Services for Supporting
Family Carers of Elderly People in Europe:
Characteristics, Coverage and Usage

EUROFAMCARE

National Background Report for Slovenia

Simona Hvalič Touzery
independent researcher
Dobrajčeva ulica 12, SI-1000 Ljubljana
simona.hvalic@guest.arnes.si

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EUROFAMCARE is co-ordinated by the
University Hospital Hamburg-Eppendorf,
Institute for Medical Sociology,
Dr. Hanneli Döhner
Martinistr. 40
20246 Hamburg
Germany

doehner@uke.uni-hamburg.de

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Content

Summary of Main Findings

- Family carers in Slovenia are not united in an association or an organisation. They act in an unrelated and unorganised manner, so that their interests do not become central interests of the Slovenian society. Our society actually takes them for granted and they do not exist as far as politicians are concerned.
- Pensioners' associations, seniors clubs, various groups and organisations have an important position in the Slovenian area. Slovenian pensioners' associations have been active already since 1946. Pensioners today are organised in local community and municipal associations as well as in clubs and groups in companies. Local community associations and pensioners' clubs are connected through regional associations and, at the national level, through the Slovenian Federation of Pensioners' Organisations (SFPO). In 2002, the SFPO connected as much as 449 local associations with 232,594 members. Almost a half of all pensioners were thus members of pensioners' associations. Local community associations provide numerous recreational, cultural, entertainment and other activities, whilst the SFPO is concerned with general social and political issues affecting the retired population. Advantages of pensioners' associations are mainly own premises and other preconditions for organisation of programmes, but the high age of its members is a major problem. The SFPO also conducts researches of older people's needs, increases their computer literacy and organises the annual Festival for Third Age (Ramovš 2003: 294-295). This Festival is important particularly because various providers of services for the elderly present themselves and experts give various thematic lectures. Clubs for elderly people are also widespread in Slovenia, these operate as associations and numerous informal groups.
- The State has a dominant position as the financer and to a large extent still as the producer of individual forms of caring for older people. However, during recent years also private non-profit (mainly religious) and profit organisations have started acting as founders of institutional care. It is mainly the first ones that try to conclude concession agreements with the State and thus ensure themselves a relatively stable public financing. The public network of social welfare and health services in Slovenia is still much more extensive than the private network. Everyone has the right to primary health care. A good decade ago there were almost no private practices but now their number is increasing every year.
- An important position in Slovenia also belongs to voluntary non-profit organisations (Red Cross, Caritas, intergenerational and various other associations), which operate in local communities and offer different services from material help to help at work and companionship etc. We

should also mention informal carers, who are mainly represented by family carers and also by neighbours.

- Besides ministries, which are competent for their sectors, there are some institutions and professional bodies, which help forming social welfare and health programmes.
- The Social Security Act (SSA) stipulates that the ministry competent for social security must found an expert Council for Social Security, which monitors the policy and gives incentives and opinions on developmental directions in the field of social security. Members are appointed by the competent minister for social security on proposals of the Social Chamber of Slovenia and are chosen from among acknowledged experts in the field of social policy (Article 8). The plan for implementation of courses and tasks of the National Social Protection Programme up to 2005 defines that priorities at the national level are determined by the abovementioned Council for Social Security.
- Professional bases for formation of health policy and doctrine issues are harmonised by the Health Council as the national expert collegiate body, which is formed by the ministry competent for health care out of representatives of expanded expert collegiate bodies, the Medical Faculty and competent chambers. The Health Council gathers systematic, developmental and staff issues regarding health care and proposes measures by defining priority tasks; it monitors health needs in the country and proposes health programmes, cooperates in preparing the health care plan, staff and working norms; it monitors supply of medicinal products and proposes measures as well as deals with other important issues of health care (Health Services Act -HCA, Article 75).
- The Slovenian Institute of Public Health performs scientific research and educational work in its field as well as prepares expert bases for health care planning. For the social field, this work is partially performed by the Social Protection Institute of the RS.
- The Social Chamber of Slovenia is also an important institution, which unites implementers of social welfare services and programmes and can essentially contribute to realisation of society's objectives in the field of social welfare as well as to assertion of expert staff and associates in this field. This includes expert aspects of social welfare activities and the role of implementers in the development of a welfare state and in formation of its social aspects.
- The non-governmental sector does not substantially influence the state policy, even though it does a lot for social welfare of older people. This also applies to informal groups. Of course, a lot depends also on lobbying and knowing the right people.

- Slovenia lacks a gerontology institute built on a social interdisciplinary level (health care, social work, sociology, psychology etc.), since such an institute could importantly influence decisions and courses of policies for social welfare and health care of the elderly. Slovenia had a gerontology institute since 1968, but it ceased to operate after 1990. A new gerontology institute is being prepared, but we will have to wait for some time before it is founded and given an important role in the Slovenian social sphere.

Introduction – An Overview on Family Care

Demographic projections show that during the next two to three decades the generational balance will be destroyed. Data proving that twice as much births as today were recorded in the decades when the present middle generation was born is ruthless and will cause a series of material, social, political, cultural, human relations and ethical problems. The present middle generation will be given care by only one half of the adults caring for the present older generation (Ramovš 2003: 235-236).

Modern countries are facing problems when playing their traditional roles towards older people. There are several reasons. The first one is rapid ageing and, consequently, a bigger number of 80-plus year olds. Experts have assessed (Kaučič 2000, Skupina avtorjev 1999, Bogataj 2003) that approximately 60 % of this age group needs help in daily activities. The number of older people living alone is increasing. Data from the last population census show that 26 % of older people live alone (widowhood is one of the main reasons) and further 27.3 % live with another older person. The share of Slovenian households with at least one person over 65 years and several younger persons is 15 %. The share of Slovenian households with only older persons is 16 %.

The other reason, which is parallel to the first phenomenon, is the decrease in fertility and in average family size. In 1985, the Slovenian fertility rate was 1.7 children per woman, whilst today it is only 1.2 children. The average household size in population census in 1991 was three persons per household and in 2002 only 2.8 persons.

We have calculated potential carers[1] using the method of Alan Walker and established that in Slovenia we have only 0.6 women per person aged 70 and more. This means that the number of potential carers is low. Additional indicator is old age dependency ratio[2], which is rising and has jumped from 19.4 % in 1998 to 21 % in 2002.

The next important factor comes from the side of supply, namely the female employment rate. This is very high in Slovenia (47.9 %) and, what is more, most women are employed full-time.

Potential 'availability' of children for care-giving to aged parents is also established through average age at marriage and first birth. The average age of women at marriage is 28.8 years and the average age of mothers at first birth is 28.5 years (SORS-SY 2003: 102, 92).

Demographic and social changes stress the issue of care-giving to the elderly in the future. An increasing number of older people will need long-term care.

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1 The share of women aged 45 to 70 in all people aged 70 and more

2 The population 65+ as the share in economically active population (15-64 years)

These people will be strongly affected by the decreasing possibility to be cared for by their closest family members (Hvalič 2001: 16-20).

Researches conducted in Slovenia show the best relationships between older persons and children develop when living under the same roof but not in a common household. In this way people do not invade each other's space and are still close enough to help each other. This form of living is quite widespread in Slovenia and is perhaps one of the reasons that make family care less obvious. Families help older persons a lot when the latter are only partially capable of caring for themselves (Hojnik-Zupanc 1994 in Hvalič 1993: 83). A problem occurs when older persons need constant care and nursing. Since Slovenia is short of adequate institutions and services, carers are facing serious problems.

For most married people their partner is the basic source of support. Normative expectations concerning help of spouses are complete help, support and personal care, if needed. Besides the above, partners (usually women) feel morally obliged to care-giving and nursing. This also applies to adult children.

The family is important to us throughout our lives. Everyday experience show that during the last years ageing Slovenian parents are one of the important economic sources of help to young families of their children, who cannot get adequate employment in tough capitalist conditions, have poor chances of solving their housing problem and are bearing huge expenses for children by themselves (Ramovš 2003: 239).

We have noticed that a two-generation nuclear family and community neighbourhood are losing touch with older people in modern alienated urban areas, whilst this situation is much better in rural and suburban areas. A major problem is that generations do not know each other and have drifted apart. Consequently, the elderly are increasingly lonely and also other family members are distressed.

In Slovenia, the State or municipalities and only to a lesser extent the private and non-profit sectors take care of social security of older persons. The latter two have only been established during the recent years and are not widely expanded yet. Most social welfare services are thus financed out of the state and municipal budgets. The Slovenian state budget also finances social prevention, first social assistance, help to families for their homes, institutional care, welfare allowances, financial allowances and investments in social welfare institutions. Municipal budgets finance personal assistance and home help services. Eligible persons and other liable persons are obliged to pay for all services provided on the basis of the Social Security Act, except for social prevention, first social assistance and institutional care at social welfare institutions for training. Municipal centres for social work decide on partial or complete relief from payment based on regulatory criteria.

The core part of public funds for health care is represented by funds from compulsory health insurance. Public funds also include funds from the state budget. Services included in general health care with co-payment are mostly reimbursed from funds of additional health insurance. However, people increasingly visit doctors with private practices, since these are quicker.

A social service offering help at home is not defined as a public service by law and these services must thus be fully paid (municipalities may con-finance them if they decide so). Heads of these services must obtain consent for their operations from the competent ministry. Private social services are not equally spread throughout Slovenia and demand for them is strong.

Home help is also *offered by individual non-experts.* This form of help is not supervised (in terms of quality of work, charging or services) and we are also not familiar with how much it is spread.

During the recent years, the private sector has also been developing in health care.

Other informal unpaid care (volunteers, neighbours, friends, church etc.) help to older people is an important supplement to formal care and private services. Volunteerism is also widespread. It is usually performed by non-experts, who are not trained for social work. Some associations are also training volunteers due to specific areas they are covering (Hospice, Social Gerontology and Gerontagogics Association of Slovenia (SGGAS), various intergenerational associations etc.). Charitable organisations operate successfully on a completely voluntary basis and offer material or non-material, human help to the elderly, for example Caritas, Red Cross, intergenerational associations for quality ageing, SGGAS etc. Our older people's homes are receiving an increasing share of voluntary help and older people are also offered help in their home environment. The act on volunteerism is being prepared at the moment. It is important to provide for legislation that will promote the development of volunteerism (Ramovš 2003).

Clergy organises regular monthly visits to people in their parishes. Priests pay monthly visits to older people, if requested.

Researches (Hlebec et al. 2001) show that neighbours and friends are the most important persons for the role of older people's confidant. Older persons can talk to them. Besides this role, they have an even more important role for those people who do not have a family or are only rarely in touch with it. For example, if old persons suffer from a milder disease, neighbours bring them groceries, check on them, make them tea etc.

Family members still offer more care and nursing to older people than institutions and public network programmes in Slovenia today. However, we do not have specific data on the extent of family care of older people in Slovenia.

Some estimates say that 12 % of 65-plus year olds can no longer take care of themselves, 5 % of them need complete nursing and medical care, 21 % to 25 % of them need help in household tasks and personal hygiene. Needs for help grow with age. 30 % of people from the 70 to 80-year age group and around 60 % of people from the 80-plus age group need help (Kaučič 2000: 92, Skupina avtorjev 1999, ZDUS 2001).

We do not have long-term care insurance in Slovenia, but its introduction is being considered. Since a separate act will have to be adopted for this insurance and a special organisation will have to be established together with staff, political willingness and funds, the achievement of this objective is still far in the future. People who manage to be admitted to social welfare institutions are thus usually in a more favourable situation than those who need nursing and want to receive it at their home. Already the possibility and conditions for being admitted for institutional care are not equal for everybody (Toth 2004: 52). This inequality in access to services will not be eliminated so quickly (the Health Care and Health Insurance Act (HCHIA) does define that everybody must have equal access to health care services) even though this is stipulated by the act in preparation at the moment. The Health Care and Health Insurance Act and other acts do provide for medical help at home but, except for free nursing care, other services almost cannot be obtained. Physiotherapy can mostly be obtained only if paid out-of-pocket and personal doctors do not have the time to visit people at their homes. Home nurses give a lot of help (with advice, information and other help) to family carers, however nursing care, which was exceptionally well developed in the past, is regressing today and receives little attention from the health care system. At the same time, social care and home help have developed. These two are not operating harmoniously in the field nor are the ministries, whose sectors have been divided over the past years and which fail to coordinate their programmes.

The number of hospital days is decreasing and people are returning to their homes too early. Carers have problems since they are not prepared for this and do not know how to take care of sick older people. The necessary training is also not available to these carers. Besides nursing care, a temporary solution is also accommodation at older people's homes (until they recover), but these homes are full so that it is difficult to get a free bed. There are private institutions where sick older people can be accommodated but the prices are high and some even do not have all papers required for their operations. Despite this, they serve as an emergency escape for carers of older people.

Taking into account that the very old population is increasing, it is to be expected that the share of sick people in need of help will increase further. Unfortunately, we can conclude that we cannot offer sufficient capacities or staff for all people who would need additional care.

Only two million people live in Slovenia, our fertility rate is low, population is ageing rapidly, labour force is decreasing and the situation will be even worse

when the post-war baby boom generation retires. For example, the present pension system is already not fit to perform its function. Pension funds are filled with contributions of the economically active middle generation and at the same time emptied for pensions of the previous economically active generation. This intergenerational agreement is working well if generations are mutually balanced, which is already not the case at the moment and will get even worse in the future. Already today the State has to cover the deficit in the pension budget. Other pension pillars and additional insurances may soften the situation and enable the wealthier part of the population additional pensions. It is thus necessary to set up new mechanisms for formation of pension security (Ramovš 2003: 236-237).

The State cannot assume the entire responsibility for social security, thus it encourages development of private institutions and services for the elderly. However, it does not offer enough support (financial, regulatory) to the non-governmental and informal sectors, which play a big role in caring for older people.

The important role of family carers and other informal carers of older people is overlooked. Without necessary support and with negative demographic trends there is a danger that increasingly less people will be prepared to take over care-giving to aged relatives. This will be further affected by weakening family ties.

Availability of health care services is slowing down and the number of hospital days is decreasing, so that sometimes people are discharged even before they recover satisfactorily. At home they are welcomed by families, which do not know how to take care of them, how to nurse and help them.

Let us also mention that people still believe that the State will take care of everything. In believing so, people forget that their own property can bring them security in their old age. People are not willing to sell apartments and move into more suitable ones. For example, a lot of older people today have big apartments or houses and receive social assistance since they cannot cover costs of daily living. Older people wish to leave their property to their children, whilst their children often do not have the time or interest to take care of their parents.

1 Profile of family carers of older people

No national research on informal carers has been conducted in Slovenia. Only a few brief researches have been carried out (Hojnik-Zupanc et al. 1996, Hlebec et al. 2001, Hvalič Touzery, Felicijan 2004, 2003), through which we have indirectly obtained some information on family care of older people. Diploma theses of students of the University of Ljubljana (Jakič 1997, Bogataj 2003, Palir Čuješ 2002, Svetičič 2002, Hlupič 2002) also served to help us define the profile of Slovenian carers.

Older people in Slovenia can get help through formal, informal and social networks. Due to changed life patterns the function of the family in the attitude towards older people is also changing. Despite this, researches show that close relatives (partner and children) are the first to help older people with problems (Hojnik-Zupanc 1997 in Hlebec et al. 2001). Family help is based on intergenerational solidarity and the feeling of responsibility (Hojnik-Zupanc 1999: 171).

Family carers are often named the sandwich generation since they are torn between caring for their family, aged parents and job responsibilities. For example, the results of one of researches (Jakič 1997) revealed that 80 % of carers of older people also had children at home.

1.1 Number of carers

Around three quarters of people over 60 years of age in the developed world are capable of taking care of their daily needs without help from others. Some older people need partial help from others to remain relatively independent in taking care of their needs. The third group, accounting for ten or more per cent, needs more or less complete care and nursing for daily needs (Redburn 1999 in Ramovš 2003: 279). Family members provide complete care to a lot of these people.

We do not have data on how much family care is widespread in Slovenia but we assume that it does not deviate substantially from data from the developed world. Considering the fact that alternative forms of institutional help have only been developing for a decade and some for an even shorter period, we may conclude that the role of the informal network in caring for older people can be very important. The number of older people in Slovenia is increasing and the group of the oldest people, who are usually of poorer health and need at least partial, if not complete help in daily activities, is growing even more rapidly.

In the continuation we will assess the state of informal family care of older people in Slovenia. The numbers we provide are only rough information since researches were not extensive enough to generalise the results for the entire population with certainty. Let us also note that we cannot define results according to the role of carers – a primary carer or only an assistant carer. Qual-

ity researches were carried out among primary carers but quantitative, to which we refer in the major part of this item, have included this target group only indirectly.

Family members still offer more care and nursing to older people than institutions and public network programmes in Slovenia today. However, their readiness and capability for this work are declining (Ramovš 2002: 27). The reasons for this are almost non-existent public support (from the socio-political and economic point of view, considering employment and social welfare policies), weak communication, increasing alienation and the lack of understanding between generations.

The research conducted by the Slovenian Federation of Pensioners' Organisations[3] (SFPO) (ZDUS 2001), which included almost five thousand older people in Slovenia revealed that 12.5 % of them could no longer completely take care of themselves. The research did not include people already living in institutions (4.3 % of older people in Slovenia), so we can assume that around 30,000 people, besides a bit more than 12,000 with institutional care, need some kind of help. According to other researchers' estimates (Kaučič 2000: 92, Skupina avtorjev 1999) 12 % of people aged 65 and more also cannot take care of themselves, 5 % of them need complete nursing and medical care and 21 to 25 % need help in household tasks and personally hygiene. Needs for help grow with age. 30 % of people from the 70 to 80-year age group and around 60 % of people from the 80-plus age group need help.

Another research[4] (Bogataj 2003) confirms our assumptions. The index of need for help included mutual relationships, health, receiving and giving of help and spending of leisure time. The results revealed that approximately one half of older people need occasional help. This number is a bit exaggerated but still important since it stresses how much help is needed. The needs of the 65 to 70-year age group are weakest and of the 70 to 81-year age group are the strongest. This fact is also related to health status since 72 % of people from the 65 to 70-year age group were of good health. This percent was lower in people older than 70 years to 50 %. One quarter of people over 81 years were of poor health.

An acknowledged Slovenian gerontologist Ida Hojnik Zupanc (1999 in Hvalič 2001a) stressed several times the important role of the informal network for ensuring social security of older persons in her articles and reports. Relatives are most important within this network. It is a fact that public forms of social security are still too weak to satisfy the needs of the Slovene population. Older

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[3] 18 associations participated in the research. Interviewing took place in the first half of 2000. The research included 4,888 people aged 64 years and more, but the sample was not representative for Slovenia.

[4] The sample included 50 persons over 65 years of age. Interviewing took place in the beginning of 2003. The research was conducted on 21 men and 29 women. The research also established the index of need for help and sources of help.

people's homes are full and waiting periods are long. A large number of sick older people in need of complete care are thus not included in adequate forms of help. The data that around 5,000 people receive public home help is also important. This help is limited in time and can only be used to help or supplement informal care but does not provide complete care of the older person. This must be borne by families, relatives or people close to older persons.

It follows from the above that in Slovenia around 30 to 40 thousand or at least 10 % of older people (excluding those in institutions) receive partial, occasional or complete help, which means that despite weakened traditional values the family still represents a plentiful source of help. It often appears as a part of a mixed form of care, in which formal and family help are combined.

1.2 Age of carers

Findings of the research carried out on users of the life-line telephone[5] (Hojnik-Zupanc et al. 1996) show that the **middle generation** most notably participates in helping and nursing their aged family members and that this generation is in a way trapped between the young and the old generation. Daughters, who were most frequently in touch with their parents, belonged to the 33 to 55-year age group and sons mostly to the 40 to 49-year age group. It has also been revealed that sisters, **female pensioners**, are also an important part of the informal network of the elderly.

1.3 Gender of carers

Even though an extensive research on family carers of the elderly has not yet been conducted in Slovenia, we may, based on researches of a smaller scope, (Jakič 1997, Hojnik-Zupanc 1996, Hlebec et al. 2001, Hvalič Touzery, Felicijan 2004, Bogataj 2003, Palir Čuješ 2002, Svetičič 2002, Hlupič 2002), claim with a high degree of certainty that the European trend of female carers of older people, most frequently daughters and wives, is also present in Slovenia. Jolanda Jakič[6] (1997) thus established with her research that responsibilities for household tasks and nutrition are mostly borne by women, as much as three quarters of the surveyed women, most frequently daughters (one third), were responsible for these tasks. This fact was confirmed by another research (Ho-

[5] In April and May 1995 an evaluation was made in Slovenia determining how the protection alarm system works, the purpose of which was to present the dynamics of social innovation development, which began three years ago in Ljubljana. The evaluation included 60 of total 66 users of the Ljubljana regional centre for home help. The method used was an interview with a structured questionnaire, consisting of 78 open and closed questions. Almost a half of people surveyed was 80-plus years old and only three men were included.

[6] The quantitative research included 40 randomly chosen close relatives providing care to an older person, regardless of whether the older person lived in a common household with the close relative providing care or alone. The research was carried out between 1 November, 1996 and 31 March, 1997. The researcher obtained data on close relatives from the Centre for Social Work.

jnik-Zupanc et al. 1996); however, this research only provides indirect information since it did not survey family care separately. Considering that the most frequent assistants for various tasks and needs of older people proved to be relatives, the information that older people most frequently see their daughters implies that in most cases it is daughters who provide this help besides partners.

1.4 Income of carers

There are no data on this issue.

1.5 Hours of caring and caring tasks, caring for more than one person

The family can be of great help to older people when they are still capable of taking care of themselves. The family can hardly be expected to offer bigger help since most middle-aged women in Slovenia are employed. Family members implement positive social control over older relatives, which means that they are interested in them and check on them, even if only with a phone call (Hojnik-Zupanc in Hvalič 1999: 83).

Care of the older person is taken over gradually – from little favours (e.g. the older person's need for companionship) and occasional help to shorter periods of care-giving during illness. Family care becomes obvious when these favours are joined by temporary help in household tasks, personal care, handling of official matters and more demanding physical work. Carers lapse into permanent care-giving unknowingly and often become aware of it only when they are already overburdened (Svetičič 2002: 60, 64).

Frequency of providing help:

Researches have shown that older people are in frequent touch with their families. More than two thirds of older people were receiving help from close relatives several times a week (Jakič 1997, Hojnik-Zupanc et al. 1996) and a good half of them even every day. There were also some cases when the carer was caring for two persons at the same time (a married couple). The data that close relatives on the average offered help for as long as nine years is also interesting. 52.5 % of them were caring for their parents for over 6 years and as much as one third of them for more than 10 years. Less than one third of people surveyed were caring for aged close relatives for up to one year (Jakič 1997).

Types of help:

Researches, which we will mention in this part, were carried out in a way not suiting best content sections of this Report. Namely, results on help older people receive most frequently were gathered in connection with the information

concerning the identity of the person providing help. For this reason, some information mentioned in this section will also be repeated in Item 1.7.

The most frequent help offered to older people by family carers is handling of financial matters (80 % of interviewed carers), which is followed by help in household tasks (75 %), accompanying (70 %), help with nutrition (62.5 %) and, in the last place, nursing and personal hygiene (55 %). The latter is provided by different persons – children (53.6 %), other close relatives (39.3 %) and home nurses (28.6 %) (Jakič 1997).

The research conducted on users of a security alarm system from 1995 revealed that family members are the most frequent source of help to older people. Children provide help most frequently - with occasional practical help, help in administration and in personal hygiene. Formal sources are also an important source of help and should not be excluded (Hojnik-Zupanc et al. 1996). In 2001 a research on users of a security alarm system[7] was repeated (Hlebec et al 2002) and confirmed previous results as well as added new findings (Table1). The research showed that informal sources are not sufficient to answer basic daily needs of older people and that formal help is necessary, though not always available. Despite this, it should be stressed that in practice private, formal and informal forms of help are combined.

[7] In 2001 the use of a security alarm system as a means of greater independence of older people was evaluated. Interviewing was carried out from June to August 2001. The evaluation was based on 62 of total 77 users of the life-line security alarm system. 11 men were included and 72 % of subjects were 80-plus years old.

Table 1: What are the activities for which elderly people need other people's help? (2001, N = 62)

	Types of help	He / She needs help and receives it	
		N	%
Household assistance	Shopping	38	61.3
	Cleaning	45	72.6
	Cooking	31	50.0
	Doing laundry	19	30.7
	Ironing	29	46.8
Various house work	Gardening	10	16.1
	Home repairs	43	69.4
Personal hygiene and care	Washing, bathing	23	37.7
	Dressing, putting shoes on	20	11.0
	Shaving / hairdressing	9	14.8
	Cutting nails on the toes	45	73.8
	Taking medicine, injecting, re-bandage	11	8.9
Mobility	Walking on the stairs	6	9.8
	Walking outside	10	16.7

Source: 2002. Uporaba alarmnega sistema kot sredstva večje samostojnosti starostnikov. Ljubljana. In Hlebec et al. 2001

1.6 Level of education and / or Profession / Employment of family carer

We do not have data on the level of education of carers or on what kind of jobs they have. Based on already mentioned and other researches we can assume that children caring for aged parents are mainly employed, considering that middle or older middle generations are involved. Regardless of the fact that women care for older people more frequently than men, there are no differences in employment. The trend of full-time employment of women is also present in Slovenia. Half-time employment is mainly due to illnesses, handicaps or retirement processes. The data that until the beginning of the 1990-ies there was almost no half-time employment in Slovenia also speaks for itself. Women, family carers, are thus mainly employed and must harmonise their informal work with their job, which takes them more than 8 hours a day. Even in exceptional cases, when an old family member is ill, they are not entitled to an allowance if they stay at home for more than one week.

Besides adult children, spouses also care for sick older people, if necessary. The research from 1997 showed that 18 of 40 interviewed close relatives

(45 %) caring for an older person were still in an employment relationship and the other 20 were retired or were staying at home (Jakič 1997).

Another research indirectly confirms that daughters, who were most frequently in contact with aged parents in need of occasional help, belong to the age group of 33 to 55 years (Graph1). These women are middle-aged and employed (Hojnik-Zupanc et al. 1996).

Figure 1: Employment situation of relatives that have regular contacts with the elderly; Slovenia

Source: Hojnik-Zupanc et al. 1996

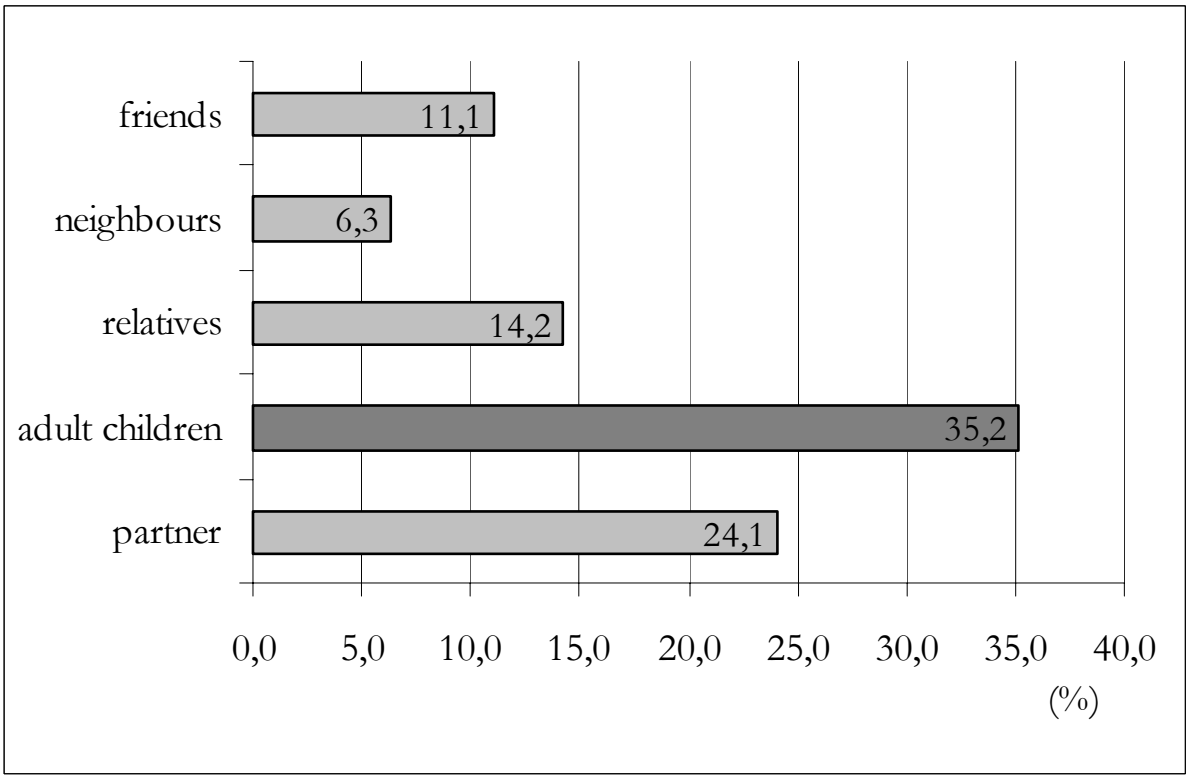
1.7 Generation of carer, Relationship of carer to OP

Four Slovenian researches (Jakič 1997, Hlebec et al. 2002, Hojnik-Zupanc et al. 1996, Bogataj 2003) partly included the relationship between older people and carers. The basic nursing part of care-giving is represented mainly by female relatives (sisters, daughters etc.), whilst more demanding physical work is usually taken over by male relatives or neighbours. Primary carers are left with no source of support unless they have their own informal network (Svetičič 2002: 63).

Older people most frequently turn for help to their partners and children and less frequently to relatives and neighbours. It has been established that the social network of individuals consists of three to five persons, but one or two persons are most frequently asked for help. Family members represent the

core part of social networks and also ensure most help (Bogataj 2003). Even more frequently, help is asked from children (35.2 %) and partners (24.1 %).

Figure 2: To whom do you turn to first when you need help (in %, N = 50, 2002)



Source: Bogataj 2003; my own calculations

The research from 1996 (Jakič 1997) provides more detailed information, namely that daughters are those adult children who mainly play the role of family carers. The sample included 40 % of daughters. The scale of family carers from the most frequent to the least frequent was determined as follows: daughter – niece – daughter-in-law, nephew – son – sister, brother – sister-in-law, female cousin, granddaughter. The research also showed that division of work in families living with an old person in fairly unequal. Women do most work. Other close relatives help only occasionally. People expect care-giving mostly from their partners (52.3 %).

The research carried out on users of a security alarm system (Hojnik-Zupanc et al. 1996) revealed that relatives are the most important source of help. A later research (Hlebec et al. 2002) on the same users was more detailed. It thus defined the person most frequently performing individual tasks an older person needs. Also in this research, the result was that ***daughters are by far the most important source of social support for performance of daily tasks***. This finding was based on information on how many different tasks they perform. Formal forms of help proved to be the second most important source of help.

Older people need most **help in daily tasks**, most frequently in housework and household tasks. The elderly get most help with shopping from **daughters** (27 %), other persons (22 %) and other formal forms of help (18 %). Cleaning is mostly taken over by other formal forms of help (57 %) and other persons (21 %). Cooking is mostly taken care of by other formal forms of help (46 %) and the "Hello help!" service (27 %). As far as ironing is concerned, the elderly are helped by daughters (42 %) and other formal forms of help (21 %). If older people need house repairs, they most frequently turn to other formal forms of help (53 %) (Hlebec et al. 2002).

Information support is mainly provided by informal sources, especially **daughters (26 %) and sons (21 %)**. Formal sources offer almost no emotional support. Older people look for emotional support in their children, other relatives and friends. Most trustworthy persons are **daughters *(29 %)*, other relatives *(31 %)*, sons *(22 %)* and friends *(14 %)*** (Hlebec et al. 2002). Older people thus satisfy their **non-material social need** for human relations by ties with family members (Bogataj 2003).

The users of the Life-line telephone would most frequently borrow larger sums of money from daughters (40 %), sons (26 %) and other relatives (19 %). Older people are given help with transport mainly by children (daughters – 29 %, sons – 25 %) and other relatives (27 %) (Hlebec et al. 2002).

1.8 Residence patterns (household structure, proximity to older person needing care, kinds of housing etc.)

As researches show, the best relations between older people and their relatives in Slovenia develop when living under the same roof but in separated households. This enables them autonomous life and at the same time provision of quick help, if needed. Such three-generation houses are common in suburban and rural areas, whilst in urban areas this trend is much weaker.

Researches further revealed that informal carers live mostly near to the old person they are caring for or whom they offer help for different tasks. The research from 1995 (Hojnik-Zupanc et al. 1996) showed that people with whom the elderly are in contact most frequently live up to 10 kilometres away. Another research confirmed this. Results of this other research showed that 18 of 40 interviewed close relatives (45 %) lived in a common household with the older person they cared for. Of all older people living in a common household with close relatives most of them (76.5 %) lived together with their children, of which 70 % with daughters (Jakič 1997). The latest research (Bogataj 2003) established that people live mostly alone or with their partner even if they need help. A bit less than one third of them lived together with their spouse and adult children (Table2).

Table 2: With whom lives the old person that is receiving family assistance? (N = 50, y. 2002)

	N	%
Alone	21	42
Partner	9	18
Adult children	4	8
Partner and adult child	12	24
Other relatives	2	4
Others		
No answer	2	4

Source: Bogataj 2003; my own calculations

The 2002 population census showed that 26 % of 65-plus year olds lived alone and further 27.3 % of them lived together with another older person, most likely with their partner. At least one 65-plus year old lives in almost one third of Slovenian households. It is also interesting that a good half of older people in non-urban areas live with at least one person younger than 65 years, whilst this applies only to a bit less than 40 % of older people in urban areas. This confirms our thesis that older people in non-urban areas live more frequently with younger generations than older people in urban areas, where also more older people live alone (Table3). Therefore we can conclude that older people in non-urban areas have potentially higher chances of having somebody from the younger generation to care for them than urban older people. This situation balances the lack of social welfare services for the elderly in many rural areas.

Table 3: Distribution of people old 65 and more by household type, 2002

Household type	Total	Urban settings	Non-urban settings
alone	26 %	30.03 %	22.3 %
With another person old 65+	27.3 %	30.16 %	24.5 %
One person 65+ living with one or more people younger than 65	29.9 %	26.1 %	33.8 %
Two persons 65+ living with one or more people younger than 65	15.2 %	12.6 %	17.7 %
Three or more persons 65+ living with one or more people younger than 65	1.6 %	1.11 %	1.7 %

Source: SORS 2003. Population census 2002; my own calculations

1.9 Working and caring

In most Slovenian families both the man and the woman are employed. Most family carers thus combine their job with responsibilities of care-giving to an older person.

The female employment rate is an important factor, which influences the quantity of family care available to the elderly. Female employment in Slovenia is very high, half-time employment is not common (see Item 1.10) and there are also no measures of employment policy that would ease 'the double work' of carers. Employed family carers thus mostly work on a full-time basis. However, it is a fact that employed people can dedicate much less time to caring for older people than unemployed people. This is stressful for both older people and family carers since additional solutions to help them in a given situation have to be looked for. In Slovenia, there are often not enough alternatives or supplementary services for older people available, which could disburden all carers across the country equally and alleviate their work.

The relation between work and care-giving is two-sided. Employment strongly affects the time left for care-giving and, on the other hand, care-giving strongly affects work (reduces concentration and, if possible, working time etc.). Slovenian family carers must assume double or triple tasks (also for their families). This does not apply to retired carers, where mutual help of partners is often the case, sometimes also help of retired daughters. Soon after the declaration of Slovenia's independence, companies did not want to discharge their employees in masses, so they bough their years of service to full retirement. In the beginning of the 1990-ies Slovenia thus recorded a lot of young, just over 50 years old pensioners. This trend is changing today and retirement (for a full pension) is no longer possible at this age.

Let us in this context also mention the recently adopted *Act Amending the Social Security Act (SSA-C)*, which allows for the option that family carers of older people are registered as 'family assistants'. The Act stipulates that those people whose care-giving affects their employment are entitled to receive a financial compensation (benefit payment for loss of income). This means that only family carers that are either unemployed or they work part time are entitled to this compensation. Maximum compensation is very low, about 300 €. Since this measure is not yet implemented in practice, we do not know to what extent it will actually be made use of by family carers, especially taking into account that, as already mentioned, they may be registered as 'family assistants' only if they care for a seriously disabled person. Thus we believe that this option will be possible only for a small number of family carers.

1.10 General employment rates by age

In most Slovenian families both partners are employed. **The female employment rate** is traditionally ***high***. In the 2002 Labour Force Survey the share of

employed women was 47.9 %, whilst the share of employed men was 59.6 %. The second important characteristic of female employment in Slovenia is the high share of **women employed full-time**.

Table 4: Principal characteristics of the population by activity, 2002-2003

	2002 / 2	2003 / 2	2002 / 2	2003 / 2
	Total (N (1000))		Women (N (1000))	
Total population (N)	1994	1995	1018	1020
Persons in employment (N)	922	896	423	409
working full time (N)	862	838	388	374
working part time (N)	61	59	35	35
Activity rate (%)	58.1	56.5	51.9	**50.2**
Employment / population ratio (%)	54.7	52.8	48.6	**46.7**

Source: Svetin, Rutar 2003

Half-time employment is mainly due to illnesses, handicaps or partial retirement. Until the beginning of the 1990-ies there was almost no half-time employment in Slovenia. The 2002 Labour Force Survey showed that 7.7 % of women and 4.7 % of men were employed part-time (Stropnik et al. 2003).

The self-employment rate is decreasing. In 2000 11.1 % of all employed people were self-employed. In the same year the female self-employment rate was only 6.5 %.

Table 5: Forms of employment by gender; % of total employment (or gender employment respectively)

Year	Full time-equivalent employment			Part-time employment			Self-employed		
	Total	Men	Women	Total	Men	Women	Total	Men	Women
1996	60.5	65.5	55.6	6.8	5.2	8.6	12.6	16.9	7.7
1997	60.9	65.8	55.9	8.2	6.7	9.9	12	15.8	7.5
1998	61.8	66.2	57.2	7.6	6.7	8.7	12.5	16.7	7.7
1999	60.8	66.5	56.2	6.6	5.6	7.8	12.6	16.6	8
2000	61.5	66.1	56.8	6.1	4.7	7.7	11.2	15.3	6.5

Source: Eurostat 2001 in Stropnik et al. 2003

From 1992 on the legally defined retirement age was 53 years for women and 58 years for men, provided that at the same time years of service were sufficient (35 for women and 40 for men). This age limit will be now gradually increased based on the new pension act from 1999 (*Act on Pension and Disability Insurance* - APDI) to the full retirement age of 61 years for women and 63 years for men. In 2002, the retirement age was thus 54 years for women and 59.5 years for men. For this reason, also the number of economically active people from higher age groups is lower.

Table 6: Activity rates by age groups and gender, Slovenia 2nd quarter 1998

	Slovenia	Men	Women
Skupaj / Total	60.0	66.6	53.7
15-19 years	20.0	24.1	15.7
20-24	69.4	71.0	67.7
25-29	91.0	92.3	89.7
30-34	93.6	95.3	91.9
35-39	94.7	94.8	94.5
40-44	92.2	94.8	89.6
45-49	86.5	90.4	82.2
50-54	63.4	79.1	48.8
55-59	34.1	44.5	23.3
60-64	17.8	21.0	14.9
65-69	15.3	19.1	12.4
70+	7.2	11.8	5.1

Source: Labour Force Survey 1997

The increase in full retirement age is necessary from the economic point of view, but will affect family care. Even a larger number of women and men caring for an older person will have to balance their work obligations with informal care.

1.11 Positive and negative aspects of care-giving

In this subitem we will mainly refer to findings from three later quality researches (Palir Čuješ[8] 2002, Svetičič[9] 2002, Hlupič[10] 2002).

Informal help to the elderly is of exceptional importance and is also one of the principles of modern gerontology. An older person should stay in his or her home environment for as long as possible regardless of his or her health. However, society's attention is directed towards older persons and neglects family carers. Their age is usually somewhere between 40 and 60 years, so that various health problems and fatigue can be expected. This is strongly influenced by views of life, emotions, expectations of the carer and objective views on the disease and options of treatment, family history, the relationship between the older person and the carer, help of family members, health care

[8] The quality research (interviews) included 5 women aged between 35 and 60 years – three were employed and two were retired; they lived together with the person they cared for.

[9] The research was based on descriptions obtained from interviews. It was carried out in the Municipality of Tolmin in May 2002. 12 persons were interviewed.

[10] The research included 8 carers of people, who were waiting to be admitted to an old people's home, and 2 social workers, who work with the elderly. It was carried out in the Municipality of Kranj in the beginning of 2002.

and social services as well as moral and social pressures from the surroundings (Hojnik-Zupanc in Čelik, 2002: 19).

The positive aspects of care-giving are not so often mentioned in our studies. Some carers have stated that the ties between family members have strengthened, that the feeling of security increased together with tolerance and that care-giving also helped reveal the inner strength, which carers were not aware of before (Svetičič 2002: 62, Čelik 2002: 20). Besides this, care-giving can deepen the relationship and ties between the carer and the person cared for.

A lot more has been written about **the negative aspect of care-giving**. Carers of older persons are most disturbed by interruptions in sleep of the patient, which also cause interruptions in their sleep; these are followed by complete immobility of the patient, inability of the person cared for to go the bathroom alone in the third place, help in moving of the older person in the fourth place and incontinence in the last place. Caring for an older person is undoubtedly a demanding task, which requires a lot of time (Hlupič 2002: 25).

In the research (Jakič 1997) which helped us obtain the most complete picture of family carers in Slovenia only one good third of carers said that they are still able to care for an older person. All the others stated that care-giving represents them different types of burdening. Carers **most frequently mentioned high bodily and physical strains** (in 27.3 %). Carers also mentioned that they *do not have spare time any more* (15 %) and that they have *less time for their families* (10 %).

Types of strains on carers can be classified into four major groups:

Bodily or physical strains – general well-being and health deteriorate; carers experience chronic fatigue; if they care for older persons, physical strains can seriously threaten their health.

Psychological or emotional strains – these are reflected in different ways – through a negative attitude to the older person (which may consciously or subconsciously lead to an abuse); the most frequent feelings are those of guilt, anger, sadness, fear, depression, helplessness and emotional exhaustion.

Social strains – conflicts and social isolation appear, which lead to less social contacts; carers do not have time for themselves anymore and may turn to different forms of stupefaction.

Financial strains – different strains appear. A financial crisis occurs since carers must leave their job to care for older persons or co-pay for additional services for older persons. Children are namely lawfully obliged to help their aged parents if these do not have sufficient funds for living (Emlet 2002, Palir Čuješ 2002, Hlupič 2002).

Care-giving thus potentially affects carers in the four spheres just mentioned above. The perception of care-giving is mostly influenced by the situation of

carers and their role in the family before care-giving as well as the intensity of their emotional attachment to the person cared for. If the emotional tie between the carer and the person cared for is strong, the carer experiences several psychological pressures and ambivalent feelings (negative emotions, feelings of guilt). The carer also feels guilty because of being torn between caring for several family members simultaneously, which may lead to stress. Those carers who bear the responsibility for their parents hardly recognize the need to care for themselves. Carers who do not have strong emotional ties with the person cared for experience care-giving mostly as a physical strain, which is reflected in worsened health status (back pain, insomnia, headache etc.), and they also feel negative emotions, such as anger and sadness. On the other hand, these carers feel a stronger need to care for themselves (social contacts with others are retained, so is their spare time), which positively influences both the carer and the person cared for and enables a higher quality of life for both persons (Palir Čuješ 2002: 89).

Care-giving also influences the family as a whole. Family relationships before care-giving are an important factor. Since care-giving causes a lack of time and overburdening of the carer, relationships with children worsen, their behaviour changes, the communication between family members becomes poorer, partners become alienated and the family socially isolated. Due to care-giving, numerous families experience conflicts and worsened relationships between relatives, e.g. between brothers and sisters. Therefore it is important to organise and divide work of the family efficiently, to clearly define the limits of the carer's responsibilities, disburden the carer and care for the carer. This is an important project for a family, within which needs of the family and the older person cared for may be satisfied (Palir Čuješ 2002: 89).

Carers often feel lonely and overburdened in their work, especially when they make important decisions and bear the consequences of these decisions. Family members represent their main source of support and the support of health services is also important. Carers are constantly accompanied by the fear that the disease of the person cared for may recur or worsen, that the present situation will never end, that care-giving will leave consequences on their children, that they themselves will break down and that their efficiency at work place will decrease. These continuous fears cause that carers are put under constant stress (Svetičič 2002: 70). After carers take over caring for an older person, changes appear in the form of increased obligations and the way of spending spare time, which is adjusted to the wishes of the person cared for. Long-term care of an older person is related to bigger physical strains, especially when the person cared for must be lifted, which can deteriorate the carer's already poor health. Long-term care without breaks is a common cause of psychosomatic problems and an increased use of psychopharmaceuticals (Svetičič 2002: 64, Hlupič 2002).

If the carer has no external support, instances of overburdening and, consequently, abuse may occur. Elderly abuse has not been thoroughly researched

in Slovenia yet, but two researches have been carried out lately (Hvalič Touzery, Felicijan 2003, ZOD 2003), which are also interesting for our Report.

The research conducted by the Anton Trstenjak Institute[11] (Hvalič Touzery, Felicijan 2003) showed that **the most frequent abusers** in domestic settings are **adult children**; one half of older people were abused by their children. Family members or relatives (Table7) were responsible for three quarters of incidences of abuse. Persons living separately from their abuser mainly lived alone. Persons who lived in a common household with their abuser (in 40 %) lived together with adult children in more than three quarters of instances. In some cases these adult children were at the same time their family carers.

Table 7: Relationship of abuser to abused person (multiple answers, N = 45)

Abuser	N	%
Family / relatives	38	69.1
Adult child	25	65.8
Partner	4	10.5
Relative living in the same household	4	10.5
Relative living in a separate household	5	13.2
Friend	4	7.3
Neighbour	3	5.4
Person employed in the institution where abused person lives	6	10.9
Other person	4	7.3
Total	55	100.0

Source: Hvalič Touzery, Felicijan 2004

Incidences of abuse, by which we exclude financial abuses, thus occur due to inadequate help for carers and insufficient information. It is women who are more often responsible for neglect, which may be conscious (active neglect) or subconscious (passive neglect).

Constant stress, overburdening and the lack of understanding with the older person cared for are risk factors for elderly abuse (Hvalič 2002). This is confirmed by the research conducted by the Institute for Homecare Ljubljana last year, which showed that family carers commit abuse often because they are so worn out. The research made among their users, 80-plus year olds, revealed that 51 of them were abused, mostly by family carers. Mental abuse and neglect were the most frequent forms of abuse (ZOD 2003).

[11] The research was carried out in September 2003 among volunteers of the Slovenian Federation of Intergenerational Associations for Quality Ageing and subscribers of the gerontology magazine Good Quality of Old Age (Kakovostna starost). The questionnaire was filled out by 43 persons, of which 3 were male. The random sample of abused people included people from urban and rural areas. Victims of abuse were mainly in the age group 75 to 80 years.

1.12 Profile of migrant care and domestic workers (legal and illegal). Trends in supply and demand

Not applicable in Slovenian case.

1.13 Other relevant data or information

We would like to provide additional research-based information (Jakič 1997), namely:

that older people who were cared for mostly belonged to higher age groups – the 80-plus age group (67 %) and the 85-plus age group (42.5 %). As anticipated due to their age, more than half of them had problems with mobility and a bit less than 30 % of them had problems with orientation in time and space;

that close relatives caring for the elderly in Slovenia miss most financial help and home help; the third place is occupied by help in accommodation of the elderly in old people's homes. In as much as 45.8 % carers did not know who to turn to for help. The others would most often turn to one of the centres for social work or to health institutions (Jakič 1997).

The latter data shows how much family carers are isolated in their work.

2 Care policies for family carers and the older person needing care

2.1 Introduction: Family ethics and expectations – the national framework of policies and practices for family care of dependent older people

National guidelines on care of older people are clearly directed to enabling older people to stay in their home environment for as long as possible. For this purpose, the State adopted two important documents in 1997, based on which guidelines on social security of the elderly are determined. Compared to the previous institutional solving of problems of the elderly, the new guidelines emphasize pluralization of services. The shortcomings of both documents are reflected in the fact that the informal family care of the elderly is not mentioned nor are family carers. The current social security policy does not pay enough attention to family carers.

Despite the above, it is expected that relatives will help in family care, which is understandable, since neither the State nor the private sector or non-governmental sector can answer the increasing needs of the elderly by themselves. But it is not understandable nor acceptable that carers do not receive adequate help for their work. As Dušan Keber, Minister of Health, said in one of his interviews, “close relatives caring for their relatives have the right to home help, but it is true that this help must be developed to a much greater extent as it is. The State should support close relatives more when they decide to nurse their relatives alone” (Žmahar 2002). Such statements are rarely heard from politicians.

The Ministry of Labour, Family and Social Affairs is currently preparing the strategy for social security development for the elderly till the year 2010, in which intergenerational solidarity will be given attention. We do not have more information on this since the strategy will only be prepared in a couple of months.

2.1.1 What are the expectations and ideology about family care? Is this changing? How far are intergenerational support and reciprocity important? Do minority groups have different ideologies?

The family as the bearer of intergenerational solidarity and reciprocity, based on moral values, is the most important part of the informal network. Its role in care of the elderly is changing due to changed life patterns. Today most older people live in a quite close physical connection with close relatives of the second and the first generation. However, in the today’s social situation none of these three generations in the family has adequate communication skills for a quality human symbiosis, thus their relationships are often empty or tense

(Ramovš 2003: 340-341). A two-generation nuclear family and community neighbourhood are losing touch with older people in modern alienated urban areas, whilst this situation is much better in rural and suburban areas. A major problem is that generations do not know each other and have drifted apart. Consequently, the elderly are increasingly lonely and also other family members are distressed. For this reason, Slovenia tries to achieve a better communication between generations and a greater level of understanding between them with various intergenerational programmes for quality old age. With an increasing number of older population and other demographic trends our society will not be able to withstand all of these social pressures without proper ties and solidarity.

Researches conducted in Slovenia show the best relationships between older persons and children develop when living under the same roof but not in a common household. In this way people do not invade each other's space and are still close enough to help each other. This form of living is quite widespread in Slovenia and is perhaps one of the reasons that make family care less obvious. Families help older persons a lot when the latter are only partially capable of caring for themselves (Hojnik-Zupanc 1994 in Hvalič 1999: 83). A problem occurs when older persons need constant care and nursing, mainly because most women in their economically active years are employed.

For most aged married people their partner is the basic source of support. Partners are expected to offer complete help, support and personal care, if needed. Besides the above, partners (usually women) feel morally obliged to care-giving and nursing. These normative expectations also apply to adult children. Another research-based piece of data (Jakič 1997) that also tells a lot is that almost a half of carers (45 %), mainly female, were of the opinion that the older person expects complete care and help from them. Carers further stated in 30 % that the old person understands them and would be prepared to receive also other forms of help.

Everyday experience show that during the last years ageing Slovenian parents are one of the important economic sources of help to young families of their children, who cannot get adequate employment in tough capitalist conditions, have poor chances of solving their housing problem and are bearing huge expenses for children by themselves (Ramovš 2003: 239). On the other hand, adult children are the source of support and help to aged parents. The amount of support depends on the situation in which the older person and the adult child are. A major problem is the lack of help to relatives, who decide to nurse aged relatives by themselves.

Minorities in Slovenia do not have a different ideology than the rest of the population. Differences could occur in immigrants since they come from environments which are still quite traditional in this aspect. But these immigrants are mainly younger people, so that they do not face this kind of problems in Slovenia.

2.1.2 Are there any legal or public institutional definitions of dependency – physical and mental? Are these age-related? Are there legal entitlements to benefits for caring?

Disability is defined in the *Act on Pension and Disability Insurance* (APDI1). According to this Act disability is established (Article 60) when the insured's possibility of ensuring or keeping a workplace or professional promotion is decreased due to changes in his or her health status, which cannot be eliminated with a treatment or measures of medical rehabilitation. Disability is classified into three categories. This Act is related to professional disability, which does not refer to older people. The *Act Concerning Social Care of Mentally and Physically Handicapped Persons* (ZDVDTP) governs the forms of social care of moderately, seriously and heavily mentally and most heavily physically handicapped persons, who cannot be trained to live independently and to work (disabled persons) and for whom it has been established that the disability occurred before 26 years of age. There is also the *War Disabled Act*, which is also not referring to the elderly (Davidovič-Primožič et al. 2003). We can conclude that the key documents referring to disabled persons fail to refer to persons who became disabled only in their old age (demented, disabled people etc.).

In the beginning of the year another important document was formed, namely the *Act Amending the Social Security Act* (SSA-C) which stipulates that the person entitled to institutional care may choose a family assistant instead of all-day institutional care. This right is given to persons of full age with disturbances in mental development or with serious locomotor disabilities. The family assistant may be a person who has the same permanent address as the disabled person or as one of family members of the disabled person. The Act defines family members as spouses or the person living with the person that needs assistance, children, stepchildren, grandchildren, nephews and nieces, brothers, sisters, grandmothers, grandfathers, uncles and aunts. The competent centre for social work appoints a person of its choice person as the family assistant. The assistant has the right to partial payment for loss of income in the amount of the minimum wage (about 300 €) or to a proportionate part of the payment for loss of income in the case of part-time work. The family assistant offers help to the disabled person in compliance with the latter's needs and interests and particularly in accommodation, nursing, nutrition, household chores, accompanying and participation in various social activities. The Act also stipulates that the assistant must obtain training, defined by the Social Chamber. Besides stipulating that persons who became disabled before 26 years of age have the right to a family assistant, Article 18 also stipulates that this form of assistance may be received also by other persons with serious locomotor disabilities and with serious disturbances in mental development. The legal service of the Ministry of Labour, Family and Social Affairs provided the information that this latter part may also refer to older people with serious health problems. This means that in certain cases family carers will be able to

obtain the status of a family assistant. By the end of June secondary legislation will be drafted, based on which it will be clear what additional conditions for obtaining the right to the status of a family assistant will be.

2.1.3 Who is legally responsible for providing, financing and managing care for older people in need of help in daily living (physical care, financial support, psycho-social support or similar)?

- Financial support:

Only one act (Marriage and Family Relations Act - MFRA) specifically defines the responsibilities of adult children and stepchildren to aged parents. Namely, *children and stepchildren of full age are obliged to maintain their parents* (or stepparents) *if these are not able to work and do not have sufficient funds for living*. A research showed that only a small share of the elderly could actually pay for accommodation at an old people's home, so this Act is definitely daily applied in practice. This is also the case for home help since as much as one third of older people cannot cover the costs of services (Jakič). It is the State that ensures material security of people. The elderly without sufficient funds for living (pensions) have the right to financial help (state pension, widowers pension, income support for pensioners, attendance allowance etc.). In compliance with the APDI1, persons entitled to old-age, early retirement, disability and survivor's pensions with permanent residence in Slovenia, the pension of whom is below the amount of the minimum pension for full retirement age, have the right to income support for pensioners if they together with family members do not have other incomes sufficient for living (Article 132). The right to state pension belongs to a person of 65 years of age, whose own income does not exceed the property census for obtaining the right to income support for pensioners.

- Social security:

Social security is ensured by public networks (state and municipal) as well as private and non-governmental organisations. Each person meeting the criteria should have the right to public social welfare services. This is not completely implemented in practice since there is a lack of these services. The family is not lawfully obliged to care for its aged family member. It is only an unwritten rule that family members care (at least temporarily) for the elderly, if needed.

- Health care:

Everyone in Slovenia has the right to primary health care. Payments are made from the primary health insurance funds. Co-payments for certain services, defined by the HCHIA, are covered with funds from additional insurance, which is paid by individuals themselves, or are paid out-of-pocket. The State is thus obliged to ensure primary health care to all people.

2.1.4 Is there any relevant case law on the rights and obligations of family carers?

No, there is no such document existing in Slovenia.

2.1.5 What is the national legal definition of old age, which confers rights (e.g. pensions, benefits, etc.)

We do not have a national legal definition of old age in Slovenia. The minimum age for obtaining certain benefits and social welfare services for the elderly vary. Persons entitled to home help are thus persons over 65 years of age, disabled persons, persons with long-term health defects and children who have permanent diseases or handicaps (Brišar Slana 2003). Full retirement age (for a full old-age pension) is being gradually increased in compliance with the new pension act from 1999 (APDI) to the full retirement age of 61 years for women and 63 years for men (Article 52). In 2002, the retirement age was 54 years for women and 59.5 years for men. Old age is also one of the criteria for obtaining other types of pensions: widowers (53 years and, in exceptional circumstances, also from 48 years on) and state pensions (65 years). The right to disability pension can also be obtained by an insured who has been incurred category II or III disability and who is not ensured adequate employment or reallocation on turning 63 years of age (men) or 61 years of age (women).

Admission to old people's homes is also provided for by the criterion of at least 65 years of age, with the exception of special cases. *The Rules on Norms and Standards for Social Welfare Services* stipulate that people over 65 years of age are entitled to services of sheltered housing (Ministry of Labour, Family and Social Affairs - MDDSZ 2002).

The Health Care and Health Insurance (HCHIA) Act provides for covering of the entire standard treatment of 75-plus year olds, of disabled persons with at least 70 % disability and of persons receiving social assistance. The Act also provides for two preventive visits of home nurses a year for 65-plus year olds.

As evidenced from the above, the age at which the elderly may exercise their rights varies. However, a consensus has been reached that older people are those who are 65 and more years old. This is also evident from compilation of statistical data. Statistical data is usually presented for the age groups under 65 and 65 and more years of age, although in the recent years they are gathering information also for 60+ age group.

2.2 Currently existing national policies

2.2.1 Family carers?

In Slovenia, family carers of older people do not have an officially acknowledged role they perform. We had some problems with translating the English term 'family carers' into Slovene since these groups of people are rarely mentioned in public, specialised literature and legislation. If mentioned, different terms are used. The fact that this group does not even have a name tells a lot. Family carers are not visible enough and this is why they are not provided for financially or legally and with other policies. We do not have a national policy that would deal with this group directly. There are some acts, which indirectly concern family carers. The *Act on Pension and Disability Insurance* (APDI1, 1999) mentions the right to attendance allowance. Family carers are not entitled to this allowance but persons receiving an old-age, early retirement, disability and survivor's pension, who need constant help and attendance of another person for basic life needs, are. A large part of the allowance mentioned above goes to people already in institutional care, but this allowance is also important for those still in family care since it partially disburdens carers financially and enables them an external, formal or informal paid help.

We have already mentioned the *Act Amending the Social Security Act (SSA-C)* in Item 2.1.2, which is not yet being implemented in practice, but has been adopted and allows for the option that family carers of older persons are also registered as 'family assistants'. It is true that they are not directly mentioned, but the third indent of Articles 18.a and 18.c allows for this. It has not yet been specifically defined what the criteria for obtaining this status will be, but it is clear that it will only involve cases of serious physical or mental disability (e.g. disabled, demented older people). Despite obligatory education and financial compensations we should not forget that this will involve serious cases, which non-experts have problems dealing with by themselves and for which institutional care might be more appropriate. As it seems that only unemployed persons, persons who have left the labour market with the purpose of performing the function of a family assistant and persons employed part-time will be eligible to become family assistants, we may justifiably anticipate that this work will be performed by non-experts. It is true that in this way more older people will be able to stay in their home environment but the quality of such care will be questionable. Education, financial help and other services would be much more welcome to carers in cases when older persons are still partially capable of caring for themselves and when also carers are still capable of performing the tasks of care-giving.

Social security of the elderly is clearly defined in the *Social Security Act (SSA)*, based on which also alternative forms of institutional care are defined. These forms are of exceptional importance also for carers since they may alleviate their work.

2.2.2 Disabled and / or dependent older people in need of care / support?

The right to social security is one of the basic human rights and is also included in the Slovene Constitution. In the end of the 1990-ies two programmes were adopted in Slovenia, which set new guidelines of caring for the elderly: *Programme for the Development of Care for the Elderly Until the Year 2005* and *National Social Protection Programme up to 2005 (*NPSV 2000). Both are directed towards development of the institutional network, formation of day-care centres and centres for home help, from which various forms of home help are managed. The programme was started being implemented in 1998 and will be concluded *in 2005*.

Social security is governed by the *Social Security Act (SSA),* which stipulates that the State must ensure and develop operations of social welfare institutions, create the conditions for private work as well as support and promote the development of voluntary work in the field of social security. Based on this Act, Slovene citizens as well as foreigners with permanent residence and in special circumstances with temporary residence in Slovenia have the right to social welfare services. The Act also defines services directly concerning older people, namely help to families for their homes, home help, social services, institutional care and financial social assistance.

We should also mention the *Act on Pension and Disability Insurance (APDI1)*, which governs the system of pension and disability insurance. This Act defines the rights to different types of pensions (old-age, disability, survivor's, early retirement and partial) and to social allowances (income support for pensioners, disability allowance, attendance allowance, pensioner's recreation grant etc.). The Act thus serves as the basis for the economic security of the elderly.

The elderly as a special demographic group are not separately treated in any act or other regulation concerning health care. No special organisational form of a health service is anticipated for them. Some provisions refer to them indirectly as a population group at increased risk. Apart from this, there are some other provisions directly referring to the elderly in the field of health insurance (Cijan V., Cijan R., 2003: 189).

Health care is regulated by the *Health Care and Health Insurance Act* (HCHIA) and the *Health Services Act* (HSA). The HCHIA stipulates that everyone has the right to health care. In Slovenia, we have compulsory and voluntary health insurance. The Act clearly defines which services are covered by compulsory health insurance and to what an extent they are covered. Article 30 of the HCHIA also provides for the right to compensation for care-giving to a close family member, with whom the insured lives in a common household. This compensation is given for not more than 7 days and, in exceptional cases, not more than 14 days. The HCHIA stipulates that insureds are reimbursed entire costs out of obligatory insurance for visits of home nurses, for home treatment, home nursing and for treatment at social welfare institutions. The HSA defines health services.

*National Programme for Health Care of the Republic of Slovenia – Health for All Until the Year 2004 (*NPZV 2000) dedicates health protection of the elderly a special chapter, which is directed towards enabling them to stay in their home environment for as long as possible, especially within their family circle. Within the framework of care of the elderly, the Programme anticipates implementers of health care from the network of public health services to develop home treatment and medical care as well as hospitals with extended hospital treatment. Within the framework of social welfare programmes, they are to participate in day-care centres and home help for the elderly as well as services of old people's homes. Old people's homes are to provide appropriate treatment, rehabilitation and medical care to their residents. These objectives have been achieved only partially.

The Marriage and Family Relations Act (MFRA) is also important in terms of obligations of adult children towards aged parents. Article 124 says that children of full age are obliged to provide for their parents if parents are not able to work and do not have sufficient funds for living. Article 127 stipulates that stepchildren are obliged to provide for their stepparents if stepparents have been providing for them and taking care of them for a longer time. If stepparents have their own children, stepchildren must provide for their parents together with these children.

There are also various other rules for successful implementation of social welfare services, such as Rules on Norms and Standards for Social Welfare Services, Rules on Procedures and Requirements for Granting of Concessions, Rules on Minimum Technical Requirements for Performing the Activity of Institutional Care, Home Help and a Social Service, Rules on Methodology for Social Service Price Formation etc.

From the viewpoint of social care it is important to mention the strategy of caring for the third generation and for better relation between generations until the year 2010, which is being currently prepared by the Ministry of Labour, Family and Social Affairs. The interest at the intersectoral national level in foundation of a new gerontological institute is also encouraging since at the moment Slovenia has no institution dealing explicitly with gerontological problems. With this institute, gerontological problems will be even more noticeable.

The White Paper on Draft Health Reform (MZ RS 2003) is also prepared. A great deal of harmonisation will be necessary since there are many disagreements concerning objectives and changes. Among other, the White Paper anticipates an increase in home treatment and home care. Close relatives and other non-expert carers are thus to obtain adequate support for home care of patients. A new national programme for health care is to be drawn, which will emphasize intersectoral and multidisciplinary operating.

2.2.3 Working carers: Are there any measures to support employed family carers (rights to leave, rights to job sharing, part time work, etc)?

Presently there are no measures in Slovenia granting special rights to employed family carers. However, there are two documents, based on which family carers have the right to absence from work and to a financial compensation, namely the *Health Care and Health Insurance Act (HCHIA)* and the *Collective Agreement for Health Care and Social Security Activities of Slovenia*. According to the HCHIA, the compensation for nursing a close family member, with whom the insured lives in a common household, may be paid for not more than seven days per year. A competent doctors' commission may exceptionally extend this period up to 14 working days (Article 30) if the health condition of the close family member requires so. The base for this compensation is the average monthly wage. The compensation equals 80 % of the base (Article 31). The Act thus anticipates compensations only for cases when the carer and the cared-for person live in a common household. As a result, this right is quickly limited to a small share of family carers since the Slovenian trend is such that younger generations do not live in a common household with older generations but nearby, perhaps even in the same house. Besides the above, one or, at the most, two weeks is often not by far enough to meet all needs.

The Collective Agreement provides for additional options of absence from work also in cases when the employee does not have the right to wage compensation for nursing a family member in compliance with regulations on health insurance, namely on the basis of a medical certificate (Article 38). The employee has the right to absence from work without wage compensation (unpaid leave) for up to 30 days in a calendar year also for nursing a family member without a medical indication, provided that his or her absence will not essentially interfere with the working process. During the employee's absence from work without the right to wage compensation the employee's rights and liabilities arising from the employment relationship are suspended. The employee may be absent from work without wage compensation for more than 30 days in a calendar year if the working process allows for this (Article 39).

According to the Collective Agreement family carers could thus stay at home without financial compensation for a longer time, but this is not as easy to realise since the Collective Agreement stipulates that the absence must not affect the working process. For most employees, a longer absence from work has a serious effect on the working process. This solution is thus not favourable to family carers both in terms of their finances and employment.

The abovementioned acts and the Collective Agreement do not provide for the option of part-time work in the case of caring for a family member, which may be introduced by the already mentioned Act Amending the Social Security Act in provisions referring to family assistants. Despite this, we can conclude that

employed family carers do not receive adequate support from the employment policy.

2.3 Are there local or regional policies, or different legal frameworks for carers and dependent older people?

Slovenia is a small country, so that social policies of regions and municipalities do not differ substantially. We do not have separate local or regional policies for carers and the elderly in need of help. Social care of the elderly is regulated by legislation (SSA, HCHIA, APDI and MFRA), which must be respected by all municipalities. Services falling within responsibilities of municipalities are thus based on the same acts. The only differences arise from service implementation since this depends on funds of individual municipalities.

2.4 Are there differences between local authority areas in policy and / or provision for family carers and / or older people?

Municipalities are responsible for some social welfare services intended for the elderly, which is why financial differences and differences in availability occur. For example, at the moment the Municipality of Ljubljana subsidises social home assistance in 100 % (from March 2004 it will only subsidise 70 %), whilst the elderly from all other municipalities have to partially cover the help service by themselves. This service is not equally developed in all municipalities and the personnel is also not adequately trained. Another problem is that the elderly have big needs but the number of social carers is dropping due to insufficient funds to enable additional recruitment.

Differences are also present in availability of institutional care of the elderly. For example, in Ljubljana old people's homes are full, waiting periods are long and they depend on health condition of applicants and their requests. The longest waiting period, up to a few years, is for one-bed rooms. Old people's homes in many other Slovenian cities also record long waiting periods.

None of Slovenian municipalities has services directly intended for family carers of older people. They are included only indirectly. We also have no statutory act based on which family carers could exercise rights and benefits.

3 Services for family carers

Services for family carers	Availability			Statutory	Public, Non statutory	Voluntary		Private
	Not	Partially	Totally			Public funding	No public funding	
Needs assessment (formal – standardised assessment of the caring situation)	X							
Counselling and Advice (e.g. in filling in forms for help		X				X	X	
Self-help support groups		X[12]				X	X	
"Granny-sitting"	X							
Practical training in caring, protecting their own physical and mental health, relaxation etc.	X[13]							
Weekend breaks	X							
Respite care services		X[14]			X			X
Monetary transfers	X							
Management of crises	This service is not available [15]							
Integrated planning of care for elderly and families (in hospital or at home)								
Special services for family carers of different ethnic groups	X							
Other								

[12] In Slovenia, we have only a few self-support groups intended for family members. These are organized within associations and are intended for a specific target group (the grieving, relatives of patients with dementia, relatives of people at old people's homes etc.) Old people's homes also have groups for close relatives, but only rarely.

[13] Training of family carers in Slovenia is not organised. The biggest source of help and information for family carers are home nurses and some non-governmental organizations.

[14] Slovenia does not have respite care as organised in many European countries but only some kinds of alternatives to this type of care, which are not highly available. Temporary accommodation is to be enabled by public old people's homes, which are overcrowded. Hotels for the elderly are thus an alternative, but these are private and have higher prices than public homes. There is also the option of temporary admission to a hospital, which is also not easily available and is very expensive.

[15] Slovenia does not yet have a special service that would prepare a complete plan of caring for an older person. If required, different services cooperate, such as a centre for social work, old people's home, nursing care and doctors.

3.1 Examples

3.1.1 Good practices

1. Hospice Association

The Slovenian **Hospice Association** has been active since 1995. Activities are carried out through regional boards at the national and local level. Their purpose is to help mostly close relatives and health care personnel in work with the dying, to do away with taboos about dying and help the grieving. The following programmes are important for close relatives of the elderly:

a) HOSPICE Programme – Monitoring of dying patients and close relatives: The basic activity is to provide complete care to dying patients and close relatives.

b) Grieving after the loss of a close person – The target group are the grieving who have lost a close person.

c) Hospice house (Anonymous 2003)

2. "Forget-me-not", the Alzheimer's Disease and Related Disorders Association of Slovenia

"Forget-me-not", the Alzheimer's Disease and Related Disorders Association of Slovenia helps patients, close relatives, expert associates and non-expert carers in overcoming problems arising from dementia and other mental disturbances of old age. It also provides education, information and advice to family members and informal carers. This association has a special programme *Forget me not*, which is intended for close relatives of demented patients still living in their home environment (Spominčica 2004).

3.1.2 Innovative practices

Training of families for better communication with older family members – the Anton Trstenjak Institute.

During the last decade intergenerational programmes for quality ageing have been developing in Slovenia. Within these programmes **family members are trained for better understanding of older people** and for better intergenerational communication. An efficient course for better communications with the elderly awards younger generations several benefits at the same time: the quality of life of older family members is increased, everybody is more pleased due to improved family relationships and younger generations become familiar with old age, which is the first step to preparing for their own ageing (Ramovš 2003: 306-307).

4 Supporting family carers through health and social services for older people

4.1 Health and Social Care Services

The field of social and health care of the elderly is regulated by the following acts: *Act on Pension and Disability Insurance* (APDI), *Health Care and Health Insurance Act* (HCHIA) and *Social Security Act* (SSA).

The SSA defines social welfare services and duties for prevention of social distresses and problems of individuals, families and population groups. The elderly are mostly entitled to services for materially deprived, thus to a social service, home help and institutional care.

The APDI defines the right to attendance allowance, eligible persons for which are all pension recipients and some groups of active insureds if their mobility abilities are decreased to at least 70 %, they are blind or weak-sighted. These people need constant help and attendance of another person in their daily life.

The HCHIA defines the rights arising from compulsory insurance, namely insureds are entitled to be fully paid visits of home nurses, treatment and nursing at home and at social welfare institutions from compulsory insurance funds. The Health Insurance Institute finances treatment and nursing of insureds at home, most of which is intended for older, chronically ill persons. It also pays for medical care of persons already in institutional care at old people's homes or at special social welfare institutions (Toth 2002).

4.1.1 Health services

The Ministry of Health is responsible for our health policy. Municipalities and cities ensure the conditions for realisation of health care in their areas in compliance with their rights and obligations.

It is defined by law (HCHIA) that every person in Slovenia has the right to health care and the obligation to contribute to its realisation in compliance with his or her abilities (Article 2). Health insurance is compulsory and voluntary. Compulsory health insurance is managed by the Health Insurance Institute of Slovenia (HIIS). Voluntary health insurance is managed by insurance companies. Compulsory insurance covers most health care services. In some cases it covers the costs of health care services and medicinal products entirely and in other cases only partially –specific coverage is defined by the HIIS.

4.1.1.1 Primary health care

Health services at the primary level include basic health activities and pharmacy activities. They are provided by 64 public health centres and 69 health care stations as well as private health workers. Health centres are situated in

local communities and provide basic preventive health care, urgent medical assistance, dentistry, nursing care, physiotherapy etc. They also perform specialist treatment if hospitalisation is not required. Since 1992 private practices are also allowed. Doctors without a concession may also have a practice but patients have to pay for their services out-of-pocket (Anonymous 2001). Health care stations provide at least urgent medical assistance, deal with general medicine, family medicine and perform basic diagnostic examinations (HSA).

Each person in Slovenia has a personal general doctor and a dentist of his or her choice, whilst women and children have also an additional doctor. Personal doctor monitors the person's health and is authorised to direct the person to a doctors' commission, to a specialist and to a hospital, prescribes prescription medicinal products and gathers medical documentation on the person's treatments (HCHIA).

Hospitalisation periods are shortening, so that early rehabilitation dropped to a minimum. We do also not yet have further rehabilitation organised within rehabilitation institutions, health spas and, most of all, not at the level of primary health care. A tertiary institution is professionally obliged for most demanding cases, whilst less serious cases are treated stationarily within the framework of health spas, nursing hospitals, old people's homes and also at patients' homes. All of these institutions have a common feature that they are not able to treat a bigger number of patients (lack of premises, financial restrictions) (Erjavec 2003). Home rehabilitation of the elderly is unequally spread across the country and is not easily available. As a matter of fact, this activity has never been satisfactorily developed (Toth 2003). Personnel norms are reduced and doctors also cannot pay visits at homes, so that home treatment is declining (Geč 2003). Conditions for home medical care are not fulfilled in terms of the number of employees or available funds.

Rehabilitation options for patients having suffered from a stroke are relatively modest. Present data shows that only 47 % of patients are given organised treatment, and even these patients are only rehabilitated at home (Goljar 2003). In 2000, only 38 % of people in Slovenia with a broken hip received additional rehabilitation at the Institute for Rehabilitation or at a health spa. Additional intense home rehabilitation is in most part not possible since we have not yet established a wide network for help of physiotherapists and occupational therapists at home, which would be able to provide intense rehabilitation besides periodic monitoring (Marn-Vukadinović 2003). Home physiotherapy is actually at the minimum since physiotherapists are already too busy with outpatient work (Grm 2003). If the financial situation of an older person is favourable, home nurses contact a physiotherapist, who then visits the older person. However, a lot of people receive low pensions, cannot afford this and are thus left without adequate care from physiotherapists and occupational therapists (Srdarev 2003). Home physiotherapy services are mainly available only if paid out-of-pocket.

Due to the abovementioned, nursing care has a very important role in the Slovenian area. A home nurse is the bearer of primary health care at home, which is a constituent part of primary health care. This is a polyvalent activity since it deals with healthy and sick persons, the family and the community. The work of home nurses includes help to individuals, families and community in the time of health, disease, disability and addiction. They are responsible for the population's health and social care, preventive, diagnostic-therapeutic and rehabilitation activities. The number of visits of home nurses is increasing (in 2000 home nurses paid 1,010,224 visits and in 2002 1,057,238). But it is true that the number of preventive visits is dropping due to home medical care of patients (Filej 2003).

According to the prevention programme of nursing care, home nurses visit healthy or ill people at their homes twice a year, whilst curative medical care of the elderly is carried out when ordered by personal doctors (Šenica 2003: 35). The frequency of home nurse visits depends on the seriousness of patients' diseases and their needs. Home nurses work in a geographical area.

The family of the cared-for person is also very important for home nurses since it is an important factor for planning nursing care. The changes occurring in the family when a disease appears may destroy its operational system. In such cases, home nurses are directed towards motivating, guiding and teaching family members as well as providing them a health education (Brložnik 2003: 29; Srdarev 2003: 44). Loving, understanding family relationships positively affect aged family members, motivate them to remain caring for themselves for as long as possible as well as offer them safety and help in the case of worsened health and diseases. Bad relationships can annul all efforts of home nurses to improve or at least retain the situation, so that sometimes it is necessary to move older persons from such an environment (Srdarev 2003a).

Unfortunately, nursing care, which was exceptionally well developed in the past, is regressing today and receives little attention from the health care system. Home nurses were successful 'social workers' in the field for families and the elderly for years. The current organisational crisis of the Slovene health care system has substantially reduced nursing care, whilst social care and home help have been well developed. These two are not operating harmoniously in the field nor are the ministries, whose sectors have been divided over the past years and which fail to coordinate their programmes. The elderly and their families need a unified social and health care approach, not only more efficient but also a cheaper one (Ramovš 2004: 22).

Other forms of home medical help are not developed, but are anticipated by the health reform presently in preparation.

4.1.1.2 Acute hospital and Tertiary care

Specialist hospital activities depend on health condition of people and do not differ from the ones of the rest of the population in the case of older people.

Each person has the right to medical care. Older people are hospitalised in order to be treated for a concrete disease or a health problem or to be given urgent assistance. In most cases hospital treatment is provided free of charge to all people in Slovenia since it is a part of primary medical care according to the law. Between 1991 and 2001 the rate of hospitalisation was the highest for the age group of up to one year and for the elderly. Older people were most frequently hospitalised for cardiovascular diseases.

Specialist secondary health care is ensured through hospitals, policlinics and health spas. University hospitals and institutes provide more complex tertiary activities. In 2000 policlinics mostly operated within the public network of health services. Actually there are only a few completely private providers of secondary specialist care and diagnostic services and most of them work based on agreements with the HIIS. Treatment at health spas (Slovenia has 15 health spas intended for adults) is based on proposal of a personal doctor or the doctor treating the patient at a hospital. A doctors' commission approves or rejects such treatment (Jakubowski (ed.) 2002: 44-45).

Table 8: Acute care and private beds by year

Year	Acute care hospital beds per 100.000	Number of acute care hospital beds	Private in-patient hospital beds as % of all beds	Number of acute short stay hospitals	Number of private in-patient hospital beds
1999	458,94	9,070	0.18	–	20
2000	448,51	8,868	0.19	–	20
2001	423,59	8,438	0.19	21	20

Source: WHO / Europe. 2003. HFA Database.

Hospitals provide approximately 75 % of secondary medical care as in-hospital or out-of-hospital treatment. In Slovenia we have 26 hospitals, including 9 regional and 3 local general hospitals and the main tertiary hospital, University Medical Centre in Ljubljana. There are also 12 specialised hospitals. Besides the University Medical Centre, there are also two other tertiary institutions, namely the Institute of Oncology and the Institute for Rehabilitation.

The number of hospital beds has dropped from 5 beds per 1,000 persons in 1990 to 4.6 in 1998. This is the result of the policy on moving towards out-of-hospital instead of in-hospital treatment. The average hospitalisation period is falling as well – from 12 days in 1987 to 8.3 days in 2001 (Jakubowski (ed.) 2002: 45).

Table 9: Hospital beds, average length of stay and in-patient care admissions by year

Year	Hospital beds per 100.000	Total number of hospital beds	Physicians per 100.000	In-patient care admissions per 100	Average length of stay, all hospitals	Average length of stay, acute hospitals only
1999	554.52	10,959	215.25	16.64	9	7.5
2000	543.44	10,745	218.34	16.82	8.6	7.08
2001	516.36	10,286	218.92	16.58	8.3	6.77

Source: WHO / Europe. 2003. HFA Database.

A special branch of medicine, geriatrics, is dealing with the problems of keeping the elderly healthy also in Slovenia but we do not have any special geriatric hospitals, so that the elderly are treated at clinics suiting the nature of their disease.

In the past, Slovenia had the Clinic for Gerontology and Geriatrics (founded in 1966) and some geriatric departments at individual health centres. In the beginning of the 1970-ies 15 gerontology departments were founded within Slovenian health centres. In 1985 veterans' departments (72) were also organised within health centres, their patients were mostly the elderly. It was expected that these departments would grow into gerontology departments, which never happened. From 1992 onwards these veterans' departments are not mentioned anymore. Their activities were included in general medicine. In that year there were six gerontology departments. In 1995 only two gerontology departments were still officially active – in Maribor and Domžale. Doctors are striving to revive and protect gerontology and geriatrics in the Slovenian area (Cijan V, Cijan R 2003: 191-192).

4.1.1.3 Are there long-term health care facilities (includes public and private clinics)?

Slovenia has been dealing with the problem of providing long-term care for several years. Institutional care solves the problems of a big number of people, but this is only one of the forms of long-term care. Slovenia does not have adequate rehabilitation centres or extended hospital accommodation at adequate centres (hospitals etc.). Parallel services for rehabilitation care are also not adequately developed (Grm 2003).

Officially we differentiate between four forms of help and services, which partially represent the existent long-term care system; home help and home care, institutional care of the elderly, institutional care of special groups of adults and institutional care of children and youth with developmental disturbances (Table10).

Persons entitled to these services are persons over 65 years of age in the field of social care or persons with disturbances in mental and physical development. The number of recipients of these services depends on their health condition and is small in the case of home help. Health insurance does not know age restrictions for rights but only medical justification of home care is necessary (Toth 2004: 50).

Table 10: The rights and organisation of help and long-term care for elderly people in Slovenia

	Home help and home nursing	Institutional care of elderly	Institutional care for special groups of adult people
beneficiaries	People old 65+, invalids, families of chronically ill and mentally handicapped children	People old 65+	Adult physically or mentally handicapped people, adult people with psychiological problems
Coverage (extent of help)			
a) according to SSA*	household assistance	–	–
	help with ADL	help with ADL	help with ADL
	help with hygiene	help with hygiene (depending on health status)	help with hygiene (depending on health status)
b) according to HCHIA**	medical home help (mostly 4h / day and 20h / tweek; the contract is renewed every 3 months)	medical care depending on health status od zdravstvenega stanja – as long as need exists	medical care depending on health status od zdravstvenega stanja – as long as need exists
Executors	public social welfare institutions, concessionaires, subjects with work persmission	public social welfare institutions, concessionaires, subjects with work persmission	public social welfare institutions
Financing	beneficiary, municipality, health insurance (CHI)	beneficiary, municipality, health insurance (CHI)	beneficiary, municipality, health insurance (CHI)
Network	municipality	state	state

SSA* = Social Security Act; HCHIA
** = The Health Care and Health Insurance Act
Source: Toth 2004: 50

Long-term care in Slovenia is mostly provided by old people's homes and special social welfare institutions; most of them are public. Such care is provided based on a doctor's recommendation. According to data of individual old people's homes, bigger cities record from 40 % to 50 % of admissions directly from hospitals, which means that patients cannot be provided basic health care at their home mostly due to a serious health condition (Lunder, Logar 2003).

In Slovenia we do not have long-term care insurance, but its introduction is being considered since thus all people would be ensured the same criteria and options, regardless of whether being provided care at their home or at one of institutions. This will call for adoption of a new act, special organisation and personnel will have to be ensured as well as political willingness and funds will be necessary. The achievement of this objective is thus still far in the future (Toth 2003).

4.1.1.4 Are there hospice / palliative / terminal care facilities?

Palliative care is not a part of the Slovenian health system. Slovenia does not have complete and adequately educated palliative teams at hospitals or in primary health care; there are no palliative departments at hospitals and pensioners' homes. The entire home palliative care is currently provided by the Slovenian Hospice Association, a non-governmental, non-profit and humanitarian organisation, which was the first to introduce palliative care in 1996. Other specific palliative activities are also being carried out in Slovenia. The Institute of Oncology started forming a palliative team in 2000, but this team is not yet complete since specialisation abroad takes four years. Some foundations for palliative care are present at hospitals, some health centres and old people's homes, but their personnel has not yet obtained basic additional education in palliative care, has no adequate additional education and is not operating in an organised network (Lunder, Logar 2003).

In Slovenia we also have no hospice house, but the first one is being prepared in Ljubljana, the capital. The house is to have five apartments for dying patients, a day-care centre for the dying and relatives and a consultation centre for health and social workers. At the moment, an interdisciplinary hospice team (professionally trained persons help ease and relieve bodily suffering) and trained volunteers take care of the dying and their close relatives. They operate at homes of the dying, hospitals or old people's homes. The Association provides complete care of terminally ill patients in their last life period according to the principles of palliative care.

Besides offering help to the dying, psycho-social support to close relatives up to the moment of the patient's death, on death and in the time of grieving is also of great importance. Psychological pains and strains of close relatives, who encounter the reality of dying, are expressed as exhaustion, frustrations, financial worries and guilt, as fear that perhaps they have not done enough, as distress when the patient's condition worsens and as stress caused by watching the family member dying. Together with the hospice team, they indirectly help settle family relations to the benefit of the dying. Besides this, both close relatives and the dying have the chance to take leave. Care of the family continues for at least one year after the patient's death or as long as relatives wish. The mourners are offered support in the time of grieving (Hospic 2004).

Let us also mention the Palliative Care Centre, which is responsible for professional and public issues concerning pain and modern partial help to terminally ill patients, especially with anti-pain medications.

4.1.1.5 Are family carers expected to play an active role in any form of in-patient health care?

As far as we know, close relatives do not participate in in-patient care except in, if necessary, discussions on the relative's health condition and medical care and on how to improve recovery and health condition after discharge from the hospital. The hospital personnel takes complete care of hospitalised persons (nutrition, clothes, medical care, administration of medicines, compilation of laboratory results etc.).

The number of hospitalisation days is dropping, so that many older people leave hospitals after basic medical care has been provided to receive domestic care. Relatives do not know what to do and, at the same time, these older people completely depend on their help in the beginning. Close relatives play an important role and are thus included in rehabilitation process. But they also need guidance and advice, which they receive most frequently from home nurses.

4.1.2 Social services

Besides health insurance, social care is the most universal field of social security in Slovenia. Eligible persons are Slovenian citizens with permanent residence in Slovenia and foreigners with permission for permanent residing in Slovenia. Slovenian citizens without permanent residence in Slovenia and foreigners without permission for permanent residing in Slovenia have the right to specific services subject to legislative criteria (Kavar Vidmar 2001).

Due to distinctively one-sided orientation of the State towards development of institutional forms of caring for the elderly, the informal social networks, above all families, relatives and neighbours, over the past fifty years bore the burden of ensuring care to those older people that were left out of institutions. Operations of private profit entities in the field of social care were not allowed, the role of the third sector was minor and directed mostly to offering support to families in order for them to take care of their aged members more easily.

In the end of the 1990-ies two programmes were adopted in Slovenia, which set new guidelines of caring for the elderly: *Programme for the Development of Care for the Elderly Until the Year 2005* and *National Social Protection Programme up to 2005* (see Item 2.2.3).

The prevailing finding applied today is that older people have to be kept in their home environment for as long as possible and that, for this purpose, different forms of help must be organised (MDDSZ, 2001a). In the last decade we have thus noticed the trend named as 'welfare mix' in Europe. The State has kept a

dominant position as the financer (Nagode et al. 2004) and is also important as the producer of individual forms of caring for older people. However, during recent years also private non-profit (mainly religious) and profit organisations have started acting as founders of institutional care. It is mainly the first ones that try to conclude concession agreements with the State and thus ensure themselves a relatively stable public financing (Nagode et al. 2004). Social welfare expenses amount to 26.5 % of GDP, of which 44 % are intended for age-related expenses (SORS-SY 2000: 195 in Hvalič 2001: 41).

Formal social assistance for the elderly is provided mainly by social welfare institutions, centres for social work and health establishments (health centres, nursing care and hospitals).

4.1.2.1 Residential care (long-term, respite)

The institutional network of services for the elderly comprises of day-care centres, sheltered apartments for the elderly and old people's homes.

Old people's homes

One of the features of Slovenian old people's homes is that they were planned mostly for mobile older people, but now mostly ill and weak people in need of special care come to these homes. More than one quarter of cared-for people at these homes die each year (Ramovš 2003). From previous social welfare institutions they are now increasingly changing into health care institutions. Cared-for people pay for services themselves if they are financially capable. If not, adult children in the first place or municipalities in the second place are lawfully obliged to help them.

The average capacity of these homes is around 200 beds; the biggest in Maribor is on two locations, offering the total of 860 beds. The lowest number of beds is in one of the homes with a concession, which has 60 beds. On the average, rooms have 1.97 beds (SSZS, 2003a, 2004). Room types are as follows: 39.5 % one-bed rooms, 40 % of two-bed rooms and 20.5 % of rooms with three and more beds (Kavčič 2000: 94).

Increasing demand proved that capacities of these institutions are not sufficient. Waiting period for admission into old people's homes is still long despite the increasing number of old people's homes, especially in the capital and its surroundings.

Hotels for the elderly and the option of respite care

Besides state homes and private homes with a concession, during the last years also the first homes with only an operating permit and otherwise founded on a completely private and profit basis have been opened in Slovenia. These facilities are hotels for the elderly, where older people live mostly temporarily and transitionally. People must pay for their services fully and their prices are higher than for homes of the public network (Ramovš 2003: 316). In Slovenia it is required that prices of basic services in the private sector are comparable to

the public sector, whilst additional supply is left to the market to choose. Such homes give family carers of the elderly the chance to take a temporary break since Slovenia does not yet have proper respite care.

Some types of respite care are provided by old people's homes from the public network. This service is called 'temporary admission'. The survey that we carried out in the beginning of February 2004 on half of old people's homes and special institutions has revealed that homes, with the exception of two, have no especially reserved beds for temporary admission. Temporary admission and the waiting period for such admission are closely related to free capacities and the problem is that these homes are mostly too full. The time for admission depends on free beds; in some places priority is given to people waiting for regular long-term accommodation and vice versa in other places. The price of temporary admission equals the price of regular accommodation. The duration of temporary accommodation varies from home to home. Some have restrictions on its duration and others do not. The average accommodation service of this type lasts from one to three months. Most homes record a high interest in these services among relatives of the elderly, especially during the summer (vacations) and increasingly more during the year. Besides the above, increasingly more people decide for temporary accommodation after discharge from the hospital. Some homes do not record higher interest in this type of services. This is attributed to poor financial capacities, which do not enable payment of both own vacation and institutional care.

In Slovenia there are only two old people's homes that offer organised temporary care for elderly citizens as an additional activity. Old people's home in Kranj offers limited accommodation up to three months; its users may stay in one of three one-bed rooms. The interest is big and this form is fully employed throughout the year. If there are no people interested in this form, the home receives residents from the regular waiting list, who are then moved. The price of such care is higher by 40 % of the regular price for accommodation up to three days and by 20 % for accommodation over three days. Old people's home in Celje has six beds available for temporary accommodation – two one-bed rooms for people with satisfactory psychological and physical condition and two two-bed rooms for people of poorer health. Prices are favourable. Accommodation is not limited and revolves around two weeks to one month.

The options of short-term accommodation at homes are thus fairly limited, depend on free beds and employed capacities and are not equally available across the country.

General hospitals are to be the second provider of respite care. They refer to this service as 'nursing beds' and include meals and a daily visit of a doctor. A contract must be concluded between the user or his or her relatives and the hospitals' management in order to be admitted. A requirement for admission is an empty bed on the department and it must be applied for a couple of days in advance. The price of the nursing bed is fully paid by the user – it amounted to

67.50 € in 2002 (as compared to public homes, where the daily price revolves around 12.60 € for basic care). If the user needs medical care, this care is added to the price of the programme. For example, in the Municipality of Slovenj Gradec no person has decided for this service, even though close relatives are interested in it. It is mostly the high costs that discourage people from using this service (Palir Čuješ 2002: 67).

Again we can establish that services which could temporarily disburden family carers of the elderly are not easily available due to high prices and, even more so, the lack of free beds at old people's homes and hospitals.

Sheltered housing

Sheltered apartments are a novelty from the past few years in Slovenia and were mainly built after 2000. In the years of introducing sheltered apartments, their construction was financed from different public and private sources. The present sheltered apartments are situated in immediate vicinity to old people's homes. They are smaller, adapted to the needs of the elderly, their residents have guaranteed minimum necessary help and care and they are also given the option of additional ordering of services. Social care and nursing are provided by a social and health service, which must be available 24 hours a day. They are most frequently provided by the existent service of old people's homes (MDDSZ 2002, MDDSZ 2003). A characteristic of these apartments is that they are private; older people may thus buy or rent them. In the middle of 2002 less than 300 units in nine places throughout Slovenia were available. These were mostly studio and one-room apartments, some were two-room apartments. There is quite some interest in sheltered apartments but in reality they are occupied relatively slowly. The reasons for this are high prices, inappropriate locations and, above all, the fact that people in Slovenia are not used to sell their home in old age and move into a smaller apartment (Ramovš 2003: 310).

4.1.2.1.1 Basic data on % of > 65s in residential care by age group and type of residential care (sheltered housing, residential homes)

The table below shows gender and age structure of cared-for persons in public social welfare institutions as at 31 December, 2002 (old people's homes, special social welfare institutions), whilst private facilities are not included in the analysis. However, age structure in private institutions does not differ substantially from the one in public institutions. The table requires additional explanation, namely that Slovenian old people's homes are as a rule intended for the population group of 65 years of age and more. Younger applicants are also accepted when these need accommodation in a home due to their health condition. The share of these persons is quite high at 13 %. At the same time, we have also special institutions and combined old people's homes, which are intended for adult mentally and physically handicapped persons. One third of persons staying at these facilities are younger than 65 years of age.

Table 11: Beneficiaries in public social welfare institutions by age groups and gender – 31.12.2002

Age groups	Old people's homes (52)						Special social welfare institutions (6)						Total (58)					
	Women		Men		Total		Women		Men		Total		Women		Men		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
up to 60 years	435	4.6	606	17.5	1041	8.1	378	47	532	64	910	55.6	813	8	1138	26.5	1951	13.4
60 to 65 years	263	2.8	334	9.6	597	4.6	74	9.2	116	13.9	190	11.6	337	3.3	450	10.5	787	5.4
65 to 70 years	566	6.0	467	13.5	1033	8.0	72	8.9	76	9.1	148	9.0	638	6.2	543	12.6	1181	8.1
70 to 80 y.	3066	32.6	1109	32.0	4175	**32.4**	133	16.5	86	10.3	219	13.4	3199	31.3	1195	27.8	4394	**30.3**
80 to 90 y.	3798	40.4	740	21.4	4538	**35.3**	111	13.8	17	2.0	128	7.8	3909	38.3	757	17.6	4666	**32.2**
90 years +	1277	13.6	204	5.9	1481	11.5	37	4.6	5	0.6	42	2.6	1314	12.9	209	4.9	1523	10.5
All beneficiaries together	**9405**	**100**	**3460**	**100**	**12865**	**100**	**805**	**100**	**832**	**100**	**1637**	**100**	**10210**	**100**	**4292**	**100**	**14502**	**100**
		73.1		**26.9**				**49.2**		**50.8**				**70.4**		**29.6**		
< 65years	698	7.4	940	27.8	1638	12.7	452	56.1	648	77.9	1100	67.2	1150	11.3	1588	37	2738	18.9
65 years +	8707	92.6	2520	72.8	11227	87.3	353	43.8	184	22.1	537	32.8	9060	88.7	2704	63	11764	**81.1**

Source: The questionnaire of The Association of Social Institutions of the RS 2002 in Kaučič 2003

In 2003 13,178 older people were provided institutional care from the public network and 131 people were outside the network (accommodated at private institutions), whilst capacities of old people's homes and special public institutions equalled the total of 15,242 beds. More than 0.2 % of older people were provided other forms of institutional care. Alternative forms to old people's homes are also poorly developed. All alternative forms include only 1.8 % of people, of which somewhat less than 1.5 % people are given home help. A substantial part of caring for the elderly is thus still in the hands of family carers.

Table 12: Table12: The share of old people in day-care centres and sheltered housing. December 2001, 2003

	Total number of population 65y.+	Number of places	Share of old people (%)
Sheltered housing	284,840*	394*	0.14*
Day-care centres	294,654	230	0.08

* data for year 2001
Sources: MDDSZ 2001a, MDDSZ 2004

4.1.2.1.2 Criteria for admission (degree of dependency, income etc.)

The commission for admission and discharge of residents decides on admission to the old people's home based on relevant rules. The following is taken into account for admission: the time of application, permanent residence (priority is given to citizens of municipalities covered by the old people's home), social and health condition of the applicant, attachment to the environment living in presently, permanent residence of close relatives, other basic grounds justifying admission of the applicant to the old people's home and age of over 65 years. Taking into account that applicants for admission to these homes are mostly of poor health, the social situation of the applicant (whether he or she has people to take care of him or her) is also an important criterion. The financial situation of the applicant is not an important criterion since mostly public institutions are concerned, which residents do pay out-of-pocket but, if necessary, also adult children or municipalities finance them.

The reasons for moving into old people's homes are the following: health (75.95 %), old age (7.35 %) and other (social, personal) (16.7 %). Only around 4 % of cared-for persons were relatively healthy, 67 % of them were disabled or partly disabled (SSZS 2004). Let us mention an interesting piece of data – in 2003, 10.5 % of residents of these homes (1,523) were over 90 years of age. The mortality at these homes is approximately 25 % annually.

Somewhat different criteria apply to sheltered apartments, for which the extent of help is smaller than at old people's homes. The Rules on Norms and Standards for Social Welfare Services stipulate that eligible persons for this service are people over 65 years of age not capable of living independently without help of another person and those people whose other psychophysical abilities enable them to live quite independently with organised help of another person and who do not need complete institutional care (MDDSZ 2002). Financial capacities of the elderly are also an important criterion since the service must be paid out-of-pocket; older people rent sheltered apartments or become their owners.

4.1.2.1.3 Public / private / NGO status

Slovenia has state homes, private homes with a concession and private elderly homes with an operating permit. In the beginning of 2004 we had no private old people's home with an operating permit and only one in 2003. Until

recently, Slovenia had only state old people's homes but now also private are slowly entering our market since from 1999 on legal and private entities may obtain an operating permit for operations of a private home.

Table 13: Total number of places in Old people's homes and Special social welfare institutions, 1.1. 2004

	Number of units	Number of places	in %
Social welfare institutions	58	14,064	93.07
Old people's homes	52	11,894	78.71
Special social welfare institutions *	6	2,170	14.36
Private Old people's homes with concession	8	1,047	6.93
Private Old people's homes with operating permission**	0	/	/
Total	66	15,111	100

* Institutional care of adults with special needs (physically / mentally handicapped)
** In the year 2003 only one such Home existed, and also this one got the concession in the beginning of the year 2004
Source: Kaučič 2004, SSZS 2003b, SSZS 2003a

Homes are mostly public, Slovenia has 52 of them. We also have 8 private homes with a concession and 6 combined social welfare institutions. Most homes are linked through the Association of Social Institutions of the RS (SSZS 2003b). According to the law, investments in institutional care must be ensured by the state budget. Our social policy aims at a bigger number of private old people's homes with a state concession, whilst the State has not privatised its old people's homes (Ramovš 2003).

4.1.2.1.4 Does residential care involve the participation of carers or work with carers?

Old people's homes and other institutions accommodating the elderly record different levels of cooperation with close relatives, though cooperation with relatives is increasingly central to them. They are aware that they cannot replace close relatives, so that cooperation is even more important. Most old people's homes encourage and take into account initiatives and proposals of relatives and expect cooperation from them. Relatives are very important already on admission of the older person since they can submit a series of important information on them. They can also help adjust the older person to the new environment. Expert teams, consisting of a social worker, occupational therapist, head nurse and the director, cooperate a lot with relatives.

It is up to relatives to determine to what an extent they will cooperate with the institution in which their aged relative is accommodated. They can be included in various activities – help in feeding, taking their aged relatives for a walk, some also cooperate in organising trips or accompany them etc. Close rela-

tives can also stay with the dying relative if they wish to. Besides this, they are continuously informed about changes in the health condition of the aged relative.

Some homes invite close relatives to various events, workshops, lectures (on dementia, diabetes etc.), trips and meetings with residents as well as have personal and group interviews and meetings with them, clubs of relatives are also formed etc. It has been proved that lectures are of exceptional importance since relatives know too little about specific diseases. The lack of understanding and poor communications between older persons and their relatives are a major problem. For this reason, lectures are important for better understanding of the elderly.

Beside this, homes are opening on the outside to wider local communities. Some homes thus offer advice or consultations to family carers, who do not have relatives in that home but care for an older person at their home.

We could say that in most institutions satisfaction of close relatives with the care of their family members is very important. Homes also work with volunteers, who lead self-support groups for the elderly or regularly meet lonely older people. Homes are becoming increasingly aware of how important it is to satisfy also non-material needs of the elderly.

4.1.2.2 Community care services (statutory coverage and whether aimed primarily at older people living alone or including support to family carers)

Within the framework of organised services, intended for implementation in home environment of the elderly, we distinguish between the Centre for Home Help – remote services and home help (social care within a public service). The Centre for Home Help operates within the framework of a social service and covers a relatively low number of people. Home social assistance and social services are more widely spread.

Table 14: The share of old receiving social home help, December 2003

	Total number of population 65y.+	Number of places	Share of old people (%)
Home Help Centre (Red button)	294,654	212 (6 centres)	0.07
Social home help service	294,654	4,500	1.53

Source: MDDSZ 2004

4.1.2.2.1 Home-help

In compliance with the law (SSA) social home help services, which belong to the sphere of a public service and are implemented in compliance with regulatory standards and norms, are to be paid by users of these services and, if

their users are eligible for a relief due to their material situation, out of municipality budgets. The activities of a social service, which is not a public service by law, must be fully paid (MDDSZ, 2000).

The social home help services include social assistance. Home help was introduced along with programmes of public works in the first half of the 1990-ies and has become well established by now. In 2002 this activity was carried out by 52 centres for social work, 5 old people's homes and 3 private providers. The total number of qualified people participating in home help was 660; they offered help to around 4,500 older people.

In order to illustrate the situation in practice, let us mention the example of the Institute for Home Care Ljubljana (IHC). Its users often live alone. Old people's homes in Ljubljana are full and hospitalisation days are shortening, which make the need for home help big. Their close relatives live elsewhere and regular working days do not allow them to help their aged family members completely (Venišnik Babić 2004). As much as 89 % of users of social home help provided by the IHC are older than 65 years of age. Among them, 28.2 % are disabled, thus completely dependent on other person's help. In 2003, one third of people were on the average receiving help five times or more a week, also up to 3 times a day. This help was a supplement to the help provided by family carers, who could not entirely care for their relatives. The problem is that cared-for persons are often persons that would have to receive adequate medical care, which cannot be provided by the social home help service. With increasing number of users, the burden carried by social carers is also growing – they must care for as much as 10 people instead of standard 5 (Venišnik Babić 2003). The Municipality of Ljubljana has so far fully financed costs (from February 2004 it will finance 80 % of costs), but the situation in the rest of Slovenia is different since people in need of help cannot financially afford this service.

Social home help is thus, despite the increased extent, for many people not easily available or even out of reach. As a consequence, family carers are often completely or partially left to themselves for care-giving, as we have seen from the example of the capital, also when disabled older people are concerned.

The second form of home help is *social service*. It provides delivery of prepared meals, shopping and delivery of groceries and other necessities, help in personal hygiene, domestic chores and social contacts. Six *Home Help Centres* exist as part of social service. Within those centres a security alarm system for elderly is operating. Despite the strong public start-up support for expensive technical equipment, these centres did not become a mass type of regular social care for the elderly, but an above-standard offer for a smaller number of older people. Centres carry out their activities in a smaller scope – for approximately 175 users (Ramovš 2003: 309). Financial contributions of its users depend on the type of a service; these services must mostly be paid out-

of-pocket, only in some cases do municipalities provide co-payment. Access to them is often restricted to those who are capable of covering costs by themselves.

4.1.2.2.2 Personal care

The elderly may obtain personal care from within home social assistance, social services and sometimes also old people's homes. The services must be paid out-of-pocket, subsidisation of individual services depends on municipalities. People also make use of private services, which are more expensive and available only to those who can bear this financial burden.

Personal care may also be provided by non-experts, who do not work within any services and whose work is not controlled. We do not have data on how much this type of care is spread.

4.1.2.2.3 Meals service

Old people's homes deliver lunch to older people living nearby these homes. This service must be paid out-of-pocket, but prices are moderate. Home delivery of meals, preparation of meals at home and help in feeding is also offered by a social service, whose services must be entirely paid out-of-pocket. Private entities must obtain permission for performing activities of a social service from the Ministry of Labour, Family and Social Affairs.

Household help is provided also within the framework of home social assistance. Services are differently spread across the country and differently subsidised. Further information is given in Item 4.1.2.2.1.

Help in lunch preparation and home delivery of meals are also offered by various voluntary organisations.

4.1.2.2.4 Other home care services (transport, laundry, shopping etc.)

Old people's homes offer various forms of home help (transport, laundry, pedicure etc.). The elderly must pay for these services out-of-pocket. These services are also provided by home social assistance, social services and private providers.

Voluntary humanitarian organisations are also important providers of help to the elderly, for example Red Cross, whose members act in local community organisations. Forms of their help vary a lot – from material help, help at work and companionship; they also cooperate with providers from the formal network of caring for the elderly. Older people are also helped by the Slovenian Caritas, whose main purpose is to help people in mental or material distress. They visit the elderly at home and at old people's homes in order to help them overcome loneliness and they also deliver various types of material help. Satisfaction of non-material needs (companionship – to prevent loneliness) is achieved through various local intergenerational associations. In some places,

also young primary and mostly secondary school students participate in caring for the elderly as voluntary assistants. They visit older people at pensioners' homes or at their homes with the purpose of alleviating their distresses and problems, which arise from loneliness and isolation from the social environment. Voluntary help to the elderly is also provided by volunteers acting within the framework of public or private services, voluntary and charitable organisations and self-support groups (Mesec et al. 1997).

4.1.2.2.5 Community care centres

Slovenia does not yet have **local intergenerational centres** (Ramovš 2002), in which various activities and programmes for quality ageing would be implemented (education, day care, provision of meals, recreational programmes and various other services). However, some municipalities are considering this type of services, so that we expect first centres of this type already in 2004.

4.1.2.2.6 Day care ("protective" care)

After 1998 smaller **day-care** departments were started being opened at Slovenian old people's homes (MDDSZ 2001b, MDDSZ 2001c). In the middle of 2002, 20 old people's homes had day-care centres; their capacities were sufficient for around 300 people (Ramovš 2003: 310). This service can occasionally alleviate the work of carers and at the same time older people are enabled to continue living in their home environment. However, practice has revealed that old people's homes are not desired for day care. The interest of people in these day-care centres is lower than actual needs are. The reason for this is that older people wish to stay at their homes for as long as possible and that they are disinclined to old people's homes. They see old people's homes only as an emergency solution. The thought of spending their days at these homes before necessary is thus unattractive and often unacceptable to the elderly. On the other side, cooperation between day-care centres and old people's homes is the cheapest form for the State since necessary infrastructure and personnel are already ensured. Mostly demented people use day-care centres today. The elderly have to pay for this service out-of-pocket and its price amounts to 70 % of regular care price (care I, II, III) at old people's homes.

4.1.2.3 Other social care services

Pensioners' associations offer consultation to elderly citizens, who may come for advice concerning family problems, legal and property issues and arrangement of home help (Rupnik, 2004: 133). In Slovenia we do not yet have courses intended specifically for family carers of the elderly. Organised training is only intended for social workers, who provide home help as a part of their job. Family carers may obtain some information concerning concrete problems (dementia, poor communication and alienation etc.) from brief courses, which are carried out by individual non-governmental organisations. The largest

amount of information at a time can be obtained at the Festival for Third Age, where various entities playing an important role in providing care to the elderly and in improving the quality of life of the elderly present themselves. At this tree-day festival, experts and practitioners from various fields give lectures. Family carers have thus the chance to directly familiarise themselves with various services and their offer as well as obtain a lot of useful information. The weakness of this source of information is that the event is only held once a year.

Let us also mention *intergenerational programmes for quality ageing* implemented by the Anton Trstenjak Institute, the aim of which is to satisfy non-material needs. Within these programmes there is a course for better understanding with the elderly. This course is also appropriate for family carers. The course proved to be highly efficient since the relationship between the older person and the person having attended the course substantially improved and the course also had a positive impact on other family members, Within abovementioned programmes older persons may include themselves in *personal companionship* or in *intergenerational group for quality ageing*. These two forms of socializing ease the loneliness of the elderly and improve their quality of life.

Slovenia also has other services for the elderly. Let us briefly mention them. **Adult foster families** for the elderly enable older people, who cannot live at their home, to live with a family more or less professionally involved in care-giving to the elderly. Based on specific criteria for standards and norms, an adult foster family takes one older person or, at the most, a smaller group of older people into its midst. The Slovenian public network of care for the elderly provides for this option, but in practice it has only been used to a minor extent, e.g. an old people's home looked for adult foster families in its surroundings to accommodate people from its waiting list (Ramovš 2003: 316, 317).

The State and municipalities finance also other social welfare services for prevention and alleviation of social distresses and problems of the elderly. **Social prevention** includes services that aim to prevent social distresses and problems and involve activities to help the elderly to help themselves. In many centres for social work the main preventive programme is "self-support group for the elderly". **First social assistanc**e for the elderly includes help in recognizing social distresses and problems, estimation of possible solutions, familiarisation of older people with possible social welfare services, duties and obligations arising from them as well as presentation of the network of people who can provide help to the elderly. **Help to families for their homes** comprises of consultation and help to families which have an older person in their midst. The purpose of this help is to mutually discover new options of improving family relationships. When providing this service, social workers often encounter people who are completely burnt out due to overburdening. The entire energy of the family is directed towards the older person, whilst the needs of other family members are often neglected. Such families need help in order to find

the time and space for the needs of other family members undergoing neglect. On provision of this service, social workers also cooperate with volunteers from the community. **Personal assistance to the elderly** comprises of consultation, arrangement, guidance, supplementation, keeping and improving of their social abilities with the purpose of keeping them in their home environment. The working method is consultation for individuals and their families as well as work with the community. Personal consultation is financed by municipalities (Mesec et al. 1997). All forms of help mentioned above are implemented by social workers at centres for social work.

The role of social workers is a big one since they are the ones who most frequently meet family carers personally besides home nurses and personal doctors. They protect the older person in the case of a negative impact of the family and, in the worst cases, even part him or her from it. They also act when common family life with the older person negatively affects other family members. If older sick people cannot take care of themselves anymore, disburdening of the family can already be achieved with inclusion of volunteers from the community into the family and also with services of home help. Unfortunately, the trend in Slovenia is such that social workers have increasing problems performing these tasks since they have less time for direct work with people due to increasing amount of paper work.

4.2 Quality of formal care services and its impact on family caregivers: systems of evaluation and supervision, implementation and modelling of both home and other support care services

Slovenian old people's homes are pleasant; mostly they are newly built or were thoroughly renovated during the last two decades. Meals, hygiene, heating, health care and nursing, occupational therapy and physiotherapy as well as other material services of Slovenian homes are on a high, above average European level. Their weakness is only too little attention to non-material social needs of the elderly, especially to a higher quality of human relationships (Ramovš 2003: 313, 315).

The quality of other public services is also good. The only problem is that there is not enough of them.

4.2.1 Who manages and supervises home care services?

'Home help service' is in compliance with the Social Security Act a special social welfare service *to be ensured by municipalities* (Article 45), which should, according to Article 99 of the Act, also ensure financing of this service from municipality budgets. Providers of home help are expert associates (Article 69 of the Act) and social carers at home as expert associates.

Prices of home help services and social services are regulated by the Rules on Methodology for Social Service Price Formation. Besides general elements, the Rules also define special features of forming prices of individual social welfare services. The costs of expert preparation, guidance and coordination are thus not included in the costs of home help to be paid by the user, but are paid to providers by municipalities, which means that municipalities subsidise these services. Municipalities may decide to pay the providers of these services also a part of other costs, which lowers the price to be paid by the user. If the provider employs home carers fully or partially based on programmes of active employment policy, then these funds from the state budget are also considered as a subsidy, which lowers the price of services to be paid by the user. Price proposal or application for consent to prices is filed by the provider of services by filling out the standard form and enclosing adequate appendices. Consent to prices is issued by the body responsible for issuing consent in compliance with the Social Security Act – for personal assistance and home help by the municipal administrative body and for other social welfare services by the ministry competent for social security. The price to which consent is issued is as a rule adjusted only once a year (no longer quarterly as in the past), in February (Pravilnik o metodologiji cen 2004).

Due to the new Rules, prices of home help are for the first time formed on the basis of a unified methodology throughout Slovenia. Since until recently home help was mainly provided through public works, prices of services were mostly not defined but municipalities only defined with their regulations the amount to be contributed by users themselves.

Home social assistance is implemented by centres for social work, institutions, old people's homes and private entities; however, centres are prevailing.

4.2.2 Is there a regular quality control of these services and a legal basis for this quality control? Who is authorized to run these quality controls?

Legal bases for control work of public social welfare institutions and concessionaires are provided by:

- *Social Security Act* (SSA, Off. Gaz. of the RS, nos. 54 / 92 and 42 / 94 – Decision of the Constitutional Court of the RS, 1 / 99, 41 / 99, 36 / 00, 54 / 00 and 26 / 01) *in Articles from 102 to 108*,
- *Rules on Professional and Administrative Control in the Field of Social Assistance and Social Services*. [Pravilnik o strokovnem in upravnem nadzoru na področju socialnega varstva] (Off. Gaz. of the RS, no. 105 / 2000), a constituent part of which is also *the Methodology for Implementation of Professional and Administrative Control* [Metodologija izvajanja strokovnega in upravnega nadzora].

Development of activities, new models of expert work, pluralisation of programmes and providers and the increasing number of them together with, above all, the need to consider dignity and other rights of users have led to a decision of the Ministry to reorganise the control function in the form of a special sector. This sector organises and implements regular professional and administrative control of professional work and procedures of all 158 public social welfare institutions as well as of all concessionaires. In compliance with the Rules (*Pravilnik o strokovnem in upravnem nadzoru na področju socialnega varstva*), three-member control commissions, appointed by the Minister from the list of experts, perform regular and irregular professional and administrative controls. The list of 45 experts, who are additionally trained for control work, is proposed by the Social Chamber of Slovenia. The MLFSA organises and implements regular and irregular professional and administrative controls of the work of providers at least once in the period of 3 years (http://www.sigov.si/mddsz/sociala/nadzor.html). The Rules further stipulate that family members of eligible persons may also file an initiative for extraordinary control with the Ministry (Article 4).

The State is not competent to implement control of the work of private entities without a concession. Slovenia thus lacks control of the work of all social networks. Therefore, it would be necessary to form a special inspection service.

4.2.3 Is there any professional certification for professional (home and residential) care workers? Average length of training?

Home assistants can be experts or persons who obtained one-year training for home social carers, confirmed by the Social Chamber of Slovenia. The educational programme for home social carers lasts one year and is implemented through twelve two-day educational units, which take place once or twice a month. The entire educational programme lasts for 168 school hours. Within this educational programme *social carers* obtain general knowledge from the fields of non-expert care, personal hygiene, work ethics and other practical skills (Firis 2004). The position of a social carer is not a health profession.

We also have training for *nurses-carers*, who provide help and care in compliance with professional standards of a medical care service. This training lasts for three years or less (if individual study is accelerated). On concluding this training, trainees obtain secondary vocational education and the profession of a nurse-carer.

Persons included in expert teams of institutions (social worker, physiotherapist, occupational therapist) have a university degree.

4.2.4 Is training compulsory?

People working within home social assistance have to obtain professional training for social care-giving; nurses-carers must also be adequately trained.

Expert associates must have adequate education and must pass a professional examination in social care.

4.2.5 Are there problems in the recruitment and retention of care workers?

The problem arising from recruitment of new social carers is mainly a financial one. City municipalities do not have sufficient funds to ensure higher level of recruitment of social carers, even though the needs for this are big. Old people's homes would also need more personnel but there is not enough money.

4.3 Case management and integrated care (integration of health and social care at both the sectoral and professional levels)

The cooperation between health and social sectors is poor. The health reform anticipates more teamwork and intersectoral cooperation. But problems already occur when choosing leaders of individual teams. One of rare exceptions is nursing care, which closely intertwines with the tasks of social security. Home nurses are important colleagues to social workers when alleviating distresses and problems of the elderly.

4.3.1 Are family carers ' opinions actively sought by health and social care professionals usually?

Family carers do not have special rights that would enable them to participate in decision-making concerning health care and social affairs. Thus it is up to experts themselves whether to listen to carers or not and whether to try to find the best solutions for an older person together with carers (and the older person). As we have already mentioned, opinions and proposals are welcome in old people's homes. Homes also successfully cooperate with home nurses and often also with general doctors. Opinions of relatives are much less taken into account in secondary and tertiary care.

5 The Cost – Benefits of Caring

5.1 What percentage of public spending is given to pensions, social welfare and health?

Table 15: Public social expenditure by type, as percentage of state budget

	1995	1996	1997	1998	1999	2000
Total current transfers to individuals and households	40.9	41	41.3	40.3	40.2	41
Transfers to unemployed	1.4	1.2	1.5	1.4	1.3	1.1
Family benefits	3.4	3.8	3.9	3.7	3.8	4.1
Social assistance	2.5	2.5	2.5	2.4	2.1	2.2
War invalids, war veterans and war victims	0.7	0.6	0.8	1	0.9	0.9
Pensions	28.6	28.6	28.1	27.5	27.3	27.5
Wage compensation	0.8	1	1	1	1.1	1.3
Sickness benefit	1.7	1.6	1.5	1.4	1.3	1.3
Educational grants	1	1	1.1	1	0.9	0.9
Other transfers to individuals	0.8	0.8	0.8	0.7	1.4	1.8

Source: SORS-SY 2001 in Stropnik et al. 2003 - p. 122, Table 4.15

Public social expenditure (current transfers to individuals and households) accounted for **40-41 per cent of the state budget**. Two-thirds of all public social expenditure were used for pensions, 8-10 per cent for family benefits, 5-6 per cent for social assistance, and smaller shares for other groups of transfers. Health care and pensions were mostly funded through separate entities that collect social security contributions and not from the state budget (Stropnik et al. 2003).

The expenditure on health care has remained at the level of some **8 % of the GDP** in the period 1996-1999 (of that, 0.7 % of GDP in 1996-1997 and 0.6 % in 1998-2000 have been covered from the central government budget). Since 2000, health care contributions have not been enough to cover expenditures. In 2001, expenditure on pharmaceuticals increased by 13.7 %; wages in health sector increased as well, and so did some other expenses. Consequently, outflows exceeded inflows of the National Health Insurance Institute by 10.4 % (Stropnik et al. 2003).

Pensions and related expenditure accounted for about **14.5 % of GDP** in recent years. In 2000, some two-thirds were financed through contributions and one-third from the state budget (Stropnik et al. 2003).

5.2 How much - private and public - is spent on long term care (LTC)?

There is no special long-term care insurance in Slovenia. The long-term care services are mostly paid for individually by people who receive care (46 % of sources in long-term care); medical services are paid by health insurance (38 % of sources), while 13 % of all sources are paid by local communities for people who are unable to secure sufficient means to pay the fee themselves. Medical services received by people receiving long-term care are defined as specialist medical services, rehabilitation and nursing care (Stropnik et al 2003:42-43).

Table 16: Structure of Compulsory health insurance expenditure in 2001

Long term care	5.3 %
Primary health care	20.9 %
Medicines and technical aids	50.3 %
Secondary health care	17.8 %
Other	5.7 %

Source: ZZZS 2002 in Horstman et al. 2002

5.3 Are there additional costs to users associated with using any public health and social services?

Social welfare services are financed out of the state and municipality budgets. However, users must still pay or co-pay some services. This is the case at old people's homes, where an individual must cover the costs alone, provided that some of his or her funds are left for personal needs; if not, the closest relatives or, if there are no or if they are not able to do so, the municipality in which the person lived before coming to the old people's home, must co-pay for these services. This also applies to day care. Services of a social service must be paid out-of-pocket, which also partially applies to home help. In 2003, two thirds of cared-for persons from old people's homes entirely covered the costs of care from own resources and with the help of relatives (out-of-pocket payers), 27.5 % of them needed help in the form of a co-payment and only 8 % of people were paid the costs of care entirely (SSZS 2004).

As we have already mentioned every person in Slovenia has the right to health care and the obligation to contribute to its realisation. Health insurance is compulsory and voluntary. Compulsory insurance covers most health care services, whilst other are, if necessary, co-paid from the funds of voluntary insurance or paid out-of-pocket. The Health Care and Health Insurance Act (HCHIA) defines which services are covered fully or at least in 95 %, at least in 85 %, at least in 75 % and in not more than 60 %. The following is fully covered: early detection and prevention of diseases, mandatory vaccinations,

treatment and rehabilitation in the case of malign diseases, urgent medical assistance, including the costs of emergency vehicles, visits of home nurses, treatment and care at home and at social welfare institutions, some prescription medicinal products and some orthopaedic devices.

An important source of funds for health care is represented by funds of insurance companies, which manage voluntary health insurance and accident insurance. Voluntary health insurance was introduced in 1992. The voluntary insurance market today is divided between two insurance companies. Approximately 1,400,000 citizens (of the total 2 million) have supplementary health insurance and, at the same time, obligatory health insurance. Other types of voluntary insurance are almost nonexistent in Slovenia.

In Slovenia, co-payments for health services, for which supplementary insurance is possible, are much higher than in other European countries and are also not socially limited. Data show that families with lower incomes (of which the share of older people is high) spend a bigger share of their funds for health than people with the highest incomes. Families belonging to the lowest 20 % in terms of incomes and which account for 9.5 % of incomes of all Slovenian families spend 16.8 % of total health expenses of Slovenian families for their health.

Increased share of additional health insurance has most negatively affected poorer social strata. In 2001, insureds receiving the minimum wage paid 70 % of their monthly wage for the annual premium. Pensioners are even more burdened. Recipients of the average pension must now give already more than half of their monthly pension to cover the annual premium. In 2000, pensioners receiving the minimum pension paid 1.6 of their monthly pension for the annual premium of additional voluntary health insurance (MZ RS 2003: 250).

Besides this, the current practice is such that when people need specialist outpatient services, we rather look for private help, which we do pay out-of-pocket but is quicker than free services covered by the public health care network.

5.4 What is the estimated public / private mix in health and social care?

Table 17: Public, private and total health expenditures in Slovenia as % of GDP

Year	Total all expenditures	Public expenditure	Private expenditure		
			Total	Voluntary health insurance	Out-of-pocket resources *
2002	8.99 %	6.89 %	2.09 %	1.22 %	0.87 %

* The data on out of pocket payments is based on the Household survey from the year 1997.
Source: MZ RS 2003. Bela knjiga.

The share of *health expenditure* in GDP increased from 8 % of GDP to 8.99 % of GDP due to private health funds. Reallocation of the burden to private funds of the population is also reflected in the changed share of public and private expenditure. Whilst in 1992 public expenditure accounted for 90.2 % of total health expenditure, in 2002 this share stood at only 76.7 % of total health expenditure (MZ RS 2003: 241).

Table 18: Health expenditures, share, 1995 - 2000

		Share % of total health expenditure	
Year	Total % of GDP	Public	Private
1995	9.1	78.1	24.9
1996	8.8	79.4	20.6
1997	8.9	79.3	20.7
1998	8.7	78.7	21.3
1999	8.7	78.6	21.4
2000	8.6	78.9	21.1

Source: WHO, World Health Report 2002 In Horstmann 2003: 109, Table 9; World Bank 2000. Table 2.15

We can claim that the trend in Slovenia is much the same as in other countries joining the European Union in May, namely that public expenditure for health care represents more than three quarters of total expenditure for health care.

As regards *social security*, we were not able to obtain specific data on the exact share of public social security expenditure in total social security expenditure. If we only take into account social welfare services for the elderly, we may claim with certainty that the State still covers the core part of expenditure for these services. We did obtain data that in 2004 the MLFSA will allocate the total of around 295,358.00 € to the programmes for the elderly (MDDSZ 2004).

5.5 What are the minimum, maximum and average costs of using residential care, in relation to average wages?

The Slovenian Rules on Methodology for Social Service Price Formation (Pravilnik o metodologiji za oblikovanje cen socialnovarstvenih storitev UL RS, 36 / 2002 107 / 2002) define the methodology according to which general elements for price formation of social services as defined in the Social Security Act are set. Price formation is separated for standard and non-standard services. However, the State regulates these prices. They are determined on the basis of planned monthly expenses for the relevant year. The Minister competent for social security once a year determines standards based on which prices are formed. The Ministry issues consent to service prices formed by old people's homes based on the Rules.

Prices of institutional care of the elderly are defined for social care services of 24 hours a day for three care categories - care I, II and III.

Table 19: Estimated daily costs of care (that beneficiary has to cover) in Old people's homes based on the care category of the beneficiary, year 2003

Care categories	Beneficiaries	Estimated price, y. 2003* (per day)	Estimated price, y. 2003* (per month- 30 days)
Care I	for person older than 65, that do not need direct personal help / assis-tance	10.80 – 16.80 €; estimated daily cost for standard room with two beds with toilets is 11.21 €*	estimated monthly cost for standard room with two beds with toilets is 336.38 €
Care II	for people with moderate health problems that need direct personal help / assistance	14.70 – 20.71 € estimated daily cost for standard room with two beds with toilets is 15.15 €*	estimated monthly cost for standard room with two beds with toilets is 454.21 €
Care III	for people with the most demanding health prob-lems needing constant direct personal help	21.64 – 24.51 € estimated daily cost for standard room with two beds with toilets is 19.06 €*	estimated monthly cost for standard room with two beds with toilets is 571.72 €

* We have calculated the average daily price for care in Old people's home, using the data from two Old people's homes; one was more expensive (Dom upokojencev Center), the other one was cheaper (Dom upokojencev Franc Salamon Trbovlje).

Service prices of individual old people's homes differ. Prices of specific care category vary according to the type of the room in which an older person is accommodated. Let us mention that additional payments (for TV, refrigerator, room service of meals, dietary food etc.) are not included in prices from the table above. It is thus difficult to talk about minimum or maximum service costs. We should also not neglect the fact that mostly people in need of at least category II care are accommodated at old people's homes. Prices of additional services vary pretty much between individual homes. A person with a diabetes diet would have to pay extra 24.15 € to 39.83 € per month for such meals. Room service of meals would cost additional 57.20 € to 65.68 €. These and other services can substantially increase the final price of institutional care.

As a comparison, let us mention that in September 2003 the average net wage in Slovenia stood at 675.66 € (SORS 2004). We obtained more detailed data for 2002, which emphasize the relationship between wages and pensions. In 2002 the average monthly net wage was 626.89 €, the average monthly net old-age pension 456.10 €, the average monthly net disability pension 370.38 € the average monthly net survivor's pension 320.49 € and the average of all pensions 413.40 €. These data do not include recipients of state pensions, military pensions, pension prepayments and agricultural pensions. In 2002, the average minimum pension base equalled 375.46 € and the maximum pension

base 1,501.83 €. The amount of an individual's pension also depends on years of service and age (ZPIZ 2003, Anonymous 2002a).

Taking into account abovementioned data, we may justifiably assume that a lot of older people cannot cover the costs of institutional care by themselves, even though they may receive income support for pensioners or attendance allowance. In 2002, 47,386 pensioners were receiving the first benefit and 24,360 pensioners were receiving the second benefit. If older persons still cannot pay all the costs, their children are lawfully obliged to help them financially (MFRA). If children are able, they must cover the entire difference in costs; if not, municipalities pay for the remaining part.

5.6 To what extent is the funding of care for older people undertaken by the public sector (state, local authorities)? Is it funded through taxation or / and social contributions?

It is mostly the State or municipalities that are responsible for *social security* of the elderly in Slovenia and only to a smaller extent the private and non-profit sectors. The latter two have only been present in Slovenia over the recent years and are not widely spread. Most social security activities are thus financed out of the state and municipality budgets. Funds for financing of social security activities are also provided by service payments, contributions of charitable organisations, self-support organisations and disability organisations, contributions of donors and other sources. The budget of the RS is the source of funds for social prevention, first social assistance, help to families for their homes, institutional care, welfare allowances, financial allowances and investments in social welfare institutions. Municipality budgets finance personal assistance and home help services. Eligible persons and other liable persons are obliged to pay for all services provided on the basis of the Social Security Act, except for social prevention, first social assistance and institutional care at social welfare institutions for training. Municipal centres for social work decide on partial or complete relief from payment based on regulatory criteria.

Pension and disability insurance is mainly financed out of regular contributions of active insureds and employers and, during the last years, also from funds from the state budget. Contribution levels are determined by the National Assembly on the proposal of the Government. The base for calculation of contributions is gross wage or gross insurance base. Payment of contributions is regulated by the *Act on Pension and Disability Insurance and the Social Security Contributions Act* (APDI1). The following types of contributions are paid for pension and disability insurance: insureds' contributions at 15.5 %, employers' contributions at 8.85 %, employers' contributions for the insurance period with an increase from 4.20 % to 12.60 %, contributions for special insurance cases. Aggregate contribution rate of insureds and employers stands at 24.35 % and is substantially lower than, for example, in 1995, when it equalled 31 %. This is

one of the reasons that made the state budget an important additional income source of the Institute during the last years (ZPIZ, 2003a).

Table 20: Public and private health expenditures by the sector covering expenses, year 2002

Public expenditures				Private expenditures		
Total	State budget	Municipal budget	Compul-sory health in-surance (CHI)	Total	Voluntary insurance	Out-of-pocket resources
76.7 %	2.5 %	0.7 %	96.8 %	23.3 %	13.6 %	9.3 % *

Source: MZ RS 2003. Bela knjiga.

The core part of public funds for *health care* is represented by funds of compulsory health insurance. Besides these, public funds also include funds from the state budget for covering the expenses of the narrower Ministry and organs under its responsibility, investments, realisation of national public health programmes and prevention. More than half of budgetary funds are allocated to investment expenditure of hospitals. Public funds further include funds of municipality budgets intended for implementation of healthcare activities at the primary level, such as payment of compulsory health insurance for the unemployed and various healthcare programmes in municipalities. Contributions for compulsory health insurance represent the main source of financing activities and they are determined according to proportionate rates taking into account incomes or other legally defined bases of taxpayers. Health insurance contribution rate of employees and employers stood at 13.45 % in 2002 (MZ RS 2003: 246).

Services included in the general health care but which must be co-paid are mostly reimbursed from additional insurance. However, people increasingly visit doctors with a private practice without a concession, whose services must be entirely paid out-of-pocket (Jakubowski (ed.) 2002: 27, 28). Health care of the elderly at old people's homes is covered out of basic health insurance and so are visits of home nurses.

5.7 Funding of family carers

At the moment, family carers in Slovenia do not yet receive any financial compensation or allowance for care-giving to the elderly. However, one month ago the *Act Amending the Social Security Act* was adopted, which allows for the option that also family carers of the elderly are registered as 'family assistants' (more under Item 2.1.2 and 2.2.1). This amending Act stipulates that a family assistant has the right to partial payment for loss of income in the amount of the minimum wage or to a proportionate part of the payment for loss of income in the case of part-time work. Taking into account that this amending Act is not

yet implemented in practice, we do not know to what an extent family carers will be registered as family assistants. Criteria for obtaining this status will be namely more specifically defined only by the end of June 2004.

5.7.1 Are family carers given any benefits (cash, pension credits / rights, allowances etc.) for their care? Are these means tested?

Family carers are currently given no financial benefits for their care (see Item 5.7).

5.7.2 Is there any information on the take up of benefits or services?

No, there is no such information existing.

5.7.3 Are there tax benefits and allowances for family carers?

There are no tax benefits nor allowances currently available for family carers in Slovenia (see Item 5.7).

5.7.4 Does inheritance or transfers of property play a role in caregiving situation? If yes, how?

We do not have specific information on this issue. But in practice people transfer their property to people who then care for them. Sometimes family members and relatives are involved, whilst in other cases also other people, strangers, who are willing to care for them. In relation with this, the danger of abuse occurs since there have been cases when relatives, who were transferred property, ‘forgot’ about the older person. There is no legal control over this issue.

5.7.5 Carers' or Users' contribution to elderly care costs

a. Medical, nursing and rehabilitation services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
General practitioner	X					
Specialist doctor	X					
Psychologist	X					
Acute Hospital	X					
Long-term medical residential care (for terminal patients, rehabilitation, RSA, etc.)						X
Day hospital						
Home care for terminal patients	X[16]					
Rehabilitation at home	X[17]		X			X
Nursing care at home (Day / Night)			X			
Laboratory tests or other diagnostic tests at home	This service is not available					
Telemedicine for monitoring	This service is not available					
Other, specify						

[16] Palliative care is not provided by the Slovenian healthcare system. We do not have complete and adequately trained palliative teams at hospitals or in the primary healthcare, palliative departments in hospitals or old people's homes do not exist. Complete home palliative care is presently provided only by the Slovenian Hospice Association, a non-governmental and non-profit organisation.

[17] In Slovenia, rehabilitation at homes of the elderly was never satisfactorily developed and is not equally nor easily available. Due to the decreasing human resources norms, doctors cannot pay visits at homes and home treatment is thus declining. Home physiotherapy is also provided in a minimum extent. If a person wishes physiotherapy services at home, he or she must mostly pay for them out-of-pocket. Free nursing medical care is important since its competencies and skills fill the void in satisfying the needs for home rehabilitation. Nursing care is well organised in Slovenia.

b. Social-care services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Permanent admission into residential care / old people's home			X[18]	X		
Temporary admission into residential care / old people's home in order to relieve the family carer			X[19]			
Protected accommodation / sheltered housing (house-hotel, apartments with common facilities, etc.)			X[20]			
Laundry service			X			
Special transport services			X			
Hairdresser at home			X			
Meals at home			X			
Chiropodist / Podologist	This service is not available[21]					
Telerescue / Tele-alarm (connection with the central first-aid station)		X[22]				
Care aids						
Home modifications			X			
Company for the elderly	X[23]					
Social worker	X					

[18] Accommodation and care at old people's homes must be paid out-of-pocket; if necessary, children are lawfully obliged to cover the costs; if children are not able to do so, municipalities cover the remaining costs.

[19] Slovenia does not have proper respite care. Old people's homes are overcrowded and it is thus difficult to obtain temporary accommodation. If accommodation is possible, the same rules of financing apply as for permanent accommodation of the elderly at old people's homes. Temporary admission to hospitals must be paid out-of-pocket and the prices are so high that they are unacceptable to most carers and older people. Hotels for the elderly are another option, but services must be paid out-of-pocket as well.

[20] Sheltered housing is a novelty from the past few years in Slovenia. Apartments are smaller and adapted to the needs of the elderly. They are private and can be bought or rented. Prices of these apartments are high and locations are inappropriate, thus they are being occupied slowly. Capacities are low. In 2002, there were 300 units in 9 places throughout Slovenia.

[21] We do not have home services of this kind, but home nurses help, if necessary.

[22] Tele-alarm service is implemented 24 hours a day throughout the year. The price of this service differs between municipalities offering them. Usually city municipalities finance one part and the other part must be paid out-of-pocket. For example, the City Municipality of Ljubljana finances 60 % of costs of direct service provision.

[23] Loneliness among the elderly is a major problem. In Slovenia volunteers from various non-governmental associations (Caritas, Red Cross, pensioners' associations, intergenerational associations for quality old age, Social Gerontology and Gerontogogics Association of Slovenia, Youth Kindness Service (Servis dobrote mladih) etc.) keep company to the elderly.

b. Social-care services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Day care (public or private) in community center or old people's home			X[24]			
Night care (public or private) at home or old people's home			X			
Private cohabitant assistant ("paid carer")			X			
Daily private home care for hygiene and personal care			X			
Social home care for help and cleaning services / "Home help"		X[25]				
Social home care for hygiene and personal care		X				
Telephone service offered by associations for the elderly (friend-phone, etc.)	This service is not available[26]					
Counseling and advice services for the elderly	X[27]					
Social recreational centre	This service is not available[28]					
Other, specify						

[24] In Slovenia, day care is organised within old people's homes. The price equals 70 % of daily care price at old people's homes. Prices vary according to care level (care I, II and III). The service must be paid out-of-pocket and the same rules apply as in the case of permanent admission of elderly to old people's homes. Day care is not developed; this service is provided to a small group of people.

[25] Municipalities are responsible for implementation of home social assistance. It is partly a public service (municipal or private with a concession) and partly a private service on a fully payable marketing basis. Municipalities subsidise services of home social assistance to different extents. The remaining part must be paid out-of-pocket.

[26] In Slovenia we do not have a telephone service intended for the elderly only. However, older people may call various SOS lines, which are intended for the wider population.

[27] Consultation for the elderly is offered by pensioners' organisations and other non-governmental organisations (Rupnik 2004). The elderly may also obtain help at centres for social work within the service of personal assistance for the elderly. The service is financed by municipalities.

[28] We do not have a sports centre intended exclusively for the elderly, but older people can join general sports centres. Pensioners' associations organise various activities, which the elderly join together, e.g. swimming and hiking etc.

c. Special services for family carers	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Training courses on caring	This service is not available					
Telephone service offered by associations for family members	X[29]					
Internet Services	This service is not available					
Support or self-help groups for family members	X[30]					
Counseling services for family carers	X[31]					
Regular relief home service (supervision of the elderly for a few hours a day during the week)	X[32]		X			
Temporary relief home service (substitution of the family carer for brief periods of time, for example, a week)			X			
Assessment of the needs	This service is not available					
Monetary transfers	This service is not available					
Management of crises	X[33]					
Integrated planning of care for the elderly and families at home or in hospital	This service is not available [34]					
Services for family carers of different ethnic groups	This service is not available / Not relevant					
Other, specify						

[29] Slovenia has only a few phone lines for advising to family members and organisations offering this help are specialized only in a certain target group (patients with dementia, Alzheimer's disease etc.).

[30] These groups for self-support intended for family members are poorly developed in Slovenia and are not numerous, even though researches revealed that the need for them is big. Groups are formed within certain associations and are intended for a certain target group (the grieving, relatives of demented people, relatives of people at institutions etc.).

[31] Consultation to family members is provided by centers for social work and non-governmental organizations. This form of help is also not well spread in Slovenia.

[32] Home help for a couple of hours is offered by non-governmental organizations (free of charge), centres for home help (partly subsidised by municipalities, partly paid out-of-pocket) and private organisations (entirely paid out-of-pocket). These services are limited and differently spread across municipalities.

[33] In the case of serious health or social crisis, the social worker from the hospital contacts the social worker from the centre for social work and from the old people's home – together they try to arrange that the older person is admitted to the hospital as soon as possible. Cooperation between general practitioners, home nurses and social workers from centers for social work is also very important for solving these problems completely.

[34] Slovenia does not yet have a special service that would prepare a complete plan of caring for an older person. If required, different services cooperate, such as centres for social work, old people's homes, nursing care and doctors.

6 Current trends and future perspectives

6.1 What are the major policy and practice issues debated on family care of the elderly in your country from the carers' point of view? Are older people and / or carer abuse among these issues?

Politics does not pay much attention to the interests and needs of family carers. There are no discussions about these issues at the political level. On the other hand, civil society is increasingly alert. Pensioners' associations, the Slovenian Gerontological Association and some other organisations managed to make the problem of elderly abuse central with their initiatives and various round table discussions. In the past, attention was namely only paid to violence on children and women. The most topical issues in political and professional discussions are the importance of good intergenerational relations, the problem of alienated generations and consequential lack of understanding between generations and, above all, the issue of how to deal with increasing share of old population and new needs. Material needs of the elderly are still more topical, but during the recent years politics has also paid more attention to the importance of satisfying non-material needs of the elderly.

Though it seems that family carers will not be on the priority list of social policy for quite some time, increasing pressures from civil society in relation with other issues concerning the elderly and their social security give hope that things will change in the future also in this field. For example, the problem of elderly abuse is big and these abuses are also closely related with family carers, so that soon family carers, their problems and neglect in policies will be talked about more.

6.2 Do you expect there to be any changing trends in services to support family carers, e.g. more state or more family support, more services or more cash?

At the moment, there is no real political interest to change and improve the situation of family carers in Slovenia. Major changes in this field are not to be expected for at least five years. The Ministry of Labour, Family and Social Affairs is currently preparing the strategy for social security development for the elderly till the year 2010, but there is only slight possibility of including family carers in the plans for the next five years, taking into account the present political climate and interests. The State does develop alternatives to institutional care, but these, with the exception of home care, do not spread efficiently. For the time being, we cannot expect a more equal spreading of services that would help carers the most – higher availability of respite care, expansion of

day care that is separated from old people's homes, trainings for family carers of the elderly etc.

As we have already mentioned, some weeks ago the *Act Amending the Social Security Act* was adopted, which allows for the option that family carers of older people are registered as 'family assistants', but only those family carers who have the same permanent address as the disabled person or those who are family members. This excludes partners of disabled persons, who are not entitled to this right. The amending Act stipulates receipt of a financial compensation, the eligible persons for which are those people whose care-giving affects their employment (payment for loss of income). This means that pensioners will not be entitled to this financial compensation. Since this measure is not yet implemented in practice, we do not know to what extent it will be made use of by family carers, taking into account that they may only register for a family assistant if they care for a heavily disabled person. We believe that the amending Act will only be of benefit to a small group of family carers.

Slovenia has strongly developed volunteer networks, which offer help to the elderly. In the future we may count on these networks more than on the public network of services, despite the fact that the former do not receive adequate support and help from the State and municipalities. Various projects are financed partly, but the amount of budgetary funds for these purposes is continuously dropping, thus decreasing partial public financing.

Whether family carers will get help from other members depends and will further depend on a specific domestic situation. Some primary carers find big support in them, whilst other are isolated in their care-giving. An additional problem of care-giving is the increasing retirement age, which means that it will be more likely that carers are in an employment relationship, that their health is weaker and that they are already older people when assuming the role of a carer. Besides this, the traditional role of the family has changed. Younger family members live on their own, have children later and women are actively employed, so that it is and will be more and more difficult to harmonise the obligations arising from their job, family and care-giving.

6.3 What is the role played by carer groups / organisations, "pressure groups"?

Family carers are not organised in groups or common organisations. Due to this lack of contacts and organisation between them, family carers are not a pressure group pressing on the society or the State. Troubles and problems that family carers are facing are not noticeable. No changes thus occur to improve their situation. The society takes them for granted and social policies overlook them.

6.4 Are there any tensions between carers' interests and those of older people?

At the political level, there are no tensions between the interests of family carers and the elderly since, as we have already mentioned, family carers are not integrated in any way. On the other side, there are tensions present on the level of individuals, which we have already discussed in the first section (see Item 1.11).

6.5 State of research and future research needs (neglected issues and innovations)

Over the last 15 years Slovenia was neglecting research of gerontological problems since we do not have a gerontology institute, which could systematically deal with this field. Some faculties, non-governmental organisations and other institutions occasionally conduct a research related to the problems of the elderly. The Anton Trstenjak Institute deals with these problems the most and it also publishes a specialised gerontology magazine; recently, the first integral social gerontology and gerontagogics monograph, Good Quality of Old Age (Kakovostna starost), was published in Slovenia. The Institute temporarily fills the void due to the absence of a gerontology institute to the best of its abilities.

A major problem in Slovenia is insufficient linking of people dealing with gerontological problems, even though there are not many of them. Another problem is also unwillingness to cooperate, which is why we do not have a clear overview of research work conducted. Also, some researches are not carried out in a satisfactorily qualitative and professional manner, thus losing their value. We strongly need an institution that would act as a binding link between the mentioned players since research work is not a purpose in itself, but has to create a basis for further work and changes as well as improvement in the field of gerontology. Recently there were a lot of discussions concerning a gerontology institute; some prominent politicians are in favour of the institute, so that we hope things will improve in the near future.

In the light of the abovementioned situation, it comes as no surprise that no national research on family care of the elderly has been made. Lately the problem of elderly abuse has been topical – three researches of a smaller scope have been made on elder abuse and quite some research work was allocated to volunteers' work with the elderly.

The need for research work at the national level is a big one since Slovenia seriously lacks it. We cannot state which specific field of research needs more attention since there was little research done on gerontology issues in the recent time.

6.6 New technologies – are there developments which can help in the care of older people and support family carers?

'Red button', tele-alarm system of the Home help centre offering help to people in a health crisis and the lonely ones is not gaining users despite heavy investments into it. This theoretically good idea has weaknesses in practice; it should be offered as a part of local intergenerational centres and not in an isolated manner since older people need a personal human relationship and only then can modern telecommunications be really helpful. It is difficult to establish a relationship with an older person over the phone (Ramovš 2003: 310). Besides this, Slovenians are not well familiar with this service.

We do not have any information that would indicate that some new technology for providing help to the elderly and family carers is being developed or set up in Slovenia.

6.7 Comments and recommendations from the authors

In our Report, we have thoroughly depicted the present situation in Slovenia. We have focused on services for sick older people and not for the prevailing group of active older people. A lot remains to be done both in the field of health care and social care. We have a lot of good plans (extending medical help at home, interdisciplinary approach to dealing with the elderly, respite care, day care, adult foster families, tele-alarm system etc.), which are written down in various national programmes and acts but these services are not really blooming in practice. Thus we have to strengthen and extend existing services as well as develop new ones, for example sheltered apartments for demented people. It is also important to develop non-institutional help for the elderly and their carers as well as to satisfy non-material needs (to decrease loneliness, improve intergenerational relationships etc.).

Still under the impression of the former socialist system, people expect that the State will always help them when they need it. The situation today is different. At the moment Slovenia does not have a sufficient network of service for the elderly (despite growing capacities at old people's homes and (quite unsuccessful) development of alternative forms of institutional care) and this situation will only worsen in the future. People will have to start seeing things differently, for example that a house or an apartment ensures material security in old age. Many older people live in big apartments and houses and do not wish to sell them to move into smaller, more appropriate and cheaper apartments since they wish to leave their property to children. A recent TV poll revealed that more than 80 % of the population would not be willing to sell their apartment or house in order to ensure themselves additional social security and care in old age.

All three sectors have to ensure that the needs of the elderly are met since one sector only is not capable to do so. In Slovenia, the public sector is still the

strongest, but the non-governmental and informal sectors, mainly families, are also very important. The State will never be able to satisfy all needs of the older population, but has to help other implementers in this cause. Slovenia must remain a welfare state, so that the social network will continue serving as an indispensable basis for minimum social security in old age. At the same time, it will have to create better conditions for formation and operations of civil social networks based on the principle of self-organisation, self-support and solidarity as well formulate appropriate criteria for operations of the profit market of caring for the elderly (Ramovš, 2003: 200). Despite discussions on declining traditional role of the family and decreasing interest in family care-giving, the family still plays and will play an important role in caring for the elderly. For this reason, it must receive help. In the future, the State has to form a special inspection service for control over operations of all social networks and thus protect the elderly from abuse.

Our society often perceives family care of the elderly as an obligation of family members. It is neglected that these members are inadequately prepared (unfamiliar with diseases etc.) to take over care-giving, that they also have other obligations, such as their jobs, which will provide them social security in their old age, taking care of their families etc. On the other hand, aged family carers (partners, brother, sisters) are also facing certain limitations due to their own old age.

We can expect that the age of family carers will rise in the future since life expectancy is increasing. This means that family carers will have more problems in physical care-giving since they will also belong to the old age group or older middle age group. Since our retirement age is increasing, we may face a situation when older middle-aged people will still be employed and at the same time care for their parents and relatives. This will be a heavy physical and mental burden for them. Only by means of special measures can we avoid the danger of losing this most important source of help for the elderly.

We definitely cannot expect changes over the night but we can gradually improve the situation of family carers. It is necessary that we provide training to family carers, organise self-support groups, enable the option of a temporary break (respite care), longer absence from work due to caring for an older person or the option of temporary half-time work during the period of care-giving. The latter should be supported by a financial compensation for partial loss of income. The Act Amending the Social Security Act (Item 6.2) is to partially regulate this.

The State and the whole society will face a series of challenges and tasks. Help to family carers is but only one of them. It is important that Slovenia finally gives family carers the name, position and help they need.

Let us conclude with a metaphor that security and care of the elderly are like a house. We must build it on firm foundations and uniformly, otherwise it will start falling apart at the most inappropriate moment.

7 Appendix to the National Background Report for Slovenia

7.1 Socio-demographic data

7.1.1 Profile of the elderly population-past trends and future projections

Table 21: The population of Slovenia at different Population Censuses

Year	Total	60+		65+	
		N	%	N	%
1961	1,591,507	196,070	12.32	124,218	7.81
1971	1,727,137	256,206	14.83	169,838	9.83
1981	1,891,864	266,022	14.06	209,182	11.06
1991	1,965,986	317,706	16.16	214,684	10.92
2002	1,964,036	392,590	19.99	288,981	14.71

Source: Popis stanovništva 1965, Statistični letopis SRS 1982, Popis prebivalstva 1994, Popis prebivalstva 2002 in Ramovš 2003

Table 22: Projection of de jure population, excluding persons who have worked abroad for more than 1 year and members of their families living with them, by sex and age groups for 2002, 2012, and 2020 de jure - medium adjusted fertility

Age	2002			2012			2020		
	Total	Men	Women	Total	Men	Women	Total	Men	Women
Total pop.	1,971,062	955,072	1,015,990	2,011,938	977,103	1,034,835	2,019,399	981,759	1,037,640
60+	384,427	153,987	230,440	446,320	187,834	258,486	520,207	226,294	293,913
65+	282,711	106,202	176,509	321,694	127,827	193,867	382,658	160,661	221,997
80+	48,080	13,318	34,762	79,179	24,086	55,093	93,276	31,347	61,929
85+	21,345	5,562	15,783	31,555	7,795	23,760	43,581	12,819	30,762

Source: SORS. SY 2002: 89, Table 4.8

7.1.1.1 Life expectancy at birth (male / female) and at age 65 years

Table 23: Life expectancy at birth and other age groups, by gender, different years

Year, period	Sex	Age (years)				
		0	1	15	45	65
1999	Men	71.0	70.4	56.7	28.9	13.8
	Women	78.6	77.9	64.1	35.0	17.6
1999 / 2000	Men	71.9	71.3	57.5	29.4	14.1
	Women	79.1	78.4	64.6	35.4	17.9
2000 / 2001	Men	72.1	71.5	57.7	29.6	14.2
	Women	79.6	78.9	65	35.8	18.2

Source: SORS. SY 2003: 615, Table 37.3, SY 2002: 609, Table 36.3, SY 2001, Table 35.3

7.1.1.2 % of > 65 year-olds in total population by 5 or 10 year age groups

Table 24: % of > 65 year-olds in total population by 5 year age groups, 2003

Age	Population			
	Total	%	Men	Women
Total	1,996,773	100.00	977,436	1,019,337
60-64	106,304	5.32	50,669	55,635
65-69	94,886	4.75	42,504	52,382
70-74	85,194	4.27	34,140	51,054
75-79	62,022	3.11	20,207	41,815
80-84	35,151	1.76	9,706	25,445
85-89	12,266	0.61	3,162	9,104
90-94	6,467	0.32	1,467	5,000
95-99	1,053	0.05	187	866
100+	104	0.01	11	93

Sources: MNZ. Central Population Register.

7.1.1.3 Marital status of > 65 year-olds (by gender and age group)

Table 25: Marital status of people older than 65 by gender and age group, years 1991, 2002

Age group	Total					Men					Women				
	Total	Single	Married	Widowed	Divorced	Total	Single	Married	Widowed	Divorced	Total	Single	Married	Widowed	Divorced
PC* 1991															
65-69	80744	7853	47978	21797	2714	29494	1631	24783	2328	688	51250	6222	23195	19469	2026
70-74	43247	4381	21535	15928	1119	15469	783	12572	1758	305	27778	3598	8963	14170	814
75-79	44543	5055	17239	21099	768	15542	885	11437	2954	214	29001	4170	5802	18145	554
80-84	29884	3732	8338	17154	359	9447	617	5879	2783	114	20437	3115	2459	14371	245
85+	15131	2197	2334	10268	116	3978	317	1735	1866	18	11153	1880	599	8402	98
PC* 2002															
65-69	95550	6135	66359	18642	4414	42069	2358	35179	3006	1526	53481	3777	31180	15636	2888
70-74	83473	6048	50323	23531	3571	33254	1571	27098	3667	918	50219	4477	23225	19864	2653
75-79	59388	5084	28095	23781	2428	18608	781	14368	3034	425	40780	4303	13727	20747	2003
80-84	29224	2739	11032	14415	1038	8183	302	5832	1885	164	21041	2437	5200	12530	874
85+	21346	2358	5787	12600	601	5304	217	2921	2071	95	16042	2141	2866	10529	506

* PC=Population census
Source: SORS. 2003. Population Census 2002, SORS 2003b

7.1.1.4 Living alone and co-residence of > 65 year-olds by gender and 5-year age groups

Table 26: Households by the number of persons aged 65 or over, number of members

Number of members	Total	Households by the number of persons aged 65 or over			Total number of persons aged 65 or over
		1 person	2	3+	
Total	217,303	156,701	59,333	1,269	279,268
1	73,036	73,036	–	–	73,036
2	73,427	35,298	38,129	–	111,556
3	28,274	16,694	10,940	640	40,494
4	15,466	11,635	3,539	292	19,618
5	14,704	12,288	2,300	116	17,256
6	8,071	5,195	2,799	77	11,037
7	2,881	1,709	1,110	62	4,135
8+	1,444	846	516	82	2,136

Source: SORS 2003b. Population census 2002, SORS 2003a

7.1.1.5 Urban / rural distribution by age (if available and / or relevant)

Table 27: Urban / non-urban distribution by age groups, 2002

Type of settlement	Selected age groups							
	0	1-6	7-14	15-18	19-26	15-59	15-64	65+
Total	16,885	108,732	174,550	102,708	234,172	1,271,279	1,374,888	288,981
Urban	8,134	51,259	82,588	50,525	118,007	655,777	709,035	146,756
Non-urban	8,751	57,473	91,962	52,183	116,165	615,502	665,853	142,225

Source: SORS 2003a. Population Census 2002, SORS 2003b

Table 28: Selected age groups by type of settlement and gender, 1991, 2002

Age groups (years)	1991			2002		
	Total	Men	Women	Total	Men	Women
Total						
Total	1,913,355	923,643	989,712	1,964,036	958,576	1,005,460
60-64	101,852	44,553	57,299	103,609	49,407	54,202
65-69	80,744	29,494	51,250	95,550	42,069	53,481
70-74	43,247	15,469	27,778	83,473	33,254	50,219
75-79	44,543	15,542	29,001	59,388	18,608	40,780
80-84	29,884	9,447	20,437	29,224	8,183	21,041
85+	15,131	3,978	11,153	21,346	5,304	16,042
Urban settlements						
Total	971,502	461,826	509,676	997,772	479,356	518,416
60-64	49,053	20,958	28,095	53,258	24,798	28,460
65-69	38,482	14,313	24,169	48,085	21,056	27,029
70-74	20,168	7,372	12,796	41,835	16,374	25,461
75-79	19,322	6,685	12,637	30,343	9,707	20,636
80-84	12,238	3,705	8,533	15,142	4,340	10,802
85+	6,272	1,514	4,758	11,351	2,779	8,572
Non-urban settlements						
Total	941,853	461,817	480,036	966,264	479,220	487,044
60-64	52,799	23,595	29,204	50,351	24,609	25,742
65-69	42,262	15,181	27,081	47,465	21,013	26,452
70-74	23,079	8,097	14,982	41,638	16,880	24,758
75-79	25,221	8,857	16,364	29,045	8,901	20,144
80-84	17,646	5,742	11,904	14,082	3,843	10,239
85+	8,859	2,464	6,395	9,995	2,525	7,470

Source: SORS 2003a. Population Census 2002, SORS 2003b

7.1.1.6 Disability rates amongst > 65 year-olds. Estimates of dependency and needs for care

Table 29: Numbers of people requiring daily care, total population, proportion of total population requiring care and dependency ratio, based on two severest Global Burden Disease study disability categories (levels 6, 7)

Year	Prevalence (thousands) by age in years					Dependency ratio (%) *
	0-4	5-14	15-44	45-59	60+	
2000	0.7	1.0	39.8	23.1	23.1	8.0
2010	0.6	0.8	36.0	26.4	44.7	8.6
2020	0.6	0.7	30.7	25.1	55.1	10.0
2030	0.5	0.6	24.4	24.6	62.0	11.5
2040	0.5	0.6	20.6	20.8	65.8	13.2
2050	0.5	0.6	18.7	18.715.7	65.1	14.6

*(total number of dependent people) / (population aged 15-59)
Source: WHO. Country profiles on Long term care.

Table 30: Sensitivity analysis. Numbers of people requiring daily care, total population, proportion of total population requiring care and dependency ratio, based on three severest Global Burden Disease study disability categories (levels 5, 6, 7)

Year	Prevalence (thousands) by age in years					Dependency ratio (%) *
	0-	5-	15-	45-	60+	
2000	1.4	2.2	54.5	33.3	56.4	11.5
2010	1.2	1.7	49.2	38.1	66.1	12.4
2020	1.1	1.5	42.0	36.1	81.6	14.5
2030	1.0	1.4	33.5	35.5	91.8	16.8
2040	1.0	1.3	28.2	30.0	97.4	19.2
2050	1.0	1.3	22.7	22.7	96.3	21.3

*(total number of dependent people) / (population aged 15-59)
Source: WHO. Country profiles on Long term care.

Table 31: Income distribution for top and bottom deciles i.e. % aged > 65 years in top 20 % of income, or % > 65s in top 20 %, and the same Distribution of pensioners in the poorest and richest income groups, 1993

Income groups	Men	Women	Total
1988			
Poorest 20 % income	23.5	21.9	22.7
Top 20 % of income	8	11.9	10
Total	14.3	17.7	16
1993			
Poorest 20 % income	19.6	22.5	21.1
Top 20 % of income	13.6	16.3	15
Total	17.6	22	19.9

Source: Anketa o porabi gospodinjstva (APG) 88, APG 93 in Stanovnik 1997:26 in Hvalič 1999

Table 32: Distribution of pensions by income deciles, Slovenia 1997-1999, in %

Income deciles	Pensions
1	4.7
2	7.6
3	8.8
4	8.1
5	9.6
6	11.1
7	11.5
8	10.4
9	13
10	15.2
Total	100

Source: Stropnik, Stanovnik. 2001 In Apohal Vučkovič et al. 2002

The households at the highest risk of poverty are households with unemployed members, with children up to 18 and with persons aged 60 and over. There are 10 % of all households in Slovenia in each income decile. The households with unemployed members and those with a person aged 60 and over are over-proportionally represented in lower income deciles. In 1997-1999 the following households were identified by the Slovenian Statistical Office has identified as the ones at high risk of poverty:

- single households, particularly those of elderly persons (27.6 %); elderly couples (19.5 %) families with three or more children below age 16 (13.7 %); single parent families (15.2 %);
- households without employed members (23.2 %);
- households with low educated heads (25.3 %);

- households where pensions and other social benefits are the main sources of income (19.6 % and 41.6 %, respectively);
- tenants in non-profit and social housing (23.1 %) - (MDDSZ 2002 in Stropnik et al, 2003).

However, the situation of elderly people is improving. The shares of households with persons aged 60 and over have decreased in the bottom two deciles in 1997-1999 as compared to 1993, while their shares have increased in the higher half of deciles (Stropnik et al, 2003:12,13).

Table 33: Social cohesion indicators – income and poverty, Slovenia 2000

	Income	
	In cash	In cash + in kind
At risk of poverty rate (total in Slovenia)	12.9	11.2
65+ (Total)	23.1	20.8
Men (65+)	18.2	13.6
Women (65+)	26.0	25.0
Retired	15.4	14.9
One person household, 65+	37.2	42.2
Two adults, no dependent children, at least one adult is 65+	21.6	18.2

Source: SORS 2003. First release: level of living.

7.1.1.7 % > 65 year-olds in different ethnic groups (if available / relevant)

The ethnical minorities (Italians, Hungarians, Austrians) in Slovenia are very old population, even older than Slovenians. On the other hand Roma (Gypsies) and immigrants from former Yugoslavian republics (Croats, Serbians, Muslims, Bosniacs, Montenegrins etc.) are young populations. They are more numerous than ethnical minorities. The fact that they are so young population is partly related to the trend that many younger people came to work in Slovenia due to the economical difficulties in their own countries. However, many people from ex Yugoslavian countries have permanently settled in Slovenia some before and many after Slovenia has proclaimed her independence (1991). They formed their families here, so it is expected that the share of older people within those ethnic groups will increase as well.

Table 34: Population by ethnic affiliation, age groups (declared by ethnicity, 2002)

	Total population	65-69	70-74	75+	Total 65+	% of 65+ in total
Slovenes	1,631,363	85,621	76,258	99,252	261,131	16.01
Italians	2,258	186	180	260	626	27.72
Hungarians	6,243	451	431	624	1,506	24.12
Roma	3,246	31	22	20	73	2.25
Albanians	6,186	54	39	23	116	1.88
Austrians	181	5	10	43	58	32.04
Bosniacs	21,542	220	99	75	394	1.83
Montenegrins	2,667	141	80	76	297	11.14
Croats	35,642	1,943	1,293	1,209	4,445	12.47
Macedonians	3,972	114	60	50	224	5.64
Muslims	10,467	107	46	25	178	1.70
Germans	499	49	46	60	155	31.06
Serbians	38,964	1,229	605	656	2,490	6.39
others	3,752	95	92	166	353	
undeclared	22,141					
didn't want to reply	48,588					
unknown	126,325					
Total	**1,964,036**					

Source: SORS 2003a. Population Census 2002.

7.1.1.8 % Home ownership (urban / rural areas) by age group

Table 35: Home ownership; people old than 64 years, 2000

	N	%
Total	4,888	
owner	4,131	84.51
tenant (pays the rent)	505	10.33
lives with relatives	169	3.46
no answer	83	1.70

Source: ZDUS 2001. Skupaj lahko naredimo več za kakovost življenja starejših.

7.1.1.9 Housing standards / conditions if available by age group e.g. % without indoor plumbing, electricity, TV, telephone, lift (if above ground floor), etc.

Table 36: Housing standard of people older than 64 years, 2000

I have …	N	%
my own bedroom	4,292	87.81
my own kitchen	4,224	86.42
easily accessible toilets	4,562	93.33
bathroom	4,555	93.19
warm water	4,171	85.33
garden	2,887	59.06
Total	4,888	

Source: ZDUS 2001. Skupaj lahko naredimo več za kakovost življenja starejših.

7.2 Examples of good or innovative practices in support services

Valuable help to families with older people is offered by associations and other non-governmental organizations. Associations are usually linked with the central European association for self-support in its field, they publish informative papers for their member and the wider public, organise trainings, vacations and other events. The non-governmental sector still provides most help to family carers of older people. But these associations are frequently local, so that their help is not available at the national level. Family carers living in the capital have the most favourable conditions.

Examples of good practices:

1) Hospice Association

The Slovenian **Hospice Association** has been active since 1995. Activities are carried out through regional boards at the national and local level. Their purpose is to help mostly close relatives and health care personnel in work with the dying, to do away with taboos about dying and help the grieving. The Association employs 9 people and has 591 members. A lot of them are volunteers. In our case, the following of its programmes (abstracted from the report on the Association's work in 2002 – Anonymous 2003) implemented at the local level should be mentioned:

a) HOSPICE Programme – Monitoring of dying patients and close relatives

The basic activity is to provide complete care to dying patients and close relatives. These are treated individually at their homes, hospitals or old people's homes. In 2002, they worked with 150 dying patients and 302 close relatives of cared-for patients. 77 volunteers helped families through 1529 voluntary hours. The average care period was 49.5 days. In 89 cases relatives of dying patients were provided individual consultations and a lot of distressed people

asked for advice and support. In line with the philosophy of hospice, relatives are visited for at least 13 months after the patient's death. In 2002 the Association thus worked with 128 relatives. Some relatives were treated individually, others joined support groups for the grieving. The Association allocates 49 % of its funds to this project.

b) Grieving after the loss of a close person

The target group are the grieving who have lost a close person. Work with the grieving is performed on a voluntary basis, except in the capital. In 2002, 347 individual consultations throughout Slovenia were given, a lot of them also at the Association's office (228) for 109 people. They also offer 5-hour educational workshops, titled "When a person is left alone". These are intended to all people who cannot participate in a support group for the grieving for various reasons. There were 7 workshops in different places throughout Slovenia. Support groups for the grieving meet on a weekly basis. In Ljubljana, one group was formed for adults who have lost a parent (9 members). Besides the abovementioned activities, there is also a relatives' club, operating as a monthly social gathering of the average of 3 hours. These meetings are held in Ljubljana, Maribor and Celje (Umek 2003, Anonymous 2003).

The Association allocates 15 % of its funds to this project.

c) Hospice house

The Association has been planning opening of a hospice house in Ljubljana with the City Municipality of Ljubljana for some years. The house is to have five apartments for dying patients, a day-care centre for the dying and patients and a consultation centre for health and social workers. Since the project is related to high expenses, arrangement of adequate documentation and other problems, it has not yet been realised. Despite low capacities, the project is of exceptional importance since only a couple of days at the hospice house could alleviate many problems of patients and relatives alike (Anonymous 2002, Slovensko združenje Hospic).

2) "Forget-me-not", the Alzheimer's Disease and Related Disorders Association of Slovenia

The following non-governmental organisation we wish to mention is *Spominčica* (Forget-me-not), "Forget-me-not", the Alzheimer's Disease and Related Disorders Association of Slovenia. Its purpose is to help patients, close relatives, expert associates and non-expert carers in overcoming problems arising from dementia and other mental disturbances of old age. It was founded in 1997 in Ljubljana in cooperation with the Psychiatric Hospital Ljubljana. The Association also provides education, information and advice to family members and informal carers. This association has a special programme *Forget me not*, which is intended for close relatives of demented patients still living in their home environment. Meetings are weekly and are held over nine consecutive weeks at the premises of the Psychiatric Hospital Ljubljana. Each meeting

lasts for 90 minutes. The educational part is followed by a discussion intended for solving problems. Besides this, it also offers relatives a consultation phone line and self-support groups for relatives of demented patients, who wish to share experience on the disease of their closest relatives (Spominčica 2003, Slovensko združenje za pomoč pri demenci).

Innovative programme:

Training of families for better communication with older family members – the Anton Trstenjak Institute

The highest rate of violence on the elderly comes from families and is committed by closest relatives, who are not aware that their words, silence and behaviour are violent towards aged parents. Therefore, it is important to train families for better communication with older family members and with family members of different generations. An efficient course for better communications with the elderly awards younger generations several benefits at the same time: the quality of life of older family members is increased, everybody is more pleased due to improved family relationships and younger generations become familiar with old age. Within the network of intergenerational programmes for quality old age, the **Anton Trstenjak Institute** implements a brief 10-hour course to **train families for better communication with older family members**. Besides basic findings on quality ageing, the course mostly offers participating family members to gain knowledge and techniques concerning essential changes in the family on transition from traditional to post-modern setting, the possibilities of complementary supplementation of generations in the modern society, the basic rules for successful family communications, the characteristics of ageing and old age necessary to understand the elderly, the way of solving concrete problems and specific tasks in better relation between the family and the elderly. The course is carried out in line with the social group learning method (abstracted from Ramovš 2003: 305, 306, 341). One of the results of this programme is also the “Club of relatives”. During the training process, relatives of people living in old people’s home have expressed the wish to have meetings also after the end of training. So they formed a club within the old people’s home. Their monthly meetings are supervised by a social worker from the old people’s home. They discuss different topics that concern them and their aged relatives.

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