

Community care for older people in Slovenia

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Abstract

The primary interest of this article is to understand the organisation of community care in Slovenia. There are several differences at the local level regarding how the formal care of the older people is organised (e.g. the existence of social home care services) and to what extent other services have developed (e.g. institutional care for the older people, intergenerational centres, community nursing, NGOs and interpersonal assistance). We focus on two services, institutional care and social home care, and present the typology of community care in Slovenia. Four clusters were obtained via a hierarchical method (k-means clustering). Clusters of municipalities are comprised of municipalities that have similar characteristics of care for older people, taking into account both institutional care and social home care. The results have shown that municipalities in Slovenia differ dramatically in the availability of care for the older people. Some offer only a poor quality of care (mainly smaller rural municipalities), while others offer higher quality of care and a strong combination of both institutional and social home care.

KEYWORDS: older people, community care, home care, institutional care, typology, municipalities

Introduction

One of the main challenges facing contemporary societies involves demographic changes and population ageing and, consequently, the organisation of care for the older people. The family is the main caregiver in Slovenia and other countries, as shown in research (Albertini et al. 2007; Kohli & Albertini 2008; Kogovšek et al. 2003; Dremelj 2003; Hlebec 2003, 2004; Mandič & Hlebec 2005; Pahor & Hlebec 2006; Hlebec et al. 2010). The other formal part of caregiving rests on the social welfare services and health services, which are mainly supplied by state institutions in Slovenia.

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The local communities in which these services are organised are not homogeneous, even in a small country such as Slovenia. There are several differences at the local level regarding how formal care for older people is organised (e.g. the existence of social home care services) and to what extent other services have developed (e.g. institutional care for the older people, intergenerational centres, community nursing, NGOs and interpersonal assistance) (Hlebec 2010; Jelenc Krašovec & Kump 2009; Kump & Jelenc Krašovec 2010; Smolej et al. 2008). For those living alone, the development of community care is particularly important,¹ and this group is quite large in Slovenia (see Mandič & Cirman 2006; Filipovič & Hlebec 2006).

The primary interest of this article is to understand the organisation of community care in Slovenia. This is linked to specific policy developments in the field of health and social care, as well as to the specificities of community development. In this article, we will present the typology of community care in Slovenia. We are interested in how well developed the care for older people is and how it is organised in individual community types and whether there are differences in that regard, focusing on two services: institutional care and social home care.² We presume that the development of community services has been diverse, and we expect to find several types of community care associated with particular characteristics of communities, such as their size and level of urbanisation.

What is community care?

According to Loughran (2003), community care has two meanings. In its wider meaning, it denotes the care of the community for older people and is linked to everyday help from neighbours, the existence of various forms of socialising, co-operation, and mutual learning (see McAulley 2001; Loughran 2003).

A narrower meaning of community care denotes a more traditional understanding of community care, i.e. the community as an arena in which the care for older people is carried out by different societal actors, such as institutions, day care centres, intergenerational centres, voluntary organisations and associations. Community care services for older people encompass services of long-term care and other supporting services (health, transport, housing), community social work and educational and informational activities and programmes based in the community (see Wacker & Roberto 2008; Mali 2010b; Kump & Jelenc Krašovec 2010). Hojnik-Zupanc (1999) describes the formal network of services in the community based on spatial criteria as the following: stationary, alternative institutional forms (e.g. day care centres), modified housing, mobile services, home services and on-line services. The work of formal services is compensated by the work of

¹ One of the important changes affecting quality of life of older people is the loss of services in local community, e.g. grocery stores and other shops, where the trend is of moving the shops in large centres in suburbia (see Uršič 2012), which can increase their dependence and the need for social home care, for example.

² Here, we will use the terms social home care, also labelled as home care, assistance at home and home help. It is help that older receive at home, and it can range from personal care (bathing, dressing, eating) to smaller amounts of household help (cooking, cleaning).

voluntary services and organisations, which are often co-financed by the state. The other part represents informal care, which is linked to informal support networks, family care and others.

In this article, we understand community care in its wider meaning, including all forms of care from institutional to home care as well as informal care. Sometimes institutional and community care are presented as being in opposition to each other. However, institutional care is based in a community and, therefore, can be an integral part of it. In addition, when observing individuals in institutional care, there is a significant difference when this institutional care is carried out in their community, i.e. if they need not change the municipality/locality in which they live, or if they need to go into institutional care outside of their known community. The all-encompassing view of community care is based on environmental gerontology and different community theories and place identity theories, which indicate the relevance of the known environment in lives of the older people, through known social networks, identity building, memories, etc. As previously emphasised, the environmental gerontology context is important for the well-being, identity and autonomy of older people, which depends on the processes of belonging, such as cognitive and emotional evaluation, the representation of physical environment and attachment to place (Wahl & Oswald 2010). Older people are attached to the communities they live in, and their known places represent possibilities of reminiscence, reinterpretation of life events, and represent an “album” in which life achievements are documented (see Evans 2009: 23; Smith 2009: 16; Ekstrom 1994). Here, one can distinguish between social meanings of the place for an individual, which are connected to social networks developed in a community (family, friends, neighbours) and autobiographical meanings of the community, as they are linked with one’s personal history connected to the place (Rowlings 1983 in Smith 2009). It is not surprising, therefore, that older people in general wish to age within their community. These preferences are linked to the abovementioned place identity and social networks established in the community, as well as knowledge of the physical space through repeated use of the space and the services within it (Smith 2009: 14). Living in an institutional setting, when this is based within the known community, therefore, can also mean keeping some of these advantages of aging in the community, such as the process of belonging and attachment to place (see Wahl & Oswald 2010). We argue, therefore, that integrated and long-term community care should encompass all forms of care and thus cater the different needs of older people in different stages of their lives. That means that a local community with well-developed community care of older people has social home care, home nursing, different forms of social work in the community, a developed NGO sector that works with the older people, educational and informational activities and programmes, based in the community, as well as institutional care, which can function not as a closed organisation, but an organisation that is open to the community through its services for older people (including those not included in the institutional care). This is something that we can see already developing in Slovenia. Consequently, in this article we will observe community care services within the community settings that are intended for the older people, which include institutional as well as social home care.

The characteristics of community care in Slovenia

We have defined community care as care services within the community setting, combined with several other services for the older people. In the article, we will elaborate on the development of institutional care and home care as two of the most important services ensuring care of elderly in a certain community, while also acknowledging that a complete understanding of the organisation of community care also requires investigation of the NGO sector and interpersonal relations.

The welfare state has gone through significant changes in Slovenia since the mid-1990s (Kolarič et al. 2009; Mandič 2012). The state is withdrawing support and transferring the burden of care to other sectors (market, civil society and family; predominantly to NGOs and the family). In the field of care for older people, several changes have been made in the previous 20 years, and several documents have been adopted that regulate its development (Hlebec 2010; Kolarič et al. 2009). The most significant changes have involved the development of institutional care (Mali 2010a) and the development of services to ensure the quality of life of the older people living at home (Hvalič Touzery 2007; Ramovš 2003; Hlebec 2010). Care for older people in Slovenia is institutionally oriented, although as early as in the 1960s different experts in the field of gerontology emphasised that older people should live in their domestic environment for as long as possible (see Mali 2011a). Only recently have some new forms of care for older people to replace institutional care started to be developed, such as day care centres and social home care for older people, increasing possibilities of living arrangements with supported housing (see e.g. Hvalič Touzery 2007). However, one of the key problems in Slovenia that has been recognised for some time now, and one that obstructs the development of care for older people, remains excessive institutionalisation. In brief, the care system is rigid, and it cannot meet the needs of older people who are an expressly heterogeneous population group (Mali 2011b).

Municipalities also differ significantly in their availability of care for the older people. Specific are differences between rural and urban communities (see e.g. Kneževič Hočevar 2012; Mali 2012; Jelenc Krašovec & Kump 2009; Kump & Jelenc Krašovec 2010). Help is often inaccessible in both urban and rural areas. In the latter, both institutional care (homes for older people) and social home care are often unavailable. In contrast, in urban areas, the range of available assistance is quite large, but still it does not adequately meet older people's needs, often due to long waiting lists (Mali 2012).

In the field of health care, there has been a negative trend toward limiting health care at home, e.g. health services (decreasing doctors' visits to homes, accessibility to rehabilitation at home is difficult and regionally diverse, shortening periods of hospital treatment, nursing care at home (Hvalič Touzery 2007; Ramovš 2003).

The NGO sector has been developing, and there is an increasing number of organisations that aim at helping older people at home.³ However, municipalities differ in

³ For example, a network of 6 of 15 intergenerational centres and 1,029 self-help groups was co-financed in 2008 by the Ministry of Labour, Family and Social Affairs (MLFSA; Dremelj et al. 2009: 103). Similarly, in 2007 voluntary work carried out by members of the Slovenian Federation of Pensioners' Organisations was extensive, as 1,384 of volunteers made home visits to 50,982 pensioners aged 69 and above. (MDDSZ 2008: 46–7).

how developed their networks of voluntary organisations and associations, educational associations and learning circles are (Jelenc Krašovec & Kump 2009; Kump & Jelenc Krašovec 2010). There are additional factors that influence the delivery of care in the community as a broader concept. Communities also differ in the extent of co-operation and interpersonal solidarity in the community among neighbours, which is linked to the level of urbanisation, type of environment, and the socio-demographic characteristics of the inhabitants (see Filipovič et al. 2005; Mandič & Hlebec 2005; Filipovič 2007). As already said, the focus in this article will be on institutional help and social home care, which we will describe in greater detail in the next section.

Institutional care

Institutional care for older people is the most developed and widespread form of care for older people in Slovenia. In 2009, 16,978 people resided in homes for older people, and in the same year the socio-political goal of enabling institutional care for five per cent of people over 65 was achieved (Hlebec & Mali 2013). The majority (80%) of homes for older people operate within the public sector. The network of state-run homes for older people is supplemented by homes within the private sector, while the voluntary sector does not offer residential facilities of the institutional type. In terms of the type and content of care, the private sector does not differ from the public one (Hlebec & Mali 2013; Flaker 2011). What is different are the funding principles and terms of operation. Private homes for older people offer institutional care according to the provisions applicable to the state-run homes; to carry out this activity they need to obtain certification from the Ministry of Labour, Family and Social Affairs (Hlebec & Mali 2013). Their services and programs are, therefore, identical to those offered by the state-run homes for older people.

The historical development of institutional care for older people and changes of care for older people can be explained in the three models of institutional care: 1) the initial socio-gerontological model (1965–1990), 2) the intermediate hospital model (1991 – 2000) and 3) the present model that is in the transition from a hospital model to a social one (from 2000 onwards). Historically, the dynamics of shifts have occurred in different periods and can also be seen today (Mali 2010a). The reasons for the shifts of the homes towards a social orientation differed in various historical periods. They were conditioned by the policy of establishing homes, the influence of socio-gerontological principles, the development of social work and, recently, by their confrontation with the changed characteristics and demands of the population of residents, such as residents with dementia.

Hlebec and Mali (2013) analysed the institutional care for older people from the historical development and local residence access perspective, which has indirect effects on quality of care. Though Slovenia has achieved the criterion of providing institutional care for 5% people older than 65 years on a national level, on the level of municipalities there are significant differences. Such differences include the presence of institutional care in specific municipalities, the size, the degree of urbanisation and the economic development of the municipality. With the typology of institutional care for older people in Slovenia from the development perspective, Hlebec and Mali (2013) demonstrated that people over 65 years do not have the same possibilities for institutional care. The

principle of the territorial building of institutions and the principle of plural social care encourage the entrance of the private sphere into the institutional care of older people. Private homes are more expensive than public ones and, therefore, inaccessible for older people in need for institutional care.

While elsewhere various types of help beyond those provided by homes for older people are available, Slovenia is characterised by an explicitly institution-oriented approach. There are various reasons for this, ranging from social, cultural, political to professional (Mali 2008: 9). For many years, homes for older people have been the driving force behind the development of care for older people, including community-based care. Homes for older people provide not only the institutional protection in the narrow sense of the word (residential facilities and care), but also assistance to older people in their homes and within a community (the most intense development of day care centres has been seen within the framework of homes for older people, and the same can be argued for home care, social services, sheltered housing and respite care).

Social home care

Social home care has developed in Slovenia relatively recently, from the beginning of the 1990s. Due to the fact that ageing at home has been recognised as important and a preferable alternative to institutional care (abroad and at home, in expert as well as political circles) there has been increasing focus on its development, e.g. in political documents it was claimed among priorities (see Strategy for the care of older people to 2010: MDDSZ 2006b; The National Social Protection Strategy of 2005 and the Resolution on the National Social Protection Programme 2006-2010; National Programme on the Fight against Poverty and Social Exclusion (MLFSA 2000) and the National Action Plan on Social Inclusion 2004–2006.).

Social home care is therefore developing in Slovenia, and the number of users is increasing every year, from 2875 users in 2003 to 6583 in 2012 (Nagode & Lebar 2013). However, the number of users is still lagging behind the goal that was set in Strategy of care for the older people to 2010 (MDDSZ 2006a) of covering 3% of older people population or at least 10,000 older people (aged 65 or more). Additionally, there are significant regional differences in the delivery of these services. Hlebec (2010) has analysed these differences and identified five types of local communities (municipalities) that differ in the following aspects: what the main actor paying for social home care (the state, municipality or user) is, and the quantity and quality of care (the duration of visits and number of users). When looking later at changes that occurred in the organisation of social home care, Hlebec (2013) found that, in 2010 compared to 2008, the heterogeneity of municipalities decreased, as fewer of models of organisations of social home care were found. More detailed analysis showed that the majority of municipalities also used their funding more efficiently. However these comparisons of municipalities only examined social home care, while in this article we wish to present a more complex view, combining characteristics of social home care and institutional care.

Typologies of community care in Slovenia

As we have presented in the above sections, the development of both institutional and social home care is interwoven and must be observed together in order to obtain a comprehensive overview on how care for older people is ensured in individual community. In this paper, we would like to establish: (1) If Slovenian municipalities have common characteristics in the organisation of care, i.e. we would like to obtain a typology of care and (2) What kind of actors and what kind of services' mix (social home care and institutional care) comprise particular types of care. We expect several types of care settings, depending on the tradition of care in specific municipalities.

Methodology

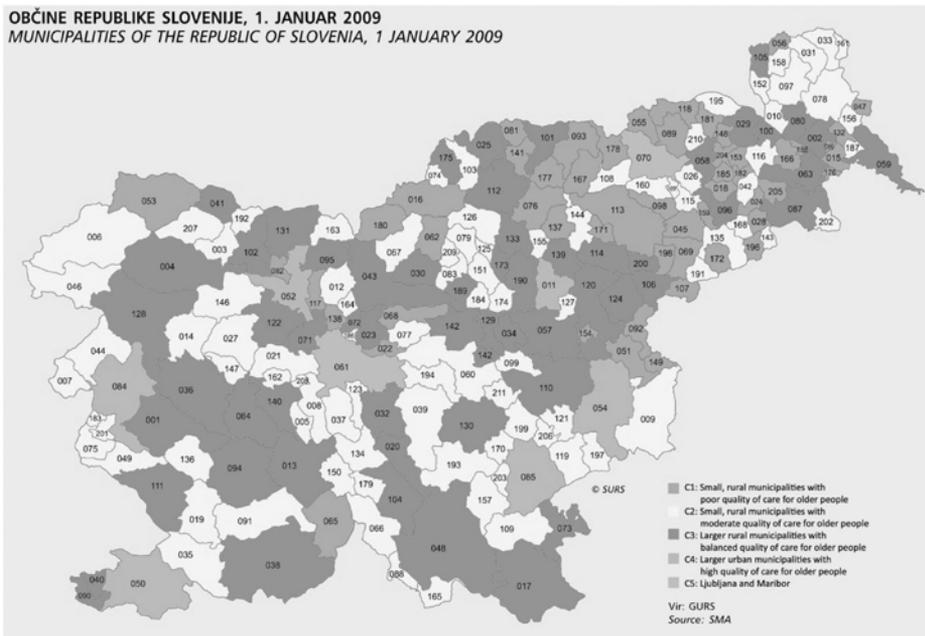
The method of analysis is a multiple hierarchical cluster analysis based on a search for similarities and dissimilarities of units. Hierarchical cluster analysis was selected, since the number of clusters is not known in advance. This is exploratory analysis, and the number of clusters is a result of analysis as well as the composition of clusters. The Ward method was used on standardised variables, and squared Euclidian distance was used as a dissimilarity measure. The proposed solution was optimised using iterative k-means clustering, using the number of clusters and centroids suggested by hierarchical cluster analysis as a starting point (Ferligoj 1989).

As we wanted to consider both social home care and institutional care when analysing types of care settings across municipalities, six variables were included in analysis: three variables describing social home care and three variables describing institutional care. The variables describing social home care were the amount of money spent by a municipality per user in euros, the price of social home care per user in euros, and the number of users of social home care that are older than 65 years (on 12 January 2010). The variables describing institutional care were the number of residents in homes for older people older than 65 per municipality (on 31 December 2009), the percentage of costs of care in home for older people per user paid by a municipality in 2009 in euros and the percentage of residents of homes for older people residing in their municipality of primary residence prior to transfer to home for older people in 2009.

Results

Four clusters were obtained via the hierarchical method and then optimised with k-means clustering. In all tables there are five groups; the fifth group is comprised of Ljubljana and Maribor, the two larger cities in Slovenia. They were excluded from clustering as they influenced results and formed a separate group. In all calculations presented in the tables, these two municipalities were included and their values considered in final calculations. The results are graphically presented in Picture 1.

OBČINE REPUBLIKE SLOVENIJE, 1. JANUAR 2009
MUNICIPALITIES OF THE REPUBLIC OF SLOVENIA, 1 JANUARY 2009



001 Ajdovščina	025 Dravograd	051 Kozje	078 Moravske Toplice	104 Ribnica	206 Šmarješke Toplice
195 Apače	026 Duplek	052 Kranj	079 Mozirje	177 Ribnica na Pohorju	125 Šmartno ob Paki
002 Belčinci	027 Gorenja vas - Poljane	053 Kranjska Gora	080 Murska Sobota	106 Rogaška Slatina	194 Šmartno pri Litiji
148 Benedikt	028 Gorinica	166 Krizevci	081 Muta	105 Rogašovci	126 Šoštanj
149 Bistrica ob Sotli	207 Gorje	054 Kriško	082 Naklo	107 Rogatec	127 Štore
003 Bled	029 Gornja Radgona	055 Kungota	083 Nazarje	108 Ruše	184 Tabor
150 Bloke	030 Gornji Grad	056 Kuzma	084 Nova Gorica	178 Selčica ob Dravi	010 Tišina
004 Bohinj	031 Gornji Petrovci	057 Laško	085 Novo mesto	109 Semič	128 Tolmin
005 Borovnica	158 Grad	058 Lenart	086 Odranci	110 Sevnica	129 Trbovlje
006 Bovec	032 Grosuplje	059 Lendava/Lendva	171 Oplotnica	111 Sežana	130 Trebnje
151 Braslovče	159 Hajdina	060 Litija	087 Ormož	112 Slovenj Gradec	185 Trnovska vas
007 Brda	160 Hoče - Slivnica	061 Ljubljana	088 Osilnica	113 Slovenska Bistrica	186 Trzin
008 Brezovica	161 Hodoš/Hodos	062 Ljubno	089 Pesnica	114 Slovenske Konjice	131 Tržič
009 Brežice	162 Horjul	063 Ljutomer	090 Piran/Pirano	179 Sodražica	132 Turnišče
152 Cankova	034 Hrastnik	208 Log - Dragomer	091 Pivka	180 Solčava	133 Velenje
011 Celje	035 Hrpelje - Kozina	064 Logatec	092 Podčetrtek	202 Središče ob Dravi	187 Velika Polana
012 Cerklje na Gorenjskem	036 Idrija	065 Loška dolina	172 Podlehnik	115 Starše	134 Velike Lašče
013 Cerklja	037 Ig	066 Loški Potok	093 Podvelka	203 Straža	188 Veržej
014 Cerkno	038 Ilirska Bistrica	167 Lovrenc na Pohorju	200 Poljčane	181 Sveta Ana	135 Videm
153 Cerkevjak	039 Ivančna Gorica	067 Lute	173 Polzela	204 Sveta Trojica v Slov. goricah	136 Vipava
196 Cirkulane	040 Izola/Isola	068 Lukovica	094 Postojna	182 Sveti Andraž v Slov. goricah	137 Vitanje
015 Črenšovci	041 Jesenice	069 Majšperk	174 Prebold	116 Sveti Jurij	138 Vodice
016 Črna na Koroskem	163 Jezerško	198 Makole	095 Preddvor	210 Sveti Jurij v Slov. goricah	139 Vojnik
017 Črnomelj	042 Juršnik	070 Maribor	175 Prevalje	205 Sveti Tomaž	189 Vrankso
018 Destrnik	043 Kamnik	168 Markovci	096 Ptuj	033 Šalovci	140 Vrhnika
019 Divača	044 Kanal	071 Medvode	097 Puconci	183 Šempeter - Vrtojba	141 Vuzenica
154 Dobje	045 Kidričevo	072 Menges	098 Rače - Fram	117 Šenčur	142 Zagorje ob Savi
020 Dobropolje	046 Kobarij	073 Metlika	099 Radeče	118 Sentilj	143 Zavrč
155 Dobrna	047 Kobilje	074 Mežica	100 Radenci	119 Šentjernej	144 Zreče
021 Dobrova - Polhov Gradec	048 Kočevje	169 Miklavž na Dravskem polju	101 Radlje ob Dravi	120 Šentjur	190 Žalec
156 Dobrovnik/Dobronak	049 Komen	075 Miren - Kostanjevica	102 Radovljica	211 Šentrupert	146 Železniki
022 Dol pri Ljubljani	164 Komenda	170 Mirna Peč	103 Ravne na Koroskem	121 Škofjanec	191 Žetale
157 Dolenjske Toplice	050 Koper/Capodistria	076 Mislinja	176 Razkrižje	122 Škofja Loka	147 Žiri
023 Domžale	197 Kostanjevica na Krki	199 Mokronog - Trebelno	209 Rečica ob Savinji	123 Škofljica	192 Žirovnica
024 Dornava	165 Kostel	077 Moravče	201 Renče - Vogrsko	124 Šmarje pri Jeļah	193 Žužemberk

Figure 1: Municipalities of the Republic of Slovenia

Clusters of municipalities are comprised of municipalities that have similar characteristics of the care for older people, taking into account both institutional care and social home care. The first two clusters are comprised of municipalities with a small number of users of social home care and a small number of people residing in homes for older people. In most of these municipalities, there is no home for older people and older people that want to stay in a home for older people have to move to another municipality. In the first cluster, the financial contribution of the municipality per user is very high, while in the second very small. The price of social home care is about the same in both clusters. Clusters differ with regards to the percentage of costs of care in home for older people per user paid by a municipality as it is the highest in the first cluster and much lower in the second cluster (C1 42%, C2 27%). The clusters also differ with regards to the proportion of users of social home care and residents in homes for older people (C1 1:3, C2 1:2), indicating that in the first cluster institutional care is more popular than in the second cluster, as there are three users of institutional care per one user of social home care.

Table 1: Results of cluster analysis

Cluster	No. of mun.	X1	X2	X3	Y1	Y2	Y3
1	53	3242	4.06	7	21	42.18	1.33
2	91	1362	4.33	15	29	26.55	1.14
3	58	1596	4.63	35	102	31.42	64.12
4	6	1764	4.23	174	317	24.50	52.69
5	2	2278	3.98	465	1963	24.45	62.98
Total	210	1922	4.34	27	74	31.76	20.64

X1: amount of money spent by municipality per user in euros, X2: price of social home care per user in euros, X3: number of users of social home care that are older than 65 years (on 12 January 2010), Y1: number of residents in homes for older people older than 65 per municipality (on 31 December 2009), Y2: percentage of costs of care in home for older people per user paid by municipality in 2009 in euros, Y3: percentage of residents of homes for older people residing in municipality of primary residence prior to transfer to home for older people in 2009.

These two clusters of municipalities can be described as (we also consider other characteristics of clusters presented in the next paragraphs) C1: Small, rural municipalities with poor quality of care for older people: no institutional care within municipality, poorer availability of social home care, C2: Small, rural municipalities with moderate quality of care for older people: no institutional care within municipality with moderate availability of social home care (as it is also more accessible during afternoons, weekends and holidays) Clusters 3 and 4 are similar with regards to the financial contributions of municipalities for social home care (price per user is higher in Cluster 3); they differ with regards to financial contributions for institutional care (C3 31%, C4 24%). When residing in homes for older people, they mostly stay in the same municipality they were in prior to moving there. These two clusters differ considerably with regards to number of users of social home care (higher in Cluster 4) and number of residents in homes for older people

(again higher in Cluster 4). They also differ with regards to the ratio between the number of users of social home care and residents in homes for older people (C3: 1:3, C4: 1:2) indicating that social home care is more popular in the fourth cluster of municipalities. These two clusters are comprised of municipalities that have higher numbers of residents and are economically more developed; they can be described as: C3: larger rural municipalities with balanced quality of care for older people: well developed institutional care and moderate availability of social home care; C4: larger urban municipalities with high quality of care for older people: well developed institutional and good availability of social home care. Such a description of clusters is a relative one with regards to the municipalities in C1 and C2. As regards Ljubljana and Maribor, these two cities are well off in terms of institutional care, as most residents of these two cities stay in institutional care within the community. The residents of Ljubljana and Maribor are also well off in terms of financial contributions for social home care. However, the number of users of institutional care is quadruple the number of users of social home care. There are two competing explanations for that; either the number of users of social home care should be increased or the number of users of institutional care is higher because these two cities offer institutional care for residents from other parts of Slovenia.

In C1 and C2, social home care is organised mostly by centres for social work as most municipalities do not have homes for older people. As regards number of visits and average time of visits, C1 is the richest while accessibility during weekends and holidays is better in C3 and C4. As regards institutional care, municipalities in C1 and C2 do not have homes for older people, while municipalities in C3 and C4 do. The majority of residents in these clusters reside in public homes for older people, which are somewhat cheaper than private homes (see table in appendix).

Municipalities in C1 and C2 have small numbers of residents and are geographically smaller with lower population densities. Municipalities in C3 and C4 have larger numbers of residents, are geographically larger and have higher population densities. In C1 and C2, there are some urban municipalities (C1 9%, C2 12%). In more than half the cases, the municipalities in C1 have lower welfare (Rovan et al. 2009). In C2, there are municipalities with moderate welfare (39% moderate, 28% low welfare). In C3, almost one third of the municipalities are urban (29%), and two thirds are in C4 (67%). A half of municipalities in C3 have moderate welfare and one third balanced welfare, while municipalities C4 are economically and socially well developed (see table in appendix).

Discussion and conclusion

In this article, we have wanted to discern how community care for older people is organised in individual municipalities. Although we understand community care as wider concept including different forms of care services and also including informal care forms, we have focused here on only two services: institutional care and social home care. We have determined that municipalities can be divided into five distinct types regarding organisation of care. Of these, two types do not have any institutional care organised, i.e. they rely on institutional care outside of the local community. When observing this from the perspective of importance of integrated community care and the relevance of aging

in place, or ageing in a known local community, as presented at the beginning of the article, we can say that these communities have less-developed comprehensive community care. Unfortunately, such communities are quite common (144 of 210 municipalities, i.e. Clusters 1 and 2).

Municipalities, therefore, differ dramatically in the availability of care for the older people. Some offer only moderate welfare (mainly smaller rural municipalities), while others offer higher welfare and a strong combination of both institutional and social home care. Considering the fact that older people do not move when they retire, it seems that quality of life in later life strongly depends on the place of living. However, it needs to be stressed that rural community does not automatically also mean poor welfare, as several rural communities (specifically larger rural ones) have moderate or good welfare.

The accessibility and availability of community care, in our case both institutional and social home care, depends on the financial support of the local community. As our analysis has shown, the costs of care are relatively high in a significant number of municipalities, such as in larger rural municipalities (Cluster 3). However, in smaller rural communities (Cluster 1), the state and municipality are co-financing care for elderly to a higher extent, making it more available for the older people as these municipalities have, for example, the lowest prices of social home care and also highest share of co-financing of institutional care. A key problem in the accessibility of care lies in the poor financial situation of the older people. Hlebec et al. (2010) point to the expanding group of the poor older people who, despite their need for services, cannot access them (due to financial and other constraints) and must reject them (as one of their poverty coping strategies). While the economic situation of older people had been improving until 2001, it has deteriorated since then (see Stropnik et al. 2010; Stropnik et al. 2003) Older women, especially single women, and people living in pensioner households are in a particularly difficult financial position. Considering these circumstances, the co-financing of institutional and social home care by state and municipality are vital in enabling accessible care for older people.

The development of institutional care in Slovenia has definitely been influenced by the situation in the area of care for older people in recent decades. The absence and uneven distribution of social home care, the inadequate exploitation of advanced technologies that would enable older people to lead independent lives and thereby prolong their life at home, the appreciation of homes for older people among all generations – all of this and many other factors have been for many years contributing to the phenomenon of long waiting lists for admittance to homes for older people.

Furthermore, our analysis has shown that institutional care has been much more used than social home care in all municipalities (ratios 1:2, 1:3). It is, therefore, understandable that in many environments homes for older people, as the centres of knowledge and experience characterised by professionalism and staff that is highly qualified to work with older people, have also become the leading providers of care for older people who still live in their own homes. This is especially evident in larger urban municipalities (Cluster 4), where half of the homes for older also provide social home care. We have therefore argued that institutional care is part of integrated community care. However, it is important how open it is toward community, whether it is offering social home care,

as well as whether it is located in the municipality where residents also previously lived. Moreover, it would even be possible to argue that the placing of homes for older people under the institutional care category is inappropriate. In reality, homes for older people have become the centres for comprehensive care, where health care and social services co-created a mutually complementary model of collaboration.

In Slovenia, there is a problem of differentiated care for the older people within a community. Research abroad has indicated that integrated, community-based care models are more beneficial to the older people in the sense that they reduce admission to institutions, and reduce the functional decline of those living in community (Barnabei et al. 2005; Fischer et al. 2003; Kodner & Kyriacou 2000; Kodner 2006). However, if we understand integrated care not only as fully integrated variety, but also as linkage, for example (i.e. health and social care providers attempting to work more closely, even though they operate within their own rules and funding schemes), as defined by Leutz (1999 in Kodner 2006: 385), one could claim that in Slovenia integrated care is also beginning to be developed. Homes for older people play here a critical role that is specific to Slovenia.

As we have already mentioned, a comprehensive analysis of organisation of community care should include also other aspects of care for older people, such as informal relations and the role of NGOs. If possible, additional analysis should be done including these data. However, since such data often is not available, it is proposed that further in-depth studies based on qualitative methods would enable a better understanding of the organisation of community care for elderly.

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APPENDIX

Table 2: Other characteristics of social home care

Cluster	X4	X5	X6	X7	X8	X9	X10	X11 (n / %)	X12 (n / %)	X13 (n / %)	X14 (n / %)
1	1214	18.64	84.43	3	2	25%	29%	3 6%	41 77%	6 11%	6 11%
2	280	16.79	53.96	2	2	34%	45%	7 8%	55 63%	21 24%	12 14%
3	440	16.92	61.09	7	6	52%	65%	58 100%	34 59%	15 26%	9 16%
4	285	22.18	52.33	11	23	100%	100%	6 100%	3 50%	3 50%	0 0%
5	180	14.16	74.00	114	86	100%	100%	2 100%	0 0%	0 0%	2 100%
Total	559	17.44	64.12	6	4	39%	49%	76 36%	133 64%	45 22%	29 14%

X4: financial contribution of the state per user in euros, X5: monthly number of visits of social carer per user on average, X6: time spent with user on average, X7: number of potential new users, X8: number of social carers, X9: % of municipalities with social home care available on afternoons, X10: % of municipalities with social home care available during weekends and on holidays, X11: number and percentage of municipalities with home for the older people, X12: organizer of social home care – Centre for social work (n / %), X13: organizer of social home care – Home for older people (n / %), X14: organizer of social home care – Other (n / %).

Table 3: Characteristics of municipalities

Sk.	N	POV	GPRES	STAR	U(OECD) %	VR %	UB %	ZB %	NB %
1	3761	58	83.91	40.75	9	0	14	33	53
2	4676	78	87.86	41.31	12	3	39	30	28
3	13405	144	138.41	41.45	29	11	32	51	7
4	41510	227	233.67	41.58	67	83	0	17	0
5	195478	212	888.00	42.75	100	100	0	0	0
Total	9725	97	112.61	41.23	19	8	29	36	27

N: number of residents in municipality, 1.7.2009 (Statistični podatki, občine, Slovenija, 2009), POV: area (km²), 1. 1. 2010 (Statistični podatki, občine, Slovenija, 2009), GPRES: population density (preb/km²), 1.7.2009 (Statistični kazalniki, občine, Slovenija, 2009), STAR: average age of population (leta), 1.7.2009 (Statistični kazalniki, občine, Slovenija, 2009), U: percentage of urban municipalities by OECD, VR: percentage of economically and socially high developed municipalities (Rovan et al. 2009), UB: percentage of municipalities with balanced welfare (Rovan et al. 2009), ZB: percentage of municipalities with moderate welfare (Rovan et al. 2009), NB: percentage of municipalities of low welfare (Rovan et al. 2009).

Povzetek

V članku želimo razumeti kako je organizirana oskrba za starejše v posameznih občinah. Občine se namreč korenito razlikujejo v tem, kako je oskrba starejših organizirana, tj. organiziranost oskrbe na domu, kot tudi institucionalne oskrbe, patronažne službe, neprofitnega sektorja ter medosebnih odnosov in pomoči. Osredotočimo se na dve storitvi, in sicer institucionalno oskrbo in pomoč na domu. Predstavimo tipologijo skrbi v skupnosti v Sloveniji na podlagi hierarhične metode razvrščanja. Skupine občin, ki so nastale, se združujejo glede na podobnost značilnosti skrbe starejših, kjer se upošteva tako institucionalna oskrba kot oskrba na domu. Rezultati so pokazali 4 skupine, ki se med seboj izrazito razlikujejo v kakovosti oskrbe starejših, saj nekatere skupine nudijo le nizko kakovost oskrbe, druga pa visoko kakovost z dobro razvito tako institucionalno oskrbo kot pomoč na domu.

KLJUČNE BESEDE: stari ljudje, oskrba v skupnosti, oskrba na domu, institucionalna oskrba, tipologija, občine

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