



The use of formal and informal care services in Slovenia: availability issues and challenges to gender and income equality*

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Introduction

The intensive demographic aging has put into question how the increasing care needs of older people will be met. Slovenia, as well as other European countries, is facing this challenge. The aging of the population calls for the development of new services and for the broadening of existing ones for older people in order to ensure their quality of life.

To better understand the use of home care services in Slovenia, and how it supplements or substitutes family caregivers, it is important to understand the characteristics of people using home care services and how these services are used – either alone or in combination with informal care. Such knowledge is vital for the development of home care services, for it would enable not only a better quality of life for the people using these services but also for the family carer.

Keywords:
Long-term care,
Inequalities,
Informal care

Within the DET_CAREMIX project, we aim to understand how dependent older people and their families make choices regarding the care mix and care tasks in long-term care in Slovenia and Austria, and to analyze possible gender and income inequalities in their use. The partners of the DET_CAREMIX project are the Centre for Welfare Studies of the Faculty of Social Sciences at the University of Ljubljana (Slovenia), the Institute for Economic Research, Ljubljana (Slovenia), and the European Centre for Social Welfare Policy and Research (Vienna, Austria). The present Policy Brief focuses on the case of Slovenia.

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Background and method

The comparative studies indicate significant differences between countries in the use of home care. As these studies show, informal care is more likely in countries with less developed home care services and residential care. Consequently, formal or mixed forms of care (i.e. both informal and formal care) are more likely to be found in Scandinavian countries and some Continental European countries, while in the Mediterranean and Central and Eastern European countries informal care only is more prevalent. Countries where the family is the main provider of care are often labelled as *supported familialism* and *familialism by default* (Saraceno & Keck). Slovenia belongs to such a familialistic model, where the family is the main provider of care. In Slovenia, there is also a legal obligation to contribute to the costs of care, and informal carers receive little support from the State in the form of either specialized support services or financial support for care (Hlebec, Nagode & Filipovič Hrast, 2014; Hlebec, Srakar & Majcen, 2016).

Home care services, which can represent an important complement (or substitute) to family care, developed slowly after the 1990s. The number of users has risen relatively slowly, from 3,909 in 1998 to 7,100 in 2015 (Hlebec & Rakar, 2017). The system is needs-based (i.e. based on the evaluation of health needs), with obligatory minimal subsidies from municipalities and additional co-payments by the users of services. However, as Prevolnik Rupel and Ogorevc (2010) note, the public long-term care funds are largely used for institutional care and only a small fraction is used for home care services. Furthermore, research has revealed significant variations between regions and municipalities in the availability and accessibility of these services (see Hlebec, 2012). During the recession, the number of users of home care services began to stagnate (Hlebec et al., 2014 a&b; Nagode et al., 2016; Hlebec & Filipovič Hrast, 2016). These amounted to 1.7% of those aged 65 and older in 2015, below the policy target of serving 3% of the elderly population (Nagode et al., 2016). Researchers have noted that the costs of the services are also too high for users and their families (e.g., Hlebec, 2012; Hlebec et al., 2014 a&b).

Nationally representative survey data based on the Survey of Health, Ageing and Retirement in Europe – SHARE – provides information regarding formal and informal care utilization in Slovenia for those living in the community (i.e. not including institutional care), which we analysed within the DET_CAREMIX project.

Use of home care services in Slovenia

Home care services can be used by those in need of care in different ways. They can either be used as the only source of care, or as an additional source of care together with informal, mostly family care. To optimise the benefits for the users and develop most appropriate services, it is important to understand how these services are used, i.e. for which kind of tasks. The most basic distinction in tasks performed is between more instrumental tasks (such as cooking or cleaning) or more personal care tasks (such as bathing, help with dressing, getting out of bed).

According to research on the quality of home care services in Slovenia (Hlebec et al., 2014b), social care workers most commonly provide help with washing and bathing, cooking or delivering lunch to the home, and cleaning. Apart from social care workers, family members also provide help with most of the aforementioned tasks. The help provided by social care workers is thus a supplement to the help provided by family members. The relationship is reversed only when it comes to washing and bathing tasks, in which case the help of social care workers is more frequent than the help of family members.

In this Brief we will distinguish between the following combinations of carers and their division of care tasks:

- formal care only; i.e. all the care tasks are provided by formal carers only;
- informal care only; i.e. all the care tasks are provided by informal carers only;
- mixed care; i.e. where the care tasks are shared between formal and informal carers, sharing either all or only some of the care tasks.

Informal care accounts for the largest share of care received by older people living in the community

The data from the SHARE¹ survey on a sample of 3,267 individuals aged 60 and above, revealed that 20.2% of all persons receive informal care only, 1.1% receive formal care only and 3.2% get a mix of both.

Among males, 18.13% are receiving informal care only, 1.3% formal care only and 2.6% receive a mix of both types of care. Among females, 21.8% are receiving informal care only, 1.0% formal care only and 3.6% a mix of both types of care.

¹ This paper uses data from SHARE Wave 6 (10.6103/SHARE.w6.700), see Börsch-Supan et al. (2013) for methodological details. The SHARE data collection has been funded by the European Commission through FP5 (QLK6-CT-2001-00360), FP6 (SHARE-I3: RII-CT-2006-062193, COMPARE: CIT5-CT-2005-028857, SHARELIFE: CIT4-CT-2006-028812), FP7 (SHARE-PREP: GA N°211909, SHARE-LEAP: GA N°227822, SHARE M4: GA N°261982) and Horizon 2020 (SHARE-DEV3: GA N°676536, SERISS: GA N°654221) and by DG Employment, Social Affairs & Inclusion. Additional funding from the German Ministry of Education and Research, the Max Planck Society for the Advancement of Science, the U.S. National Institute on Aging (U01_AG09740-13S2, P01_AG005842, P01_AG08291, P30_AG12815, R21_AG025169, Y1-AG-4553-01, IAG_BSR06-11, OGHA_04-064, HHSN271201300071C) and from various national funding sources is gratefully acknowledged (see www.share-project.org).

**Formal care only
is more often used by
men than by women**

Comparing those receiving care, men and women receive a similar amount of informal care only (82.6% as compared to 82.1%), but women receive less formal care only (3.8% vs. 6.0%) and more mixed care (13.6% vs. 11.8%).

Figure 1: Share of individuals aged 60 and above receiving care (by care type), in %

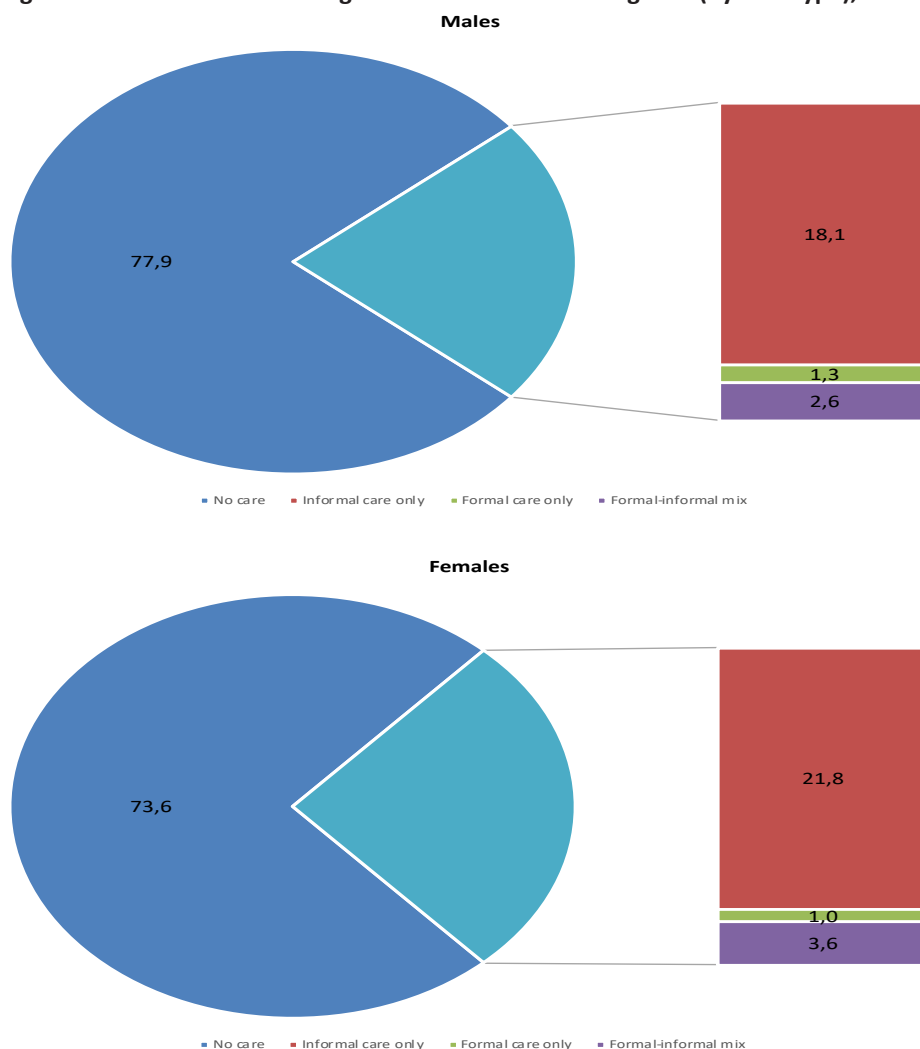
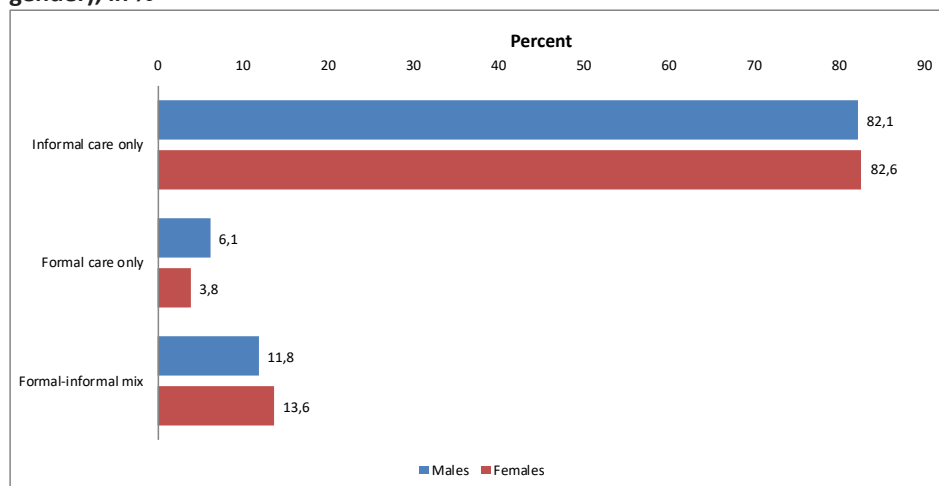


Figure 2: Share of older care users receiving informal, formal or mixed care (by gender), in %

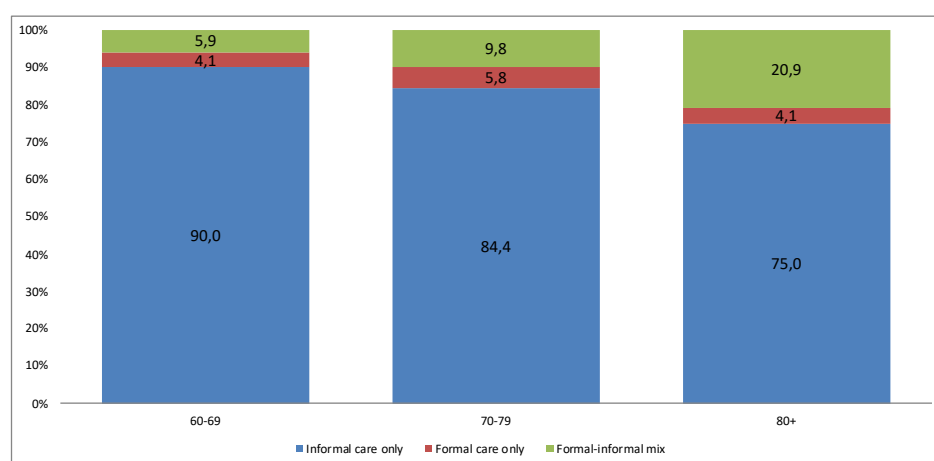


Age and functional differences in care utilisation

With age, the use of the formal-informal care mix significantly increases

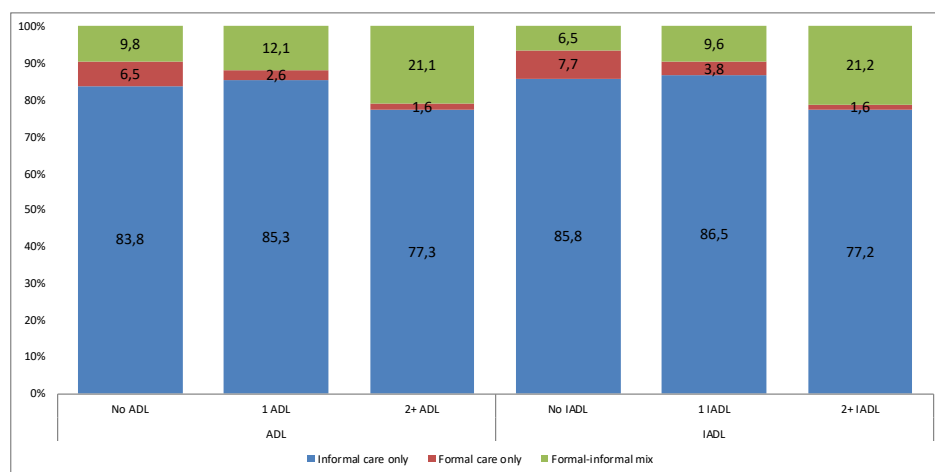
When compared across age groups, informal care only predominates among the youngest (60—69) age group, where 90% of users reports this type of care, followed by 84.4% in the 70-79 age group and 75% in the 80+ age group. This indicates that with increasing age and health care needs, formal care becomes necessary to supplement or substitute informal care. The share of formal care only is more evenly spread: among the youngest group (60-69 years of age) 4.1% receive this type of care, compared to 5.8% among the 'middle' group (70-79 years of age) and 4.1% in the oldest group (80+ age). Mixed care, on the other hand, predominates among the oldest group, with 20.9% of the respondents receiving it. In comparison, only 9.8% of respondents in the middle group receive it and 5.9% of respondents in the youngest group reported this type of care.

Figure 3: Share of older care recipients using informal care only, formal care only and mixed care by age group (%)



Among those with limitations in at least one Activity of Daily Living (ADL), 85.3% of respondents receive informal care only, 2.6% formal care only and 12.1 % a mix of both care types. On the other hand, among those with two ADL limitations or more, 77.3% receive informal care only, 1.6 % formal care only and 21.1% a mix of both care types. The picture for those with limitations in Instrumental Activities of Daily Living (IADL) is similar: informal care only is predominant among those with "less needs". Among those with one IADL limitation, 86.5% receive informal care only, 3.9 % receive formal care only and 9.6% receive a mix of both care types. On the other hand, among those with at least two or more IADL limitations, 77.2% receive informal care only, 1.6% formal care only and 21.3% a mix of both care types. The use of formal care only is actually higher among the groups with no IADL or ADL than among those identifying these needs, which indicates specific use of these services.

Figure 4: Share of older people using informal, formal and mixed care (by functional status)

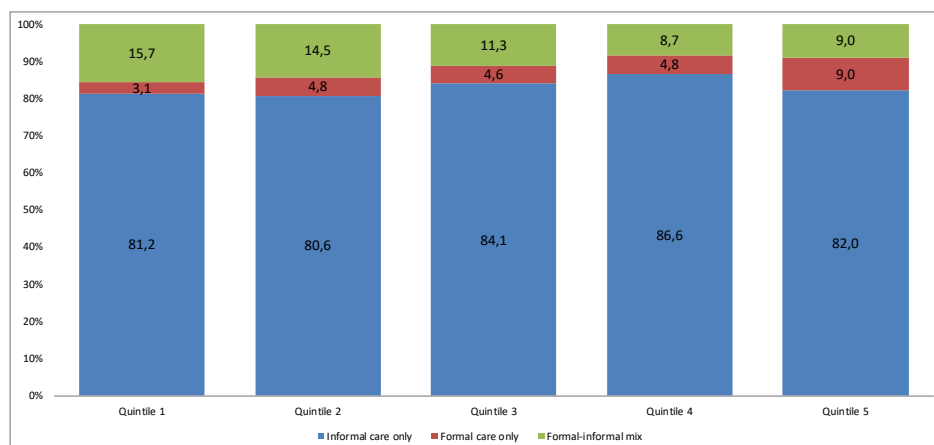


Income differences in care utilisation

Among those with the lowest income (i.e. in the bottom income quintile), 81.2% receive informal care only, 3.1% formal care only and 15.7% a mix of both care types. Among those in the second income quintile, 80.6% receive informal care only, 4.8% formal care only and 14.5% mix of both care types. In the middle of the income distribution, a larger share of respondents receive informal care only (84.1%), while 4.6% receive formal care only and 11.3% receive a mix of both care types. The largest share of informal care only is received among the fourth income quintile group (86.6%), which also receive 4.8% of formal care only and 8.7% of mix of both care types. Among the top income quintile, 82% receive informal care only, 9% receive formal care only and 9% a mix of both care types.

The use of formal care only is three times higher among the highest income quintile compared to the lowest income quintile

Figure 5 Share of older people using informal, formal and mixed care (by income quintiles)



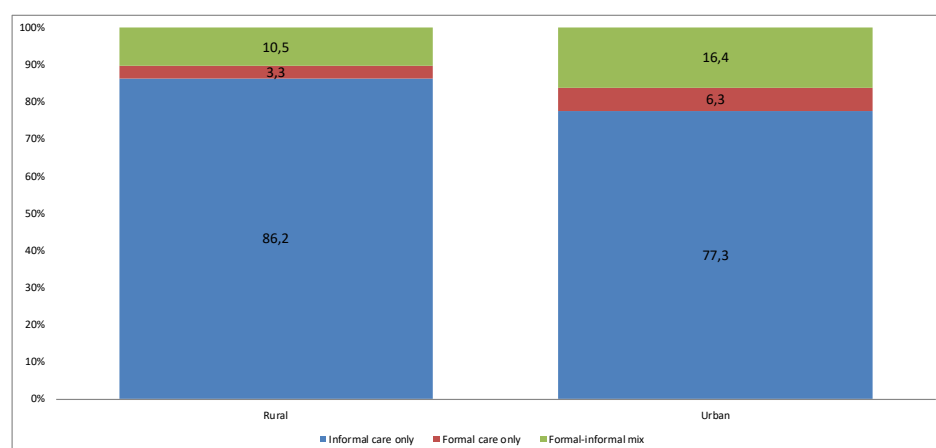
The use of formal care only is highest among the highest income quintile: it is three times higher than among the lowest income quintile. This seems to be linked with an ability to afford formal care support, potentially also in case of lower care needs.

Urban and rural divide

Those living in urban areas are more likely to use formal care

Among rural respondents, informal care only is significantly more prevalent than among people residing in urban areas (86.2% as compared to 77.3%). Urban respondents, on the other hand, receive more formal care only (6.3% as compared to 3.3%), as well as mix of both care types (16.4% as compared to 10.5%). This is linked to lower availability of formal care in rural areas as well as potentially higher costs, as has been indicated in other research already (see Hlebec, 2012).

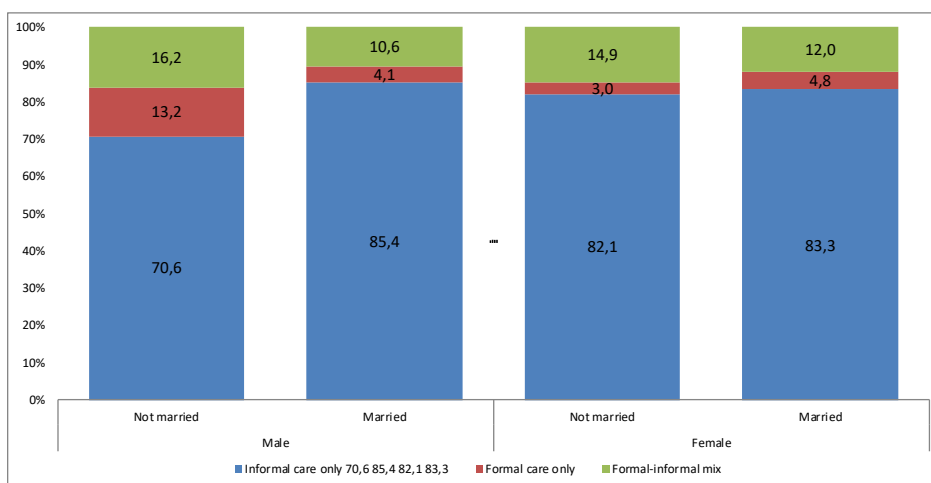
Figure 6: Share of older people using informal, formal and mixed care (by location)



Gender differences in care utilisation

Figure 7 shows the distribution of care types by gender and marital status. Among men, those who are married are more likely to receive informal care only in comparison to those who are not married (i.e. including the categories divorced, widowed and single) (85.3% as compared to 70.6%, respectively), while the former are less likely to receive formal care only (4.0% as compared to 13.2%) and a mix of both care types (10.6% as compared to 16.2%). Among females, the distribution is significantly more even: married women receive only a negligible higher share of informal care only (83.3% as compared to 82.1% for not married), a slightly higher share also of formal care only (4.8% as compared to 3% for not married) and a lower share of a mix of both types (12% as compared to 14.9% for not married).

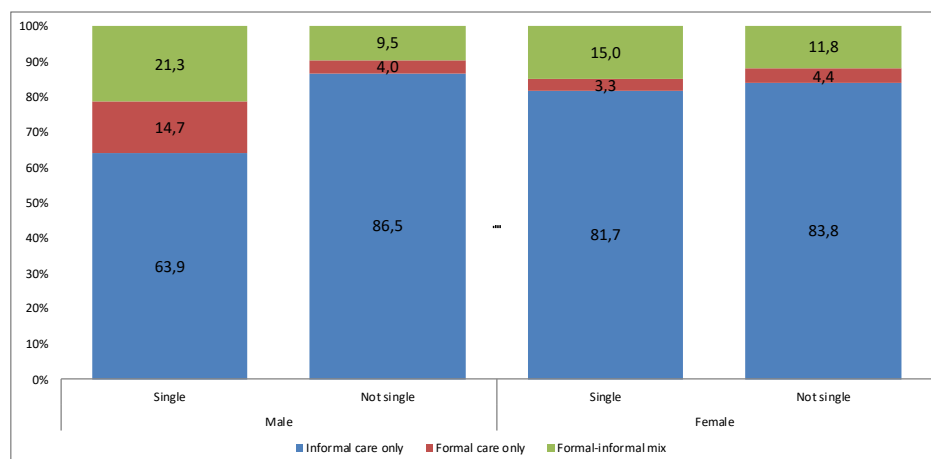
Figure 7: Share of older care recipients using informal, formal and mixed care (by gender and marital status)



Single men are less likely to use informal care only

To summarize, married men and women similarly rely mostly on informal care, while men who are not married rely much more on formal care only or on a mix of both types of care, even when compared to women who are not married. This points to quite different patterns of use of formal care by gender and marital status. This difference is further emphasized if we look at the differences between men and women living alone. Namely, a much higher share of women living alone uses informal care only – 81,7%, while this share is 64% among men living alone.

Figure 8: Share of older care recipients using informal, formal and mixed care (by gender and type of household)



Differences in informal care provision

In provision of care one also needs to address the issue of gender equality, as care is often understood as a female role and can represent an unequal division of the burden of care for frail older people in society. As social policies need to address (financial) accessibility of support to informal carers, socioeconomic differences matter too. This can be monitored by analysing differences in informal care providers' socioeconomic status.

Results from a representative survey among users of social home care services and family caregivers (Šadl & Hlebec, 2018) have shown that daughters provide care to their parents regardless of different circumstances. Conversely, sons step in primarily when they live in the same household as their parents, and according to their disposable income (lower level of education and lower income is associated with increase in care). It seems that sons provide care mainly when there is no other choice, with higher income and higher level of education likely enabling the purchase of other forms of care. Gender differences are evident also in the intensity of assistance, both with ADL as well as IADL. Compared to sons, daughters perform both types of care more intensively.

A higher share of women provided care compared to men

SHARE data indicates similar gender differences in care. Of the 4.186 respondents aged 50 and above in the sample, 873 (20.9%) are providing informal care outside the household. A slightly higher share of women provide care (22.8%), compared to men (18.3%). As can be expected, more care is provided among the younger age groups, i.e. within the age group 50-64 (27.4%), followed by the age group 65-74 (19.1%) and the 75 and above age group (12.1%). There are no large differences regarding the place of residence in the share of those providing informal care.

There are, however, notable differences regarding income. A larger share of caregivers is found among those from the top income quintile (27.5% within the highest quintile provide informal care), whereas the differences in the other income quintiles were not very large and in the bottom quintile the share of those providing informal care was only 17.5%. This might indicate different family support systems and motivations and obligations. For example, bequest may present a stronger incentive for support in higher income quintiles. But on the other hand, it might also indicate that only this group can care for older people with more intensive care needs with the support from formal care (see the previous section on the higher use of formal care among those in the top income quintile), while other groups must choose other forms of care, such as retirement homes in cases of higher care needs. Therefore these income differences merit further investigation.

Table 1: Percentage of those respondents (50+) providing informal care outside the household in Slovenia (Share)

	Providing informal care, in %
People providing informal care outside the household	20.9%
People providing informal care outside the household, by <i>gender</i>	
Male	18.3%
Female	22.8%
People providing informal care outside the household, by <i>age</i>	
50-64	27.5%
65-74	19.1%
75+	12.1%
People providing informal care outside the household, by <i>income quintile</i>	
Bottom	17.5%
Second	21.1%
Third	18.35%
Fourth	20.07%
Top	27.5%
People providing informal care outside the household, by <i>education</i>	
Primary	9.2%
Secondary	20.5%
Tertiary	29.5%
People providing informal care outside the household, by <i>marital status</i>	
Married or living with partner	18.4%
Not living with partner	21.7%
People providing informal care outside the household, by <i>geographic location</i>	
Living in rural areas	20.7%
Living in an urban area	21.3%

Note: Total population 50+ (4.186).

Discussion / Policy recommendations

Slovenian long-term care has traditionally relied on informal care, albeit with limited instruments of support for informal carers. In this sense, Slovenia may be characterized as falling into the group of countries described as familism by default. Data presented here show that heavy reliance on informal care is still present, and that formal care to a large extent only plays a supporting role to family carers in their caring positions. Formal care only is extremely rare and more commonly formal and informal care are combined.

Further development of home care services is vital to ensure ageing in place for older people and provide support to family care-givers

Our findings confirmed that the majority of informal carers are women. Therefore, further support measures for family carers would need to be developed, also to reduce gender inequalities in the provision of care. Gender differences in the use of home care services are intertwined with marriage and household structures. Men who are not married have a much lower share of informal care use and more often use formal care only or mixed forms of care, compared to married men or women who are not married. It is between men and women living alone that the differences in use of formal and informal care are more pronounced, with women relying much more on informal care, and men relying much more on formal care. With the changing demographic trends this can become a salient issue that will need policy attention. This could be addressed by measures aiming at strengthening community ties that could compensate for potentially smaller family support networks among specific groups. Also, accessibility of formal care is related to this issue, as this can be an important resource for those who lack informal networks.

The unequal use of home care services by gender, income and place of residence should be addressed to ensure equality of access to care services

The findings stated in this Policy Brief confirmed what has been put forward already by other research (see Hlebec, 2010, 2012, 2014; Hlebec and Filipovič Hrast, 2016). Namely, that accessibility of formal care is a pressing issue; for example, users of home care services in rural areas rate availability ($B=-.070$) and affordability ($B=-.067$) less favourably than users in urban areas (Hlebec, 2018). The different use of formal care by older people belonging to dissimilar income quintiles indicates divergences in accessibility, possibly underpinned by affordability. Also, differences between urban and rural residents indicate that accessibility is still geographically clustered and thus results in inequalities among users. This should be further addressed by policy-makers.

These empirical findings therefore further emphasize differences in groups of users, indicating that access to formal care among people ageing at home is a pertinent issue for policy-makers. This Policy Brief has not discussed other issues, such as when is formal care carried out and whether the times of care are actually tailored to older people's needs and preferences (or those of informal carers), which may raise additional issues in terms of inequality of access. Importantly, formal care should be offered to potential users at all of numerous entry points to long-term care services in Slovenia, to ensure better accessibility of services. Policy-makers should also consider the need for awareness-raising processes in the population of older people and their informal carers. Fragmentation of services and numerous access points prevent potential users from seeking information and accessing services. The target of 3% of home care users was set administratively and has little to do with the reality of everyday lives of older people and their informal carers. As a principle, every older person with needs for care should be offered access to formal care, regardless of place of living, income and gender.

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