Dignity first – priorities in reform of care services (Sweden, 26-27 September 2013)

Reforming care services in Slovenia[1]

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What are the current situation and the recent trends in your country in relation to home care? Are innovative approaches similar to the Swedish case already applied (e.g. free choice systems, person-centred approach)?

The provision of long-term care in Slovenia was initially based on institutional care. Home care was only introduced in late 1980s and started to develop more intensively at the end of the 1990s. Before that, home care was provided through community nursing within the primary health sector, but was only available to a limited extent. In the second half of the 1990s, non-institutional forms of long-term care were increasingly facilitated (Republic of Slovenia 2005[2]).

Governance on home care is fragmented and the responsibility is split over two ministries. **Community nursing falls under the Ministry of Health** and is governed by the Law on Health Care Provision and Health Care Coverage, and Health Insurance Act. Community nursing as the main service of health care at home is financed entirely form Health Insurance Institute of Slovenia on the basis of compulsory health insurance scheme. Apart from the ministry and national and regional offices of the Health Insurance Institute other important players in community nursing are also municipalities.

Personal care, domestic aid and social care, encompassing all other home care services **falls under the responsibility of the Ministry of Labour, Family, Social Affairs and Equal Opportunities** and are governed by the Social Security Act. Municipalities have even more significant role in regard to the other types of home care, namely **home help**. However, home help as the main social care at home (personal and domestic help) is in charge of 211 municipalities who are obliged to organise, provide and finance (at least 50% of the price) the service.

Community nursing and home help are regulated within different regulatory systems. Therefore providers are not the same and operate separately under different regulatory systems. **Community nursing** is provided by community nurses, who perform preventive and health education services, health-related services at home and to a certain extent also home help services. They are one of the first professional workers to identify health and social hardship as well as the needs of individual insured persons and their families for home and long-term care

[1] Prepared for the Peer Review in Social Protection and Social Inclusion programme coordinated by ÖSB Consulting, the Institute for Employment Studies (IES) and Applica, and funded by the European Commission.

[2] Republic of Slovenia (2005) National Report on Health Care and Long-Term Care in the Republic of Slovenia Ljubljana.

(Republic of Slovenia 2005, 13[2]). In last decade, the need for curative community nursing has significantly grown and it is expected that the trend will continue to grow. Nowadays the ratio between preventive and curative community nursing has been disrupted – the preventive community nursing represents only about 20% of total community nursing. Along with detected trends, the basic role of community nursing is becoming questionable (Berčan 2012, 36-38[3]; Džananović 2010, 117-125[4]). There is a great need for organisational changes of community nursing since the need for community nursing will continue to grow and since the current system is not able to satisfy existing needs. Analysis of the reports on the work of nursing services (Džananović 2010, 117-125[4]) point to changes in the structure of the patients, as the proportion of older people is rising, as well as the changes of content and complexity of community nursing.

Home help is adjusted to the needs of an individual and includes housework assistance (IADL); assistance in essential daily activities (ADL) and assistance in maintaining social contacts. The Social Protection Institute of the Republic of Slovenia carried out a few analysis of the situation of home care in Slovenia. The last analysis (Nagode and Lebar 2012[5]) showed that home help is provided mainly by public agencies (i.e. centres for social work and homes for older people) and only few were private organisations with concessions. The analysis shows further that 62.3% of the users were 80+ years old. Only 1.7% of the population 65+ receive formal home help, although the national goal stated in The Resolution on the National Programme of Social Assistance 2006-2010 (Ministry of Labour, Family and Social Affairs 2006) was set to 3.0%. The new Resolution on the National Programme of Social Assistance 2013-2020 (Ministry of Labour, Family, Social Affairs and Equal Opportunities 2013) is setting this goal even higher – 3.5%.

The development of this service is still facing weaknesses as well as new challenges. The basis for the implementation of home help is standards that provide the general framework for the implementation of these services across the country. As the service is organised by municipalities the potential users may have different prices, depending on the amount of subsidies of the municipalities. The approach of different municipalities and providers also influences the availability of home help in single municipality. The same holds true for the timetable of the service, for some providers (in most cases a single provider in each municipality) offer home help every day of the year, some only 5 days per week or not in the late afternoon, etc. Aiming to reduce the unmet needs of the dependent elderly people there is a strong need to expand home help and other services provided at the users' home as well as increase the flexibility in the implementation of all community services.

People who would otherwise be institutionalised have the right to choose a **family assistant**. The family assistant provides support for every-day living activities and enables the person to stay at home; the services of a family assistant are financed by a combination of public and private sources. A family assistant is a kind of personal assistant who lives with the person and provides daily assistance (Social Care Act). Family assistant comprises the characteristics of service, cash benefit and informal help. There were 727 family assistants in 2012.

[3] Berčan Mateja (2010) Staranje prebivalstva in patronažno zdravstveno varstvo. Kakovostna starost, letnik 15, številka 2.

[4] Darinka Zavrl Džananović (2010) Novosti–izkušnje–pobude–odmevi: patronažno varstvo Slovenije včeraj, danes, jutri: Analiza poročil o delu patronažnega varstva od leta 2000 do 2008. Obzornik zdravstvene nege, letnik 44, številka 2.

[5] Nagode Mateja, Lebar Lea (2012) Izvajanje pomoči na domu. Analiza stanja za leto 2012. Ljubljana: Inštitut RS za socialno varstvo.

Within different social security sub-systems the **special cash-benefit for care** is provided as an additional payment: "supplement payment for help and support" – "cash-benefit for care". A person is entitled to this additional benefit for care, if he or she is not able to perform ADLs without another person's support. According to Pension and Disability Insurance Act there are three different amounts: the lower amount for those, who need support for the most of the ADLs € 142.08, the higher amount for those who need support for all ADLs € 290.15; and the highest amount for special cases around € 414.5. There were 31.238 recipients of cash benefits in 2012. The benefit is given directly to the person in need of care. In general, the benefit is given as cash for free use by the recipient. Cash benefits are mostly used by recipients for covering the costs of formal and informal providers (home help, institutional care etc.).

As has been shown, formal home care in Slovenia is relatively undeveloped and the main aim of the government is to increase home care in Slovenia. Along with that the government is aiming to enhance the coordination between different types of care providers, i.e. individuals, family, the third sector, the market and the state. In this manner, the new legislation is under preparation – Long-Term Care and Insurance for Long-Term Care Act (Ministry of Labour, Family and Social Affairs, 2010). Innovative approaches as Sweden has already applied (free choice system, person-centred approach) are the part of guidelines in the new Resolution on the National Social Assistance Programme for time period 2013-2020, which was adopted in the spring of 2013. However, they have been also impelemented in the proposed new act.

What is the experience of your country regarding the use of technology in home care?

Social alarms as the basis of assistive technology are the most developed type of assistive technology in Slovenia. Social alarms were first introduced in 1992 in Ljubljana. Despite this fact, two years ago they were available only in five out of twelve regions and were not nationally covered. At least five key constraints on assistive technology uptake in Slovenia were identified: unequal access and unequal price; unknown service – marketing strategy; lack of cooperation; lack of funds; lack of political will (Dolničar and Nagode 2010[6]). Now they are offered by provider which provide national coverage. New organisation of **social alarms** and **telecare** was introduced in 2012 (Telecare) and as already mentioned for the first time at the national level. The practice consists of SOS at Home, SOS Mobile and SOS Doctor. The latter two are new services in Slovenia. The price compared to previously existing social alarm is lower and more affordable for potential users. High price was one of the factors for small number of users (after 15 years of operating there were still no more than 300 users). The technology is easy to use (suitable and convenient for elderly) and it can be also used when being abroad. The first impulse to introduce new service was to offer the service with one technical solution (comparing with previous practice that had almost as many technical solutions as there were providers) on a national level (national call centre). Mainly, for the purpose of reducing costs (administrative). Another impulse was to provide the basic service that would enable elderly to stay at home for as long as possible. As known, social alarm (SOS at Home) as the base for more developed technological solutions was highly underdeveloped in Slovenia (regarding the territorial coverage). On the other hand, the new legislation that is still in

[6] Nagode, Mateja, Dolničar, Vesna. Assistive technology for older people and its potential for intergenerational cooperation: critical review of the present situation and identification of key constraints for wider uptake. Teorija in praksa, nov. - dec. 2010, let. 47, št. 6, str. 1278-1294.

preparation anticipates classifying this sort of service among other public social services.

Home telehealth services in Slovenia are under-developed to date. Some services have been developed but all are only at the demonstration or pilot stage offering sample solutions and have not yet been integrated within the mainstream home care services. The most known example of telehealth application was telemetric service called Telelink that was available till recently (and started in 1997). Telelink enhanced the relationship between a doctor and a patient with heart/cardiac difficulties. The service allowed the recording and transmitting of ECG copy by telephone. Rudel (2008[7], 28) claims that the presence of Telelink was hardly detected mainly due to the fact that the provision of immediate response to the received patient data are financially and organisationally too difficult task. At the moment the most developed service of telehealth is the system of **national teleconsultations** in the Slovenian blood transfusion service (used since 2005). It provides remote work capabilities to specialists of transfusion medicine. Breskvar et al (2012[8]) explain that telemedicine allows for substituting on-premises specialists with a remote on-duty specialist, and as such provides a comparable level of service for all patients, with considerable savings in the national health budget as an added bonus. The current system, planned only for teleconsultations, outgrew its primary scope with the reorganisation of Slovenian transfusion service, which increased the number of B2B services. Rapid growth of the delivered services outpaced the current IT infrastructure, thus demanding the ongoing development of a new system.

Within the framework of national E-health project also telemedicine services will gradually be evolved in the context of subproject **Comprehensive health care at a distance**. It includes methods such as: telemetry (sensors for monitoring blood pressure, blood sugar, body activity, medication, etc.), teleconsultation (visit the doctor at home distance), monitoring needs (keeping in bed, fall, wetting the bed, seizure, etc.), telerehabilitation, monitoring the living environment for staying safe (mouth water, fire, etc.), distance education (educational programmes in IP TV, video on demand), individualised reminders related to specific health problem of an individual etc. (Vončina Slavec and Meglič 2010[9]). As stated in the feasibility study (Drnovšek et al 2009[10]), the aim of the subproject is to provide (until mid-2015) unified organisational, information and telecommunication support necessary for the implementation of services and health care at a distance on the national level.

There is one **smart home** in Slovenia – IRIS. IRIS Smart home is a demonstration apartment of about 90 m^2, located at the University Rehabilitation Institute. It has been equipped with appropriate technical aids and numerous electronic systems, which allow the user to control the living space and to perform certain activities (opening doors and windows, drawing window blinds, switching the heating system on/off etc.) with minimal physical effort and in various manners (remote control, voice control, wheelchair joystick, eye-movement control etc.). It has also been equipped with modern communication technology adapted to different types of disability, which enables people with disabilities to communicate with the outside world, partake in distance learning, work, leisure, and entertainment. It has been

[7] Rudel, Drago (2008) Zdravje na domu na daljavo za stare osebe. Informatica Medica Slovenica 13 (2): 19–29.
[8] Breskvar M et al (2012) Novi telemedicinski sistem v slovenski transfuzijski službi. Infor Med Slov: 2012; 17(1): 14-23.
[9] Vončina Slavec Smiljana, Meglič Matic (2010) Nacionalni projekt eZdravje in telemedicina. Infor Med Slov: 2010; 15(supl): 3-4.
[10] Drnovšek S et al.(2009) Študija izvedljivosti projekta zdravje - Predinvesticijska zasnova in investicijski program s študijo izvedbe. Ljubljana.

introduced in December 2007 and is a unique project in Slovenia but it also differs from similar practices in other European countries in the fact that it covers two activities at one place. It is a research laboratory and apartment in which person can live for few days and try medical and communication aids, so that he/she can try out solutions in practice. This type of treatment enables individual approach to each user and through the treatment several possibilities could be tried out to achieve the highest possible level of functional independence. IRIS Smart home operates as research laboratory and as a part of public health service (which is covered from one's health insurance). On the other hand, similar smart homes in other countries are designed mostly as laboratories without being part of public service or treating immediate users. Since this is an unique project surpassing several similar projects around Europe, it was presented during Slovenian EU presidency as one of the most important developmental and technological achievements in Slovenia in the area of e-inclusion. IRIS is a part of the efforts and initiatives by the EC in the area of e-inclusion.

As shown, the **development of technology in home care** in Slovenia is still very low and undeveloped, although the government is setting goals for the development of this area since 1997 when The Programme of Social Care of Older People in Slovenia till 2005 (Ministry of Labour, Family and Social Affairs, 1997) was adopted. After more than 10 years the goal was not achieved, even though it was further supported by The Strategy of Care for the Older People till 2010 – solidarity, good intergenerational relations and quality ageing of the population (Ministry of Labour, Family and Social Affairs, 2006). Also, the proposal of Long–Term Care and Insurance for Long-Term Care Act (Ministry of Labour, Family and Social Affairs, 2010) refers to stimulating the use of new technologies in the field of long–term care. However, the legislation is not introduced yet. On the other hand, the active project E-health is planning to introduce telemedicine and telecare till 2015. The progress and results are not evident yet.

How is the quality in the provision of services monitored in your country (e.g. quality registers)? Which information/indicators are being used?

The field of long-term care is not systematically settled and regulated since the services and benefits are organised, provided and financed within the framework of different legislation. In line with that, social and health care sector operate separately. These services are not integrated, especially when providing care at home. Along with that, the **quality of services is not uniquely defined at the national level**; there is no national strategy for quality management in long-term care as is also the case in many other countries. The new Resolution on the National Social Assistance Programme 2013-2020, has set a target that all providers of social services with at least 10 employees till 2020 will acquire a certificate from certified quality management systems. About 50% providers of institutional care have already obtained E-Qualin or ISO certificate; some of them are also providing home help.

Quality measures for long-term care are still in their infancy. Irrespective to this, there is a national strategy for measuring quality of health care provided, but it is more developed for hospital than for home care.

Regulation on quality assessment of social service providers is laid down in the 'Social Security Act' and the 'Rules on Professional and Administrative Control in the Field of Social Assistance and Social Services'. Home help providers are controlled professionally and administratively by a special commission/inspection (at least every three years). Furthermore, according to The Rules family members of eligible

persons may also ask for a quality evaluation. Family assistants are, at least yearly, obliged to report about their care to the social work centres. Centres for social work must annually report about information or opinions of the disabled person. Some providers of home help (homes for older people, centres for social work) are using the E-qalin model that is implemented in many homes for older people and some centres for social work in Slovenia.

Quality evaluation and control of community nursing is in its infancy in Slovenia. Monitoring data collected by the National Institute for Public Health seem not to be used for quality improvement in primary care but are rather administrative data. In addition, administrative and financial control is performed by the Health Insurance Institute, for instance on evidence-based prescribing.

Formal complaint procedures are obligatory for nursing care providers (Patients' Rights Act). Health care providers must appoint someone to receive and process client complaints. Complaints usually deal with the quantity of services and with lay helpers. If clients are dissatisfied with personal care and domestic aid, they may appeal against the provider at the council of the social welfare institution, and against a private undertaking at the Social Chamber (Social Security Act).

The Social Protection Institute of the Republic of Slovenia yearly **monitors** the organisation and provision of home help using a special questionnaire (since 2007). The data are provided by municipalities (211 in 2012) together with home care providers (76 in 2012; there is mainly one home care provider in each municipality). The minimum set of data is reported. Data set consists of information about the cost, price and structure of the service, users, carers, service provision, detected needs etc. Data on community nursing are collected on a statistical form, finally harmonised in 2000. Information on completed tasks are provided by all Regional Public Health Institutes. The report also covers private providers active in particular regions. Data contain the following information on community nursing staff, preventive and (1st) curative home visits, categories of health services, indications for first curative home visits, etc.

Evaluation of client satisfaction as a component of service quality evaluation is not obligatory in Slovenia. Irrespective of this, some providers of home help measure client and carer's satisfaction on their own using own instruments. These instruments are usually not comparable between providers and over time which would facilitate to detect developments. Similarly, some community health care centres perform client satisfaction studies. There is a tendency to set nationwide rules on measuring client satisfaction as a component of quality evaluation.

Although there is no systematic approach to the quality of care in Slovenia and it is not legally settled, some activities are developing in different fields and are waiting to be integrated into an uniform system of quality assurance. There are many private as well as public initiatives to ensure and measure quality in care processes and results, and recent years have seen more research and analyses being undertaken in Slovenia in this field (Prevolnik Rupel et al 2012[11]). For example, the Faculty for Social Sciences in cooperation with some other faculties and institutions is running a basic research project *Community care of the elderly in Slovenia (2011-2014)* aiming to evaluate the quality of care. The new legislation on long-term care that is still under preparation is expected to be introduced in 2013. It will provide a firm basis for establishing quality assurance in long-term care in a systematic way from many view points. And, as already mentioned, The new Resolution on the National Social Assistance Programme 2013-2020 has given

[11] Prevolnik Rupel Valentina, Ogorevc Marko, Majcen Boris (2012) Quality Assurance Policies and Indicators for Long-Term Care in the European Union: Country Report Slovenia.

special attention to the improvement of quality services and programmes with implementing efficient quality managing.

What kind of impact have the related policies on the different actors involved in the care process – users, carers, health professionals – for example in terms of independent living, quality of life or work-time savings? In which ways can quality and accessibility of care services be balanced with sustainable finances?

Clear objectives related to improve of accessibility, quality and provision of sustainable financing of long-term care are laid down in several strategic documents and the adoption and implementation of the act on long-term care and long-term care insurance is one of priority goals for the ministries responsible for social affairs and health. The act will include next solutions:

- Long-term care will be delivered as an integrated service (integrated health and social care).
- Individuals in need of care will be provided with equal and fair accessibility to quality public network of long-term care services.
- The user will be able to enter the long-term care system through "one door" by means of a long-term care co-ordinator. This will enable long-term care services to be planned in line with the user's needs (tailor made services).
- Systematic support to non-professional providers will enable greater quality of services and implementation of long-term care at a user's home. The financial assistance to non-professional providers of long-term care will increase their social security.
- Preventive activities, rehabilitative care and care based on individual treatment is to be promoted.
- Mechanisms will be established for the promotion of programmes and activities of non-governmental organisations and volunteers, aimed at increasing the social inclusion of an individual, greater awareness of the need for long-term care, and reduced isolation and loneliness.
- The compulsory social insurance for long-term care will be introduced; financing of long-term care services will be based on solidarity and mutuality, and must provide for fairness and accessibility.