per day and the daily cost of LTC has been increasing since 2010 (see Figure A3 in Appendix). The cost of home help varies across municipalities and providers – from EUR 0 (in the municipality of Odranci) to EUR 8.43 (in the municipality of Vodice) per hour. The average confirmed cost of services peaked in 2012 at EUR 5.27 per hour, before decreasing until 2015, when it amounted to EUR 5.04 per hour. In 2016 it again increased – to EUR 5.11 per hour. The total amount spent on home help in 2016 was EUR 21.96 million.

At the end of 2016 there were 7,374 users and 79 providers of home help in Slovenia. Home help is available in 123 out of 211 municipalities every day in the morning and afternoon. In 58 municipalities, it is available only on weekdays in the morning. As concerns potential unsatisfied need, it would seem that at the end of 2016 there were 680 users of home help who needed more home help than was actually available to them, and 700 non-users who were eligible to receive home help. Due to various approaches to the organisation of social home care across municipalities, access to services varies greatly, especially regarding financial accessibility (Lebar et al., 2017).

Quality challenge

There is no national LTC quality management strategy in Slovenia, and the field is not regulated. The LTC quality indicators have not been defined at the national level, but are rather being introduced via the E-Qalin model.[2] Currently, 16 homes for the elderly possess the internationally accredited E-Qalin certificate, and seven more have an E-Qalin certificate on the basis of self-evaluation (Firis Imperl d.o.o., 2017). Quality assurance in the healthcare part of LTC is regulated by healthcare quality indicators, defined in the National Strategy on Quality and Safety in Health Care 2010-2015 (Simčič, 2010), clinical pathways and quality indicators. Currently, inspection is still the main mechanism for assessing the quality of care in LTC. The Ministry of Labour, Family, Social Affairs and Equal Opportunities is responsible for social care inspection, while the Ministry of Health is responsible for the inspection of health care.

In 2014, Hlebec et al. carried out a study on a sample of 4,917 users of home care in 154 municipalities. Most of those users (80.4%) were happy with the amount of help provided. The main reason (in 61% of cases) for not receiving care was its cost. Among those who needed more help, the majority would prefer it to come from a social care worker (58.9%). The others would prefer help from a daughter (29.8%), son (28.8%) or partner (13.5%). Only 10.3% of users would choose institutional care. Satisfaction was measured in terms of timing of care (87.9% of users were happy), duration of service (88.2% were happy), and good work and attitude (93.6% were happy). The figure was somewhat lower for accessibility of service in urgent cases (sudden need) – 64.5% were satisfied with that. Unfortunately, further information on the quality of jobs, working conditions and training is not available.

Employment challenge

The number of social workers providing home care has been fairly stable since 2010; it reached 943.3 employees, on average, in 2016, of whom 96.2% had a permanent contract (61.8% in 2010). One social worker cared for 7.8 users in 2016 (7.2 in 2015). According to Hlebec et al. (2014), most of the social workers (93.4%) were satisfied with their work with users, as well as the freedom and flexibility of the work (86.6%). They were less happy with the opportunities available to contribute to decision making (60.6%), working time (66.9%), and education and development possibilities (53.3%). The main issue was physical strain, causing backache, neck pain and physical tiredness.

[2] The E-Qalin partnership developed standards and methodologies for the quality management in social care. Standards are based on a bottom-up model. The development of the E-Qalin model started in 2004 in five countries: Austria, Germany, Italy, Luxembourg and Slovenia. In 2004, it was first applied to institutional care only (homes for the elderly in Slovenia).

Less than a third of the workers felt stressed, worried, unsure or unhappy with their income.

In 2015, there were 11,040 employees in institutional care, with 1.87 users per employee. There was no difference between private and public homes (SSZS, 2016).

There are 200,000 family members and 20,000 neighbours (around 10% of the Slovenian population) taking care of chronically ill or/and elderly persons in need (SPIRS, 2010). The Social Protection Institute of the Republic of Slovenia (SPIRS) organises courses for informal carers (a course is organised at least once a month; each lasts 8 weeks and takes up 2 hours per week). These are free of charge for participants. The courses are financed by company donations. There are also many local initiatives and projects to arrange education and training courses, a telephone line to support informal carers, etc. So far, no initiative to support informal carers has come from the state. Adequate workplace arrangements for informal carers are not available. Discussion of skills validation for informal carers to assist them in becoming LTC professionals is also lacking. Generally speaking, the burden of informal care for dependent relatives remains a female issue. It is evident that more women than men are inactive or in part-time employment due to family responsibilities or because they are looking after children or incapacitated adults (see Table A2 in Appendix). To achieve a significant improvement in conditions for the reconciliation of long-term care and work, more flexible employment arrangements are needed for employees with LTC obligations. There is also a clear need for the training of, and more support for, informal carers – such as respite services, an allowance to compensate for (part of) the cost of respite services, social security insurance of informal carers, etc. (Stropnik and Prevolnik Rupel, 2016).

Financial sustainability challenge

Using a dynamic microsimulation model, Majcen et al. (2016) made projections of LTC expenditure, based on the reference and risk scenarios (EC, 2015). The projection for sources and expenditure if no reforms or changes are implemented shows a big increase in the shortfall in LTC funding, reaching 1.4% of GDP by 2060 (compared to the current 1.27%). Further projections included the changes proposed by the draft Act on LTC, including the abolition of complementary health insurance and the introduction of a special LTC levy. As the system would still not be sustainable, it was calculated that it would be necessary to increase the contribution rate, in order to cover the difference between sources and expenditure (see Table A1 in Appendix).

Assessment of the recent or planned reforms

The draft Act on LTC (MoH, 2017) was opened to public debate on 20 October 2017. In the course of this, it turned out that the financial sources and the issue of financial sustainability were not properly defined and formulated. The draft Act has been criticised for being vague on several points. First of all, LTC financing is not clear: there are doubts as to the accuracy of the estimated sources needed. It is fact that the calculations of the costs of formal care were based on the structure of recipients of informal LTC, where virtually nobody is in the highest care category.[3] The existing financial sustainability projections were not taken into account in preparation of the draft Act (see Table A1 in Appendix). Rights are left to be defined by sub-laws, in clear violation of Article 87 of the Slovenian Constitution, which states that all rights and obligations are to be defined only

[3] In a recent study (Majcen et al., 2016), the structure of recipients of informal LTC was estimated by category of care. The authors presumed that there were not many recipients of care in the highest (most severe) care category. If a recipient needs a lot of care, he/she is usually transferred to formal care. When the financial projections were under preparation to estimate LTC expenditure, the estimates for the structure of recipients of informal LTC were used to estimate the structure of recipients of formal LTC, although more recipients of formal care are expected in higher categories of care. This means that the total LTC expenditure was underestimated.

by laws and not by inferior legislation. Due to such ambiguities, it is impossible to define the life situations of, and consequences for, potential recipients of LTC solely on the basis of the (draft) Act on LTC. Five categories of care (rights) are defined in the draft Act, which draws on German legislation (Pflegestärkungsgestz II). However, the draft Act does not take into account the differences between the Germany and Slovenian systems, such as the recipients' income levels. Criteria for classifying recipients into care categories are not part of the legislation. Since these criteria are a crucial tool for the definition of rights, they ought to be part of the Act. A lot of LTC recipients in the current system are estimated to be left out of the system (ASSS, 2017). The requirement for providers to be public providers is not clear: being public is conditional on the fulfilment of certain quality and safety criteria, which makes the draft Act discriminatory. In spite of demographic trends (population ageing), the draft Act does not present financial and capacity projections, and so it is not possible to determine whether the relatively high new levy to be implemented, in combination with other financial sources, would suffice to cover the needs of the population for LTC in the coming years. It was estimated that the proposed 30% out-of-pocket coverage of LTC service costs is far too big a burden for the population.

In substance, the challenges in the LTC system remain the same as in recent years: to ensure access to quality services for people who need them.

Policy recommendations to improve the access and adequacy, quality and sustainability

It is very important that LTC is not seen as a separate system, since the number of LTC users depends on measures and policies taken outside, as well as within, LTC. Some policy recommendations that do not relate to LTC policies directly, but that have an impact on LTC through other policies, are:

- labour market (training and education programmes for the elderly, skills development; measures to change the attitude of employers and the general public towards the elderly; incentives for employers for the employment and prolonged employment of older workers; intergenerational cooperation in the workplace, introduction of more flexible employment arrangements for employees with LTC obligations),
- health care (active and healthy ageing; preventive healthcare programmes, decreasing inequalities in health; ensuring quality of life in families; efficient social system),
- social inclusion, volunteering through the use of ICT, intergenerational cooperation and exchange, protection and rights of the elderly), and
- adequate environment for the elderly (infrastructure, traffic, residential space, development of new products and services, education).

The second set of recommendations is related to issues within LTC, such as: ensuring proper financing of the LTC system through a combination of sources; development of criteria to define the rights of LTC users; development of ICT support and quality guidelines and indicators in all forms of care; development of support guidelines and education programmes for informal carers; preparation of a single Act on LTC to achieve a better coordination of LTC.

3. Analysis of the indicators available in the country for measuring long-term care

In this section, only those indicators are listed that are available in national administrative databases. As already noted, the databases that include LTC indicators have not been built systematically, as Slovenia does not have a separate LTC system. Even the basic data – such as lists of services across institutions, costs of services and the number of recipients of various forms of care – are not available from administrative

national sources, but only from surveys and ad-hoc research. There are no specific indicators on the quality of LTC. The available data can be grouped into seven categories.

Demographic data (adequacy and access)

Source: Statistical Office of the Republic of Slovenia.

Available at: http://pxweb.stat.si/pxweb/Dialog/varval.asp?ma=05C4002S&ti=&path=../Database/Dem_soc/05_prebivalstvo/10_stevilo_preb/20_05C40_prebivalstvo_obcine/&lang=2Twice a year data.

- Share of population 65+ (in %) – '*Delež prebivalcev, starih 65 let ali več (v %)*'
- Coefficient of ageing for men/women/total – '*Indeks staranja za moške, Indeks staranja za ženske, Indeks staranja*'
- Average age in years – 'Povprečna starost prebivalcev'
- Population growth (per 1,000 population) – '*Skupni prirast (na 1.000 prebivalcev), Naravni prirast (na 1.000 prebivalcev)*'
- Share of population aged 15-64 in % – '*Delež prebivalcev 15-64 v %*'
- Number of births and number of deaths (per 1,000 population) – '*Število umrlih in število živorojenih (na 1.000 prebivalcev)*'
- Age pyramids according to 5-year age groups and gender, for municipalities and Slovenia - '*Prebivalstvo po petletnih starostnih skupinah in spolu, občine, Slovenija*'.

Sheltered Housing (number and location) – '*oskrbovana stanovanja*' (adequacy and access)

Source: Social Protection Institute of the Republic of Slovenia.

The data includes the municipality, name and address of sheltered housing, along with its geographical latitude and longitude. Available at: http://www.irssv.si/upload2/zemljevid_pregled%20OS_2.png

Annual data.

'Elderly for Elderly' project (access)

Source: Slovene Federation of Pensioners' Associations.

The data includes data on volunteering from the 'Elderly for Elderly' project (Number of active volunteers, Number of elderly in the programme). Available at: http://www.zdus-zveza.si/docs/STAREJ%C5%A0I%20ZA%20STAREJ%C5%A0E/Knjiga_SZS_2017.pdf

Annual data.

Data on the programmes for elderly, co-financed by Ministry of Labour, Family, Social Affairs and Equal Opportunities (access)

Source: Social Protection Institute of the Republic of Slovenia.

The data consists of lists of programmes. Available at: http://www.irssv.si/programi-socialnega-varstva

Annual data.

Home care – public network (affordability and access)

Source: Social Protection Institute of the Republic of Slovenia.

Available at: http://www.irssv.si/raz-porocila/socialne-zadeve#dolgotrajna-oskrba-in-varstvo-starej%C5%A1ih

Annual reports.

- Price for users in EUR – '*Cena storitev za uporabnike v EUR*'
- Accessibility of service on working days, in the afternoons, on Saturdays, Sundays and holidays – '*Dostopnost storitev ob delavnikih, popoldne, sobotah, nedeljah in praznikih*'

- Economic price of service per hour in EUR – '*Ekonomska cena storitve na uro v EUR*'
- Provider of services – '*Izvajalec storitev*'
- Share of persons 65+ in LTC across municipalities – '*Delež prebivalcev, starih 65 let in več, po občinah, v dolgotrajni oskrbi*'
- Number of LTC users – '*Število uporabnikov dolgotrajne oskrbe*'
- Co-financing of LTC by municipalities – '*Sofinanciranje dolgotrajne oskrbe s strani občin'*
- Location of services – '*Lokacija storitev'*.

Institutional care (affordability and access)

Source: Association of Social Institutions of Slovenia (SSZS).

Available at: http://www.ssz-slo.si/splosno-o-domovih-in-posebnih-zavodih/mapa-domov-clanov/ and http://www.ssz-slo.si/splosno-o-posebnih-domovih/pregled-kapacitet-in-pokritost-institucionalnega-varstva-starejsih-in-posebnih-skupin-odraslih/

Annual data.

- Price of a care day (in EUR) for various levels of care – *'Cena oskrbnega dne (v EUR) za oskrbo 1 in oskrbo 4*'
- Name, status and geographical latitude and longitude of the institutions – '*Ime doma upokojencev, Status doma, Zemljepisna dolžina in širina lokacij socialno-varstvenih zavodov oziroma domov za upokojence*'
- Services offered by institutions – *'Storitve, ki jih dom ponuja'*
- Number of users according to gender and number of all places – *'Število oskrbovancev po spolu, število vseh mest*'
- Share of population 65+ in institutional care – *'Odstotek prebivalcev, starih 65 let ali več, v institucionalni oskrbi*'.

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Sources: Ministry of Labour, Family, Social Affairs and Equal Opportunities; Google maps.

Annual data.

- Municipality, name and address of the social service providers – *'Občina, naziv, naslov ponudnika socialnega servisa'*
- Geographical longitude and latitude of the social service location – *'Zemljepisna dolžina in širina lokacije socialnega servisa*'.

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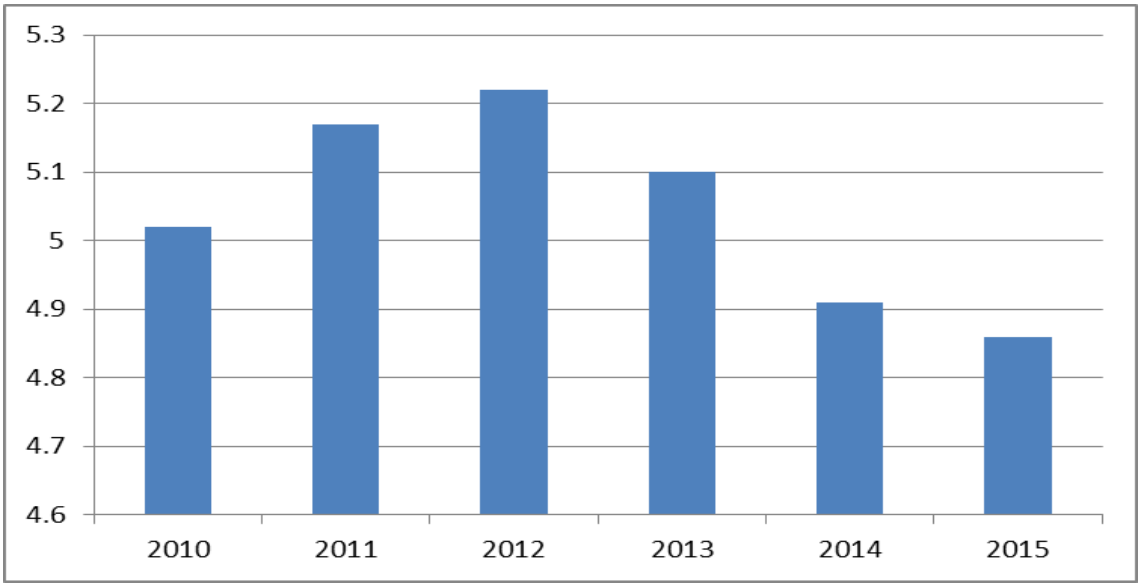
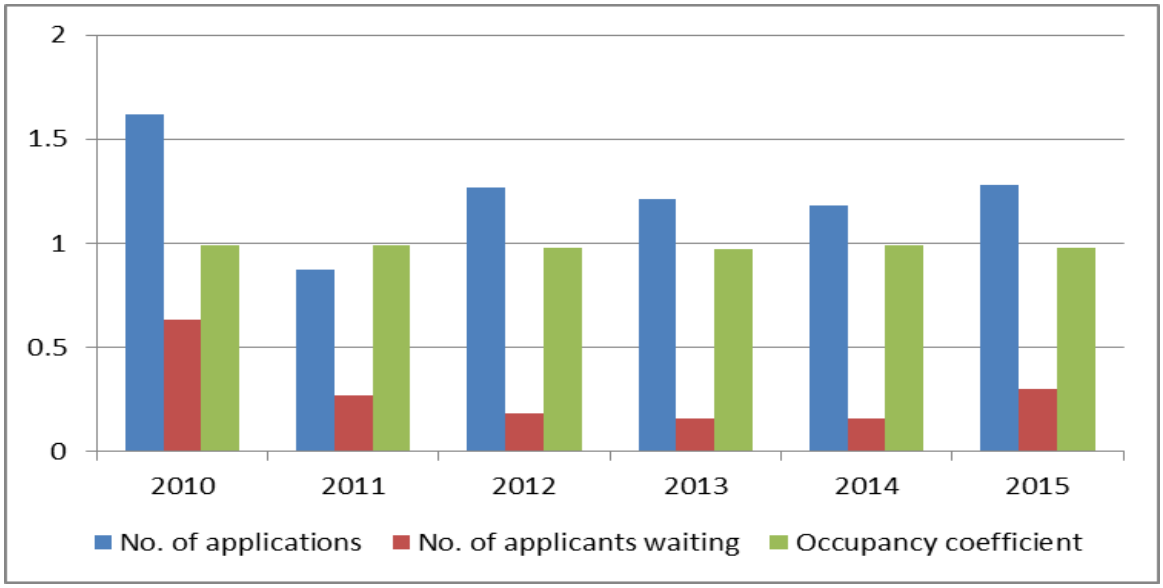
Appendix

Figure A1: Coverage of capacity needs in homes for the elderly, % of population 65+ covered, 2010-2015



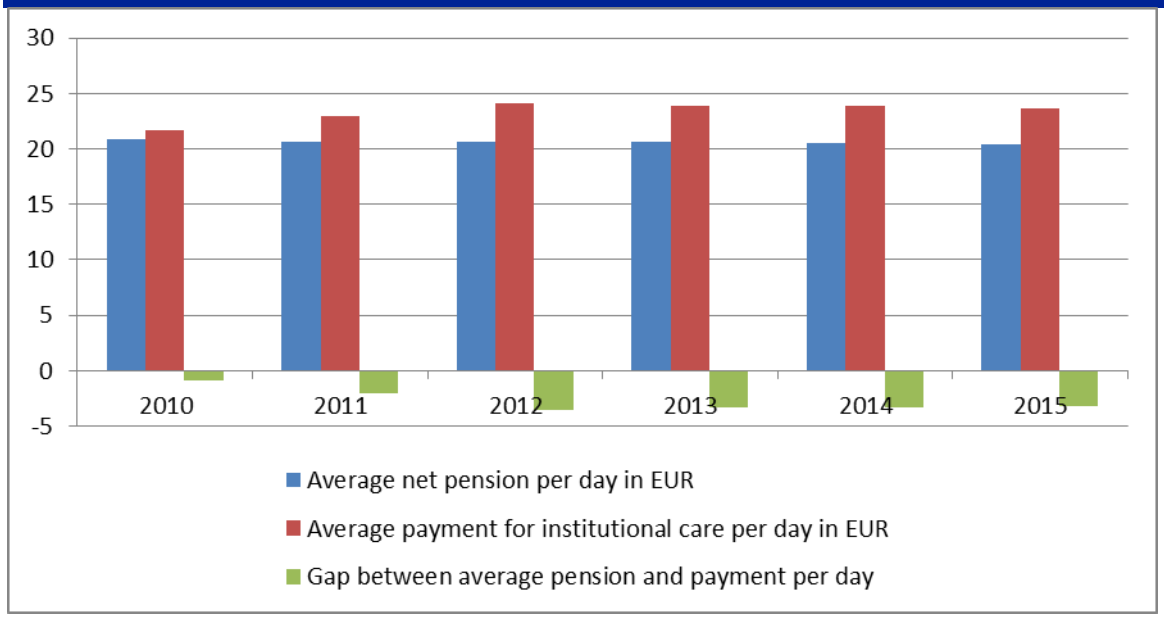
Source: SSZS (2016), Figure 2.

Figure A2: Number of applications per capacity unit, number of applicants actually waiting for admission per capacity unit, and occupancy coefficient



Source: SSZS (2016), Figure 3.

Figure A3: Comparison of average pension per day and average payment for institutional care per day, in EUR



Source: SSZS (2016), Figure 14.

Table A1: Projection of deficit and possible sources to cover deficit (public part) based on the reference and risk scenarios (as % of GDP), LTC, Slovenia

				2020	2030	2040	2050	2060
REFERENCE SCENARIO	DEFICIT	Base scenario	LTC – health care	-0.18	-0.30	-0.60	-0.77	-0.89
			LTC – social care	-0.02	-0.04	-0.08	-0.10	-0.11
			Total	**-0.20**	**-0.34**	**-0.68**	**-0.87**	**-1.00**
		No complementary health insurance	LTC – health care	-0.18	-0.31	-0.61	-0.78	-0.90
			LTC – social care	-0.02	-0.04	-0.08	-0.10	-0.11
			Total	**-0.21**	**-0.35**	**-0.68**	**-0.88**	**-1.02**
	POSSIBLE SOURCES	Special levy	LTC – health care	3.8	6.4	12.7	16.3	18.8
			LTC – social care	0.5	0.8	1.6	2.1	2.4
			Total	**4.3**	**7.2**	**14.3**	**18.4**	**21.2**
		Contributions (%)	**As % of gross wage (13.45% in 2014)**	**14.0**	**14.3**	**15.2**	**15.7**	**16.1**
RISK SCENARIO	DEFICIT	Base scenario	LTC – health care	-0.18	-0.48	-0.89	-1.30	-1.66
			LTC – social care	-0.02	-0.06	-0.11	-0.17	-0.21
			Total	**-0.20**	**-0.54**	**-1.01**	**-1.47**	**-1.87**
		No complementary health insurance	LTC – health care	-0.18	-0.49	-0.90	-1.32	-1.67
			LTC – social care	-0.02	-0.06	-0.11	-0.17	-0.21
			Total	**-0.21**	**-0.55**	**-1.02**	**-1.48**	**-1.89**
	POSSIBLE SOURCES	Special levy	LTC – health care	3.8	10.2	18.9	27.5	34.9
			LTC – social care	0.5	1.3	2.4	3.5	4.5
			Total	**4.3**	**11.4**	**21.3**	**31.0**	**39.4**
		Contribution increase (%)	**As % of gross wage (13.45% in 2014)**	**14.0**	**14.9**	**16.1**	**17.3**	**18.3**

Source: Majcen et al. (2016).

Table A2: Main reasons for not seeking employment or being in part-time employment by sex, 2011 and 2016, Slovenia

Inactive population in thousands, 2011	Total	Female	Male
Looking after children or incapacitated adults	8,030	6,977	1,053
Other family or personal responsibilities	33,304	26,067	7,237
Part-time employment in %, 2016			
Looking after children or incapacitated adults	1.3	1.4	n.a
Other family or personal responsibilities	10.6	14.4	3.4

Source: Eurostat (2018).