ANALYSIS OF THE
HEALTH SYSTEM IN SLOVENIA

Long-term care

Final Report

European Observatory on Health Systems and Policies
a partnership hosted by WHO

World Health Organization
REGIONAL OFFICE FOR Europe

REPUBLIKA SLOVENIJA
MINISTRSTVO ZA ZDRAVJE

Long-term care

Final report

15 December 2015

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Long-term care

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Acknowledgements

The extensive support and comments of the Slovenian local working group were highly appreciated in the development of this report, namely Dušan Jošar, Eva Zver, Boris Kramberger, Stane Vencelj, Davor Dominkus, Franc Kluzer, Elda Gregorič Rogelj, Mateja Nagode and Anita Jacović. The author wishes to thank them for all their insight and facilitation of data gathering.

Introduction

The ageing of the population in Slovenia brings challenges for the health sector and pensions as well as for long-term care (LTC). While the rate of growth in pensions can be reduced with policies to postpone retirement benefits and encourage continued participation in the workforce, LTC needs are likely to grow rapidly. Most estimates of the growth in LTC costs are based on adjusting existing spending for changes in numbers in different age groups, taking into account current patterns of usage.

There is some evidence to suggest that age-specific disability rates are falling across Europe (e.g. Wren et al., 2012), and this might reduce the pace of growth in LTC spending. However, it is still likely that needs for LTC will grow faster than general economic growth, so that LTC spending as a share of GDP will grow. It is also likely that most (if not all) of the increase in costs will fall on public sources given the limited incomes of most recipients of LTC.

An additional challenge is that there are unmet needs for LTC, and improved provision is likely to meet current unmet needs as well as new needs. There is also evidence of current waste in the provision of LTC needs, especially a tendency for too much care to be in residential and hospital settings and too little that supports people to remain at home.

Neither of these issues is analysed in detail here, but it is likely that greater efficiency in the organization and delivery of LTC will release some resources at least to help meet current unmet needs, and possibly make a contribution to the cost of meeting the growing needs. While the estimated increases in costs of LTC are large, they may be relatively low estimates since they do not take account of current unmet needs.

Key issues in LTC in Slovenia

A number of issues relating to the future of LTC in Slovenia have been identified and form part of current policy discussions. To varying extents these issues are found in most European countries. Some are legacy issues from the historical development of health and social care. In most countries the fragmentation, inappropriate models of care, unclear entitlements and difficulties in navigating access to care are more serious in LTC than in other parts of the health and social care system. Particular issues that have been identified in Slovenia are:

- too much of the provision is in institutional settings, with too little support to help people to remain in their own homes;
- too little emphasis on preventing disability and on helping people to regain skills and independence;
- too many different government and non-government agencies are responsible for (overlapping) provision of LTC services;
- lack of transparency, because of different entry points and different needs assessment procedures, resulting in access to care being uneven, and at times inequitable;
- lack of coordination between services because of different oversight and regulatory mechanisms.

The consequences of these issues include some (substantial but hard to quantify) unmet need, some inefficient use of existing LTC resources, unnecessary burdens on families both in terms of providing care and in helping navigate the system, difficulty in planning for the growing needs and difficulty in building quality and standards into care provision.

The government in Slovenia has recognized these issues and the draft Resolution on the National Health Care Plan 2015–2025 seeks to address several of these issues through creating a "unified way to access services, integrated implementation of activities in various forms and a uniform method of financing". Various studies and analyses have provided a better understanding of existing patterns of funding and provision, and potential future costs (Nagode et al., 2014; Dominkus et al., 2014; Rodrigues, 2014; Zver & Dominkus, 2015; IMAD, 2014; Majcen, 2015).

Before and during the financial crisis there has been a growing burden on families and recipients in the funding of LTC, and it is unlikely to be feasible to shift costs further from public to private finance to meet the growing needs for care.

In the projections given in this report it is assumed that the share of public funding of LTC will remain at least at its current level, and an additional analysis considers the consequences of capping private contributions to growing in line with incomes.

New models of LTC funding might nevertheless aim to have fairer systems of user charges that recognize the capacity of some users to contribute, and that recognize that some costs in LTC substitute for costs that would fall on service users in other settings.

Current patterns of LTC spending

LTC services are classified in the System of health accounts 2011 (OECD, Eurostat, WHO, 2011) into two broad categories – health LTC services and social LTC services. Each of these is subdivided into different types of service. Patterns of use of services and growth rates differ. Put simply, all types of service needs are growing, but the rate of growth is faster for the social LTC areas. The current pattern of use of health and social LTC is shown in Table 1. More detail on how much the different funders pay for different services is presented in Appendix 1.

Table 1

Current pattern of health and social LTC in Slovenia

	Elderly users	Non-elderly users
Health LTC	69%	31%
Social LTC	58%	42%
Total	63%	33%

Source: SURS, own calculation.

Although social LTC need is growing more rapidly it is still the smaller part of the total, and the absolute growth will be greater in health LTC needs.

While there are unmet needs, and some small areas of growing need for LTC for non-elderly people, the main driver of growth relates to increasing numbers of older people and age-related disability and deficits. In making projections of future needs, the estimates assume there will be only limited growth in needs of the younger population. However, it is likely that an improved availability of accessible services will reveal some unmet needs in the non-elderly population. This was the experience in other countries when service delivery was improved and previously unmet needs emerged.

While nine different funding groups have been identified in LTC spending in Slovenia, by far the largest funder is the Health Insurance Institute, with over one-third of total spending and over 45% of public spending (see Appendix 1 for details). The Pensions Institute and local government each pay around 20% of public spending (15% of total), Ministry of Labour around 7.5% of the current total. The only significant private source is from service users and their families (27% of total). The role of private insurance in LTC is very small (0.3% of total).

Organizational issues in LTC in Slovenia

There are several disadvantages in the current funding and delivery model.

- At the strategic level, it makes planning more difficult.
- Looking at patterns of provision by funder shows that some similar needs are being met by different funders, and eligibility criteria can differ.
- Many users require inputs from services that are currently funded under different ministries and agencies, making coordination difficult.
- Some services that would reduce costs in hospital care are paid for from outside the health sector, leading to perverse incentives. There is a risk that public resources will be used to achieve less for more.
- Navigating the different funding streams to ensure a coherent pattern of care to meet individual needs is complex for users and families, and this leads to some important needs being left unmet.

Many countries have similar problems, with a split between health and LTC funding and with multiple funders of LTC (e.g. England). There have been initiatives to give lead responsibility to one of the funders (in this case local government) but difficulties in ensuring coordination of care have remained. Some recent pilot schemes have aimed to improve the linkages between funders of care. Since the 1970s there have been experiments in the use of care coordinators in several countries that aim to assist service users in navigating the different entitlements and to help coordinate the care provided by different agencies (Davies & Knapp, 1981).

Even jurisdictions that have single agencies with lead responsibility for health and social care (such as Ireland and Northern Ireland; see e.g. Layte, 2009) have had difficulty in ensuring coherent use of funds to meet complex combinations of need, but they do have the major advantage of having incentives to provide appropriate mixes of care.

Ireland recently introduced a system of funding nursing home care that requires families to repay some of the costs of care from the value of the service user's home after the death, with a mixture of loans and grant funding to pay for care.[1] The experience has been that only very small amounts are recovered in this way (given that many older people do not own houses, and in many cases they are not the sole owner. While it is possible to find mechanisms that place some part of the cost of LTC on the users, experience suggests that at best this makes a small contribution to overall funding needs.

A common experience in different countries has been that it is easier to attract public funding for residential care services than for support for people to remain in their own homes. For people with relatively low levels of need it is clearly better and cheaper to support them at home. Paradoxically, the breakdown of care at home and the shift to residential care is often associated with less serious deficits (with the so-called Instrumental Activities of Daily Living – IADLs) such as difficulty with shopping and preparing meals (Nolan et al., 2014, Murphy, Whelan & Normand, 2015; McNamara, Normand & Whelan, 2013). Generally it is cheaper to support someone at home if their needs are mainly IADL deficits.

When a person has more serious levels of disability (that is, difficulties with the so-called Activities of Daily Living – ADLs) it can be better and cheaper to remain in the home. But in many cases the argument for care at home is more about the quality of life than the costs, since home care costs can rise significantly with higher ADL deficits (Davies & Knapp, 1981). While it is clear that some LTC in Slovenia is unnecessarily expensive and provides sub-optimal care experiences, it is not likely that more than a small part of the increasing costs of LTC will be found simply from improving the existing care, and the main argument for changes in models of care will be to improve the experiences of service users.

Experience suggests that it is easier to achieve better value for money in LTC with fewer agencies and closer links with health care provision. The important issues are to coordinate the activities of different funders and to work towards simpler systems of entitlement.

1 See: http://www.hse.ie/eng/services/list/4/olderpeople/nhss/

Demographic change and complex changes in needs

While ageing of the population is a key driver of growing need for LTC, there are several reasons why needs in future may differ from those of equivalent populations today. Two key issues should be considered in specifying alternative scenarios for future costs. These are the changing patterns of life expectancy for men and women, and the evidence of a slow but potentially important fall in disability at any age.

The demographic projections for Slovenia suggest that men's life expectancy is rising more rapidly than that for women, which will have the effect of there being fewer single elderly households. Living alone is known to increase the risk of hospital and nursing home admission and to increase costs of care at home (Murphy, Whelan & Normand, 2015).

Although there will be many more older people in Slovenia in 2035, the proportion of single-person elderly households will certainly fall, and it is probably that the absolute number of single elderly households will fall. This is likely to reduce slightly the absolute growth in LTC costs but, more importantly, it will reduce the need for care in nursing homes and hospitals and increase the need to support care at home. More older people means that there are more carers as well as more people needing care. The relationship between formal and informal care is complex (Brick et al., 2015) but with more households with two people it will be possible to provide more care at home.

Estimating the effect of improved health on disability in older age is complex, partly because there is a tendency now for people to report previously unreported disabilities. The best of the (limited) evidence suggests that age-specific disability rates are falling at around a half of one percentage point per year (Wren et al., 2012). This would translate into a useful fall in needs at any age by 2035. However, as can be seen in the estimates below, the costs of LTC are still likely to increase more rapidly than economic growth, so a larger share of GDP will be needed to meet the needs.

The approach taken to estimating growth in LTC expenditure

The European Commission Ageing Working Group has undertaken a number of exercises to project growing needs for health and LTC expenditure (European Commission, 2015). Essentially, their methods extrapolate from current patterns of service utilization to the changing population demographics and in several scenarios they assume different impacts of non-demographic factors (changes in the age-specific disability rates, in the ratio between formal and informal care, and in the ratio between institutional and home care). While there are good reasons to think that the future patterns will be even more complicated than this, and there is some evidence to suggest that longer life is associated with changes in patterns of needs and disability, for relatively short-term forecasts this approach provides useful estimates.

The forecasts given in the next section adapt the AWG (reference scenario)[2] rate of growth in LTC spending but make estimates of how this will be distributed between the different payers. The AWG report provides estimates of the shares in percentages of GDP for overall public long term care expenditure for 2013 and every five years from 2020 to 2060. This report projects only to 2035 since the main aim is to understand how the growth will affect the different funders of LTC, and the present pattern is unlikely to remain unchanged till 2060.

The AWG report also provides projections of economic growth rates in nominal and real terms. From the estimated growth rates for GDP estimates of real GDP were made for 2020, 2025, 2030 and 2035. From the real GDP estimates and the AWG estimated percentages of GDP for long term care spending the spending on LTC (at 2015 prices) was estimated for 2020, 2025, 2030 and 2035. Thus the estimates for public spending on LTC used in this report are compatible with the estimates in the AWG, but the spending is expressed in euros at 2015 prices rather than in percentage points of GDP. It was not the purpose of this report to provide alternative estimates of the overall growth of public LTC spending, but rather to demonstrate how this spending growth will be distributed between different funding agencies.

The AWG does not provide estimates for private expenditure on long term care. Data are available for Slovenia on the current levels of private LTC spending and on recent trends. What is clear is that there has been

2 The "AWG reference scenario" is based on the assumption that half of the projected gains in life expectancy are spent without disability (i.e. demanding care), thus taking an intermediate position between the "pure demographic" and "constant disability" scenarios assumptions. In this scenario, public long-term expenditure is thus driven by the combination of changes in the population structure and a moderately positive evolution of health (non-disability) status. This scenario is the point of reference for comparisons with the 2015 Ageing report and is used in the multilateral budgetary surveillance at EU level (AGW, 2015).

a shift of the burden of LTC spending towards individuals and families in recent years. The growth in private LTC spending has been strongest in services that are mainly used by older people, and therefore in services that are most likely to see rapid growth with population ageing. In this report the growth rate for public LTC spending is used to estimate growth in private spending.

Estimates are made of how the overall growth in LTC spending will fall on the different funders of care. Data are available for Slovenia on the different client groups and the services provided for them by the different agencies. These data were used to estimate the proportion of services funded by each funder that are for older people, and therefore are likely to grow with population ageing. Thus the main estimated in this report take the overall growth in LTC spending based on the AWG methods, and reported in euro at 2015 prices, and allocate the estimated increases on the basis of the proportion of spending that is on services for older people.

Two additional sets of estimates are provided – those that show the effects of plausible falls in disability rates, and ones that cap the likely spending by households and service users.

The forecasts are based on an analysis of the current patterns of LTC spending by each payer, and by each user group. For example, the Health Insurance Institute funding is almost all for what is classified as health LTC, and the majority of users are elderly. The estimate of the growth in expenditure for this funder is based on the increased share of costs for elderly users and the likely relative growth of health and LTC spending.

While a much more sophisticated analysis would allow greater precision in the distribution of the growth between funders of care, the purpose here is to show which funders (assuming no change in responsibilities) are likely to face the most significant growth.

There has been a rapid growth in the share of private expenditure on LTC in Slovenia in the past, and an additional set of scenarios in this section assumes that the affordability of private LTC expenditure will grow only at the rate of GDP growth – in other words, we are now close to the limit for additional private spending on LTC and it will only grow as incomes in general grow.

These estimates do not take account of unmet needs or changes in the ways in which care might be provided. To a limited extent, current unmet need might be accommodated through greater efficiency in the use of current funding, especially with some shift of care for less dependent people from institutional care to domiciliary care. However, it needs to be understood that this change will take some time, and will in many cases improve quality of life for those receiving care, but have only modest effect on costs.

The funders of LTC face different rates of growth in costs since the needs for the different components of LTC are growing at different rates. The projections below are based on the overall rate of growth in LTC funding. Within this, the relative rates of growth of health LTC and social LTC, and the proportions of each funded by each funding organization, are estimated. Funders who pay for care for non-elderly people with LTC needs will see slower growth in their costs.

The rise in funding from recipients and families is not evenly balanced across health LTC and social LTC. As will be discussed below there are reasons to be worried by the growing out-of-pocket costs for LTC, both on grounds of affordability and equity, and on grounds of sustainability. The estimates below include variants that show what would be the consequence if the burden on service users is capped.

Projection of LTC expenditure by payer (compatible with AWG projections)

The first projections of the growth in expenditure on LTC by payer use the assumption of the European Commission AWG reference scenario for Slovenia (European Commission, 2015). To be consistent, this involves accepting the AWG estimates of GDP growth. The estimates in Table 2 are based also on the reference AWG estimates of the effects of population ageing and health status on care costs. These estimates are on a "policy neutral" basis, and are driven purely by the changing cost of providing the current levels and types of access to LTC but for the expected size and composition of the population in 2025 and 2035. The robustness of estimates is greater for shorter time periods, so the estimates here go only to 2035 – a shorter period than that used by the AWG (which goes to 2060).

Baseline scenario

It is assumed in the first scenario that the growth in out-of-pocket payments will grow in line with overall costs of LTC. Analysis of the trends in private out-of-pocket expenditure shows that this has been largely spent on paying for care in homes for the elderly. There has been rapid growth in private spending on LTC. Since the ability to pay for private LTC may be limited, alternative scenarios are estimated that cap the increase in out-of-pocket payments to growth incomes. A detailed set of assumptions for these estimates is provided in Appendix 2.

It is not surprising that the most rapid growth in spending is in the organizations that currently tend to fund LTC for older people. Although the rate of growth of social LTC is higher than that for health LTC, the very rapid rise in spending by the HIIS is explained by its focus on LTC for older people. Local government is also a significant funder of care for older people, and also faces large proportionate increases.

The slow projected growth for the Ministry of Labour, Families and Social Affairs reflects its focus on care for non-elderly people, which will grow only slowly. On the basis of current patterns of spending, the burden on recipients will rise very rapidly since they are substantial payers for elderly care (currently in care homes and for home helps).

The AWG assumptions on economic growth in Slovenia reflect the population changes and the reduced numbers in the working population. However, they are lower than the growth rates achieved in years before the crisis. If a steady growth rate of 3% per annum in real terms were achieved the percentage of GDP spent on LTC would be only 1.55% – a small increase from the current level of 1.44%, and would be 1.6% in 2035. This shows that the affordability of the increase in LTC costs depends on the level of economic growth that is achieved.

Table 2
Estimated LTC expenditure by payer

	In million €, real terms			Structure, in %			Level in % of GDP			Change in pp of GDP	
	2013	2025	2035	2013	2025	2035	2013	2025	2035	2013–2025	2013–2035
TOTAL	471.1	715.4	1,017.1	100.0	100.0	100.0	1.32	1.55	1.92	0.23	0.60
PUBLIC	341.5	495	684.3	72.5	69.2	67.3	0.96	1.07	1.29	0.11	0.33
HIIS	159.6	250.7	363	33.9	35.0	35.7	0.45	0.54	0.69	0.10	0.24
PIII	77.1	103.7	136.4	16.4	14.5	13.4	0.22	0.22	0.26	0.01	0.04
MLFSA	35.4	40.7	47.3	7.5	5.7	4.7	0.10	0.09	0.09	-0.01	-0.01
Municipalities	69.4	100	137.7	14.7	14.0	13.5	0.19	0.22	0.26	0.02	0.07
PRIVATE	129.6	220.4	332.7	27.5	30.8	32.7	0.36	0.48	0.63	0.11	0.26
CHI	2.0	2.7	3.6	0.4	0.4	0.4	0.01	0.01	0.01	0.00	0.00
OOP	126.3	215.8	326.7	26.8	30.2	32.1	0.35	0.47	0.62	0.11	0.26
NGOs	1.4	1.8	2.0	0.3	0.3	0.2	0.00	0.00	0.00	0.00	0.00

Source: SURS; own calculation.
Notes: HIIS (Health Insurance Institute of Slovenia), PIII (Pension and Invalidity Institute, MLFSA (Ministry of Labour, Families and Social Affairs, CHI (Complementary Health Insurance), OOP (out-of-pocket payments), NGOs (non-profit organizations), pp of GDP (percentage points of gross domestic product).

Capped user payments scenario

As can be seen in Table 2, the estimated increase in payments by recipients would involve more than doubling of the current level of funding. Concern has already been raised about the burden on recipients, and the capacity to meet this large increase is questionable. As an illustration, the second set of estimates limits the increase to the overall increase in levels of income (Table 3). The additional cost to other funders has been estimated on the basis of the current funding of those services that are paid for privately. The largest additional costs would be paid by the Health Insurance Institute of Slovenia and local government.

Reduced disability scenario

The two scenarios above accept the AWG assumption that costs of LTC will rise in line with the change in the numbers in each age group. Since it is likely that improved survival is associated with some fall in disability at any given age, the growth in the need for LTC may be slower than estimated by the AWG. The estimates in Table 4 use

Table 3

Estimated LTC expenditure by payer with capped recipient charges

	In million €, real terms			Structure, in %			Level in % of GDP			Change in pp of GDP	
	2013	2025	2035	2013	2025	2035	2013	2025	2035	2013–2025	2013–2035
TOTAL	471.1	715.4	1,017.10	100.0	100.0	100.0	1.32	1.55	1.92	0.23	0.60
PUBLIC	341.5	608.1	840.6	72.5	85.0	82.6	0.96	1.32	1.59	0.36	0.63
HIIS	159.6	307.9	445.9	33.9	43.0	43.8	0.45	0.67	0.84	0.22	0.39
PIII	77.1	127.3	167.6	16.4	17.8	16.5	0.22	0.28	0.32	0.06	0.10
MLFSA	35.4	50.0	58.0	7.5	7.0	5.7	0.10	0.11	0.11	0.01	0.01
Municipalities	69.4	122.8	169.1	14.7	17.2	16.6	0.19	0.27	0.32	0.07	0.12
PRIVATE	129.6	158.8	187.1	27.5	22.2	18.4	0.36	0.34	0.35	-0.02	-0.01
CHI	2.0	2.7	3.6	0.4	0.4	0.4	0.01	0.01	0.01	0.00	0.00
OOP	126.3	154.3	181.1	26.8	21.6	17.8	0.35	0.33	0.34	-0.02	-0.01
NGOs	1.4	1.8	2.3	0.3	0.3	0.2	0.00	0.00	0.00	0.00	0.00

Source: SURS; own calculation.
Notes: HIIS (Health Insurance Institute of Slovenia), PIII (Pension and Invalidity Institute, MLFSA (Ministry of Labour, Families and Social Affairs, CHI (Complementary Health Insurance), OOP (out-of-pocket payments), NGOs (non-profit organizations), pp of GDP (percentage points of gross domestic product.

Table 4

Estimated LTC expenditure by payer assuming reducing disability rates

	In million €, real terms			Structure, in %			Level in % of GDP			Change in pp of GDP	
	2013	2025	2035	2013	2025	2035	2013	2025	2035	2013–2025	2013–2035
TOTAL	471.1	675.4	916.0	100.0	100.0	100.0	1.32	1.46	1.73	0.14	0.41
PUBLIC	341.5	467.3	616.4	72.5	69.2	67.3	0.96	1.01	1.16	0.05	0.21
HIIS	159.6	236.6	326.9	33.9	35.0	35.7	0.45	0.51	0.62	0.06	0.17
PIII	77.1	97.8	122.9	16.4	14.5	13.4	0.22	0.21	0.23	0.00	0.02
MLFSA	35.4	38.5	42.6	7.5	5.7	4.7	0.10	0.08	0.08	-0.02	-0.02
Municipalities	69.4	94.4	124	14.7	14.0	13.5	0.19	0.20	0.23	0.01	0.04
PRIVATE	129.6	208	299.6	27.5	30.8	32.7	0.36	0.45	0.57	0.09	0.20
CHI	2.0	2.6	3.3	0.4	0.4	0.4	0.01	0.01	0.01	0.00	0.00
OOP	126.3	203.8	294.3	26.8	30.2	32.1	0.35	0.44	0.56	0.09	0.20
NGOs	1.4	1.7	2.1	0.3	0.3	0.2	0.00	0.00	0.00	0.00	0.00

Source: SURS; own calculation.
Notes: HIIS (Health Insurance Institute of Slovenia), PIII (Pension and Invalidity Institute, MLFSA (Ministry of Labour, Families and Social Affairs, CHI (Complementary Health Insurance), OOP (Out-of-pocket payments), NGOs (Non-profit organizations), pp of GDP (percentage points of gross domestic product).

the estimated fall in disability used in Wren et al. (2012). While a small reduction in disability will, in itself, reduce care costs, it may also be associated with more people being able to remain in their own homes with support from informal care as well as formal care services. The key point is that spending on LTC would rise more slowly, but would still more than double by 2035.

A variant on the reduced disability scenario also caps the increased spending by recipients to increases in GDP. The cap has less effect in this case since the growth in total LTC spending is reduced, but the increased cost to the HIIS of this cap would still be over €90 million per year.

Summary and key messages

- LTC expenditure in Slovenia represents only a small component of GDP, and is much lower than health care spending, but is growing much more rapidly. Even on optimistic assumptions about the levels of disability, the effects of demographic change will be to more than double LTC expenditure level in millions of euros by 2035 and the share of total LTC expenditure in GDP will increase by more than 0.5 of a percentage point by 2035.
- There are four main public funding sources for LTC, but nearly half of the public LTC spending is by the Health Insurance Institute.
- The Health Insurance Institute will see the largest absolute growth in LTC spending because of its focus on LTC for older people. The Ministry of Labour will see only a smaller increase given the focus on LTC for non-elderly people.
- Private spending on LTC is almost all out-of-pocket spending by recipients and this has been growing significantly. On current policy and practice, this would increase rapidly (given that the services paid for privately are likely to grow rapidly) and this might not be sustainable.
- There is unnecessary complexity in the current public funding of LTC that leads to confusion about entitlements, difficulty in brokering access to combinations of services needed by users, and this may be a factor in the over-reliance on residential care.
- Consideration should be given to reducing the complexity of (particularly the public) funding of LTC. This might be achieved either by shifting responsibility to a single government department and/or agency, or by mechanisms that aim to coordinate the spending and entitlements between the different funding organizations.
- This report shows that LTC spending is likely to grow rapidly, and that the rate of growth will vary hugely between the different public funders of care. With a much longer time scale it would be possible to derive more precise estimates of the changing costs to the different funders, but the current calculations display clearly the patterns of likely change.

Appendix 1

Composition of Long Term Care Expenditure in Slovenia 2013

	SHA Class'n		Elderly or non-elderly	Health LTC Elderly	Health LTC Not elderly	Social LTC Elderly	Social LTC Not elderly	Total Non elderly	Total Elderly	Total Spend by Payer
PUBLIC SOURCES										
HIIS	HC	Homes for the elderly	E	9 794 4017					97 944 017	97 944 017
	HC	Work Training Centres	NE		11 923 677			11 923 677		11 923 677
	HC	Special institutions	NE		10 115 363			10 115 363		10 115 363
	HC	Nursing and palliative care in hospitals	E	9 338 521					9 338 521	9 338 521
	HC	LTC disabled youth	NE		8 839 461			8 839 461		8 839 461
	HC	Hospital dementia	E	2 276 994					2 276 994	2 276 994
	HC	Day care in homes	E	394 942					394 942	394 942
	HC	Work training	NE		464 386			464 386		464 386
	HC	Community nursing	E and NE	8 821 095	8 821 095			8 821 095	8 821 095	17 642 190
	HC	Community nursing sheltered housing	E	635 039					635 039	635 039
		Total								159 574 590

	SHA Class'n		Elderly or non-elderly	Health LTC Elderly	Health LTC Not elderly	Social LTC Elderly	Social LTC Not elderly	Total Non elderly	Total Elderly	Total Spend by Payer
PUBLIC SOURCES										
Pensions Institute	HC	Attendance allowance	E and NE	13 239 412	13 239 412			13 239 412	13 239 412	26 478 824
	HC	Attendance allowance	E and NE	21 601 146	21 601 146			21 601 146	21 601 146	43 202 292
	HC	Attendance allowance	NE		895 440			895 440		895 440
	HC	Attendance allowance	NE		6 489 506			6 489 506		6 489 506
		Total								77 066 062

	SHA Class'n		Elderly or non-elderly	Health LTC Elderly	Health LTC Not elderly	Social LTC Elderly	Social LTC Not elderly	Total Non elderly	Total Elderly	Total Spend by Payer
PUBLIC SOURCES										
Ministry of Labour, Family, Social Affairs and Equal Opportunities	HC	Centres training	NE		6 516 470			6 516 470		6 516 470
	HC	Family assistance	E and Non E	1 456 584					1 456 584	1 456 584
	HC	Assistance severe disability	E and Non E	282 4870					2 824 870	2 824 870
	HC	Attendance allowance	E and Non E	321 512					321 512	321 512
	HC	Attendance allowance	E and Non E	674 634					674 634	674 634
	HC	Attendance allowance	E and Non E	113 999	113 999			113 999	113 999	227 997
	HC	Special child-care allowance	NE		8 169 824			8 169 824		8 169 824
	HC	Partial payment	NE		5 535 615			5 535 615		5 535 615
	HCR	Group homes	NE				1 719 798	1 719 798		1 719 798
	HCR	Employment subsidies	E and NE			1 169 021	1 169 021	1 169 021	1 169 021	2 338 042
	HCR	Home help	E			376 797			376 797	376797
		Total								30 162 142

	SHA Class'n		Elderly or non-elderly	Health LTC Elderly	Health LTC Not elderly	Social LTC Elderly	Social LTC Not elderly	Total Non elderly	Total Elderly	Total Spend by Payer
PUBLIC SOURCES										
Local governments	HC	Homes for the elderly	E	21 207 578					21 207 578	21 207 578
	HCR	Special social welfare institute	NE				10 337 880	10 337 880		10 337 880
	HC	Training, Work Instititute	NE		5 368 900			5 368 900		5 368 900
	HC	Training, Work Institute	NE		9 324 376			9 324 376		9 324 376
	HC	Family assistant	E and NE	3 695 655	3 695 655			3 695 655	3 695 655	7 391 310
	HCR	Home help	E			15 156 140			15 156 140	15 156 140
	HCR	Group homes	NE				655 218	655 218		655 218
		Total								69 441 402
Total Public										336 244 196

	SHA Class'n		Elderly or non-elderly	Health LTC Elderly	Health LTC Not elderly	Social LTC Elderly	Social LTC Not elderly	Total Non elderly	Total Elderly	Total Spend by Payer
VHI	HC		E and NE	980 443	980 443			980 443	980 443	1 960 885
Recipients and family	HC	Homes for the elderly	E	112 383 499					112383499	1 12383 499
	HC	Special social welfare institute	NE		875 596			875 596		875596
	HC	Training, work institute	NE		1 606 442			1 606 442		1 606 442
	HC	Training, work institute	NE		3 517 795			3 517 795		3517 795
	HCR	Home help	E			4 252 337			4 252 337	4 252 337
	HCR	Group homes	NE				776 759	776 759		776 759
	HC	Household Out-of-pocket payments	E and NE	1 242 664	1 242 664			1 242 664	1 242 664	2 485 327
		Total								125 897 755
Donations		Group homes	NE		6238			6238		6238
Other non-public		Group homes	NE		16 209			16 209		16 209
FFDHOS		Group homes	NE				249 403	249 403		249 403
		Other programmes	E and NE	564 048	564 048			564 048	564 048	1 128 095
		Total								1 377 498
Total Private										129 258 585
Total LTC Expenditure								144 468 436	320 670 944	465 502 781

Appendix 2

Assumptions for basic AWG compatible model (Table 2):

- needs for LTC will grow in line with Ageing report (European Commission, 2015) reference scenario assumptions
- more rapid growth of social LTC (in line with recent changes and the projected population changes)
- no additional services to meet currently unmet needs
- growth for each funding source will be in line with the balance of services currently provided with funding from each
- funding from recipients and families will grow only in line with GDP growth
- there are no efficiency gains from shifting services from institutional care to community-based services
- there are no efficiency gains from changing staff mix etc.
- GDP growth in line with AWG (European Commission, 2015) assumptions.

Assumptions for model with capped user payments (Table 3):

- needs for LTC will grow in line with Ageing report (European Commission, 2015) reference scenario assumptions
- more rapid growth of community social care (in line with recent changes and the projected population changes)
- no additional services to meet currently unmet needs
- growth for each funding source will be in line with the balance of services currently provided with funding from each
- funding from recipients and families will remain the same proportion of total spending as in 2014
- there are no efficiency gains from shifting services from institutional care to community-based services
- there are no efficiency gains from changing staff mix etc.
- GDP growth in line with AWG (European Commission, 2015) assumptions.

Assumptions for reduced disability model (Table 4):

- needs for LTC will grow more slowly than Ageing report (European Commission, 2015) reference scenario assumptions taking account of likely reduced age-specific disability
- more rapid growth of community social care (in line with recent changes and the projected population changes)
- no additional services to meet currently unmet needs
- growth for each funding source will be in line with the balance of services currently provided with funding from each
- funding from recipients and families will remain the same proportion of total spending as in 2014
- there are no efficiency gains from shifting services from institutional care to community-based services
- there are no efficiency gains from changing staff mix etc.
- GDP growth in line with AGW (European Commission, 2015) assumptions.

References

Brick A et al. (2015). Economic evaluation of palliative care in Ireland. Trinity College Dublin. Report prepared for The Atlantic Philanthropies (www.medicine. tcd.ie/health_policy_management/assets/pdf/Final-report-July-2015.pdf).

Davies BP, Knapp MRJ (1981). Old people's homes and the production of welfare. London, Routledge & Kegan Paul.

Dominkus D et al. (2014). Long-term care – the problem of sustainable financing. Host country paper. Peer Review on financing of long-term care, Slovenia. (http://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=2097&furtherNews=yes).

European Commission (2015). The 2015 ageing report, Ageing Working Group report. Brussels, European Commission. (http://ec.europa.eu/economy_finance/publications/european_economy/2015/pdf/ee3_en.pdf).

IMAD (2014). Expenditure on long-term care. Development report 2014. Ljubljana, IMAD (Institute of Economic Research) (http://www.umar.gov.si/fileadmin/user_upload/publikacije/pr/2014/IV/A/A_4_9.pdf).

Layte R (ed.) (2009). Projecting the impact of demographic change on the demand for and delivery of healthcare in Ireland. ESRI Research Series 13. Dublin, Economic and Social Research Institute.

McNamara A, Normand C, Whelan B (2013). Patterns and determinants of health care utilisation in Ireland. Dublin, Irish Longitudinal Study on Ageing. (http://tilda.tcd.ie/assets/pdf/Tilda%20Health%20Care%20Utilisation%20Report.pdf).

Majcen B (2015). Long-term projections of revenues and expenditure for health and LTC. Presentation at project meeting on financing the health care system. Ljubljana, November.

Murphy CM, Whelan BJ, Normand C (2015). Formal home-care utilisation by older adults in Ireland: evidence from the Irish Longitudinal Study on Ageing (TILDA). Health and Social Care in the Community, 23(4):408–418. doi: 10.1111/hsc.12157.

Nagode M et al. (2014). Long-term care: use of international definition in Slovenia. Working paper 2/2014 XXIII. Ljubljana: IMAD (http://www.umar.gov.si/fileadmin/user_upload/publikacije/dz/ 2014/DZ_02_14p.pdf).

Nolan A et al. (2014). The over-50s in a changing Ireland: economic circumstances, health and well-being. Dublin, Trinity College Dublin (http://tilda.tcd.ie/assets/pdf/Wave2-Key-Findings-Report.pdf).

OECD, Eurostat, WHO (2011). A system of health accounts. Paris, OECD Publishing (www.who.int/health-accounts/methodology/sha2011.pdf).

Rodrigues, R. (2014). Long-term care: the problem of sustainable financing. Discussion paper. Peer Review on financing of long-term care, Slovenia (http://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId= 2097&furtherNews=yes).

Wren M-A et al. (2012). Toward the development of a predictive model of long-term care demand for Northern Ireland and the Republic of Ireland. Dublin, Trinity College Dublin, Centre for Health Policy and Management (http://medicine.tcd.ie/health_policy_management/assets/pdf/CARDI%20report.pdf).

Zver E, Dominkus D (2015). Long-term care reform in Slovenia: financing perspective. 4th Meeting of the Joint Network on Fiscal Sustainability of Health Systems. Paris, OECD.