Peer Review on "Financing Long-term Care"

Peer Country Comments Paper - Slovenia

Financing Long-term Care

Estonia, 22 – 23 September 2020

DG Employment, Social Affairs and Inclusion

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1 Introduction

This paper has been prepared for the Peer Review on "Financing Long-term Care". It provides a comparative assessment of the policy example of the Host Country and the situation in Slovenia. For information on the Host Country policy example, please refer to the Host Country Discussion Paper.

2 Situation in the peer country

Societies across the world are experiencing a fast ageing process. Slovenia is no exception. The data in the table below show that the elderly are the fastest growing population and in 2060 one third of Slovene citizens will belong to the elderly age group. According to demographic projections, the process of population ageing in Slovenia, and thus the composition of Slovenian society will change more intensively than elsewhere in Europe. The labour market, education, living and working environments, as well as the whole social protection system will have to be adapted to the new demographic conditions. The question, however, is how many people will still be working and how many people will be retired. This issue is very important from a financing perspective: as the Slovenian social protection system relies on solidarity and intergenerational reciprocity – the long-term public financial sustainability of the social protection system is in question. Slovenia's 'Active Ageing Strategy1' is based on active aging, creativity, healthcare, solidarity and intergenerational cooperation. However, the strategy has not been fully implemented yet. One of the goals is also the acceptance of LTC Law Proposal.

DEMOGRAPHIC DATA

	2016	2030	2060	2070	Change 2016-2070
Population[2] (million)	2.1	2.1	2.0	2.0	**-0.1**
Share of 65+[3] (%)	18.7	25.2	30.2	28.5	**9.8 p.p.**
Share of 80+[4] (%)	5.0	6.9	12.9	13.5	**8.5 p.p**
Life expectancy at 65[5] Men (%)	17.7	19.2	22.2	23.1	**5.4 p.p**

[1] Active Ageing Strategy: https://www.umar.gov.si/en/topics/single/theme/news/strategija-dolgozive-druzbe/?tx_news_pi1%5Bcontroller%5D=News&tx_news_pi1%5Baction%5D=detail&cHash=91530e6342889f6bbda83dff5bb560fe.
[2] The 2018 Ageing Report, EU; link: https://ec.europa.eu/info/sites/info/files/economy-finance/ip065_en.pdf.
[3] The 2018 Ageing Report, EU; link: https://ec.europa.eu/info/sites/info/files/economy-finance/ip065_en.pdf.
[4] The 2018 Ageing Report, EU; link: https://ec.europa.eu/info/sites/info/files/economy-finance/ip065_en.pdf.
[5] The 2018 Ageing Report, EU; link: https://ec.europa.eu/info/sites/info/files/economy-finance/ip065_en.pdf.

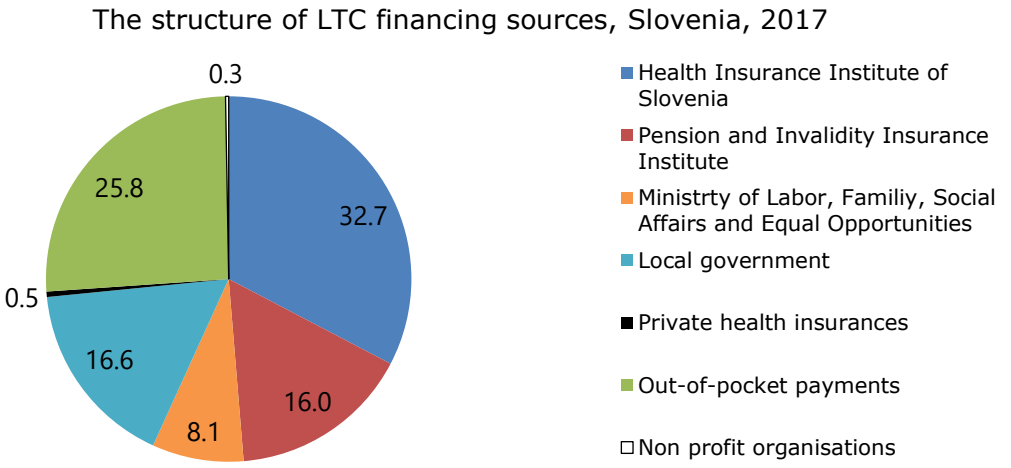
Life expectancy at 65[6] Women (%)	21.4	22.8	25.6	26.4	**5.0 p.p.**

LONG-TERM CARE DATA[7]

Internationally comparable data on long-term care expenditure, which is one of the functions of healthcare in the context of the System of Health Accounts (SHA) methodology, increased in Slovenia in 2017 by 3.1% compared to 2016 and amounted to EUR 521 million. Real GDP growth was in the same period 4.8% and long-term care expenditure as a share of GDP stayed about the same as in 2016, i.e. 1.21%.

In 2017, 73.4% of long-term care expenditure was financed from public funds and the remaining 26.6% from private sources. The main providers of funds for long-term care are the social security funds, which covered 48.7% of long-term care expenditure in 2017 (please for more details look Graph 1 below).

Figure 1 - The structure of LTC financing sources, Slovenia 2017



Source: Statistical Office of the Republic of Slovenia.

The ratio between the health side and the social side[8] of long-term care does not change significantly from year to year; in 2017 it was 66 vs 34. In 2017, in the context of long-term health care most of the expenditure was earmarked for the implementation of long-term care in institutions (nearly three quarters), followed by

[6] The 2018 Ageing Report, EU; link: https://ec.europa.eu/info/sites/info/files/economy-finance/ip065_en.pdf.
[7] Statistical Office of the Republic of Slovenia; link: https://www.stat.si/StatWeb/en/News/Index/8579.
[8] The social part of long-term care includes assistance care services (the so-called IADL services or help by instrumental activities of daily living, e.g. help with shopping, laundry, etc.) that allows individuals to live independently in their own house or apartment. On the other hand, the health part of long-term care includes medical or nursing care and personal care services (the so-called ADL services or help by basic activities of daily living, e.g. help in washing, dressing, etc.). They are provided by different institutions, in the context of day-care services and in the context of home-based services, where also cash benefits are included.

long-term care at home (a little more than a quarter) and finally day-care services (about half a percent).

As regards the method of implementation or the provision of long-term care, in terms of the structure of total long-term care expenditure in 2017, most of the expenditure was earmarked for the provision of long-term care in institutions (77.6%), mostly in homes for the elderly (58.2%), followed by long-term care in different social institutions (15.3%) and finally in hospitals (4.1%). The rest of the expenditure (22.4%) was intended for the provision of home-based long-term care, either in the form of services or as care provided by providers of community nursing care, providers of home help service, personal assistance and family assistants or in the form of cash benefits. Compared to 2016, in 2017 there was a slight increase in the share of home-based long-term care expenditure (by 0.2 p.p.).

In 2017, there were 64 433 long-term care recipients (around 1 800 more than in 2016). The share of recipients receiving long-term care in institutions was the largest at 35.5% (or around 22 900). They were followed by recipients of long-term care at home with a share of 34.9% or almost 22 500, and recipients who were receiving only cash allowances to cover different services in the context of long-term care with a little more than a quarter or around 18 500[9].

According to the demographic data and long-term care data presented above, the ageing of the population will remain a challenge for Slovenia. Slovenia already ranks in the upper-third of the EU Members as for the share of the population over the age of 65; this trend will continue to increase and the share of the population over the age of 80 will grow particularly fast.

The ageing of the population, and thus the increased demand for long-term care,will represent a huge burden for future public finance. The Slovenian social protection system is based on intergenerational cooperation and solidarity (Bismarck model), which means that different subsystems (pension, health and social) are (mainly) financed through social contributions. In the long run, this can threaten the sustainability of public finance as working population will shrink, according to the 2018 Ageing Report[10].

LONG-TERM CARE IN SLOVENIA: PRESENT SITUATION

In Slovenia, at this point, there is still no valid uniform definition of long-term care (LTC), neither is the area systematically regulated (e.g. by a specific act). Currently, LTC is regulated within the framework of different legislations and is provided via separate social protection systems, namely:

- Pension and disability insurance, i.e. the Pension and Disability Insurance Act (hereinafter: PDIA-2),
- Health insurance, i.e. Health Care and Health Insurance Act,
- Parental protection insurance, i.e. Parental Protection and Family Benefit Act (hereinafter: PPFBA),
- Social benefits and social welfare services, i.e. Social Security Act (hereinafter: SSA), Financial Social Assistance Act and Exercise of Rights to Public Funds Act,
- Care for war veterans, i.e. War Veterans Act (hereinafter: WVA) and War Disability Act (hereinafter: WDA), and
- Within the Act Concerning Social Care of Mentally and Physically Handicapped Persons (hereinafter: ACSCMPHP).

[9] The actual number of recipients of cash benefits in the context of long-term care is much higher (a little more than 43,700), but the final number of recipients follows the rule if the recipient receives both a service and a cash.
[10] The 2018 Ageing Report, EU; link: https://ec.europa.eu/info/sites/info/files/economy-finance/ip065_en.pdf

Since 2002, the relevant bodies (i.e. the Ministry of Work, Family, Social Affairs and Equal Opportunities, the Slovene Federation of Pensioners' Associations, the Association of Social Institutions and the last by the Ministry of Health) have been working on the preparation of an umbrella act that would regulate the area of LTC. In the last few years there was a particular pressure coming from the public (from those who need care) and from the European Commission through European Semester on the Government to regulate this area and to provide necessary legislation. These pressures were mostly related to problems linked to sustainable financing from public funds and private sources (which amounted to 26.6% in 2017), the lack of staff and available (and affordable) places in the homes for elderly.

The main weaknesses of the present arrangement of LTC in Slovenia are the following:

- No uniform system of LTC;
- Fragmented and segmented needs assessment procedures;
- No unified entry point;
- Uneven garantee of rights, as certain services are provided in home institutions but not to recipients at home;
- Unmet needs;
- LTC benefits in kind and cash benefits are provided and and financed with different social protection systems;
- Unequal financing of the same needs;
- Lack of integration between home-based services (health vs. social sector).

The reform of LTC has been thus on the top of the relevant policy agendas[11] for the past few years. In 2018, the pilot project 'Implementation of pilot operations: testing new solutions for an integrated long-term care' started to test some of the solutions envisaged in the future LTC system (look Annex 4 for the new concept of LTC arrangemenet), such as:

- **Eligibility assessment** – testing at the entry point (assessment tools and procedures, entry threshold, preparation of personal plans, monitoring the implementation plan).
- **New services and integrated care** – testing at the LTC provider (the new profile »care coordinator« and her/his role, integrated LTC team consisting of care unit and unit for maintaining autonomy, combinations of formal and informal care, new services, including e-care, the implementation plan, and quality monitoring).
- **Coordination activities** between integrated LTC team and between different service providers of social and health care.

With this project some of the proposed legislative solutions in the field of LTC are being tested in three pilot environments (urban, rural, semi-rural) in the Eastern Cohesion Region of Slovenia. The expected outcome of the pilot is to provide information whether these new solutions can result in the improvement of access to LTC, particularly at home, and reduce inequalities in access, whether they are accepted by the users and providers, and if they address the needs accordingly. The

[11] With the Resolution on the National Healthcare Plan 2016-2025 (hereinafter: Resolution) which is a strategic document that addresses key problems of health and the health-care system in Slovenia, both the Slovenian Government and the National Assembly of the Republic of Slovenia confirmed the strategic orientation of Slovenia towards greater integration of health and social services, the transformation of supplementary health insurance and the provision of additional new resources for health care and long-term care.

pilot activities should have ended in June 2020 but due to the Covid-19 crisis, they were extended until the end of the year.

The evaluation process, which is being carried out throughout all stages of the pilot project, is showing some valuable results regarding the tested solutions. These have also been used in the preparation of the latest LTC Law proposal by the Ministry of Health (presented to the public 21 August 2020).

The aim of this proposal is to facilitate and ensure the implementation of LTC as the new pillar of social security, which means that all rights will be funded through social contributions.

The proposal establishes:

- The uniform definition of LTC[12];
- The unification of rights;
- A uniform assessment of needs, a one-stop shop (single entry point), personalised planning, the new professional figure of the 'care coordinator', and the delivery of services with active involvement of user;
- Integrated provision of defined LTC services with emphasis on the delivery of LTC services at home;
- Support for informal caregivers (training, counselling, respite care);
- New services to promote independent living;
- Improvement of financing arrangements and financing of LTC from public sources (with the introduction of a new social security pillar for the LTC);
- Quality management and public supervision (regular re-assessment of needs, internal quality assurance systems of LTC providers, public supervision, new quality and safety standards etc.);
- Promotion of prevention.

3 Assessment of the policy measure

Estonia and Slovenia are among the Member States with smallest populations. This could be an advantage when trying to regulate a certain area – in this case LTC. But as it is obvious from the Host Country paper on LTC, Estonia is going towards a more decentralised approach in regulating LTC, applying a needs-based approach and local financing of services. On the other hand, Slovenia decided to adopt a more centralised regulation of LTC, also applying a needs-based model with emphasis on the new profile of the 'care coordinator', but with a different financing mechanism– based on the newly established public treasury for LTC. Certainly, differences among countries in changing existing arrangements of LTC systems are largely related to differences in the organisation and development of present LTC systems, social protection systems in general, economic development, and the traditional role of the family. It will be interesting to see the effects of these changes on the recipients of services, their providers, and on the ratio between public funds and private sources.

3.1 Similarities[13]:

Although Estonia and Slovenia are taking different approach regarding the future

[12] We used uniform definition of LTC written by international institutions (Eurostat, WHO, OECD), where long-term care is defined as a range of services required by persons with a reduced degree of functional capacity (physical or cognitive) and who are consequently dependent for an extended period of time on help with basic (ADL) and/or instrumental activities of daily living (IADL).

[13] We're comparing host country with our last LTC Law proposal and not with present situation in the field of LTC.

regulation of the field of LTC, some solutions are recognised as good for both countries. Below the main similarities are presented:

- **A needs-based model/approach** (and the emphasis is on the new profile of 'care coordinator').
- As foreseen by the Slovenian proposal, the 'care coordinator' (care manager) will be responsible for organising proper and high-quality care for each eligible recipient of LTC services. This means that she/he will have to have access to all valuable information about the specific needs of individual (to draw up an implementation plan for the provision of services) and about the network of providers in a certain environment. The funding of LTC services, which will be clearly defined by law, will be paid from the special treasury for LTC and thus will not represent a financial obligation at the local level. The role of the 'care coordinator' is important within the concept of integrated care, i.e. integration of health, social, and LTC services (please see Annex 3, where a schematic overview of the idea of integrated care is shown).
- A standardised assessment tool for all potential beneficiaries of LTC services.
- As highlighted by the Estonian plan to develop a common voluntary standardised needs-assessment tool and methodologies to assess LTC needs, the idea of having a standardised assessment tool is important for achieving the goal of ensuring "the same rights for the same needs". Namely, the present arrangement of LTC in Slovenia is unfair regarding the needs (the same needs but different rights, as they are granted under different legislation) (please see Annex 4, where differences between present and future LTC system are shown). In different local environments, the home help services vary according to the availability of provision of home services and the amount of subsidy. According to the social law, the minimum subsidy per hour of home help service is 50%, which means that some environments (i.e. municipalities) can finance some services at 100% and this is unfair and creates inequality between recipients with the same needs.

3.2 Differences:

The main difference between Estonian and Slovenian approach to regulate future LTC system is in financing and in the adoption of a specific law for LTC.

- The oganisation of LTC.
- According to the recent LTC Law proposal written by the Ministry of Health (MoH) of the Republic of Slovenia, the clear definition of LTC rights and the list of services, as well as their financing, will be under the responsability of the State (MoH). LTC services will be financed from the public treasury for LTC, which will be financed through social contributions and under the auspices of the Health Insurance Institute of Slovenia (HIIS). This is opposite from the Estonian model, where regulation and financing are kept on local level. Individuals, who will not pass the treshold to enter LTC system at entry points, which will be located at regional units and branch offices of the Health Insurance Institute of Slovenia, municipalities will be encouraged to take care of them, e.g. through the network of volunteers etc.
- While Estonia does not have a specific law for LTC, in Slovenia the LTC Law proposal is just under discussion. The proposal provides a clear definition of LTC, the rights and the list of services, the financing mechanism (public treasury for LTC), quality assurance, supervision, data collection etc. The present system, where rights are covered and yet financed within different legislation, is unfair and non-transparent (please see Annex 4, where differences between present and future LTC system are shown).

4 Assessment of success factors and transferability

Among all success factors listed in the chapter 5 of the Host Country Discussion paper, an interesting concept is the idea that the organisation of LTC services and other assistance should remain at local level and therefore close to service recipients. We plan to have a similar organisation in Slovenia, at least from the view of entry points, which will be located at regional units and branch offices of the HIIS, where potencial LTC recipients of services will be assessed through a uniform assessment tool. The 'care coordinator' (care manager) will be identified by providers of LTC services in a local environment and will be responsible to coordinate different service providers (from LTC, and also from health and social sector, if necessary) in order to take good care of recipient. This kind of coordination of services will be also helpful in better targeting the resources in a certain local environment. On the other side, regarding the first solution, the difference between both countries is in defining services (in Slovenia at national level and in Estonia this is split between local and national level) and financing (in Slovenia from the new public treasury for LTC and in Estonia on local level with possible State subsidies). Certainly, it will be interesting to see in the future how these solutions will be implemented in practice. It is possible that the proposed financing model in Slovenia will be the best (especially when starting to face a shrinking of working population). But, as already mentioned, differences in LTC systems are largely related to differences in the organisation and development of present LTC systems, social protection systems in general, economic development, and the traditional role of the family.

5 Questions

- There is no specific law for LTC (LTC services are split between health and social sector and thus financed from different sources). We have now in Slovenia such a situation, which proven to be problematic. Do you plan to adopt in the future a specific law just for LTC?
- When you are talking about nursing care, where exactly these services are granted? If we read correctly, within certain hospitals?
- Who will be responsible for assuring high quality services and provide quality indicators? Each environment itself, different indicators, or will that be defined on general (state) level and thus the same for all? We think this must be done from the recipients point of view and to force providers to provide high quality services.
- Is any supervision planned – supervision in sense of suport to providers of LTC services, also in sense of exchanging information about good/bad practises etc.?
- How do you plan to provide equal access to services in each local environment – regards to providers and financing?

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Annex 1 Summary table

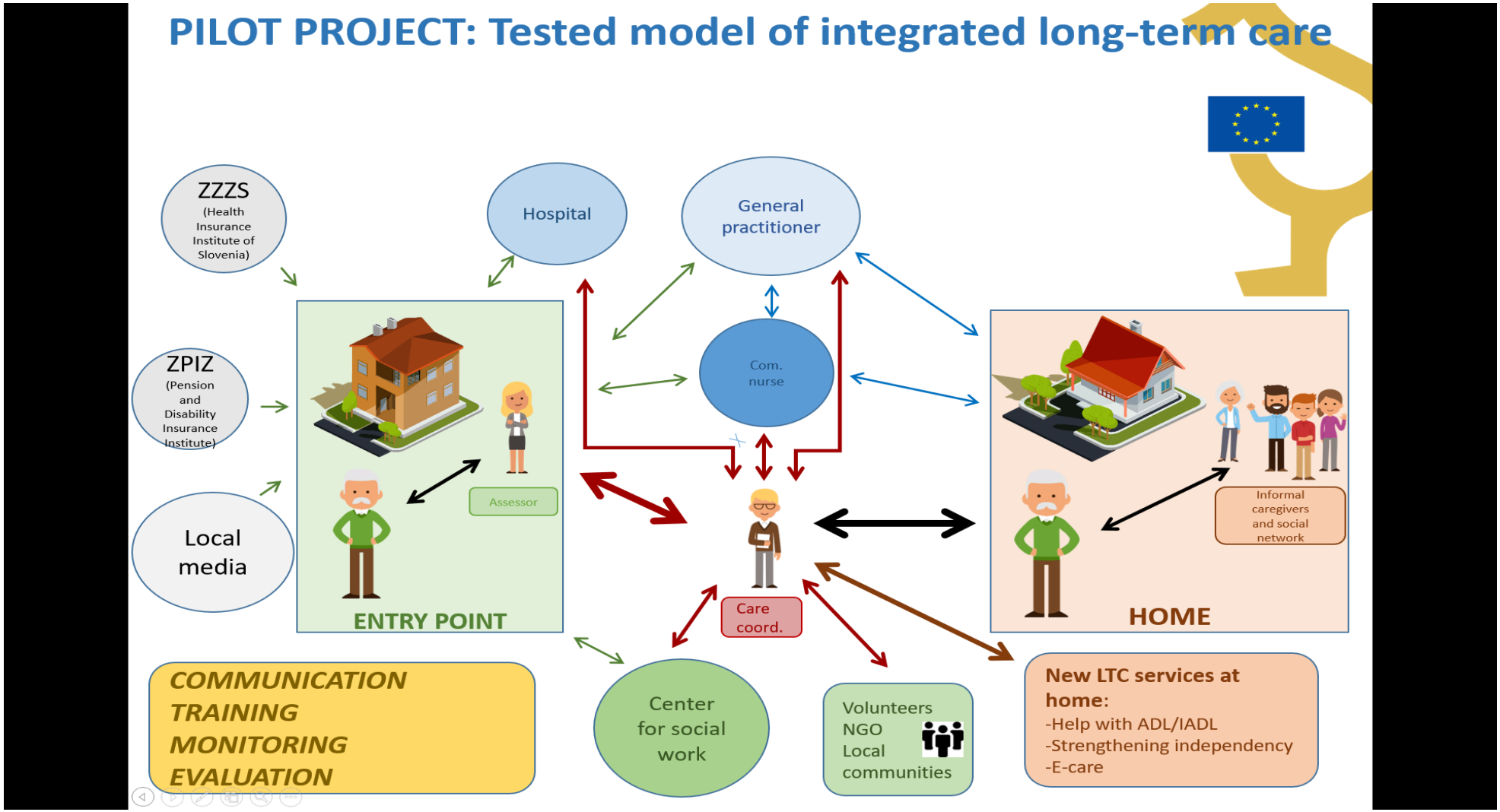
The main points covered by the paper are summarised below.

Situation in the peer country
• High share of old population (65+ and 80+). • Special law for LTC. • Emphasis is on the integrated delivery of services, especially in home environment. • Increasing the share of public funding of LTC services. • Unburden informal carers and give them suitable support – financial and the possibility of training/education.
Assessment of the policy measure
• A needs-based model is a good approach but it can lead to challenges from a financial perspective. • The new professional profile of the »care coordinator« (care manager) is of great importance for the integrated delivery of LTC, health and social services to the recipients of care. • Public funding should be increased to unburden recipients and their families. • A uniform assessment tool is necessary for avoiding differences in care (categories).
Assessment of success factors and transferability
• Decentralised approach in regulating LTC. • Needs-based approch from the view of individual, her/his needs, where special role will have »care coordinator« in assuring high quality services by integrating LTC, health and social sector.
Questions
• There is no specific law for LTC (LTC services are split between health and social sector and thus financed from different sources). We have now in Slovenia such a situation, which proven to be problematic. Do you plan to adopt in the future a specific law just for LTC? • When you are talking about nursing care, where exactly these services are granted? If we read correctly, within certain hospitals? • Who will be responsible for assuring high quality services and provide quality indicators? Each environment itself, different indicators, or will that be defined on general (state) level and thus the same for all? • Is any supervision planned? • How do you plan to provide equal access to services in each local environment – regards to providers and financing?

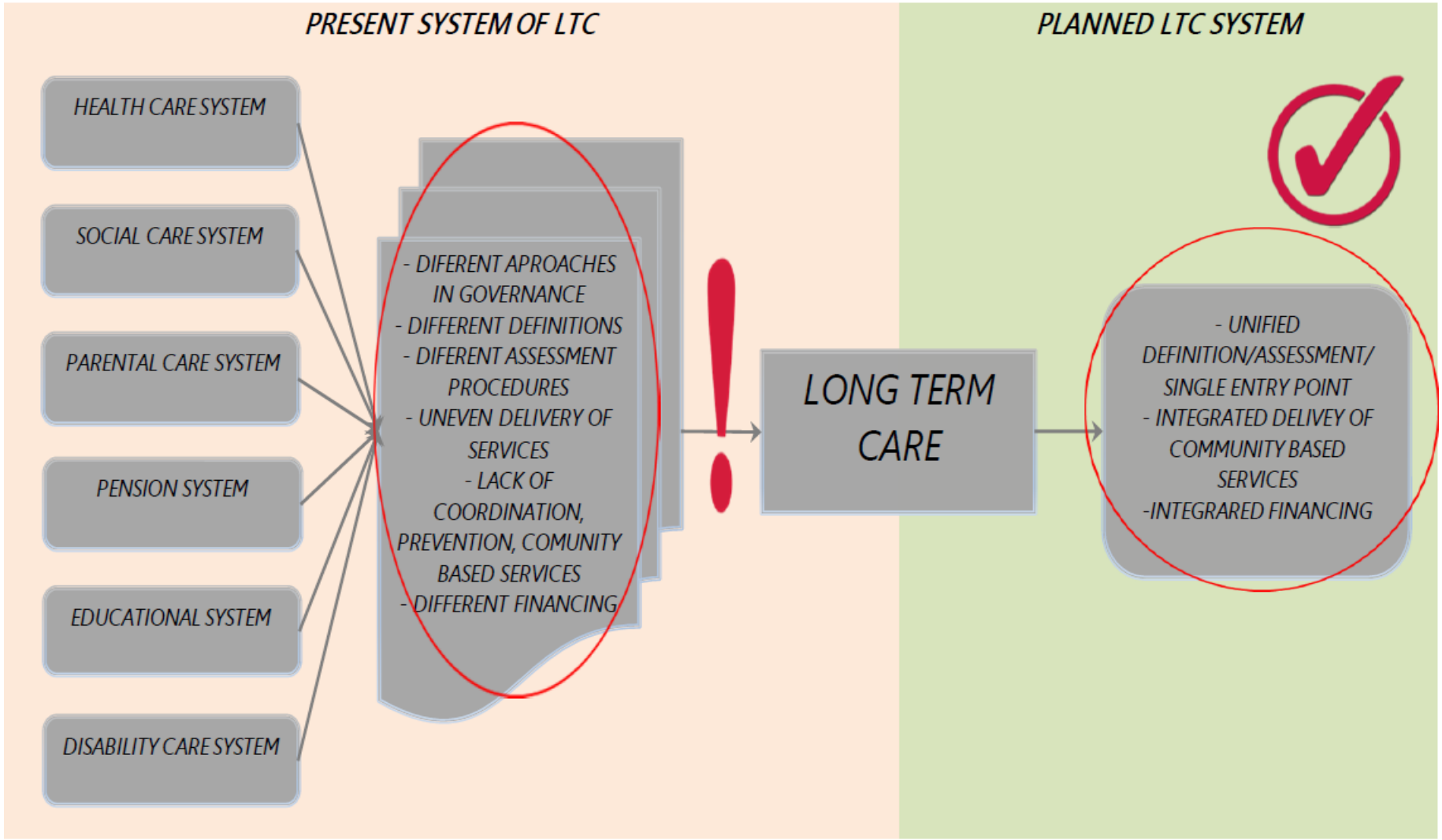
Annex 2 Example of relevant practice

Name of the practice:	**Pilot project "Implementation of pilot operations: testing new solutions for an integrated long-term care"**
Year of implementation:	2018 – 2020
Coordinating authority:	Ministry of Health (funded by ESF in the amount of 80%)
Objectives:	With this project some of the proposed legislative solutions in the field of LTC were being tested (still are) in three pilot environments (urban, rural, semi-rural) in the Eastern Cohesion Region of Slovenia. The expected outcome of the pilot is to provide information whether the new solutions can result to improve access to LTC, particularly at home and reduce inequalities in access, whether they are accepted by the users and providers, and if they address the needs accordingly.
Main activities:	With an integrated approach and a defined model of integrated, coordinated and person-centred care (look Annex 3), in the pilot were being tested (still are): • Assessment tool (also the set height of threshold), procedures and entry points into the LTC system. • New services and integrated delivery of them in the home environment. • Support and training for providers of formal and informal care. • Coordination of providers in the field of social and health care in order to provide an efficient integrated care. • IT support for all activities.
Results so far:	The Ministry of Health signed the contract with the external experts to conduct objective (external) evaluation of the pilot project. Before start of the project input, process and output indicators were being set-up and monitored (still are) regularly through the whole project. External evaluator also measured (still are) some quality of life issues – from users and providers side on procedures, organisation of help, new services etc. –, which will be analysed for final report in December 2020. Until now, the Ministry already got some insights from the pilot from several intermediate reports that external evaluator wrote. These are: • The assessment tool was well accepted by the assessors and users and the threshold seems to be set to the right height. • The new services, especially the one for maintaining independence, are very well accepted – by the user and provider; because of them user can pass into lower category of dependence, what is good for the system as costs as lower. • We got the structure of recipients by LTC categories (five of them), which we used for calculating the expenses of new system.

Annex 3 The model of integrated care tested in the pilot projects in Slovenia



Annex 4 Long-term care reform – Paradigm shift

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