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Family Care Experience in a Decentralized Social Home Care Context

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Abstract This survey analyses the scope and intensity of informal care for the elderly residing in their homes in Slovenia and their determinants: the residing municipality of the care recipient, geographical distance between the informal carer and the care recipient, to the care recipients' and the care givers' individual characteristics. With the increasing private out-of-pocket financial contribution, which is determined by municipality, the scope and intensity of informal care shows a significant increase as shown by regression analysis. Inter-municipal cooperation and the introduction of gradual private financial contribution are proposed as tools for improving accessibility of social home care in Slovenia.

Keywords: • aging in place • long-term care system • informal care • care tasks • community care • social home care

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1 Introduction

The rapidly ageing population in Europe places the organization of care for older people in the research spotlight. In Europe the share of the population aged 80 and over, which is most likely to need care, will rise from 5% (2013) to 12% (2060), while the share of those aged 20-64 will decline greatly (from 61% to 51%) (The 2015 Ageing Report: 13). The increasing demand for care combined with the diminishing pool of potential informal carers may create a greater pressure on informal carers, as the majority of the older people want to age in their own homes and maintain independency for as long as possible (Kavčič et al., 2012). Similarly, there may be an increased demand for the formal services provided in old people's homes or in the community. For the older people living at home, informal and formal care provided within the community are of vital importance as they enable ageing in place for those older people in need of care. European countries differ greatly as to how they finance and organize care for the older people (Colombo et al., 2011; Gennet et al., 2012), varying from strongly centralized with universal access to services to fragmented long-term care systems with means tested access to services. Particular structures of the long-term care system and the provision of home care within the community represent a broader context within which care is provided. Both shape the care experience for care recipients as well as for their informal carers (e.g. Andersen and Newman, 2005; Groenou and Boer, 2016).

The provision of the formal long-term system in Slovenia is highly decentralized and fragmented (Colombo et al., 2011; Nagode et al., 2014), with high end users costs, and difficult access to formal long-term care services (Anderson, 2012: 128). Moreover, the organization and financing of social home care (Gennet et al., 2012), which is an essential part of the formal long-term care service within the community, is held on the level of municipalities (Smolej et al., 2008). The eligibility of social home care depends on the permanent residence of the care recipient, which creates a variability in the temporal and financial accessibility to home care across municipalities. The amount the users need to pay is set by the municipality. Consequently, users residing in different municipalities pay different fees for the same service, sometimes even when this service is provided by the same social home carer. In 2014 social home care in the 210 municipalities was provided by different types of providers, such as centres for social work (33), nursing homes (21) or specialized providers of social home care (19) - most of which were private providers with concession (17) (Lebar et al., 2014: 20–23). Some social home care providers offer services to users in several municipalities, e.g. the centre for social work in Ptuj provides social home care for 15 municipalities (Lebar et al., 2014: 18). Therefore, we could define the Slovenian social service model in the area of elderly care (see Hoffman, 2012, for a classification that lacks the Slovenian case) as a settlement based care model with voluntary inter-municipal associations. Over the past 10 years, we have witnessed a clear shift from the provision of the service from centres for social work to nursing homes and private providers with concessions. The recent trends in the

number of users of social home care services unambiguously indicate the effect of the economic crisis, as the number of users has been on a steady increase over the years, following the adoption of the service by an ever greater number of municipalities, until 2011 (Lebar et al., 2014: 24–25). The number of users has increased once again in 2014.

Past research has shown that there is a constant discrepancy in the availability, accessibility, accommodation, affordability and acceptability of social home care across Slovenian municipalities (Hlebec, 2010; Hlebec, 2012; Hlebec, 2014; Hlebec et al., 2014a), yet we do not know how this is reflected in the care experiences of informal carers. In Slovenia, informal carers provide a great amount of care for the older people (Hlebec et al., 2016); however, their role in the long-term care system is often neglected. Thus, it is essential to discover what type of care informal carers provide for the older people in Slovenia and how does the variability in the care tasks depend on the characteristics of formal care provision in municipalities. The purpose of this study is to explore the informal care experience in Slovenia. The main research question we wish to address is whether informal carers in Slovenia differ significantly in their care tasks depending on the context of care, i.e. the characteristics of the residing municipality of the care recipient, the geographical distance between the informal carer and the care recipient, and the care recipients' and care givers' characteristics. Our original contribution will be to show how the local government policy is reflected in the quality of life of the residents - users of social home care and their informal carers.

2 Long-term care system and the development of social home care in Slovenia

Long-term care (Colombo et al., 2011: 11–12) encompasses a range of services required by individuals with a reduced degree of functional physical or cognitive capacity, who are consequently dependent on help with the basic activities of daily living (ADL or BADL) or help with the instrumental activities of daily living (IADL) for extended periods of time (see also Katz et al., 1963; Lawton and Brody, 1969). Dependency over a longer period of time is usually a result of a disability caused by frailty and various health issues and may affect people of all ages, but most LTC recipients are older people (Colombo et al., 2011: 40–43). Long-term care systems in Eastern European countries are characterized by the late development of formal services and frequent informal care, less generous public expenditure as a share of GDP and, with few exceptions (which include Slovenia), low private household out of pocket expenditure for long-term care (Colombo et al., 2011).

In Slovenia, institutional care for older people has a long tradition, however, community care in the form of home care is a new phenomenon (Hlebec, 2010; Hlebec, 2012; Hlebec, 2014; Hlebec et al., 2014a; Hlebec et al., 2014b; Hlebec,

2015). Nonetheless, this represents the most important form of formal care within the community, with the sole exception of community nursing. The initial development of social home care in the post 1992 period placed the responsibility for organizing and financing the service on the municipal level and in the beginning not much attention was paid to monitoring the program. The first evaluations of the program showed a slow uptake of social home care across municipalities and a low number of users (e.g. Smolej et al., 2008). Later analyses (Hlebec, 2010; Hlebec, 2012) showed that several distinct models for organizing the service have emerged and these differed systematically with respect to the following characteristics: who contributed to the financing (municipality, state and/or user), efficiency of the use of finances and equality and consistency in access to services across municipalities. The organizational factors (the price of the services and the services provided in the afternoons, weekends and holidays) were not indicative of the use of social home care on an aggregated level of municipal data, however, they could be used to predict the number of tasks performed by social home carers on the level of individual care recipients (Hlebec, 2012; Hlebec, 2014). Namely, the scope of social home care was lower for users in municipalities with higher overall costs and shorter temporal availability of social home care, which influenced the needs and availability of the informal care network. These findings suggest that even though nowadays almost all municipalities provide social home care, there are underlying differences in the provision of social home care that may have an effect on the way in which informal carers provide care to dependent family members. We established the hypothesis that informal carers in municipalities with high private out of pocket contributions for social home care costs will perform a higher scope of care tasks than informal carers in municipalities with low private out-of-pocket contributions.

Based on the estimate from the SHARE survey (Hlebec et al., 2016) 78,182 (9.87%) people in Slovenia aged 50+ and 50,617 (14.87%) aged 65+ were receiving informal care within and/or outside of the household in 2013. In 2011, the share of older people receiving formal care in institutional facilities was approximately half this number (21,093) (Nagode et al., 2014) and even less received formal care within the community in their homes (16,199). The characteristics of informal carers, their care experiences, and the effects caring has on their wellbeing were explored to a lesser extent. Evidence from a small study carried out on a convenient sample (Hvalič-Touzery, 2009) and the SHARE data (Survey of Health, Aging and Retirement in Europe, is a multidisciplinary and cross-national panel database of micro data on health, socio-economic status and social and family networks of) that focuses on people aged 50+ (Nagode and Srakar, 2016), show that the majority of family carers can be found amongst the ranks of the children of the older people, followed by partners and children in-law, mostly women. In most cases the informal carers of the users of social home care within the community (Hlebec et al. 2014b) are women; 57% of the informal carers provide care for their parents, 22% for partners, 7.9% for parents-in-law,

10.8% for other relatives and only 2% for non-relatives. Our hypothesis is that the gendered experience of care will pertain in the division of care tasks according to the gender of the informal carer; namely, female carers are more likely to perform instrumental and personal activities of daily living than their male counterparts are. In line with other studies (e.g. Allen et al., 1999; Blomgren et al., 2008; Edelman and Hughes, 1990) we assume that children are more likely to perform advanced activities and instrumental activities of daily living, while partners are more likely to perform care in personal activities of daily living. Research also shows that intensive care is associated with a higher level of health issues, varying from low general health, to a high level of depressive symptoms or restrictions in activities (e.g. Noelker and Bass, 1989; Bookwala et al., 2004; Lamura et al., 2008; Jacobs et al., 2014). We expect to see a similar connection between the health status of the informal carer and the care scope.

Compared to other European countries the Slovene population of older people ageing in place and receiving formal as well as informal care is very low (11,922, 3.50%) (Hlebec et al., 2016; Suanet et. al, 2012). Most of the research involving this population focused on older people and their care arrangements. The complementary model (e.g. Chappell and Blandford, 1991; Denton, 1997) states that formal care is activated either when an older person lacks the key components of an informal social network in the geographical proximity (compensation), or when the care burden exceeds the abilities of the informal carers (supplementation). Evidence of the complementarity of formal services within the community and informal care has been confirmed also in the Slovenian context. Namely, the complementary role of formal care is emphasized in the instrumental and personal activities of daily living (Hlebec et al., 2014a). The analysis of specific groups of users of social home care and their care models showed that formal care has a supplementary role for older people with large needs who live in multigenerational households in predominantly rural areas (Hlebec, 2015). The organizational factors such as the temporal availability of social home care and the number of users per provider have a significant effect on the care arrangements of social home care users in the activities of daily living (Hlebec, 2014; Hlebec and Filipovič Hrast, 2016). If we look at the issue in greater detail, we can see that in small, rural municipalities, in which social home care is limited, formal carers were significantly more likely to provide the advanced activities of daily living when compared to their counterparts in urban municipalities. Furthermore, the personal activities of daily living were more likely to be assisted by formal caregivers (with or without informal carers) in urban communities than in rural ones. Based on these findings we assumed that the provision of formal care should be reflected in the care experiences of the informal carers. More specifically, we expect that informal carers residing in rural communities in close proximity to the care recipients will provide help with personal activities more often than informal carers residing in urban communities. We also assume that geographical proximity is essential for the provision of care in instrumental and personal activities of daily living.

To a certain extent the recent and slow development of social home care in Slovenia (compared to institutional care for older people), its positioning in the social protection field and the low number of users explain the invisibility of the Slovenian case in international classifications (e.g. Hoffman, 2012). This also explains the lack of interest in regular monitoring of the service development from researchers focusing on local public services in Slovenia (e.g. Pevcin and Rakar, 2015; Rakar et al., 2015; Finzgar and Oplotnik, 2013). Providing formal care for older people ageing in place is one of the most important mechanisms for ensuring a higher quality of life of the older people and their informal carers. All aspects of providing the service, including organizational, economic and financial aspects, as well as the impacts these have on the quality of life, should be addressed in research.

This paper focuses on the informal carers of older people living in their own homes in Slovenia and their care experience with regards to specific, highly fragmentized provision of formal services for older people within the community. This specific population of formal care users within the community and their informal carers provides a unique opportunity to explore the effects that the uptake of formal services by older people aging in place have on the care experience of their informal carers. We will observe to what extent does the provision of social home care shape the care experience of informal carers. With this knowledge, we hope to gain a better understanding of the role of the local self-government in the provision of care for the older people. The consequences of specific organizational solutions and constraints on the everyday life of older people and their informal carers may be recognized and addressed by the policymakers and practitioners on the local level.

3 Method

Slovenian national survey of social homecare users was conducted in 2013 on a representative sample of users, municipalities and social home care providers (Hlebec et al., 2014b). Social home care users and subjectively selected family carers were invited to participate in paper and pencil survey. Only care dyads (care recipient and family caregiver) were taken into account in this paper – questionnaires, which were completed at the same time by care users and informal carers. The average response rate was 30%, thus resulting in 1,057 completed questionnaires. Only care recipients aged 46+ were taken into account in our analysis.

The scope and intensity of informal care – the dependent variables (Y1, Y2 and Y3), were calculated as the Likert indexes across 22 tasks. The number of tasks in which the family carer assisted was pondered according to the frequency of the task (daily, weekly, monthly, less often and never). We distinguish three types of tasks, namely advanced activities of daily living (AADL, e.g., completing errands, organizing travel, finding out information about things, managing financial affairs,

assisting in buying and taking medications), instrumental activities of daily living (IADL, e.g. household management tasks and housework), personal activities of daily living (PADL, e.g. getting in and out of bed, dressing or bathing and feeding oneself).

The contextual variables on the municipal level were drawn from the annual report on social home care (Nagode and Lebar, 2012). We used multiple linear regression analysis. Independent variables were entered in three stages: a) according to the care recipients needs, b) according to the geographical distance between the informal carer and the caregivers characteristics and c) according to the parameters of the formal care characteristics of the residing municipality of the care recipient.

The need of care recipients for care was evaluated with the use of two variables: X1 - the existence of a long-term physical or psychological impairment, illness or disability that limited the respondent in the daily life activities (0 - none or one, 1 – more) and X2 - memory problems (0 - not at all, 1 - some, considerable).

We measured caregivers' age (X3), gender (X4, 0 - female, 1 - male), marital status (X5, 0 – does not have a partner, 1 – has a partner), education (X6, 0 – vocational school or below, 1 - secondary school or higher), health (X7, Likert index of self-reported health issues, 0- 20), subjective evaluation of family income (X8, 0 – we can manage with our family income, 1 – it is (very) difficult to manage with our family income) and care provision to multiple care recipients (X9, number of care recipients who receive care weekly or daily). The geographical distance between the family carer and the main care recipient has three categories (X10, 0 – the same house, 1 – up to 15 min drive, 2 – more than 15 min drive). The out-of-pocket private contribution for SHC/per hour/ (X11) and the number of users as a proxy to the degree of urbanization (X12) were indicators of characteristics of the residing municipality of the care recipient.

Model:

$$Yi = b0 + b1X1i + b2X2i + b3X3i + b4X4i + .. + b10X10i + b11X11i + b12X12i + e$$

Yi = scope of informal care
b0 = intercept
bi = regression coefficients
Xi = independent variables
e = error

4 Results

On average, the informal carer of an older person using social home care is 60 years old. The majority (62%) are women, and most of them are married or living together as married (73%). The majority (69%) also have at least high school

education and can manage (78%) with their family income. On average informal carers, provide care to one care recipient and report on approximately two health problems of their own. The average informal carer most frequently provides care in instrumental activities of daily living. Most of them live in the same household as the care recipient (59%). The majority of care recipients have two or more long-term care physical or psychological impairments, illnesses, or disabilities that limit them in their daily life activities and approximately one third have severe memory problems.

Table 1: Descriptive statistics

	N	Mean	St. Dev.	Min	Max
AADL scope and intensity	980	2.31	0.95	1	5
IADL scope and intensity	1022	3.31	1.49	1	5
PADL scope of intensity	1029	2.42	1.50	1	5
CG Age	1012	60.13	14.85	20	97
No. of care recipients per CG	1057	1.0	0.74	0	5
CG health	1005	2.12	0.93	1	5
Out of pocket private contribution for SHC per hour	1057	4.78	1.31	0	9.07
Number of Users	1057	124	163	1	644

CG- Care giver
AADL - Advanced activities of daily living
IADL - Instrumental activities of daily living
PADL - Personal activities of daily living

Table 2: Descriptive statistics II

		%
CR Long term disability	0 – None or one 1 – More	37 63
CR Difficulties with memory	0 – None, some 1 – Considerable	68 32
CG Gender	0 Female 1 Male	62 38
CG Marital status	0 – Does not have partner 1 – Has partner	27 73
CG Education	0 – Vocational school or less 1 High school or more	31 69
CG Income	0 – We can manage with our family income 1 – It is (very) difficult to manage with	78 22

	our family income	
Geographical distance between CR and CG	0 – Reside in the same household	59
	1 up to 15 min drive	29
	2 – more than 15 min drive	12

CR – Care recipient, CG- Care giver

The three theoretically based models were estimated on three dependent variables – scopes and intensities of informal care across the three types of daily living activities (Table 3). We examined the quality parameters for multiple linear regression analysis. The standardized residuals showed a normal distribution. The independent variables showed no multicollinearity nor heteroscedasticity. All models were statistically significant.

Table 3: Results of Multiple Linear Regression Analysis.

	Model 1 – AADL			Model 2 – IADL			Model 3 – PADL		
Predictor variables	B	Std. Err.	b	B	Std. Err.	b	B	Std. Err.	b
CR Need									
Long-term disabilities	.126	.067	.071*	.253	.091	.095**	.365	.105	.118***
Problems with memory	.173	.068	.095**	.330	.091	.122***	.410	.107	.130***
CG characteristics and distance btw. CG and CR									
CG Age	-.008	.002	-.121**	-.003	.003	-.034	-.001	.004	-.012
CG Gender	.061	.067	.034	-.292	.090	-.111***	-.209	.106	-.068*
CG marital status	.025	.077	.012	-.072	.104	-.024	.301	.122	.084*
CG education	.136	.076	.070	-.060	.102	-.021	-.173	.119	-.052
CG health	.261	.039	.260***	.331	.052	.224***	.436	.061	.252***
Evaluation of family income	-.157	.083	-.073*	-.083	.113	-.026	.073	.130	.020
Provision of care to multiple care recipients	.158	.047	.125***	.127	.063	.068*	.025	.073	.012
Geographical distance between CR and CG	-.237	.048	-.188***	-.686	.064	-.371***	-.685	.075	-.317***
Community, and SHC context									
Out of pocket private contribution for SHC/per hour/	.003	.025	.004	.007	.033	.008	.089	.039	.081*
Number of users	.000	.000	.013	.000	.000	.050	.000	.000	.035
R^2			.155			.271			.262

* ≤ 0.05; ** ≤ 0.01; *** ≤ 0.001

We have noticed considerable differences in the percentages of explained variance in the scope and intensity of the care givers' tasks across the activities of daily living, with the least percentage of explained variance in advanced activities of daily living (16%), followed by personal activities of daily living (26%) and instrumental activities of daily living (27%).

The community and social home care organizational context has a significant effect on the provision of informal care to older people only in the personal activities of daily living (Model 3). More specifically, with an increase in the

private out-of-pocket financial contribution for social home care the scope and intensity of informal care would increase significantly.

The need for care has a systematic and significant effect in predicting the scope and intensity of informal care. Indeed, informal care increases with the increased need of the older people. The effect is stronger across all ADLs when linked to memory issues rather than long-term care physical or psychological impairment, illness, or disability (Btas – standardised regression coefficients).

We will look at the influence the caregivers' characteristics have on the provision of informal care to older people. With age, caregivers are able to perform significantly less care in advanced activities of daily living, while their care in instrumental and personal activities of daily living is not effected as much. Female caregivers provide significantly more care than male carers in instrumental and personal activities of daily living (Models 2 and 3). Married caregivers provide significantly more care in personal activities of daily living (Model 3) than those without a partner. The caregivers' level of education has no effect on the performance of informal care whatsoever. Caregivers who report more health problems of their own provide significantly more care across all activities of daily living. Caregivers living in households with difficulties in managing their family income perform significantly less care in advanced activities of daily living (Model 1), but provide roughly the same care in instrumental and personal activities of daily living (Models 2 and 3). Caregivers who provide care to multiple care recipients provide significantly more care in advanced and instrumental activities of daily living (Models 1 and 2), but not as much in personal activities of daily living (Model 3). With an increasing geographical distance between the caregiver and the care recipient, the scope and intensity of the provided care decreases significantly. The effect is much stronger for instrumental and personal activities of daily living (Models 2 and 3) than for advanced activities of daily living (Model 1).

5 Discussion and conclusions

In this paper, we have explored the care experience of informal carers of older people in Slovenia living within a community and using formal as well as informal care. While this group is not representative of all informal carers in Slovenia, for most informal carers provide care to older people on their own, without any help in the form of formal care (Hlebec et al., 2016), it is nevertheless important to pay special attention to these informal carers as they provide care to their close ones in a specific mixed care context. In this respect, they provide a unique opportunity to observe the uptake of formal care by old people aging in place and the effects this has on the care experience of informal carers. Formal care is common in countries with a long tradition in formal care provision to older people ageing in place, e.g. Scandinavian or continental countries such as Denmark or the Netherlands, however, it has appeared more recently and is less

frequent in Eastern European countries such as the Czech Republic or Slovenia (Suanet et al., 2012). Once we consider the extremely slow uptake of formal care by people aging in place within the Slovenian welfare context, the high fragmentation of long-term care system and high private out of pocket contributions (Hlebec et al., 2016), the understanding of the care experience of informal carers may provide important guidelines for the future development of formal social home care. Especially, as users - once they are introduced to the formal social home care - are mostly satisfied with the service (Hlebec et al., 2014b; Hlebec and Filipovič Hrast, 2015). We are therefore implying that the policy is delaying further development of formal care within the community and that our findings will support the policy makers in their refinement of the provision of this service to older people living within the community.

We have come up with three sets of hypotheses; the first set is connected to the needs of the older people. The second set is linked to the characteristics of the informal caregiver, and the geographical distance between them, while the third set is related to the contextual determinants of care. Unsurprisingly, and in accordance to a number of previous studies (e.g. Andersen and Newman, 2005; Armi et al., 2008; Edelman and Hughes, 1990; Jacobs et al., 2014), the needs of the older people significantly determine the scope and intensity of the care provided to them by their informal carers. However, to a large extent the predictive power of the needs of the older people varies across the activities of daily living in such a manner that the percentage of explained variance in the care givers' scope and intensity of care is the lowest for advanced activities of daily living, and the highest for personal activities of daily living. Taking this into account, our findings support and extend the idea (Broese Van Groenou et al., 2006) that the provision of informal care might be channelled more by the availability of informal carers and their opportunity to provide care (e.g. geographical distance between the care provider and the care recipient), rather than by the care needs themselves. Our findings also support the task specification model (Litwak, 1985; Messeri et al., 1993), which suggests a specialization of care tasks between informal and formal care systems. We brought to attention the specific characteristics of the specialization across the different task areas, something that has not been explored to such an extent in previous research (e.g. Denton, 1997; Edelman and Hughes, 1990; Jacobs et al., 2014) and we also took into account the high number of daily living activities as well as assessed their scope and intensity. When we attempted to explain the informal carers' scope and intensity of care in specific task areas, we established that the availability of informal carers has a greater explanatory power over the needs of the care recipients. More precisely, the availability of an informal carer is more indicative of the scope and intensity of informal care in advanced activities of daily living (Model 1). On the other hand, the need for care has a more predictive power in more specialized, fixed in time and space, and physically more demanding care tasks within the personal activities of daily living (Model 3). We claim that the

higher need for care has a more explanatory power for the more specialized informal care tasks.

The characteristics of the informal carer and care dyads have the strongest explanatory power in predicting the variability in the informal carers' scope and intensity of care. To a certain degree, the characteristics of the informal carers might be entangled with the characteristics of the care recipients. More specifically, when the care dyad is comprised of marital partners, they are likely to be of a similar age and they will share the characteristics of the same household (e.g. income). When the care dyad is comprised of an older person and adult children, they may also share the characteristics of the same household. As the age of the caregiver increases, the scope and intensity of the advanced activities of daily living decrease significantly (Model 1). This could mean that the reduced activities of daily living might indicate a lesser degree of mobility, less frequent socialisation outside of the household and less social participation as the age of the caregiver and care recipient increases. This effect is strengthened by the economic situation of the household as, with the increasing difficulties in managing the household income the scope and intensity of informal care in advanced activities of daily living will decrease.

Being female and being married significantly increase the scope and intensity of informal care in personal activities (Model 3) of daily living as similar to other countries (Messeri et al., 1993; Allen et al., 1999; Blomgren et al., 2008). Women provide care in instrumental and personal activities of daily living significantly more often than men, while partners provide personal activities of daily living significantly more often than adult children, similarly as in other countries (Allen et al., 1999; Blomgren et al., 2008). As we have only observed care dyads with mixed care, which are - according to Blomgren et al. (2008) - more likely to consist of adult children and a dependent elderly parent (as children are more likely to seek for formal care) the effect of the task's specificity is more likely to be weaker while the gender division of care is more likely to be stronger in care dyads that engage solely in informal care. It is also possible that informal carers in Slovenia carry a heavier burden than informal carers in other countries, for there is very little formal support for older people ageing in place (Hlebec et al., 2016). Nevertheless, it is also possible that a higher need for care could lead to the institutionalization of the older person. This could happen sooner in Slovenia than in other European countries as formal care provided in community prolongs the ageing in place also by supplementing informal care with formal care (e.g. Bookwala et al., 2004; Blomgren et al., 2008).

Care provision to multiple care recipients significantly increases the scope and intensity of care for advanced and instrumental activities of daily living (Models 1 and 2). The fact that the scope and intensity of care in personal activities of daily living (Model 3) did not increase significantly, may be interpreted with the task specificity model (Messeri et al., 1993; Allen et al., 1999). The less specialized

tasks, such as care in instrumental activities of daily living, may be performed through time and across carers more easily than the more specialized tasks, such as care in personal activities of daily living. An informal carer could therefore provide care in advanced instrumental activities of daily living for two or three dependent old people at the same time. Household management tasks, i.e. grocery shopping and other shopping, preparing a hot meal (or organising meals on wheels), washing the dishes, light housework (cleaning and organising the garbage), making the bed and cleaning the bedroom and doing the laundry are care tasks that can be provided by an informal carer simultaneously to both parents as well as parents in law. However, the more specialized and more demanding tasks in the personal activities of daily living, such as dressing, bathing, using the toilet or feeding oneself, can only be performed for a single person at the time.

As the geographical distance between the care recipient and caregiver increases, the scope and intensity of the provided informal care decreases significantly. This effect is stronger with instrumental and personal activities of daily living (Models 2 and 3) than with advanced activities of daily living (Model 1). These results confirm the important role of the availability of informal care for older people as shown by numerous studies in other countries (e.g. Noelker and Bass, 1989; Edelman and Hughes, 1990; Chappell and Blandford, 1991; Denton, 1997; Blomgren et al., 2008). The geographical proximity of adult children to their older dependent parents could be a crucial determinant of informal care provision in the Slovenian welfare context as the percentage of multigenerational households and adult children living in geographical proximity to their parents is very high compared to other European countries (Hlebec and Filipovič Hrast, 2015; Hlebec et al., 2016). Similarly, informal care is very frequent (e.g. Colombo et al., 2011; Gennet et al., 2012; Suanet et al., 2012). The geographical proximity of informal carers may outweigh the otherwise absent policy support for informal carers who provide care to their family members as a determining factor for informal care.

Community and SHC organizational factors were less predictive of the informal carers' experience than expected. The number of users per SHC provider, which is closely correlated to the size of the community and degree of urbanization as well as to the temporal availability of SHC, has no effect on the scope and intensity of the informal carer's workload. Contrary to Hlebec and Filipovič Hrast (2016), it was shown that the informal carers' care in personal activities of daily living is statistically unaffected by the provision of formal care. The authors observed that the dual specialization, a situation in which a formal carer and an informal carer provide specialized care, was more frequent for personal activities of daily living in the organizational context with a higher number of users. Task specialization (Messeri et al., 1993) is most likely observed only if ones assess informal and formal carers at the same time. It is possible that additional care provided by formal carers in a mixed care situation would reflect in a lower share of unmet needs of the older people in urban communities (as shown by Hlebec et al., 2016). Compared to urban communities, older people residing in rural communities had a

lower probability of receiving formal care and a higher probability of having unmet needs; on the other hand informal care was unaffected by community determinants. This emphasizes the importance of the formal services within the community, for they enhance the quality of life of older people ageing in place and fill the gap in care needs that informal carers cannot meet.

Out-of-pocket private contributions for social home care is determined on the level of municipality, as, by law, the municipality has to provide at least 50% of the funding for the social home care. In municipalities with generous co-funding and lower out–of–pocket private contributions by older people, the scope and intensity of informal care is significantly lower. This finding complements the previous evidence of the negative effect of the total SHC costs on the scope of care provided to the users by social home care workers (Hlebec, 2014). On top of the limited provision of SHC in municipalities with higher total costs, informal carers face a larger scope and intensity of care in personal activities of daily living (Model 3) in municipalities with higher out-of-pocket private contributions towards SHC costs. It is therefore of utmost importance to encourage the municipalities to further reduce their out-of-pocket private contributions to SHC. This will increase the satisfaction with SHC (see Hlebec and Filipovič Hrast, 2015), for the financial affordability of the service was the least favourably evaluated by SHC users, and reduce the informal carers' care burden in personal activities of daily living. Apart from the temporal availability of social home care, which can be enhanced by linking the social home care to other services (such as institutional care) or by linking the social home care across municipalities in joint organizational units, the financial affordability of the service should be addressed by the policy makers on the local level. One way of reducing the financial burden to users and their families, as adult children are obliged by law to provide financial assistance to their dependent parents, would be to introduce a gradualism in out-of-pocket contribution. This way the costs of the social home care would be easier to meet by users with a lower income and this would foster further development of the service, which was hindered by the economic crisis over the recent years.

Social home care is organized and delivered on the level of municipalities and as such represents an important mechanism for enhancing the quality of life of older people residing within the community as well as their informal carers. Regardless of the fact that in a comparative analysis, Slovenia belongs to the group of countries with a relatively high degree of municipality spending on education (Finzgar and Oplotnik, 2013; Halásková and Halásková, 2014; Halásková and Halaskova, 2015) and much lower spending on social security and health, social home care will gain importance as a crucial mechanism for increasing the number of people ageing in place. It is worth noting that – similar to the institutional care for older people, i.e. nursing homes (Pevcin and Rakar, 2015) - a high, but varying proportion of the costs is covered by users and their families. Contrary to Koo (Koo et al., 2014) we do not advocate that the financial responsibility for welfare

services should be transferred from the local to the national government. We suggest that the financing of social home care should adopt similar mechanisms to the ones established in childcare in Slovenia, i.e. contributions based on income testing and the purchasing power of users. In order to enhance the efficiency of financing the service, users should have a choice of providers, for the current legislation allows only residents of two municipalities to choose between providers (Lebar et al., 2014). Inter-municipal cooperation in the field of social protection is at a level of 10% of that in the field of administrative tasks (Pevcin and Rakar, 2015: 193), thus we would like to encourage inter-municipal cooperation as we believe it can significantly improve the temporal availability of social home care and other forms of care as well as overcome issues of financial sustainability of small size municipalities (Kukovič et al., 2016).

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