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Ageing Policies in Slovenia: Before and After "Austerity"

Abstract: Similarly, to other European countries, Slovenia is facing ageing of the population. The European Year for Active Ageing and Solidarity between Generations in 2012 (EY2012) and the recent economic crisis have influenced social policy in the area of ageing and care for older people. While the EY2012 has raised awareness about issues related to the ageing of the population, the economic crisis after 2008 has put pressure on the welfare system. The purpose of the chapter is to examine the influences of the EY2012 together with the changes in social policies, i.e., austerity measures, which were the results of economic crisis. We analyzed the dominant trends in the development of the care for older people (including both institutional care and home care services), starting from 1992, when Slovenia gained independence, until the recent economic crisis. We have confirmed the main thesis, claiming that the EY2012 had beneficial effects in raising the awareness about population ageing in general population, but was not followed by the policy development, which would be useful

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for older people. Moreover, the social policy development was marked by results of austerity measures, which significantly worsen the quality of life of older people and their families.

Key words: Austerity, Care Services, Economic Crisis, Long-Term Care

Introduction

Similarly, to other European countries, Slovenia is facing relatively rapid ageing of the population. The recent development of social policy in the area of ageing and care for older people has been under the influence of recent economic crisis as well as of the European Year for Active Ageing and Solidarity between Generations in 2012 (EY2012). The economic crisis after 2008 has put pressure on the welfare system. The purpose of the chapter is to identify the dominant trends in the development of the care for older people (including both institutional care and home care services), starting from 1992 when Slovenia gained independence until the recent economic crisis. We will focus on the changes in policies for older people with the introduction of the austerity measures and how this affected the quality of life of older people in Slovenia regardless awareness process raised by the EY2012. We will examine the development and changes in the ageing policies in Slovenia within the recent policy discourse of the main trends in welfare policies such as de-familialization and re-familialization (Blum et al., 2014), individual responsibility, increased selectivity (Taylor-Gooby et al., 2017) and delegated governance (Morgan & Campbell, 2011; Greve, 2015).

The first part of the chapter will give a short overview of the ageing policies after the Slovenia independence in 1992. The second part will focus on the description of the main changes that were introduced with the new social legislation and austerity laws as a consequence of the global economic crisis. The next two sections will present the data on the main trends in institutional care and home care and the policy issues with an emphasis on the development of welfare mix in the shared responsibility of the state, market, and the community (focusing on the role of civil society organizations and the family). Particular attention will be

paid to the issue how these policy changes have affected the social situation of older persons and their quality of life. Our main thesis is that despite the special attention to ageing issues and ageing policies advocated through the EY2012 those policies in Slovenia were not sheltered from "austerity measures" and retrenchment trend was evident in all areas and has significantly affected the social situation and quality of life of older people in Slovenia.

Ageing Policies in the Framework of the Slovene Welfare System Before and after the Crisis

Slovenia is a small country that was once part of Yugoslavia and the established socialist regime. Through the specific circumstances of the development of former socialist societies, a particular type of welfare system[3] evolved: a state-socialist welfare system, in which the state had the dominant role. The state was the owner, financier, and controller of all institutions and organizations that provided services or paid for the provision of social protection and welfare of its citizens. An important fact regarding the development of the Slovene welfare system during the transition period in the 1990s is that, contrary to some other post-socialist countries, Slovenia did not experience a so-called "welfare gap" (see Kolarič et al., 2009, 2011). Hence, in the context of the transition from socialist to post-socialist society, the Slovene welfare system went through gradual reforms and constituted as a dual model, combined with elements that are the basic constitutive elements on one side of the conservative-corporate. On the other side, social-democratic welfare system. First of all, the compulsory social insurance systems (including old age), which are based on social partnership and are as such the basic constitutive element of a conservative-corporate welfare

[3] The welfare system we understand as a concept that embraces not only the institutions, programs and measures with which the state provides social protection and social well-being to its citizens, but also those evolving and functioning according to the logic of the market, as well as those operating within the domain of civil society, the community and the family (Kolarič et al., 2009, 2011).

system, are in Slovenia the primary instrument for the provision of social protection for employees and their family members. On the other hand, the strong public and state sector maintained the status of the main service provider of all types of services to which all citizens are equally entitled. Gradually, a complementary relationship between public and state and the non-profit voluntary sector was established, as well as state support for the informal sector. The characteristics mentioned above are distinctive elements of the social-democratic welfare system (Kolarič et al., 2009, 2011).

In terms of services for older people, the system in Slovenia had three components: the public sector, the informal sector and the "grey" sector. In the public sector, a well-developed and regionally dispersed network of public (state) organizations and institutions provided formally organized professional services, including numerous institutions for the care of older people (nursing homes). The second sector—the informal sector—provided services that were lacking in the public sector. They were provided by close and extended family members, friends, and neighbors. This voluntary and unpaid provision of services, largely based on strong value orientations, normative expectations and emotional closeness within informal networks (Nagode et al., 2004; Filipovič Hrast, & Hlebec, 2008, 2009; Hlebec & Filipovič Hrast, 2009; Hlebec, 2009, 2010), was not supported by policy measures. The last sector, that is, the grey sector (Kolarič, 1992; Kolarič et al., 2009) comprised employees in public institutions and organizations who were offering services for direct (illegal) payment and was tolerated by the state for its compensatory role.

Hence, at the beginning of the transition, Slovenia built its care policies for older people on a well-developed tradition of institutional care (Nagode et al., 2004; Mali, 2009). On the other hand, community care services, such as home care, day care, and others have developed only after the transition. The development of community care was relatively supported in the policy documents. For example, the National Program on Social Protection 2006–2010, the Program for Development of Care for Older People in the Field of Social Protection until 2005, and the Strategy of Care for Older Adults 2006–2010.

The National Social Protection Strategy by 2005 and the Resolution on the National Social Protection Program 2006–2010 defined new forms of mobile assistance, day care centers, care in a family other than the birth family and care in sheltered housing for older people. The Social Security Act (MDDSZ, 2006a; Amendment to the Social Security Act, 1992) defined services for social prevention, and services intended for eliminating social distress and difficulties (first social aid, personal help, help to the family, institutional care, guidance, protection and employment under special conditions, help to workers in enterprises, institutions and at other employers). One measure related to care for older people is the possibility for a family member to become a family attendant with the right to partial payment for lost income at the minimum wage level or to a proportional part of the payment for lost income in the case of part-time work (Hlebec, 2010).

Policy measures since 1991 have targeted both the development of institutional care and support for older people living at home and their careers. However, the persistence of the characteristic of the previous system through "path dependency" is clearly evident in the slow development of home care services. This services still cover a very small part of older people (approx. 3%) while the adoption of these services by older persons currently is not growing anymore, mainly due to financial inaccessibility (Nagode et al., 2013). Flexible forms of care and support for family careers are still underdeveloped (see Filipovič Hrast & Hlebec, 2009; Mali, 2008). Adoption of a coherent long-term care act has been discussed for a decade and drafts have been prepared. However, the actual adoption of such an Act is still pending.

In regard to pension system the main issue throughout the period was the financial sustainability due to unfavorable demographic trend further exacerbated by the early retirement policy as a solution to solve high unemployment rates following transition of Slovenia to market economy, which placed an additional burden on the national pension system (Filipovič Hrast & Rakar, 2015). Slovenia has the so-called pay-as-you-go pension

system that is based on three pillars (the first is compulsory, and the other two are supplementary).

Ageing Policies in Times of Economic Crisis and "Austerity" Discourse

More recently following the trends of the "Great Recession," the well-developed welfare systems have been under significant pressures due to the recent economic crisis and demographic pressures. Slovenia enjoyed strong economic growth before the crisis but faced one of the most pronounced recessions among the countries members of The Organization for Economic Co-operation and Development (OECD) in 2009. The gross domestic product (GDP) growth after 2008 was negative and shows a slower recovery than in 28 European Union (EU) member states (Eurostat). On the other side, as in many other European countries, Slovenia is facing an ageing of the population. The old age dependency ratio was 24.4%, in 2012, which is slightly below the EU27 average. However, it is projected to rise to 57.6 % in 2060 (Eurostat). Hence, what has been in the public, policy and media arena most discussed is the sustainability of the pension system.

In Slovenia, the pension reform has been highly contested, and the first proposed major reform was rejected at the referendum (in 2011). In 2012, a new reform was negotiated and adopted, increasing the retirement age, and further strengthening bonuses and maluses to stimulate labor market participation of older workers (Filipovič Hrast & Rakar, 2015).

The economic situation of older people has deteriorated since 2001, with the most affected being those aged 75+ (Kump & Stropnik, 2009; Stropnik et al., 2010; Stropnik et al., 2003) and the poverty rates among older people are high (20.5% in 2014) (Eurostat). It is therefore not surprising that evaluations of the quality of the pension system are rather negative and the average has decreased from 5.1 in 2003 to 4 in 2011 (EQLS 2003, 2011).

Since economic crisis austerity laws have been adopted in 2012,[4] which froze pension indexation and pension adjustments, further affecting the living standards of older people. These acts introduced temporary austerity measures with an unpredictable time limit, as they will be in force until the year that follows the year in which the economic growth exceeds 2.5% of GDP. These reforms made benefits for older people and social benefits more means-tested and lowered the level of some benefits.

Furthermore, besides the austerity measures introduced by the austerity laws as a direct response to the crisis, there was a major reform in welfare policies, with the adoption of the new social legislation which came into force on 1 January 2012 with two acts: the Exercise of Rights to Public Funds Act and the Financial Social Assistance Act, regulating the noncontributory social benefits. The implementation of the two acts brought significant changes in the field of social benefits and subsidies. For the first time the law introduced a common entry point to access all family and social benefits, it defined uniform criteria for eligibility for different benefits and for accessing income and property of households. Besides including a wider definition of family income (taking property and savings into account) it also set an order in which benefits are being claimed. According to the main goals of the new legislation, this was supposed to ensure a fairer distribution of social transfers and targeting the most deprived. However, the data show worsening of the financial situation and well-being of some of the most vulnerable groups and among those also older people (Dremelj et al., 2013). Most important was the change in supplementary allowance that pensioners with lower pensions were eligible (also those residing in institutional care). Now, the additional allowance is no longer granted on the basis of pension and disability rights but became a social benefit and people residing in institutional care are no

[4] As a direct response to the crisis two intervention acts were adopted. The first, Act on Additional Intervention Measures for 2012, came into force on 1 January 2012, the same day as the new social legislation. The second, Fiscal Balance Act, came into force on 31 May 2012.

longer eligible for it. Consequently, the number of beneficiaries dropped dramatically by 78% between 2011 and 2012 (Trbanc et al., 2014). Furthermore, the striking drop in the number of beneficiaries can be linked to stricter conditions for accessing benefits, taking into account a broader definition of income (including property). The most important change was a state mortgage on the property of those receiving a supplementary allowance as well as social assistance recipients. This relates to issue of the "take-up of benefits," since the implemented changes resulted in "non-take-up of benefits" from older people in fear of losing their property as well as the property inheritance rights of their children. Moreover, state pensions were abolished, which used to be a universal right and support for older people not eligible for insurance-based pensions. Those older persons have now become dependent on social assistance and supplementary allowance, now changed to social assistance benefit, and hence dramatically reduced the number of beneficiaries (Trbanc et al., 2014).

Due to the problems with the implementation of the new social legislation and its negative impact, there were subsequent modifications of the new social legislation that came into force on January 1, 2014, and September 1, 2014. The changes involved softening of some of the access rules in terms of income and property calculations in accessing the benefits and less strict rules in regard to property mortgage for the supplementary allowance[5] and social assistance beneficiaries.[6] Despite the positive connotation of these improvements, this was more "make-up" changes and as shown by data did not have an effect on the increase in the number of beneficiaries (see Trbanc et al., 2016, pp. 53-54).

[5] Limitation of inheritance rights only to 2/3 of the value of the assets.

[6] The return of the received social assistance benefits applies only to beneficiaries that received social assistance for more than 12 months with the adjusted return of funds minus 12 months of the highest amounts and minus 1/3 of the monthly amounts of social assistance.

The described changes in the ageing policy, which can be labeled under the trend of increased selectivity, have happened despite older people having a strong political presence, as their political party, the Democratic Party of Slovenian Pensioners (DESUS), has been part of every governing coalition since the earliest years of independence (1996). Also, the EY 2012 activities did not have any major effect on improving the position of older people or to shelter them from the major cuts in policies and benefits. This could be explained by the fact that the focus of the activities was mainly on raising the awareness on active ageing and intergenerational solidarity, promoting discussions, good practices and preventing discrimination on the basis of age in general. However, topics in regard to illness and disability, employment and active work were much less pronounced. Very few actions were directed to policy makers (Narat et al., 2012). The activities within the EY 2012 made a good basis for further work in this area. Still, in the future, the focus should be more on the concrete proposals and actual implementation of active projects (Narat et al., 2012).

In terms of the austerity measures, there were no major reforms in regard to services for older people. However, in practice, a trend toward the privatization of services is evident, both in institutional services as well as home care services. Hence, a trend toward "contracting out" and delegated governance in the service provision for older people can be noticed. In terms of ageing policy developments, the changes in social protection benefits for older persons and on the other in the service provision, have resulted in some more pronounced issues of the affordability of services in institutional care as well as home care services as shown in the next section.

Developments in Institutional Care

The institutional care in Slovenia is by tradition well developed. Mali (2009) refers to three main periods of the development. Namely, the first period before the transition was a socio-gerontological period, where nursing homes were designed as geriatric institutions focused on sick old people. The period after a transition from 1991 to 2000 as a hospital model of nursing homes

where hospital-like rules of living were in use. The period after 2000 as a social model of institutional care. The implementation of this last model has been based on a rising number of people who have dementia and the inability of the medical model of care to provide highly individualized care. In the following paragraphs, the development of institutional care will be presented in figures. Data was gathered from various sources, mostly from the Statistical Office of the Republic of Slovenia (SURS) but also from other institutions such as the Association of Social Institutions of Slovenia (SSZS), the Ministry of Labour, Family, Social Affairs and Equal Opportunities (MDDSZ) and the Social Protection Institute of the Republic of Slovenia (IRSSV). A detailed list of sources is given below each table.

The number of institutions along with the number of residents has been increasing throughout the whole period, which is in line with the demographic trends producing a greater need for institutional care as shown in Table 1. However, what is unexpected, is that in 2012 there was a decrease in the number of residents in institutional care, which could be linked to the effects of the economic crisis and introduced austerity measures as well as the described changes in the social legislation exacerbating the issue of the affordability of the institutional care.

The average pension was raising up to 2009 as shown in Figure 1. In 2012 there was a significant drop in average pension, with a slight increase in 2013 and again dropping in 2014 and 2015. Halting of the increase in pensions and even the lowering of the level of pensions along with constant increase in the expenses for nursing homes and the decrease in the public funds from the health insurance budget (SSZS, 2016), could explain the decrease in the number of residents due to the possible drop out from institutional care as they were no longer able to afford the services. Additionally, the described changes in the social legislation in 2012 contributed to this drop, since we would expect that the lowering of the pension levels would be supplemented by municipality funds, however, this was not the case, due to take-up of benefits gap, since the beneficiaries did not apply for them by fearing of losing their property (SSZS, 2016).

Table 1 Nursing Homes and People in Care

	Old people's homes	Number of residents
1990	53	11,260
1991	NA	NA
1992	53	11,178
1993	NA	NA
1994	50	10,664
1995	47	10,757
1996	48	11,057
1997	47	11,500
1998	48	11,645
1999	50	11,951
2000	49	11,905
2001	55	12,346
2002	58	13,051
2003	61	13,498
2004	63	13,098
2005	68	13,641
2006	69	13,699
2007	69	13,856
2008	84	15,235
2009	83 87*	15,994 17,216*
2010	89	17,676
2011	91	18,195
2012	93	18,076
2013	93	18,352
2014	93	18,643
2015	94	18,247

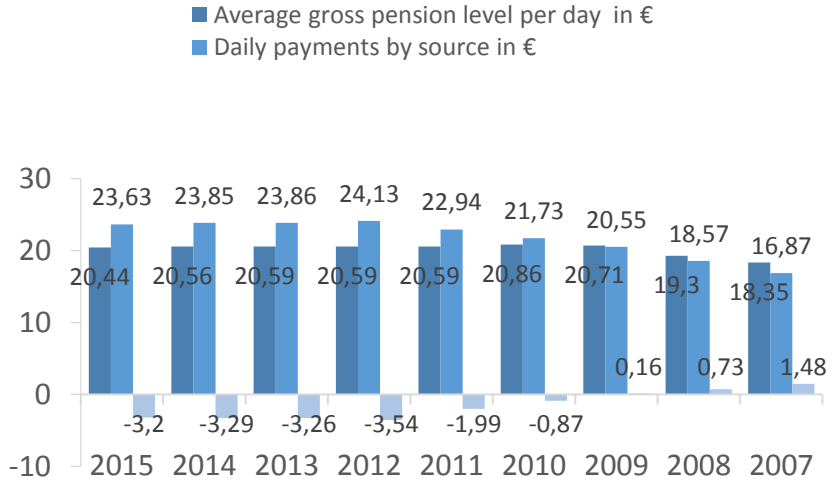
Source: SURS, 2004, 2007: 2009; Association of Social Institutions of Slovenia 2009-2015. *Reported data are about the number of residential units and differs from data reported by SURS, which reports about the number of residential institutions among which some may have more than one residential unit. *Reported on December 31 of each year.

The salient issue of the affordability of the institutional care exacerbated by economic crisis, the austerity measures and increased selectivity within the changes in the social legislation is also evident in Figure 2, showing the trends in the difference between users' daily payments and average gross pension level per day.

Figure 1 Average Pension

Source: SSZS, 2016, p. 8.

Figure 2 Difference Between Users' Daily Payments and Average Gross Pension Level per Day



Source: SSZS, 2016, p. 8.

There was a sharp decrease in the ability to pay after 2010 when the average pension was no longer covering the average

expenses of the nursing homes (SSZS, 2016). Taking into account the more restrictive legislation for the eligibility of social transfers (e.g., state mortgage on real estates), this significantly increased the burden on families and relatives for the payment of services as well as taking care of the family members indicating a trend toward re-familialization and greater emphasis on individual responsibility. Perhaps also the increasing number of private homes for older people with higher daily payments has contributed to the trend.

The issue of affordability of services combined with the quality of services could become one of the salient issues in the future, and it is something that should be urgently addressed by the welfare state in Slovenia. Furthermore, we should have a closer look at the structure of the provision of institutional care for older people in regard to the type of providers and trends in the examined period as shown in Table 2.

Table 2 Public/private Nursing Care Institutions

	Private (licensed)	Public
2001	5	58
2002	5	58
2003	11	58
2004	11	59
2005	14	60
2006	18	60
2007	18	60
2008	28	56
2009	28/ 32*	55/ 55*
2010	34	55
2011	36	55
2012	39	54
2013	39	54
2014	39	54
2015	40	54

Source: Dremelj et al., 2009: 98; Association of Social Institutions of Slovenia, 2007, p. 16 and 2007, pp. 24-31; Association of Social Institutions of Slovenia 2009-2015. *Reported data are about the number of residential units and differs from data reported by SURS, which reports the number of residential institutions among which some may have more than one residential unit. *Reported on December 31 of each year.

In 2001 there were only five private providers of institutional care for older people, and in 2015 the number was 40 institutions in private provision of care. Hence, during the last 15 years we have seen a rising number of privately-owned nursing homes with a licensed care program (the vast majority also have concessions) and a decrease in the number of public institutions, showing a trend toward the privatization of services in terms of contracting out the services to private providers instead of filling the demand by establishing public institutions (by the state or municipality). The price of services in private nursing homes is defined and approved by the state. However, the private institutions are in general more expensive than the public institutions, which is not always the case of higher standards in comparison to public institutions. In terms of a number of residents in private institutions, there was a smaller increase than in the number of private institutions itself. However, also showing an increased trend toward contracting out as a way of privatization of services. A closer look at the list of private providers of institutional care (SSZS, 2016[7]), shows that those are registered in different forms. Among the non-profit organizations, many of them are established by the Roman Catholic Church. The majority of private providers are for-profit institutions, showing a trend in the direction of the liberal welfare system as defined by Kolarič et al. (2002). The public intuitions are still predominant. However, the trend of privatization in the direction of market provision and marketization of services should be taken into account when discussing the current changes in ageing policies.

Developments in Social Home Care

Social home care is a social assistance service which was developed in the first half of the 1990s by centers of social work. Its first occurrence dates to 1984 (Nagode et al., 2016, p. 910). It is a social assistance service intended to improve the quality of life

[7] A list of all institutional care providers in Slovenia is available on the webpage of Association of Social Institutions of Slovenia (www.ssz-slo.si/seznam-domov-clanov-s-povezavami, 21.12.2016).

of people living at home who are unable to care for themselves due to old age or illness and whose family cannot provide them with sufficient care. It was developed to cut the number of waiting applicants for nursing homes and to improve the quality of life of those living at home. An individual is eligible for up to 4 hours of care per day or a maximum of 20 hours per week. In 1992 in legislation concerning social protection, the social home care was established as social protection service as a part of public social protection network. A year before that the state has introduced co-financing of the services by public works (Nagode et al., 2016). Along with expansion and professionalization of the service in the next decade, the payment for users was introduced in 2000. In 2001 the Ministry of Labour, Family Affairs, and Social Affairs had introduced a special financial support for the social home care by contributing to the labor costs of the service provider by partially covering the costs of salaries for workers that participated in public works program before that. The measure was in place until 2011 (Nagode et al., 2016). The financial burden of the service is now partially carried by the municipality, which by law is obliged to cover at least 50% of the cost of the service. Users are obliged to pay the rest of the costs of the social home care, if unable to cover for financial burden; firstly the family members must contribute to the payment if able. Only if family resources are insufficient users can apply for a reduction of payment.

The first evaluations of how the service has been implemented show slow uptake of the service, the number of users reported from 3.909 in 1998 up to 7.100 in 2015 as shown in Table 3. Early evaluations of the service show considerable variability in users' financial contribution ranging from 1.90 EUR up to 10.94 EUR (Hlebec, 2010) and point out that not every municipality provided at least 50% of the cost of the service. The Social Protection Institute of the Republic of Slovenia (IRSSV) has started to evaluate the service in 2006 systematically, and to date, nine reports are publicly available. We summarize major trends in terms of a number of users, users cost, and type of providers.

Table 3 Number of Social Home Care Users

	Number of social home care users 65+
1998	3.909
First half of 2002	4.590
At the end of 2004	4.732
2006	4.612,7*
2007	4.880,3*
2008	5.096,8*
2009	5.676**
2010	5.764**
2011	5.827**
2012	5.801**
2013	6.540**
2014	6.888**
2015	7.100**

*An average number of users per month; **Number of users on December 31 each year.

Source: Compiled from Nagode et al., 2016, pp. 11-13; Lebar et al., 2015, p. 23.

The municipalities are obliged to provide social home care services, which means that they need to provide a public network of services and establish a concession agreement with at least one of the providers either public or private. For example, in 2006 six municipalities did not provide social home care services and, for instance, in 2015 two municipalities did not provide social home care (Nagode et al., 2016). Hence, the coverage of services improved but still, they are not provided in all municipalities, or as shown in the IRSSV evaluation they are provided on paper but not in practice (Nagode et al., 2016).

Among the home care providers, the majority are public institutions (centers for social work), followed by nursing homes (the data about the public vs. private types of nursing homes is not available). From 2007 till 2015 there was an increase in the number of municipalities that contracted out the services to private providers (for 23 municipalities) or the nursing home or special social institutions (for 31 municipalities), and there was a decrease in the number of municipalities where centers for social work provide home care services (for 43 municipalities) or specialized

institutions for home care (for 4 municipalities) (Nagode et al., 2016, p. 27). By comparing the number of municipalities where social home care is provided by private institutions with those where home care is provided by public institutions, we can notice a trend of the decrease in the number of municipalities with public providers (from 186 to 170) and at the same time the number of municipalities with private providers of social home care is increasing (from 19 to 42) (Nagode et al., 2016, p. 27). In regard to the affordability of services, the average price for services is the highest from the private providers with concessions. Also, the subventions from municipalities are in average lower for private providers than for public institutions (Nagode et al., 2016, p. 32). Although in the recent years there was a decrease in the prices of home care (Nagode at al., 2016), the increase in the private providers of home care, which are more expensive in comparison to public providers, may exacerbate affordability issues of home care services in the future.

Hence, as shown by the presented data in terms of social home care services providers we can notice a trend toward privatization of services in terms of contracting out the services to private non-profit (civil society organizations) and for-profit providers such as companies and individual entrepreneurs, which at the same time increases the price of services and exacerbates the affordability issues of social home care services.

Conclusion: Major Trends in Ageing Policies Marked by "Austerity"

The purpose of the chapter was to identify the dominant trends in the development of the care for older people (including both institutional care and home care services), starting from 1992 when Slovenia gained independence until the recent economic crisis. We focused on the changes in policies for older people, more specifically on the introduction of the austerity measures and the major reform in welfare policies regulating noncontributory social benefits as well as the major trends in the service provision, and how this affected the quality of life of older people population in Slovenia, regardless awareness process raised by the EY2012. We examined the development and changes in the ageing policies

in Slovenia within the recent policy discourse of the main trends in welfare policies such as de-familialization and re-familialization, individual responsibility, delegated governance, and increased selectivity.

The first finding is that the financial situation of older people has worsened in the recent years as a consequence of changes in the ageing policy in Slovenia comprised of austerity measures and reform of the social legislation. These induced the salient issues of service affordability, which forced older people to drop out from the nursing homes as shown by the data on nursing homes. It also caused severe problems of financial access to the home care services for the majority of older people. Hence, the introduced changes show a trend toward more reliance on individual responsibility for the well-being as well as a trend toward re-familialization, forcing older people to rely more on the families twofold regarding home help and in terms of financial help. Besides, there is a pronounced trend toward increased selectivity based on means-testing criteria in order to be eligible for benefits and services financed by the state. These trends are evident in a tightening of the criteria on one side for different social benefits for older people as well as public (co)financing of the services for older people.

The second finding is that in regard to service provision we can interpret the recent trends in policy developments in terms of different roles of service providers such as supplementary or complementary role to the public services (Rakar, 2007). As shown by the data on the level of privatization of services a trend toward the subsidiary role of other providers, such as non-profit as well as for-profit organizations, besides the state, is evident in institutional care and home care services. The role of other providers, rather than the state, is no longer only complementary to the services provided by the public sector. More specifically, other providers, especially the non-profit voluntary organizations, acted as an alternative to the services of the public sector in the past, not replacing those services, but only contributing to the freedom of choice as the vast majority of services was provided by the public sector. In the recent developments of the increased reliance of municipalities on the private provision of services, by

non-profit as well as for-profit providers, the trend towards the subsidiary role of other service providers can be noticed. The private providers are not only complementing the services, provided by the public sector in terms of freedom of choice, but they are also replacing them by filling up the gap of the withdrawal of public providers. In other terms, the state or municipality, rather than providing its own services, contracts out service delivery to other providers in line with austerity measures and retrenchment of the welfare state in general. More specifically, it can be labeled under the trend of delegated governance as the "delegation of responsibility for publicly funded social welfare provision to non-state actors" (Morgan & Campbell, 2011, p. 19).

Finally, our main conclusion is, that regardless of the beneficial effects of EY2012, such as raising the awareness on active ageing and intergenerational solidarity, promoting discussions, good practices and preventing discrimination on the basis of age, the ageing policy in Slovenia severely suffered from the effects of the economic crisis and consequent austerity measures, which had a prevailing impact on the quality of life of older population and their families. A more comprehensive approach to ageing policies in Slovenia is becoming one of the major issues that should be tackled by the Slovenian welfare state in the future.

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