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# LONG-TERM CARE SYSTEM IN SLOVENIA


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## Table of contents

## List of tables and figures

# 1. LONG TERM CARE SYSTEM OF SLOVENIA

## *1.1. Overview of the system*

Long term care is becoming more and more visible part of social policy in European Union and other developed countries. The main reason is the ageing of the population, which is evident in the growing number and share of the aged in the total population. The current debate is opening questions of responsibility for elderly, who and in what part different stakeholders are responsible for taking care of the elderly. Is this government or just family? The traditional view which saw care provision as a task of the family is vanishing with the modern way of life – generations not living together and all family members working or schooling – and more and more the role of the government in care provision and financial support for care takers is demanded and asked for. Women represent 90% of the providers of long term care, therefore the LTC policies are targeted on women.

The main available long term care services can be divided into institutional care, home care and social services. Due to certain condition defined by legislation and described later on, people can be entitled to benefit in cash, which can be used for any purpose when assigned.

In Slovenia, long term care of the future is to be oriented towards home care. Such orientation has its humane, moral and economic advantages. Living at home strongly impacts quality of life and the successfulness of care as well as its costs, which are lower in a case of cooperation of family and friends of the elderly. Strategy of care for elderly by year 2010 therefore presents long term care as care at home and institutional care is provided only in a case when the care is so demanding or costly that it is impossible to be provided at home. Since it is illusionary to expect that all needed care will be provided as home care due to a new way of life, working habits and usually different residence between generations, a new institute of paying non professional care of the relatives and family is being promoted. The payment is low but represents a compensation for the invested efforts and work in long term care of the relative. Such »family helpers« can take part in pension and health care social insurance schemes.

On the providers' side the problems emerge in the questions of capacities and capabilities or sufficient education. Due to the lack of capacities and carers it is urgent to include relatives, family and different non-governmental and humanitarian organizations in the provision of LTC. The current legislation in different areas of LTC does not regulate the area sufficiently and does not provide the healthy basis for meeting the growing demands for LTC. The legislation that handles LTC field is diverse. These are mainly Act on Social Care, Act on Pension and Disability Insurance, Act on Health Care and Health Care Insurance, Act on War Veterans and War Disabled and Act on Social Care for Mentally and Physically Handicapped Persons with their decrees and orders. In spite of presence of LTC field in all these the field is

still largely systematically unregulated and a big part of care is not mentioned in the legislation at all.

The demand for LTC is growing and cannot be met by providers. In the last years Slovenia tried to meet the high demand by building new homes for elderly and by increasing the capacities of the existing homes. The nursing wards in hospitals as well as prolonged hospital stays were introduced. All these measures still did not satisfy the needs, which are going to increase even more in the following 15 to 20 years with the aging of the population.

In 2004 different forms of home care started to develop, offered by homes for elderly, centres for social works and different voluntary institutions and organizations. In reality, the connection among providers of different kinds of services is weak, which lowers the efficiency of the service. There are obvious differences in the accessibility of services between persons in the institutional care and persons in home care (access to physiotherapy, working therapy, other services). Persons in home care have to pay a higher share of the price for those services than persons in the institutional care. Besides, there are high regional differences in the availability of these services. The fact is that currently the whole system is based on the institutional care and auxiliary services are therefore concentrated around homes for elderly and not available for persons in home care. The access and prices of the services in reality is hence not equal for everybody.

## *1.2. Assessment of needs*

The medical needs of persons in institutional care are paid by Health Insurance Institute of Slovenia and are defined according to the criteria from General Agreement for each separate year. They are valid for all homes for elderly in Slovenia. The criteria are binding.

### *1.2.1. Institutional care for elderly – homes for elderly*

The applicants in the homes for elderly are classified into different levels of health care according to their health states and needs. The care is categorized according to the time of caretakers that need to be devoted to the applicant (due to applicant's needs).

Care category 1 is usually for mobile applicants, who can be stable chronical patients or slightly mentally ill persons, who need general supervision and the following health care services: smaller re-bandages and smaller compress application, preparation, distribution and application of medicines, health status monitoring, syringes application, inhalations, vital functions observation and measurement, changing urine bags etc. In order for care category 1 to be paid for the applicant, at least 15 minutes of time per day need to be spent performing services that form this category.

Care category 2 is usually intended for partially mobile, partially incontinent applicants with medium dementia levels and non-psychotic mental problems, unstable somatic chronic

applicants, applicants after amputations of extremities, who need the following health care services: application of clisma, medium re-bandages, material drop for laboratory, catheterization, medicine application in chronical dermathosis and decubitus prevention, oxygen application or therapeutical inhalations, application of intraveinal shots, taking care of unstable diabetes patients, control of drug programs, help with ADL. In order for care category 2 to be paid for the applicant, at least 30 minutes of time per day need to be spent performing services that form this category.

Care category 3 is intended for immobile patients, who depend on medical staff help due to their physical or psychical problems. Those are usually very unstable, delirious patients, all their need are satisfied by medical staff.

A special category of care 4 is also defined but rarely used in reality. It is meant for persons with all degrees of mental development who have heavy behavioural or personality disorders. Those persons would be totally dependent in some life functions due to isolation or physical borders. They need 24-hours individual supervision of their physical and psychical status.

Categorization of home inhabitants is performed according to the decision of the physician who is responsible for basic health care in the home. Data need to be collected and evidences presented for each person for each day. The evidences need to be accessible to Health Insurance Institute of Slovenia physician on demand, who supervises and controls the categorization of the persons into different categories.

### *1.2.2. Attendance and Allowance Benefit*

The right to Attendance and Allowance Benefit as a single cash benefit is d based on criteria defined by Pension and Disability Act. Assessment criteria for persons that fulfil the status needed to obtain the benefit, are based on the ability to satisfy basic life needs. The benefit can be acquired by the person who is due to permanent deterioration of health status in need of care and help from others. The assessment of the conditions for the person to be eligible for cash benefit is performed by the physicians of Pension and Disability Insurance Fund. The right to Attendance and Allowance Benefit is firstly defined by the status – the right is only possible to obtain by those who are residents of Slovenia and:

1. receive old age, disability, widower or family pension;
2. are blind or weak sighted insurers who have just entered the employment or self employment;
3. get blind or weak sighted while in employment or self employment ;
4. persons who got blind while having the status of pensioners;
5. blind persons who are eligible to health insurance after another active insured person;
6. immobile insured, whose capability of mobility is lessened at least for 70%, who are employed according to their capabilities, but at least half time. 70% lessened capability of mobility exists when due to problems with extremities the insured have

big difficulties with their mobility even with help of orthopaedic technical devices. This category is further defined in details by legislation.

When persons with described status are not able to satisfy all or most of the activities of daily life, they are entitled to Allowance and Attendance Benefit. The assessment criteria that define persons in need are the same all over Slovenia and are binding. They are based on the definition of »being unable to satisfy basic life needs« and »being unable to satisfy most of the basic life needs«. Being unable to satisfy all basic life needs means that the person is unable to move inside and outside of its living quarters independently, to feed self, dress and undress, put shoes on/off, take care of personal hygiene and perform other necessary ADL independently.

Being unable to satisfy most of the basic life needs independently means that person is unable to satisfy most of the defined needs independently or when he/she needs permanent supervision as difficult psychiatric patient in home care.

The Pension and Disability Fund physician must give the opinion whether person is in need of permanent help and services from their persons to satisfy all or most of the basic life needs, whether person is blind or weak sighted or she/he needs permanent supervision or that her/his mobility capability is lessened for at least 70%.

## *1.3. Available LTC services*

Social Security Act (OG RS 54/92, 3/07) defines the available long term care services in Slovenia, that are primarily intended for ill, handicapped and elderly persons. These are:

1. **institutional care**, as a form of replacing and complementing the functions of home and family; it consists of basic care, social care and health care;
2. **home care**, as a form of social care in a case of disability, age and other cases, when social care can replace institutional care;
3. **social service**, a form of providing housework and other homemaking in a case of childbirth, sickness, disability, age and other.

The providers of social care are centres for social work, homes for elderly, special social institutions for disabled and handicapped, private providers and family helpers.

Based on Health Care and Health Care Insurance Act (OG RS 9/92, 72/06) Health Insurance Institute of Slovenia is responsible for financing legally defined health care services for all insured persons. Home nursing services are 100% financed from compulsory health care insurance.

Pension and Disability Insurance Act (OG RS 106/99, 109/06) defines the right to Attendance and Allowance Benefit. The eligible persons for this benefit in cash are all recipients of age pensions, disability pension, family or widowers' pension who are residents of Slovenia. Also

the persons who are employed, but blind or weak-sighted, and immobile persons who are employed for at least 50% of working time, are eligible. Those persons are eligible for the benefit if they need help in carrying out activities of daily life and cannot satisfy the basic needs due to permanent changes in their health care status. Act does not define the monitoring of use of the benefit although it assumes the benefit will be used for acquiring help in ADL. There is no control over the use of the benefit and it is not known or analysed what the funds in reality are used for. The right to Attendance and Allowance Benefit is also defined in War Veterans Act (OG RS 63/95, 59/06) and War Disabled Act (OG RS 63/95) and Social Care for Mentally and Physically Handicapped Persons Act (OG RS 41/83, 122/07) under the same conditions. The settings of care, available services and eligibility for them are presented in Table 1.

**Table 1**: The existing regulation of long term care for elderly

| | **Home care** | **Institutional care** |
|---|---|---|
| Eligible persons | Persons 65+, handicapped, mentally ill children, chronically ill persons | Persons 65+ |
| Social Care rights | 1. homemaking<br>2. social networking<br>3. help with personal hygiene | 1. basic care<br>2. social care<br>3. health care |
| Health Care rights | Health care and nursing | Nursing depending on health status |
| Volume and time of services | Max. 4 hours per day and 20 hours per week | As much as needed |
| Providers | Public institutions, private institutions with concession, legal and physical entities with work permission | Public institutions, private institutions with concession, legal and physical entities with work permission |
| Financing | Recipient and family, municipality | Recipient and family, municipality, Health Insurance Institute of Slovenia |
| Net | Municipality | Central government |

Source: Adapted on Draft Act on Long Term Care and Long Term Care Insurance, 2006

### *1.3.1. Institutional care*

The **institutional care** is a form of care with the longest tradition in Slovenia and is the most spread in all Slovenian regions. In the last years many new homes for elderly were open or modernized. Homes for elderly cover 4,4% of aged 65+ and have around 15.000 places. In many homes the day care centres are also open, which have around 200 places. Institutional care can also be provided in **sheltered housing**. Such form of care is mostly intended for

elderly who cannot take care of themselves fully, but are still capable of living a relatively independent life. The *basic care* in sheltered housing is help with living (cleaning, trash removal and bed making), organized meals (bringing prepared meals or cooking in the house, dishwashing) and help in washing and ironing the clothes. The *social care* in sheltered housing is help in sustaining personal hygiene and daily activities like taking clothes on/off, care and help in social networking. The users of this care are provided also with 24 hours urgent help through call centres. The provider is obliged to provide health care and nursing if needed. The users can buy or rent sheltered housing, they are primarily located close to homes for elderly. There are 11 sheltered housings available in Slovenia.

### *1.3.2. Home care*

**Home care** is intended for persons who are not able to satisfy their needs due to age or disability, but have other conditions for living in their home environment. Home care is divided into three areas of care:

1. homemaking: preparing food, shopping for food, dishwashing, basic cleaning and trash removal, bed making.
2. help with personal hygiene: help in taking clothes on or off, washing, feeding, help in basic life needs, up keeping and cleaning of orthopaedic medical devices.
3. Social networking: keeping up social contacts in the neighbourhood, with relatives and volunteers, escorting the recipient, informing institution on status and needs of the recipient and preparing the recipient for institutional care.

As a part of home care there is an important institute of **»family helper«,** introduced in 2004. The user is hereby entitled to choose family helper instead of institutional care – the family helper offers him help in home environment. The family helper is a right of a handicapped person, who needs permanent care, attendance, help and assistance. It is a person, who was until then taken care of by one of the parents, who needs help for carrying out his/her basic life functions or is a person with difficulties in mental development or immobile person. The local centre for social work and Disability Commission at Pension and Disability Insurance Fund decides on the eligibility and right to family helper.

Family helper is a person, who offers help to disabled person. Family helper can be family member, who gave up his/her employment (at least partially) for the purpose of offering help to handicapped person. The tasks of the family helper are personal care (hygiene, feeding, drinking, taking clothes on/off, use of toilet, getting up, turning around etc.), health care (working together with GP, taking care of pills, taking care of wounds, providing prescription drugs, cleaning and taking care of medical devices etc.), social care (networking, handling mail, giving information to the institution on the status and needs of the person) and homemaking (preparation of meals, cleaning the living quarters, bed making, cleaning, ironing etc.). Family helper is eligible to social contributions coverage and receives a minimal wage as a compensation for lost income (in 2006 this amount was 521 EUR per month). Centre for social work is responsible for monitoring the care provided and has to prepare

annual reports. Social inspection also inspects the work of family helper. Family helpers are financed through municipality budget.

The **program of personal assistance** in Slovenia is in its very beginnings and is currently financed as a project. The organizations had several different criteria for eligibility to personal assistance: 70% of them used disability status as one of the criteria. Additionally, they used criteria like degree of dependence on others, inability to perform ADL independently, socio-economic status of the user, degree of activity, living alone, living outside the institution, bad health or sickness, high age. Also the organizations did perform different services under the program of personal assistance, like help in performing ADL, advising in use of medical devices, help in homemaking, escorting, driving around, and social networking.

#### *1.3.3. Home nursing care*

**Home nursing** is organized as an independent organizational unit within primary health care institutions. The provider of home nursing care is a nurse, who is normally employed within the primary health care institution. Home nursing care is provided 24/7. The number of persons aged 60+ who need home nursing care is increasing. The home nursing is carried out based on the opinion by family physician. All the services provided by the nurse in home nursing are 100% paid for by Health Insurance Institute of Slovenia. The nurses who carry out the home nursing are independent in their work and provide services according to the needs of the recipient.

## *1.4. Management and organization – role of different stakeholders*

Due to the wide area of activities in LTC there are many different stakeholders involved in the provision, management and organization of the field. LTC is very fragmented and the responsibility is mostly divided between social care and health care. The cover governmental organization that is responsible for the overview and general organization of the area is Ministry of Labour, Family and Social Affairs. The Ministry is running the policy in the field of care for elderly based on five-year strategies for the care of the elderly, through which we want to ensure the conditions for quality ageing and care of the fast growing third generation and increase solidarity and quality of interpersonal coexistence among all generations. The Ministry has to ensure the general overview of the needs, demand and supply of social care for the elderly through strategies and resolutions.

The Ministry is responsible for meeting the demands for the institutional care, which it can manage through granting licenses to providers (builds and modernizes the public institutions and grants concessions to private providers). It monitors the volume and quality of provided care through special social inspectors.

Home care is the area of social care, for which the municipalities are responsible. Municipalities grant licenses to the providers of home care and supervise the quality and provision of care.

Important stakeholders are not only regulators but also those who provide financial means. Institutional care and home care can be subsidized by municipalities as well as central government budget.

Important stakeholders are centres for social work, who decide on the eligibility of users to different benefits in kind (family helper, subsidized home care or institutional care). Pension and Disability Fund or more exactly, its Disability Commission, decides on the eligibility for benefit in cash according to the set criteria (Attendance and Allowance benefit). Centres for Social Work from the association called Association of Centres for Social Work. Its role is to define the list of the tasks that should be carried out by the centres and defines standards and norms for carrying them out.

Social Protection Institute of Republic of Slovenia is the central body that provides Ministry of Labour, Family and Social Affairs with periodical information on social care issues. It also provides propositions and possible solutions and measures, on which the Ministry can base its decisions. It follows and evaluates the effectiveness of new measures and prepares judgments and assessment of the policies enacted.

The institutional care providers are connected into Association of Social Care Institutions of Slovenia. This association represents its members in negotiations with other stakeholders in the system, foremost with Health Insurance Institute of Slovenia. It carries out different analyses and collects data, provides its members with the information for easier management (e.g. calculation of prices, costs, setting norms, preparing financial plans and reports). It offers educational and informational support to its members and follows international policies and activities in the field. It is the official carer of the central database that consists of individual data of the users of institutional care services; it defines criteria for defining different levels of care.

Important stakeholder in the system is Health Insurance Institute of Slovenia who is a payer of all health care services provided in the homes of elderly as well as in home nursing. The volume and provision of services is negotiated every year through the process of tripartite negotiations with Association of Social Care Institutions and Ministry of Health. All health care services provided are fully covered from compulsory health insurance funds.

## *1.5. Integration of LTC*

There is no separate LTC system in Slovenia. LTC field is fragmented and regulated in different areas as well as in different legal acts. The act being most responsible for regulating long term care is Social Security Act. Further on, the long term care is discussed in Health

Care and Health Care Insurance Act, War Veterans Act and War Disabled Act and Social Care for Mentally and Physically Handicapped Persons Act. The integration within the LTC system is therefore nonexistent in the current system. However, there are strategies and resolutions on national level as well as draft acts in the field that intend to integrate LTC as a special field and separate it from other areas of social fields.

Care for the elderly is very much discussed in a sense of integration with other fields of social care, like employment of elderly, system of pension and disability insurance, family policy, health care, education, housing policy, personal and other security of elderly and other. In the Strategy of Care for Elderly by year 2010 the goals in all those areas are set and the most important areas are presented in 4.2.

In this point only integration with health and social services is presented.

### *1.5.1. Integration with health services*

There is no clear division between long term care and health care since the services are very connected to each other. They are regulated under different legislation and financed by different stakeholders in the system. Due to the nature of the services it is sometimes difficult to define the area to which the services belong and there are many issues open on the categorization of the services, for example for prolonged hospital stay.

The health care policy in general promotes the healthy ageing, keeping the elderly healthy and living in home environment as long as possible, even with nursing if necessary. It aims for provision of integrated multidisciplinary and interdisciplinary home care or institutional care, when elderly is not capable of independent living. In these sense preventive programs for healthy living, physical exercise, healthy nutrition and suitable social contacts are promoted, especially on local levels. The area provided and paid for by health care insurance in total, is home nursing. Nurses that provide home nursing are employed in primary health care centres. Following the general health care policy, they promote preventive activities, health promotion and encourage elderly for more intensive care for their own health and health of the families. Home nursing is important in management and coordination of integrated long term care for the elderly. In the local environment it may include other workers, depending on the needs of the elderly. An inclusion of physiotherapist in the home nursing team is suggested. On primary level the GPs are responsible for planning the process of treatment of patients so that no unnecessary waiting time is caused. The equal accessibility to health care services for all is assured. On secondary level the elderly are treated in acute care if needed. The further development of non acute forms of care is promoted - special nursing wards for long term care in all regional hospitals are being established. Palliative care due to ageing of the population is also becoming more and more important and the national program of palliative care is in preparation. It will be a part of national health care net and carried out in special palliative units with technical support and financial means that will assure the suitable care of the patient and quality of life.

### *1.5.2. Integration with social security services*

Social services do border and intrude the LTC in many areas. Ministry of Labour, Family and Social Affairs sets as a task of the municipalities and central government the assurance of the conditions that will enable the individuals such a level of quality of life that will fit the standards of human dignity. If the individuals are not able to assure such security, they are eligible for certain rights in social care field. The social help cash (financial social assistance) are financial means for meeting minimal living needs for survival. The minimal living needs are defined as minimal wage. The amount of financial social assistance to entitled persons is determined as the difference between the minimum income to which the eligible person is entitled in the manner specified by the Social Security Act and his/her actual income. The amount of financial assistance to a family is determined as the difference between the sum of minimum incomes to which individual eligible persons or family members are entitled, and the actual incomes of all the family members. In December 2006 the share of elderly (65+) among all the recipients of the financial social assistance was 2,82% or 1.548 persons. The share of 65+ among all the recipients has the increasing trend which is evidently showing the worsening of the social situation of the elderly (the absolute share is still low).

The other area where the social services integrate with care for elderly is financing of long term care programs through active employment programs. The employment of family helpers and other unprofessional' employment in the area are subsidized.

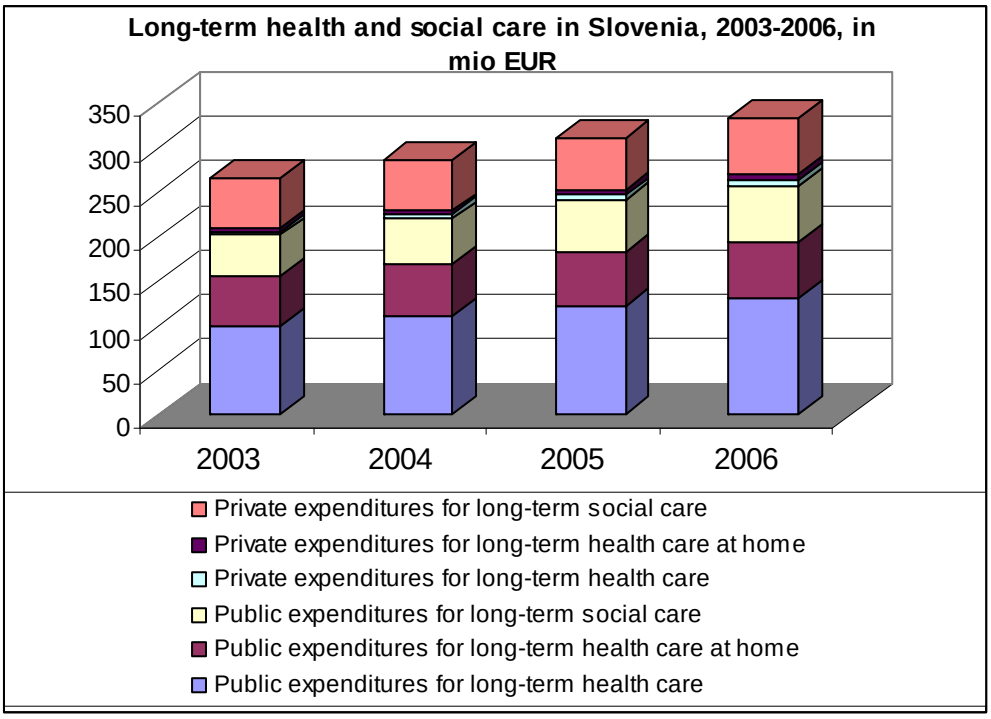
# 2. FUNDING

## 2.1. Introduction

Elderly have specific needs due to high age; they need more health care services that guarantee adequate health care and high quality life even in high age. The main diagnoses as a reason for hospital admittance in population over 65 in Slovenia were diseases of circulatory system, followed by neoplasm, diseases of respiratory system and injuries. There are multiple strategies developed to ensure the high level of health and health care in the population of elderly. On all the levels the organizational structure of the delivery of health care needs to adapt to the ageing population, the changes need to be made in the direction of focusing on the services for elderly and introducing new forms of delivering health care that are more suitable for elderly (prolonged hospital care, non-acute care, palliative care, home nursing). To some degree, these forms of long-term health care for elderly intervene with long-term social care.

The long-term care expenses are divided into public and private expenditures and expenditures for health and social long-term care. All categories of expenses are presented in the graph below for period 2003-2006 for Slovenia.

**Figure 1**: Long-term health and social care in Slovenia, 2003-2006




Source: Statistical Office of Slovenia – National health Accounts (unpublished), 2006

Almost 80% of all expenditures for long-term social and health care are public expenditures. In private expenditures the private expenditures for health care are almost non-existent and amounted to 13 million EUR in 2006. All long-term private expenditures are spent on long-term social care. In comparison to other selected countries, Slovenia has lower expenditures for long-term care than most of the northern and western European countries and higher than southern and eastern European countries. Slovenia can be compared to Netherlands, France and United States of America, that spend around 1% of GDP for long-term social and health care.

Long term care in Slovenia is financed from multiple sources. According to the Social Security Act (UL 3/07) these sources are central budget, municipal budget, direct payments and other sources like voluntary contributions, donations and sponsorship money. The LTC sectors financed from central government budget are institutional care and programs of personal assistance. The services financed from municipal budgets are home care (at least 50% of the service offered) and family helpers. Other costs of services that are not covered from budget money are financed directly by their users. Based on the rules set by the Government of the Republic of Slovenia (Decree on criteria for defining exemptions in the payment of the services, OG RS 110/04,124/04,114/06) the competent local Centre for Social Work decides on partial or complete exempt of the user from the payment of the services. The Decree defines *the border of social security*, set as an amount of money that has to remain in the hands of the user of the service after the payment of the LTC services. Further on, the Decree defines the *ability to pay* as the maximum amount up to which the user is able to participate in the payment of the LTC service. The *payment contribution* is the amount that

needs to be paid to the provider of the LTC service and the *exempt from the payment* is defined as the amount which the user of the service is not able to pay according to his/her calculated ability to pay.

The *exempt from the payment* is defined as the difference between the value of the service and user's contribution, whereas the *exempt of the one, who is liable to pay for the services*, is defined as the difference between the amount of the exempt of the payment of the user of the services and the payment contribution. The one being liable for the payment is a physical or legal entity that is not a family member and is obliged to pay the costs of the services. If the contributions of the user and the liable person do not cover the costs of the services, the difference between the value of the services and both contributions is paid by the local community or Republic of Slovenia. In this case the user must ask the competent Centre for Social Work for the exempt from payment of all the costs.

Additionally to the criteria defined in the aforementioned Decree, the local communities can decide on the additional exemptions from payment of the costs of home care services.

If the user of the LTC service who is asking for the exemption from payment of the services is the owner of the real estate property, the issuing of the written order on exemption from payment contains the inhibition on alienation or burdening of this real estate to the credit of the municipality which finances the institutional care of the user. If the user asks for the exemption from the payment of home care LTC services, the inhibition on alienation or burdening is issued only for real estate in the property of the user which is not used as the permanent residence of the user.

Family helper has a right to the partial coverage of the lost income on the level of the minimal wage or to the proportional coverage of the lost income if he/she stays in a shorter than full time employment. The family helper has full pension and disability insurance contributions paid as well as contribution for the case of unemployment and parental leave. The time spent for providing the services as family helper is included into the pensionable period (which is a condition for receiving old age pension after retirement).

In 2006 there was 342 million EUR spent for long term care services, which is 1,1% of GDP (Statistical Office of Slovenia). Out of this 264 million EUR was spent for long term care services of the population aged 65+.

74,35% of all LTC expenditures were public. 71% of all LTC expenditures for the population aged 65+ were public.

Most of the expenditures went into institutional care, which weighed 288 million EUR (equal to 0,93% of GDP or 84% of all LTC expenditures). Institutional care is still the one that represents traditional way of taking care of the elderly in Slovenia. 71% of institutional care expenditures were public and 29% of them were private.

Further 8,4% of LTC expenditures (almost 29 million EUR) was spent on home care. 84% of all expenditures for home care were public.

Further on, 7,4% of all LTC expenditures were used for home nursing care, all of which is public. Home nursing care is financed through Health Insurance Institute of Slovenia and is a part of health care – the funds are collected through compulsory health care contributions standing at 6,36% of gross wage for employees and 6,56% of gross wage for employers.

According to the explanation the LTC system in Slovenia could be defined as tax based financed (except in the part of home nursing care which is financed through health care insurance and is therefore insurance based).

Care receivers, no matter which type of care they receive, can be entitled to Attendance and Allowance Supplement that is based on Social Security Act. The supplement is monthly cash benefit, that can be acquired by pensioners and some other insures, who are residents of Slovenia. It is intended to cover part of the costs, which arise because of the permanent changes in health status of the recipient due to which the recipient is unable to satisfy most or all of his/her basic life needs and needs care and help from others permanently. The Attendance and Allowance Supplement depends on the base on which it is calculated: it is equal to the base for the most severe cases. It equals to 70% of the base for blind and immobile for fulfilling all basic life needs. It amounts to 50% of the base for fulfilling all basic life needs for persons who need help in most of their basic needs or are sight impaired. Severe cases are persons who need 24-hour supervision of relatives and compulsory help of a professional. In February 2009 there were 29.800 recipients of the supplement in Slovenia. 422 of them were severe cases, who received 398,48 EUR of supplement; 11.318 were receiving 70% of the supplement or 278,94 EUR and 17.378 received 139,47 EUR. The rest of the recipients (657) received other amounts.

Beside care receivers, also care givers can be entitled to compensation. First option is to register as “family helper”. The Social Security Act stipulates that those people whose care-giving affects their employment are entitled to receive a financial compensation, meaning that only family carers that are either unemployed or they reduced working hours from full-time to part time are entitled to this compensation. Since maximum annual compensation is rather low (equal to minimum wage), only a small number (1.349) of caregivers are receiving it. The other possible compensation is offered through Health Care and Health Insurance Act which provides the right to compensation for care-givers who live in a common household with the insured. This compensation is given for no more than 7 (exceptionally 14) days a year. The base for compensation is average monthly wage, where compensation equals 80% of the base. Since the trend in Slovenia is such that young generations do not live in common household, but nearby, this right is limited to a small number of family carers. Not only that, seven days a year is often by far not enough.

## *2.2. Institutional care*

The total income of institutional care thus consists of three sources: 55% of income comes from direct payments for the social care received – out of this, 85% is paid directly by users or liable persons and 15% is paid by the local communities. 37% of the income are payments from the Health Insurance Institute of Slovenia, that is paying for health care services provided to the users of the institutional care. The rest 8% of the income comes from other sources (selling lunches, lottery, and donations).

## *2.3. Home care*

The average price paid by the user of the LTC services home care amounted to 4,3 EUR per hour in 2007. The highest average price for the hour of home care is paid by the users in Coastal Karst region (6 EUR) and the lowest in Carinthia region in the north (2,5 EUR). The prices paid by the users and the total costs of the services are shown in Table 2.

**Table 2**: The price of the home care paid by the users and total costs of home care services, hourly fee, first six months of 2007, according to the Slovenian regions

| | ***Price paid by user for hour of home care*** | | | | ***Total cost per hour of home care*** | | | |
|---|---|---|---|---|---|---|---|---|
| *REGION* | *Average* | *St. Dev.* | *Min* | *Max* | *Average* | *St. Dev.* | *Min* | *Max* |
| Upper Carniola | 5,5 | 1,2 | 3,0 | 8,9 | 14,7 | 2,7 | 10,2 | 21,9 |
| Gorizia | 3,8 | 1,1 | 1,8 | 5,4 | 15,4 | 6,2 | 8,5 | 28,1 |
| Southeast Slovenia | 4,4 | 1,6 | 0,5 | 7,0 | 14,9 | 1,8 | 11,5 | 17,7 |
| Carinthia | 2,5 | 1,4 | 1,0 | 4,8 | 11,3 | 0,6 | 10,3 | 12,0 |
| Inner Carniola | 4,2 | 0,4 | 3,8 | 4,7 | 16,7 | 10,0 | 8,0 | 35,2 |
| Coastal-Karst | 6,1 | 1,7 | 3,9 | 7,7 | 20,2 | 7,9 | 14,2 | 34,4 |
| Central Slovenia | 4,9 | 1,8 | 0,8 | 9,2 | 14,4 | 4,1 | 7,5 | 25,9 |
| Drava region | 3,3 | 0,9 | 0,4 | 4,0 | 12,1 | 3,5 | 6,5 | 31,0 |
| Mura region | 4,7 | 1,3 | 3,8 | 9,7 | 14,5 | 2,5 | 11,8 | 23,9 |
| Savinja region | 4,6 | 2,4 | 1,7 | 10,9 | 13,1 | 1,7 | 8,8 | 17,3 |
| Lower Sava region | 4,8 | 0,1 | 4,7 | 5,0 | 15,2 | 0,8 | 14,6 | 16,4 |
| Zasavje | 3,4 | 1,4 | 2,4 | 5,0 | 11,9 | 1,9 | 9,8 | 13,4 |
| **Slovenia** | **4,3** | **1,8** | **0,4** | **11,2** | **13,9** | **4,1** | **6,5** | **35,2** |

Source: Smolej S., Jakob P., Nagode M., Žiberna V.: Analysis of home care, final report for Ministry of Work, Family and Social Affairs. Social Protection Institute of RS, Ljubljana, 2008

The highest share of the price covers the costs of the service itself (80,4%), whereas the rest are the costs of organization and administration.

According to the Art. 99 in the Social Security Act (OG RS 3/07) it is stated that the municipalities are to cover at least 50% of the price of the home care service (most municipalities abide to the law (in 2007 there were 9 municipalities who did not assign financial means for this purpose). The municipalities assigned 3,8 million EUR for that purpose in the first half of 2007. The further subsidies from the central budget (in the frame of active employment policy) in this period amounted to 0,95 million EUR and according to the Decree on exemption, the municipalities assigned further 0,55 million EUR for home care. Or, presented in the average shares, the municipalities did subsidize 53,6% of the price of the service and additionally covered 6,2% of total costs of service due to exemptions. This means, that the municipalities did pay 59,8% of all home care costs. 11,4% was added from the central budget and the rest (28,7%) was paid by the final users of home care.

The price of providing home care is higher with private providers (the average hourly fee is 4,99 EUR) whereas the average for all providers is 4,15 EUR (data available only for 2008).

## *2.4. Personal assistance program*

Personal assistance program financing does not have ensured financial means in Slovenian environment. Almost all programs of personal assistance are financed through Employment Office (82%) and only some receive support of the municipalities or Ministry of Labour, Family and Social Affairs. Most of the organizations carrying out the programs of personal asssistance combine different sources of financing and are financed from four or five sources/bodies. The program mostly runs on the level of different associations or disability and humanitarian organizations. In the first six months of 2007 there were 705 users of these programs, among them 29,2% are aged 65+.

## *2.5. Family helper*

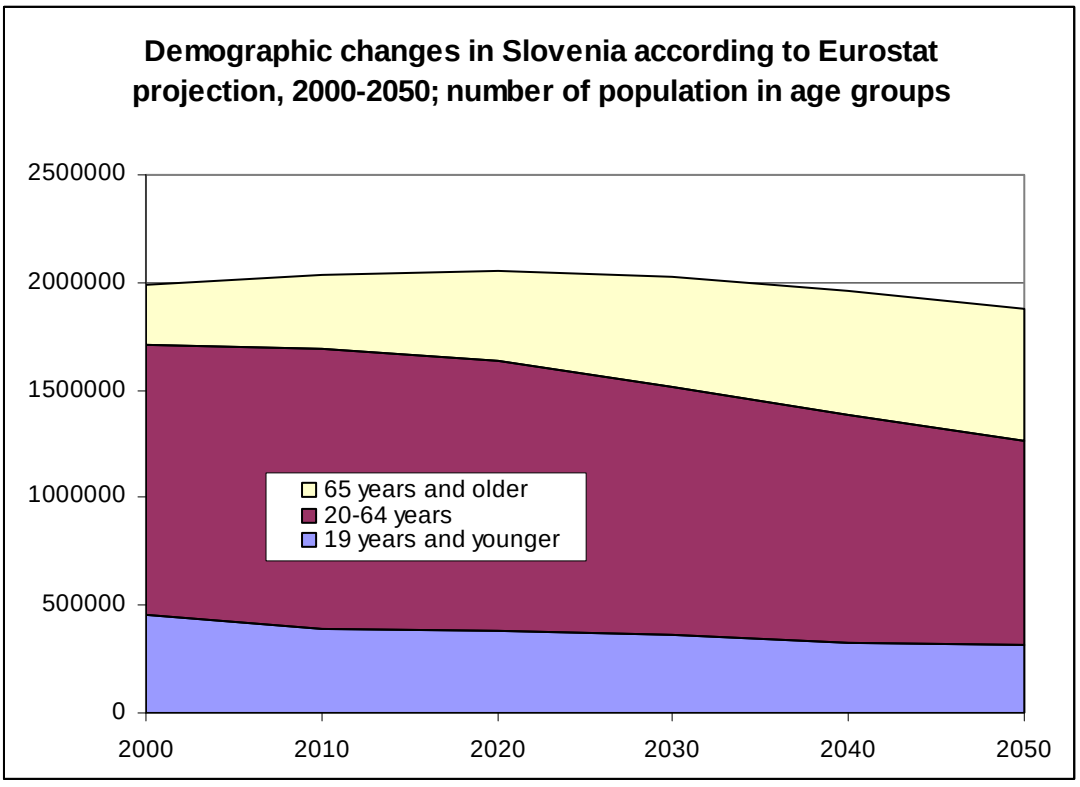
Family helper program was introduced in 2004 and has a very important role in preserving quality ageing of elderly and disabled people. It is intended for those who think that institutions do not offer them enough intimacy, individuality, solidarity, personal communication, feelings of being at home and personal warmth.

# 3. DEMAND AND SUPPLY OF LTC

## *3.1. The need for LTC (including demographic characteristics)*

The total population of Slovenia was 1.990.272 (972.581 male and 1.017.691 female) in the year 2000 and is going to decrease to 1,878,003 by 2050. The population projection is based on Eurostat assumptions until year 2050. The demographic projections show a fast ageing of the population. According to the Eurostat projections (http://epp.eurostat.ec.europa.eu/portal/) the population in Slovenia will decrease to 1,87 million people by 2050. Net migrations which are estimated at 6 to 7 thousand immigrants per year are the ones that hinder even faster decline in the number of the population.

**Figure 2**: Demographic changes in Slovenia according to Eurostat projection




Source: Eurostat projections http://epp.eurostat.ec.europa.eu/portal/, Statistical Office of Slovenia www.surs.si, own calculations, 2008

The share of elderly population (65 years and older) is high – until year 2050 its share will double: from 14% in 2000 the share of elderly will grow to 32,5% in 2050 (Table 3).

**Table 3**: The number of population according to the age groups and share of age groups, 2000-2050

| | **2000** | **2010** | **2020** | **2030** | **2040** | **2050** |
|---|---|---|---|---|---|---|
| $P_{0-19}$ | 456.145 | 388.471 | 385.146 | 360.368 | 324.376 | 320.135 |
| $\%_{0-19}$ | 22,9 | 19,1 | 18,7 | 17,8 | 16,6 | 17,0 |
| $P_{20-64}$ | 1.255.897 | 1.307.598 | 1.252.640 | 1.150.971 | 1.064.200 | 947.438 |
| $\%_{20-64}$ | 63,1 | 64,3 | 60,9 | 56,9 | 54,4 | 50,4 |
| $P_{65+}$ | 278.230 | 338.151 | 420.217 | 511.533 | 569.360 | 610.430 |
| **$\%_{65+}$** | 14,0 | 16,6 | 20,4 | 25,3 | 29,1 | 32,5 |
| $P_{80+}$ | 45.630 | 79.622 | 111.320 | 135.110 | 193.333 | 224.641 |
| **$\%_{80+}$** | 2,3 | 3,9 | 5,4 | 6,7 | 9,9 | 12,0 |
| **Total** | **1.990.272** | **2.034.220** | **2.058.003** | **2.022.872** | **1.957.936** | **1.878.003** |

Source: Eurostat projections, 2008, Statistical Office of Slovenia, own calculations

According to the experience from the western countries there are around 25% of people aged 65 years + that need some form of help in everyday activities (Strategy of care for the elderly until 2010 – solidarity, coexistence and quality ageing of the population). 10% of them are those who need a fair amount of everyday help – a simple calculus shows that next year (in 2010) there will be around 34.000 elderly in Slovenia needing a lot of help with everyday activities and further 50.700 who will need some help. The institutional care should according to European experience be ensured for 5% of the population aged 65 or more and the capacities in Slovenia are close to that coverage, although they are not regionally well allocated. The other part of the services, home care, 24 hours care, family helper, personal assisstance, palliative and some other non acute forms of care are more underdeveloped and will need special attention and investments in the coming years.

The official assessment of needs for long term care was done in 2006 with data from 2004 for the purpose of preparation the Draft Act on Long Term Care and Long Term Care Insurance. In assessing the needs for long term care the baseline population projection of Eurostat used in Ageing working group (AWG) was taken into account. The data used are the available data on the number, age and gender structure of persons in institutional care – homes for elderly and the data on the number of recipients of Allowance and Attendance Benefit through Pension and Disability Insurance Fund. Using Eurostat methodology for the projection of dependent population (The 2005 EPC projection of age-related expenditure: Agreed underlying assumptions and projection methodologies, European Commission, EPC, Brussels, November 2005, pg. 149, Table 5-5) it was estimated that there are 59.000 dependent persons in Slovenia. Based on different scenarios (pure aging scenario, constant disability scenario and AWG reference scenario) the number of dependent persons in households is estimated and amounts to from 64.300 to 68.800 in 2010, from 68.300 to 76.200 in 2015 and from 71.800 to 84.700 in 2020). The long term care in year 2010 should be provided for 60% of dependent population according to the Draft Act on Long Term Care and Long Term Care

Insurance. The numbers of recipients of institutional care, home care and benefits in cash according to different scenarios in years can be seen from Table 4.

**Table 4**: The projection of number of dependent persons according to different scenarios and following proposed solutions in Draft Act on Long Term Care and Long Term Care Insurance, in 000

| | ***2004*** | ***2010*** | ***2015*** | ***2020*** |
|---|---|---|---|---|
| **Dependent population** | | | | |
| Pure aging scenario | 59,0 | 68,8 | 76,2 | 84,7 |
| AWG reference scenario | 59,0 | 66,5 | 72,2 | 78,0 |
| Constant disability scenario | 59,0 | 64,3 | 68,3 | 71,8 |
| **Institutional LTC recipients** | | | | |
| Pure aging scenario | 13,1 | 20,0 | 22,2 | 24,6 |
| AWG reference scenario | 13,1 | 20,0 | 21,7 | 23,5 |
| Constant disability scenario | 13,1 | 20,0 | 21,2 | 22,4 |
| **Home care LTC recipients** | | | | |
| Pure aging scenario | 10,0 | 10,6 | 11,8 | 13,1 |
| AWG reference scenario | 10,0 | 10,0 | 10,8 | 11,7 |
| Constant disability scenario | 10,0 | 9,3 | 9,9 | 10,4 |
| **Benefit in cash recipients** | | | | |
| Pure aging scenario | 26,0 | 10,6 | 11,8 | 13,1 |
| AWG reference scenario | 26,0 | 10,0 | 10,8 | 11,7 |
| Constant disability scenario | 26,0 | 9,3 | 9,9 | 10,4 |

Source: Draft Act on Long Term Care and Long Term Care Insurance, 2006

## *3.2. The role of informal and formal care in the LTC system (including the role of cash benefits)*

The long term care in Slovenia is one of the main topics in the last 5 years since the baby boom generation started to retire and came into the age span of 60 years and over. The role and views of long term care started to change drastically and the questions were posed about who is responsible for the older people? Who and to what extent needs to offer the care to the person who cannot tackle the activities of daily life without help? From the traditional point of view this was family. However, such moral obligation and postulate is merely theoretically possible; in reality, the phenomena like generations not living together, the employment of family members, time constraints, careers at work becoming one of the top priorities etc., make care of the elderly inside the family circle impossible. The modern view is therefore to include government in the care provision for the elderly where the family members have no possibilities to do so. The responsibilities are not only moral, but as well financial – so the ways for the government to provide care are numerous: legislative, through direct provision of material conditions, introducing special insurance for long term care.

The current position towards long term care is the emphasis on home care for as long as possible home care should be provided for persons needing care. Such an orientation has its humane, moral and economic advantages. Living in home environment has a strong impact on quality of life and the successfulness of the long term care. If the person stays at home, he/she usually gets some help and cooperation from family members making care cheaper. Also the investments in special residences/homes for elderly are not needed in a case of home care. Since the number of elderly will be growing extremely fast in the next decade or two, such investments would mean a big burden for the tax payers.

In the division between roles of home care and institutional care there is also an important question of care providers: it is impossible to educate the sufficient number of qualified providers. Hence the inclusion of relatives, friends, non-governmental and humanitarian institutions is a must.

The next issue arising is the equalization of rights between persons receiving home care and persons receiving residential institutional care. In homes for elderly certain rights are assured since they are being offered on spot – the word is mostly about health care rights, physiotherapy, work therapy and similar. Such services are covered in larger share for persons receiving institutional care than for those who receive home care. The rights equalization between all users no matter the place of dwelling or type of care received is among the top priorities. The long term care should be accessible from one entry point and the regional differences should be lessened.

The exceptional role in the social care system in Slovenia is given to the Assistance and Attendance Supplement. It is a major benefit in cash, given to the users of care services (given they fulfil the conditions for receiving it) and the users can use it for any type of care. It is intended to cover part of the costs, which arise because of the permanent changes in health status of the recipient and due to which the recipient is unable to satisfy most or all of his/her basic life needs and needs care and help from others permanently. In February 2009 there were 29.800 recipients of the supplement in Slovenia. The total amount intended for benefit in 2006 was around 70 million EUR.

## *3.3. Demand and supply of informal care*

Although some researchers (Hvalič Touzery 2004) assume that informal care is widespread in Slovenia, they cannot rely on any "real" data, since there hasn't been any research conducted on the national level. There have been however some small sample (N≈ 50) studies carried out by researchers (Hojnik-Zupanc et al. 1996, Hojnik-Zupanc 1997, Hvalič Touzery, Felician, 2004, 2003, Hlebec et al. 2001) where some information can be obtained.

These studies show that close relatives, especially children and partners are the first to help older people with problems. Children and children in law account for 35% of informal care giving, partners - mostly spouses for 24%, other relatives for about 17% while others (not

related) provide the rest. More specifically daughters aged 33 – 55 and sons belonging to age group 40 – 49 were found to be most in touch with their elders. Not only that, family members offer more care and nursing to older people than institutions and public network programmes, where a rough estimate shows that providers usually assist their elders for about 9 years.

Most frequent help provided by informal care givers are that of handling financial matters, household tasks, accompanying, help with nutrition, nursing and hygiene. These tasks, however, are usually combined with forms of formal care.

There are no data available on the level of education of carers or on what kind of jobs they have and hence no data for income of carers.

## *3.4. Demand and supply of formal care*

### *3.4.1. Introduction*

The analysis of data on demand and supply seem to be inevitable and absolutely necessary in the process of planning the future development of the long term care capacities in a sense of needs satisfaction. The needs should be evaluated on a national level, based on the demand for different kinds of care. With all the informatization and computerization, automatic proceedings of applications it is hard to believe that the data we receive on the population using long term care services as well as population needing long term care services is so incomplete. In Slovenia at the Association of Centre for Social Work a database is in a set up process that will contain the social, demographic and economic data on the users of the long term care services – the data will be sent to the database from all LTC formal home care and will be collected on a national level. The database is going to contain the age, gender, education, postal address of the user as basic information. Such database was already implemented in 2008, unfortunately the efforts did not show the results since the data are of very bad quality and not suitable for use. On the level of national institutional care (Association of Social Care Institutions of Slovenia) the idea of setting up a national waiting list for institutional care started almost a decade ago. Its purpose was to check the demand for long term institutional care and plan and adjust the capacities accordingly. Due to high increase in the number of people on the waiting list it was soon obvious that the program included many mistakes (putting on the list the same person twice as soon as somebody asked about free capacities in two institutions (homes for elderly), not deleting people who died while waiting etc). The national waiting list nowadays hence does not reflect the real needs and is too long, not maintained and not cleaned. The data are available daily; however they are not of much use.

For the purpose of analyzing demand for LTC services in Slovenia we identified the above mentioned two sources that could throw the light on the estimation of needs for such services. Due to their, in our opinion major, imperfections, however, we decided not to use them. The

analysis of the demand in the continuation is therefore rather limited and gives by far the most reliable estimates for the area of home care, where the one and only analysis of demand for home care services in Slovenia was performed in 2008.

On the other hand, since the financing system is mostly capacity oriented (for example health care services in homes for elderly are still paid according to the standards and norms of staff, number of beds and not according to the needs that those staff satisfy) we do have some data that can show us pretty exactly the supply side of long term care services in institutional as well as in home care.

### *3.4.2. Institutional care*

#### 3.4.2.1. Institutional residential care – homes for elderly

The **institutional care** is a form of care with the longest tradition in Slovenia and is the most spread in all Slovenian regions. In the last years many new homes for elderly were open or modernized. In the end of 2007 there were 55 public homes for elderly and 18 private homes for elderly in Slovenia. In public homes there were 12.318 places and in private homes 1.974 places were offered. In the end of 2006 there were 13.816 people older than 65 living in residential homes. According to the Strategy for elderly, the aim is to provide capacities to accept 5% of the population aged 65+ in the homes for elderly – this means that there is a lack of 3.200 beds (the capacities cover 4,4% of the population aged 65+). The waiting lists for institutional care do exist on the national level but are unfortunately not updated and not accurate as well as overstrained: they cannot be used for planning and policy making purposes. In many homes the day care centres were opened, which have around 200 places. There is also nine sheltered housing available for more than 300 recipients. In homes for elderly there is more than half of persons aged 80+. Among them there are 86% of women. The age and gender structure is shown in Table 5.

**Table 5**: Age and gender structure of the population in homes for elderly, 2006

| | **Age groups in years** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Gender** | **Up to 39** | **40-49** | **50-59** | **60-64** | **65-69** | **70-74** | **75-79** | **80+** | **All** |
| **Male** | 15 | 73 | 343 | 237 | 397 | 563 | 712 | 1.098 | **3.438** |
| **Female** | 20 | 54 | 198 | 206 | 406 | 910 | 1.856 | 6.634 | **10.284** |
| **All** | 35 | 127 | 541 | 443 | 803 | 1.473 | 2.568 | 7.732 | **13.722** |
| **%** | 0,3 | 0,9 | 3,9 | 3,2 | 5,9 | 10,7 | 18,7 | 56,3 | **100,0** |

Source: Statistical Office of Slovenia, SOC-DOM 2006 forms

The reasons why people stay in homes for elderly can be seen from Table 6. The most important reason is age (person can be healthy or sick). Most persons in homes for elderly are there due to their age (68%). The rest of the residents stay there for disability of any kind or for other reasons like no other place to stay, bad family relations or other.

**Table 6**: Reason for stay in homes for elderly, 2006

| All | **Age - healthy** | **Age-sick** | **No place to stay** | **Bad family relations** | **Mentally ill** | **Physically ill** | **Other** | **All** |
|---|---|---|---|---|---|---|---|---|
| | 1.438 | 7.871 | 508 | 466 | 1.242 | 1.610 | 609 | 13.744 |
| % | 10,5 | 57,3 | 3,7 | 3,4 | 9,0 | 11,7 | 4,4 | 100,0 |

Source: Statistical Office of Slovenia, SOC-DOM 2006 forms

Institutional care can also be provided in **sheltered housing**. Such form of care is mostly intended for elderly who cannot take care of themselves fully, but are still capable of living a relatively independent life. The *basic care* in sheltered housing is help with living (cleaning, trash removal and bed making), organized meals (bringing prepared meals or cooking in the house, dishwashing) and help in washing and ironing the clothes. The *social care* in sheltered housing is help in sustaining personal hygiene and daily activities like taking clothes on/off, care and help in social networking. The users of this care are provided also with 24 hours urgent help through call centres. The provider is obliged to provide health care and nursing if needed. The users can buy or rent sheltered housing, they are primarily located close to homes for elderly. There are 11 sheltered housings available in Slovenia.

3.4.2.2. Palliative Care

In Slovenia there is 1 inpatient palliative care unit with 4 beds located at the specialized hospital Golnik. There are also 3 hospices in Ljubljana, Maribor and Celje, but there are no beds. There are also a number of hospital beds (20-30) used for patients on palliative care at the Institute of Oncology Ljubljana, but they are located in various departments. 99% of patients receiving palliative care have a cancer diagnosis and 1% of patients have other incurable conditions. There are no palliative care physicians in Slovenia, however there are 10 nurses, 5 social workers, 4 psychologists, 2 physiotherapists and 2 spiritual leaders working in palliative care. The estimation of volunteers working in palliative care is about 120. Palliative care department in Golnik is funded by government, while palliative care services in the three hospices are supported by a combination of private and public funds.

3.4.2.3. Prolonged hospital stay

Prolonged hospital care in Slovenia was introduced in year 2000 in Hospital Sežana and Murska Sobota and by 2002 the program got a wider dimension as a part of non-acute care. In 2002 further three providers joined in the program: hospitals Novo mesto, Slovenj Gradec and Jesenice. The fourth prolonged hospital care centre was opened in 2008 in hospital Ptuj. The increases in the use of the programs were almost fourfold from 2003 to 2007. The length of stay in this programs is long, but is falling - it amounted to 8,6 days in 2005 and 8,1 days in 2006. However, the program of non-acute care did not reach the goals set around the quality

and cost effectiveness since the non-acute care is not always carried out in special departments, which is the point of the program (to take the patients out of the acute care environment and assure a different type of care for them).

### *3.4.3. Home care*

#### 3.4.3.1. Supply

The organization of home care LTC services in Slovenia is the responsibility of the municipalities. Home care work hand in hand with home nursing, which is, however, organized by primary health care level centres in the municipality. 91% of providers of home care cooperates well with home nursing providers (Smolej S. et al, 2008) Home nursing care is financed through compulsory health care insurance, whereas municipalities finance home care through their budget (tax based). There were 78 different organizations carrying out home care in Slovenia in 2008. Home care was not offered in 9 municipalities (out of 200). All municipalities who financed the home care gave the concession for carrying out home care to a single provider, except one municipality, who issued two concessions. Home care is mostly carried out by Centers for Social Work. 88,5% of organizations who carry out home care are public institutions, the others are private providers (9 out of 78).

There were 743 social workers in 2007 carrying out home care. 58% were regularly employed, the rest were performing home care through active employment programs. On average one social worker took care of 7 users of home care, although the maximum defined standard or norm is 5 recipients per one worker. There were also high differences among different municipalities – in a municipality Braslovče there were 22,2 users per one social worker on average in 2007. On average, one social worker visited user 16,3 times per month and spent there around one hour per visit effectively. Less than half of the municipalities provide home care on weekends and holidays.

The average price paid by the recipient of care was 4,3 EUR per hour of help in 2007. The prices differed among the regions in Slovenia, the highest average regional price was 6EUR and the minimal average regional price was 2,5 EUR per hour. The overall costs of help per hour (confirmed price, paid by recipient plus subsidies from state and municipality) amounted to 13,9 EUR on average per hour. Minimal average regional price was 11,3 EUR per hour and the maximum average regional price was 20,2 EUR per hour.

Home care on weekends, holidays and in the afternoons is only offered in less than half of the municipalities and remains a hot issue in all other municipalities where it is only being offered in the mornings during the work days. The other problem occurring on the supply side in the rural regions are long distances between the users of the services, making the time of the carer less efficient and services more expensive.

#### 3.4.3.2. Demand

The number of users of home care is growing since 2006 when it was first introduced. In 2006 home care was used by 5328 users, in 2007 by 5595 users and in 2008 by 5780 users. Most users of home care are older than 80 years – in 2008 53,4% of home care users were aged 80+. The share of the home care users aged from 65 to79 was 34,8%, leaving only 11,8% of users younger than 65.

84% of users use home care due to age reasons or other occurrences connected to ageing: chronical illnesses or some sort of disability that makes them unable to perform in everyday life.

Resolution on National Program of Social Care 2006-2010 assumes providing home care to at least 10.000 persons aged 65 or more, which is 3% of all such population. In 2008 home care was received by 5096 persons aged 65+, which is 1,5% of all such population. The averages presented do not give the complete picture though. There is a region Carinthia where only 1% of population aged 65+ receive home care.

In 54% of the municipalities at least one person would need home care services but has no access to it (for any reason). All needs are estimated to 1070 potential users, who do not have access to the home care services. The reasons for that are lack of carers, demand for services in the time of the day when the service is not provided and demand for the greater extent than allowed by the norms (5 hours a day). Most unsatisfied demand is in two major cities (Maribor and Ljubljana) – in only those two cities 450 persons expressed interest in home care services.

#### 3.4.3.3. Family helper

As a part of home care there is an important institute of **»family helper«,** introduced in 2004. The user is hereby entitled to choose family helper instead of institutional care – the family helper offers him help in home environment. The family helper is a right of a handicapped person, who needs permanent care, attendance, help and assistance. The local centre for social work and Disability Commission at Pension and Disability Insurance Fund decides on the eligibility and right to family helper.

Family helpers are financed through municipality budget. In the end of 2006 there were 1.245 persons eligible for family helper in Slovenia. Among them there were 62% of women and 38% of men. 60% of them were older than 65. There were 1.349 family helpers available, 981 were family members, the rest of them were other persons with the same residential address.

#### 3.4.3.4. Personal assistance

The **program of personal assistance** in Slovenia is in its very beginnings and is currently financed as a project. The program is primarily intended for handicapped persons and is carried out in 24 organizations, mostly associations. The data are available for only 17 organizations. Out of them 7 provided only up to 14 hours of care per week, whereas the other ten provided from 7 to 43 hours of care per week. In 2007 there were 705 users of personal assistance program, the average number of users per organization is 51. 57% of all users are female, 29,2% are older than 65 years. 37% of the users were blind or weak-sighted and further 11,5% were deaf. The number of assistants per organization is from 2 to 127, half of them are volunteers, half of them are paid through active employment policy. 79% of all assistants are women and 75% of them are aged between 25 and 54, they are mostly graduates of high school or less.

### *3.4.4. Home nursing care*

As home nursing care is financed through Health Insurance Institute of Slovenia (HIIS) the only data are the ones collected there. There were 1.069.186 home nursing visits in 2006 made by 645 home nurses or, on average one home nurse made 1.657 home visits (4,5 per day). All the needs for home nursing in Slovenia are covered since home nursing is a right from compulsory health insurance (99,7% of Slovenian population has compulsory health insurance).

The number of persons aged 60+ who need home nursing care has an increasing trend, which is shown in Table 7.

**Table 7**: Number of persons aged 60+, who needed home nursing, 2001-2007

| **Year** | **No. of persons** |
|---|---|
| 2001 | 28.557 |
| 2002 | 30.797 |
| 2003 | 32.978 |
| 2004 | 34.507 |
| 2005 | 38.681 |
| 2006 | 43.686 |
| 2007 | 46.774 |

Source: Health Statistical Yearbook, Institute for Public Health, 2001-2007

# 4. LTC POLICY

## *4.1. Policy goals*

The primary goal of the LTC policy in Slovenia is increasing social security and quality of life of the elderly, sick, injured and disabled who depend on help from others in carrying out their activities of daily life. Such help is intended to become a part of the total social security in Slovenia and should be regulated according to the principles of social insurance.

The next goal of LTC is to eliminate the differences in the accessibility to LTC and assure the access to these services to all population in need. The differences among regions are to be eliminated as well as the differences in access to services for those, who use such services at home and those, who use such services in institutional care.

The new form of special social insurance for long term care is proposed that would be based on solidarity among all insured, the same as in the system of pension or health care. The insurance would be based on the satisfaction of needs and not on profit – this would be public, compulsory and non-profit insurance. In this sense the solidarity would be introduced in the intergenerational relations, based on the principle of contribution according to equal possibilities and rights according to the needs. The Draft Act on LTC rests upon the presumption that the government is responsible for assuring LTC. As a consequence, the contribution rate for health care insurance and pension insurance would decrease, since some services provided now within those systems would be transferred in the system of LTC insurance. The compulsory insurance would ensure the users the coverage of costs of LTC that assure the security and prevent the formation of further dependence on help and care of others. The costs of dwelling and food would not be included. The additional rights or higher standard would be assured through voluntary insurance. The insured person could use their right to LTC if there is a need for care of other for more than 7 hours per week. The users of LTC will be distributed into 5 categories of care depending on the severity of their needs. For this categorization 15 criteria would be used.

The new legislation is proposing a case manager and a new work organization. The user will be granted one entry point into the system, which will make things more transparent and simpler. The case manager will guide and advise the user through the whole process and plan and organize the provision of services (individual plan of LTC).

The important goal of LTC is the assurance of stable sources of financing of LTC, including public and private financial sources. The transparency of all sources would be increased if all the LTC would be financed from one source.

The goal of LTC is higher inclusion of families and their members and other non-professional providers into the provision of LTC. To achieve this, the special benefits and stimulus would

be introduced. The home care is put in the forefront of providing LTC also for the reasons of rationality and accessibility.

One of the most important goals of LTC is the connection of all LTC providers into a single and integral system to achieve higher effectiveness, quality of services and satisfaction of the users. The connections should be financial, professional as well as organizational.

## *4.2. Integration policy*

### *4.2.1. Employment*

Employment policy is connected to long term care through active employment programs where the state subsidizes unemployed persons for help to the elderly. These programs are led through the Ministry of Labour, Family and Social Affairs and are mostly intended for home care, but also for family helper and personal assistance programs. The employment policy is also promoting the design of the products and services suited to satisfy the needs of the elderly.

### *4.2.2. Pension and Disability policies*

The goal of the pension system is to assure the level of pensions that together with other social benefits ensure at least coverage of minimal life costs.

### *4.2.3. Social care*

The goal connected to long term care refers to the assurance of social security of the elderly. This means that it is urgent to continue with the reconstruction, modernization and development of the existing program of social security for the elderly. This refers to the extension of the capacities of institutional care (homes for elderly) with public and private providers; extension of the day care capacities, extension of the net providing home care, further extension of the sheltered housing and continuation of the program of distant help. Also new social care programs, intended for intergenerational care and to elderly should be developed, especially education of the families with elderly persons, creating local intergenerational centres, that help and educate families on taking care of the elderly, provide day care, home help, provide volunteering and programs like intergenerational workshops, social activities. Pluralisation of providers who can take care of the elderly is a goal since the number of elderly is increasing fast and new forms of care and new gerontological knowledge should be included in the provision of care. The third generation should be included in the social life and provided quality ageing and cooperation with younger generations.

### *4.2.4. Family policy*

The goal connected to LTC is to take care of education and local help for day care and temporary care of elderly persons for families that include elderly person. The active

inclusion of elderly into the society is promoted, especially through local centre and in the activities where their contribution is needed and welcome, like in caring for children or social activities. Also the education and training in caring for elderly should be provided for families that include elderly persons. Through education and public promotion the conditions for equal distribution of care for elderly among all vital family members should be improved. The measures for more flexible working hours that would enable employees to care for the elderly and not lose work due to provision of care are promoted. The systematic right to shorter working hours and a right to payment for caring for older family member should be introduced.

#### *4.2.5. Health care*

The number of hospital acute cases for 65+ is increasing. The main reason for hospitalization are diseases of the circulatory system, followed by neoplasm, diseases of the digestive system, diseases of the respiratory system and diseases of the genitourinary system. The health care policy in general promotes the healthy ageing, meaning keeping the elderly healthy and living in home environment as long as possible, even if with nursing. It aims for provision of integrated multidisciplinary and interdisciplinary home care or institutional care, when elderly is not capable of independent living. In this sense preventive programs for healthy living, physical exercise, healthy nutrition and suitable social contacts are promoted, especially on local levels. Nurses that provide home care, promote preventive activities, health promotion and encourage elderly for more intensive care for their own health and health of the families. Home nursing is important in management and coordination of integrated long term care for the elderly. In the local environment it includes other workers, depending on the needs of the elderly. An inclusion of physiotherapist in the home nursing team is suggested. On primary level the GPs carefully plan the process of treatment of patients so that no unnecessary waiting time is caused. The equal accessibility to health care services for all is assured. On secondary level the elderly will be (the same as now) treated in acute care if needed. The further development of non acute forms of care is promoted - special nursing wards for long term care in all regional hospitals will be established. Palliative care due to ageing of the population is also becoming more and more important and the national program of palliative care is in preparation. It will be a part of national health care net and carried out in special palliative units with technical support and financial means that will assure the suitable care of the patient and quality of life.

#### *4.2.6. Education*

In schools the proper education on intergenerational coexistence should be presented in books and in education process. Therefore the education materials should be adapted, national documents like education plans, catalogues of knowledge and didactic materials and devices should be prepared. The proper education should prepare the youngsters to understand the process of ageing, the possibilities of coexistence and the intergenerational transfer of knowledge and experience. The young should be included in the provision of care through

school process and the elderly should be included into the education process through help in difficult life occassions, advising on life dilemmas and in other school projects.

#### *4.2.7. Research and development*

The project »Safe home« is a project, which tried to provide a perfectly computerized and technically perfect living space, intended for the dwelling of elderly, immobile and paralyzed persons. Safe home is a place where information and communication equipment enables the elderly to live a completely autonomous life, because all equipment in the room is computerized indirectly through voice activation or remote control. In the living space there are movement detectors, that enable the monitoring of unwanted situations like fall or non movement for a specific period of time and starts rescuing action. All equipment is specific and adapted and would enable a person that should otherwise live in a hospital or other institution to live at home.

A more integrated policy in the area of intergenerational solidarity and gerontology should be promoted and should receive more attention. Interdisciplinary gerontological institute that would deal with the ageing topics and achieve professional research results should be established.

#### *4.2.8. Housing policy*

The needs of the elderly demand also proper housing dictated by those needs. In providing the proper housing, independence of the elderly, accessibility and enabling elderly to take part in all fields of social life should be taken into account. The regular housing, not specifically intended for elderly, should provide access for all categories of population (elderly, handicapped, mothers with babies). These should go for the modernization of older house and of course, for new buildings. The homes for elderly should be integrated in the normal living surroundings and not separated from other housing in the area, so that the elderly do not lose touch and social network. The legislation should promote exchange of flats (owned or rented) for the ones that suits the needs of elderly better, good loan conditions (low interest rates) for the reconstruction of housing, rental buying of flats and houses, which enable elderly an active life, but also provide their stay in units till the end, provide more sheltered housing, increase the quality of institutional homes for elderly, design the environment and recreational facilities, parks to the abilities of the elderly.

### *4.3. Recent reform and the current policy debate*

There has been no reform lately in Slovenia – the preparation of new legislation has been in the process since 2006 and currently a new working group is created at the Ministry of Labour, Family and Social Affairs that adapts the proposed legislation. The new Long Term Care and Long Term Care Insurance Act was supposed to be passed in the government in

2009, but it is still not fully prepared. The most important issues in the new proposed legislation, around which the policy debate is active, are:

1. The introduction of new form of social insurance for long term care. The insurance is to be non-profit, compulsory and public. The issues are whether such insurance is needed or will it only further burden the already burdened wages. The proposed carer of this insurance is Health Insurance Institute of Slovenia.

The second issue is the introduction of copayments for 10 to 60% of the price of the services. This amount would be covered by the user alone or by his family. The persons without incomes or property, who are exempt from the payment of other social care services, would be also exempt from copayments. Since the copayments could be high, the legislation foresees complementary LTC insurance that would cover the copayments. Since this solution did not work out in health care (voluntary complementary health care insurance introduced higher inequality, lower accessibility to services for low income users, even for services, covered from compulsory health care insurance) there is a strong debate of repetition of the system in other social care field. The further debate surrounds the introduction of voluntary supplementary insurance that would ensure more rights or higher quality of rights for insurees – the debate is based on the fact that providers nowadays are not able to offer higher quality or more services since the supply of those services is not sufficient.

2. The one entry point into the system represents the idea of introducing case manager and individual plan of LTC for user and integration of all kinds of LTC services into one single system. This system would easier coordinate with other systems like health care system or social services and would make processes and financing, waiting lines and organizational issues more transparent and open to the user.

3. The bigger emphasis on home care instead of on institutional care is introduced – the subsidies and incentives for home care for family members and relatives are proposed as well as changes in work legislation that would make the care for elderly easier for otherwise employed family members. The reasons are better condition of the user since he/she is left longer in home environment, rationality, bigger capacities (institutional care is not able to provide enough capacities according to the demographic trends in the next 15-20 years), integration of all kinds of care and higher accessibility to services.

4. The rights for LTC are newly defined and can be claimed only if needed for more than 7 hours per week. The users of LTC are, according to their needs for care, categorized into 5 categories of LTC according to 15 criteria. If the person needs less than 7 hours of care per week, she/he is not eligible for using the right to LTC. The 5 categories are defined as following:

1. category: the person is mostly capable of performing all ADL and needs care of other person from 7 to 14 hours per week.

2. category: the person is occasionally dependent on the care of others from 15-21 hours per week.
3. category: the person is at all times partly dependent on others for performing ADL and needs help from 22-28 hours per week.
4. category: the person is in performing ADL mostly dependent on help of others, from 29-36 hours per week.
5. category: the person is completely dependent on help of others in performing ADL, from 37-42 hours per week.

The criteria for defining the category of care needed are the following:

1. capability of the person for feeding and drinking
2. capability of person to independently secrete
3. capability of person to adjust the body position to needs
4. capability of person to move without help
5. capability of person to satisfy own need for sleeping and resting in normal rythm
6. capability of person for independently taking clothes on/off
7. capability of person to protect himself from temperature changes by choosing proper clothing
8. capability of person to keep himself clean and tidy
9. capability of person to protect himself from dangers in the environment
10. capability of person to communicate with the surroundings and to express emotions, needs and feelings
11. capability of person to establish, keep and conclude contact with others
12. capability of person to obey the rules
13. capability of person to plan daily activities independently (in home or institutional environment)
14. capability of person to take part in daily activities independently (in home or institutional environment)
15. capability of person to acquire new knowledge and skills and keeps them.

## *4.4. Critical appraisal of the LTC system*

The existing system of LTC was based and built in the environment of much smaller needs and demand for LTC services. Although in the last years the capacities of institutional care were extended, homes for elderly modernized and new forms of care introduced (prolonged hospital stay, home care, family helper, care on distance, sheltered housing) it is evident that the system is growing too complicated and fragmented as well as it is still not capable of satisfying all the demand. The most apparent difficulty is probably the fragmentation of LTC among different sectors (health care, social care) and limited communication between the system that would assure efficient and transparent provision of the services. The user of LTC is separately handled for different kinds of care and for benefits and the procedures are long. The existent waiting lists for different kinds of care are useless since they are not updated and the same people are on waiting lists for number of institutions, even of the same kind, in

different regions. The systematic data that would enable the estimation of needs are therefore mostly not available and are only provided ad hoc thorough questionnaires and due to scientific research (they are collected for the purpose of research projects, thesis, but are not collected systematically). The users therefore are not granted fast access to most proper services and are not informed properly of their options, since such information are simply not available in one spot.

The second thing stemming out of the fragmentation of the system is regional inequality in the accessibility of the services. Since the needs are not known the planning of the capacities is lagging behind the actual situation. The differences in accessibility are not only regional but are also wide in the access to services like physiotherapy or work therapy among users of institutional and users of other forms of care. The differences are in the supply of such services as well as in financing rights of such services – the users dwelling in institutional care have bigger rights for such services than the ones in home care.

The fact is that the financial sources for providing sufficient volume of services are not there - the problem is being solved as one goes along, for example through employment policies, through pilot projects, but the systematic collection of funds in one place would enable easier organization and provision of services.

The monitoring and quality assurance is not legally settled. In reality there are many complaints and cases of improper care and nursing in different forms of care and such cases are not taken care of.

The new legislation is tackling the fragmentation of the system and aims to connect all the providers in a single net, but is mostly concentrated on financing side. On the provision side it introduces case manager, who is coordinating the care of the user based on the individual plan of LTC services. Through the integration of the services the higher coordination, effectiveness and rationalization of the services will be achieved. The equality in accessibility is to be achieved (as noted in previous chapter, the proposed complementary LTC insurance tend to increase the inequalities in the accessibility to LTC services) and regional imbalances eliminated. The question of quality is not really widely discussed in the draft act: The Ministry of Health and Ministry of Labour, Family and Social Affairs are earmarked to establish the National Professional Council of Long Term Care with the purpose of increasing the quality, safety and development of the field. The standards of quality and safety are to be defined by Health Insurance Institute of Slovenia and confirmed by both competent ministries (Ministry of Health and Ministry of Labour, Family and Social Affairs).

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# ANCIEN

**Assessing Needs of Care in European Nations**


***FP7 HEALTH-2007-3.2-2***

Launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

1) How will need, demand, supply and use of LTC develop?

2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

***For more information, please visit the ANCIEN website (http://www.ancien-longtermcare.eu).***