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THE LONG-TERM CARE SYSTEM FOR THE ELDERLY IN SLOVAKIA

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The Long-term Care System for the Elderly in Slovakia

ENEPRI Research Report No. 86/June 2010

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1. The long-term care system of Slovakia

1.1 Overview of the system

Long-term care (LTC) in Slovakia concerns the provision of complex medical, nursing and custodial services for a long period, in some cases in the context of permanent care. Slovak legislation does not define the term ‘long-term care’ as a combination of social and health services provided on a regular and long-term basis. Also, the public perceptions of these two systems of care are strictly divided. Health care is legally and also formally provided by the state, while social care (including care of elderly, the disabled or chronically ill) is partly provided by the state, regions, charitable and private institutions.

The integrated provision of social care and medical care in the Slovak Republic is not systematically regulated by national legislation. In addition, the approach to long-term social and medical care in Slovakia has undergone several major changes during the last 15 years. In 2005, a proposal for an act on long-term care and the integration of persons with disabilities was presented by the Ministry of Health, with the concept of an integrated LTC system. This proposed act was not approved and the concept reverted back to providing separate social and medical care services.

Nowadays individual features of the LTC system are covered by several regulations and acts. LTC is interpreted in terms of meeting two needs – for social care and medical care. This includes LTC from the point of view of disabled persons and their needs and social inclusion. Also included is care for elderly persons with chronic diseases. The main principles are incorporated in several national health care and social strategies. More transparently, the various parts of the Slovak LTC system are presented in Figure 1.

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Figure 1. Development of long-term social and health care facilities

The system is vertically divided into three types of facilities, which lack home care services		
Facilities providing social services	Facilities providing mixed social and nursing services	Hospitals providing social services (currently being transformed into nursing facilities)
The establishment of a network of integrated facilities has been suggested, providing horizontal services at home and in every facility offering long-term services. The level of care is set by an independent, expert review team for LTC. (There are separate review teams for the elderly, psychiatric clients, etc.)		
Social services providing basic nursing care		
Social services providing a medium level of nursing care		
Social services providing extensive nursing care		

LTC services are provided on the long-term basis (monthly, weekly, daily) according to the specific needs.

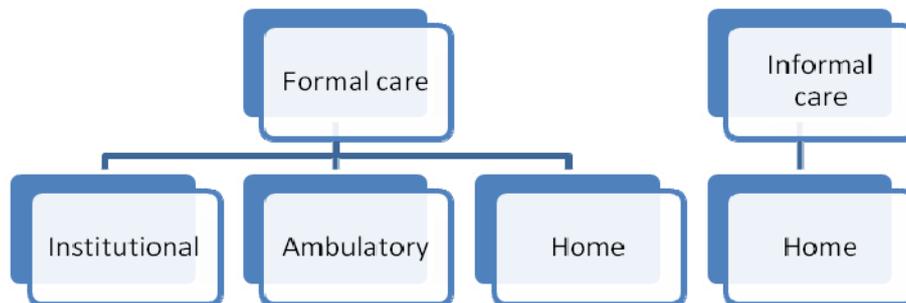
LTC principles are covered by the following main acts and regulations:

- Decree No. 910/2000 on **state health policy** in the Slovak Republic, which provides basic guidelines for LTC legislation;
- Act No. 576/2004 on **health care and services related to providing the health care**;
- Act No. 578/2004 on providers of health care, medical workers and medical professional associations;
- Ordinance No. 640/2008 on a minimal public network of health care providers;
- Ministry of Health Regulation No. 770/2004, which determines the characteristic signs of classes of individual medical facilities;
- Ministry of Health Regulation No. 364/2005, which determines the scale of nursing services provided by nurses independently and in cooperation with physicians and the extent of birth assistance services provided by birth assistants independently and in cooperation with physicians;
- Act No. 447/2008 on financial allowances for the compensation of several disabilities and on changes and the addition of some regulations that determine the level of financial support given to persons in need;
- Act No. 448/2008 on social services described major principles on the availability of social care, social nursing care and social palliative care. This act also describes providers of long-term social care. It replaced several previous acts on social services and offers the possibility of integrated service provision under the system. Social care facilities can provide medical services in a limited way (they have to obtain a licence from the Ministry of Health and have medical personnel); and
- care for disadvantaged persons and social inclusion is part of the programme declared by the Slovak government in 2006.

Both social and medical LTC services in Slovakia can be divided into formal and informal care (see Figure 2). Formal care is provided through the public network of social and health care facilities or through private medical facilities. Institutional care (for longer than a day) is

provided on an institutional basis and also through ambulatory care and home nursing care. The ambulatory care can be provided on a daily basis and is usually medically related. Formal home care can be divided according to the type of service. Services that are medically related, such as home nursing care, are covered by health insurance. Social care services are provided by the social welfare system; the costs are covered by the lower level administrations (municipalities and regions) through taxation and the co-payments of care recipients. Informal home care is given by a family member or a close contact of the dependent person. A family member or close contact providing intensive informal care can be supported by benefits in cash or similar benefits (a social contribution can be paid to the caregiver). Other types of informal care are not covered by any legal agreement and are unusually not paid.

Figure 2. Overview of the LTC system in Slovakia



Ambulatory care is provided as primary care (by a general practitioner) and in the form of specialised medical care.

Institutional, geriatric medical care is provided by the geriatric departments of hospitals for urgent cases, as it is by the gerontopsychiatric departments; chronic cases are treated in sanatoria for patients with long-term diseases. Institutional geriatric care is also provided by palliative care facilities and hospices. The various types of institutional care are described in more detail in later sections of this paper.

One of the basic principles of the health system is the freedom to choose the care provider. In the LTC system, this principle is also applied with respect to social services, but there are some funding limitations. Social services are provided by the local administrations. If the patient selects a service in another region, this will be provided only for the full price without any right to a subsidy.

In 2006, the share of older persons aged 65+ in the population was 11.8%, which represented approximately 640,000 persons. The number of persons aged over 60 was about 814,000, which represented about 15% of the population. According to the Ministry of Health (2005a), 38% of the population of pensioners is relatively healthy and 32% has some kind of chronic disease for which health care is being provided. The remaining 21% is in degenerating ill health and 9% has a serious illness or is reliant on long-term care and the help of others.

1.2 Assessment of needs

Formal LTC services in Slovakia are offered by a wide range of facilities. Services are provided according to the level of disability (in activities of daily living, ADLs). Entitlement to receive services is general, conditioned by the disability level. There is an assessment to determine the kind and amount of benefits required. The assessment is carried out by an advisory committee comprised of physicians and social workers. Each patient is assessed individually according to a set of strict guidelines, which are specified by special legislation. The results of this assessment

are used for the selection of the most suitable type of LTC. The costs of the social services are usually covered by the local or regional administration with co-payments by the care recipient.

The level of dependence of a patient is considered according to a six-grade scale. Act No. 448/2008 on social care defines 12 criteria (e.g. eating, drinking, sitting, walking, hygiene, washing, orientation, etc.) for which an individual score (of 0-10 points) is assessed on the performance of a particular personal activity. The total sum gives the degree of dependence, as shown in Table 1.

The advisory committee is established by the municipality or region by contract with an assessment physician and social worker. The assessment physician scores the health status of the patient according to the categories in Table 1. When the category determined is from levels II to VI, the patient is assessed as being dependent on assistance.

Table 1. Degrees of patient dependence on care by another person

Degree of dependence	Total points	Average time of dependence (hours/day)	Average time of dependence (hours/month)
I.	105-120	0	0
II.	85-104	2-4	60-120
III.	65-84	4-6	120-180
IV.	45-64	6-8	180-240
V.	25-44	8-12	240-360
VI.	0-24	More than 12	More than 360

Source: Act No. 448/2008.

The social and family situation of the patient is subsequently assessed by the social worker according to the four criteria (i.e. personal care, household activities, basic social activities, supervision), resulting in a written statement. Based on the medical assessment and social statement, an expert report is issued, which outlines a proposal for the most suitable social services for the patient.

1.3 Available LTC services

Institutional, long-term medical care is provided at the following facilities:

- medical facilities, which also include those providing institutional medical care
- facilities for ambulatory medical care, which include
 - stationary/day care facilities designated to offer short-term care with medical care
 - agencies offering home nursing care
 - mobile hospice care (home palliative care)
- facilities for institutional medical care (with licences approved by self-governing regions)
 - hospital care, both general and specialised, with licences approved by the Slovak Ministry of Health
 - sanatoria
 - hospices (palliative care)
 - nursing homes.

These facilities are discussed in greater detail below.

- **Facilities for institutional medical care** provide medical care to persons whose state of health requires continuous medical care with the expectation of staying in a bed in a medical facility for longer than 24 hours.
- **Stationary/day care facilities** are designated to give ambulatory medical care to persons whose state of health requires repetitive ambulatory medical care on a daily basis, and are always linked to institutional or ambulatory medical care. These facilities are also appropriate for patients receiving informal care from their family or other relatives, who are economically active during the day.
- **Agencies that provide home-based nursing care** provide complex home nursing care and assistance to persons for whom it is anticipated that their state of health will not require continuous medical care in any institutional health-care facility, or to persons who refuse the latter form of care.
- **Hospitals** provide continuous, requisite medical care and specialised medical care in conjunction with ambulatory care and pharmaceutical care by a hospital pharmacy. At **general hospitals**, institutional medical care is given by different specialised departments. At **specialised hospitals**, institutional medical care is given mostly in one particular medical field, possibly also in departments coordinating with the main specialised medical field.
- A **sanatorium** offers specialised medical care oriented primarily towards health disorders of a chronic character with prolonged treatment.
- **Hospices** give medical care to patients with incurable, advanced and actively progressive diseases, which usually lead to death (palliative care). The aims of this form of medical care are to improve patients' quality of life, reduce suffering and stabilise their health condition. Some parts of hospice facilities may also be used to provide ambulatory medical care, including home-based medical care in the residence of the ill person. **Mobile hospices** offer home-based palliative care by professional employees of the hospice.
- At **nursing homes**, continuous nursing care and rehabilitation are provided to patients whose health status does not require continuous medical care provided by a physician. This includes providing the necessary, related ambulatory medical care. Some parts of nursing home facilities can be used for stationary (daily) nursing care.

Ambulatory care is provided as **primary care** and specialised medical care. Primary medical care is given to geriatric patients through the network of general medical doctors for adults, who cooperate with specialists in the relevant medical areas. An essential part of primary medical care is made up of **agencies providing home nursing care**, which offer complex medical care mainly to geriatric patients and which is usually provided in conjunction with nursing care provided by the organs of the state's social care system.

Specialised ambulatory care is provided to geriatric patients on request by a general medical doctor for adults or by a specialist in geriatric care or other field. Specialised ambulatory, geriatric care includes preventive and dispensary care provided under current legal regulations. Geriatric ambulatory care also provides care for patients with dementia. Ambulatory care for gerontopsychiatric patients is given through the net of gerontopsychiatric departments and the stationary/day care facilities that are being established (as nowadays there is rather a lack of them).

Facilities and services for long-term social care, according to Act No. 448/2008 on social services, provide social services related to LTC as described in part five of the Act. This part concerns services aimed at alleviating poor social situations that arise from profound disabilities and worsening health after individuals reach retirement age. Slovakia has a very elaborate and extensive system of social care facilities. In future, it is planned to simplify this system and also integrate these facilities with medical facilities for LTC.

Social care institutions offer general social counselling and social rehabilitation, along with accommodation in facilities long-term care. Other assistance provided by social care facilities (besides stationary/day care facilities and supported housing) includes help with laundry, cleaning and cooking. Specific services for the retired and for persons dependent on help from others are listed below, together with a description of the particular facilities offering them:

- **Supported living facilities** offer social services to persons dependent on help or supervision, through which they can lead an independent life. At such facilities the assistance mainly entails social care, accommodation and cooking.
- **Facilities for seniors** provide social services to pensioners, those who reach retirement age and are dependent on another person's help, or those needing help for other serious reasons. Alongside basic social services, nursing care and spare-time and cultural activities are arranged.
- **Nursing care facilities** offer services to dependent adults for shorter periods, for whom it is not possible to arrange another service. Physical assistance, nursing care and basic social services are rendered.
- **Rehabilitation centres** provide social services to dependent persons who are blind, deaf or profoundly hearing-impaired. Their services include physical help. Centres where only ambulatory care is provided do not feature assistance with cooking, accommodation, ironing and laundering. If accommodation is provided, however, these forms of assistance can be made available but only for a defined period. At rehabilitation centres, counselling for rehabilitative purposes is offered to the client or his/her family members who ensure help for the client in the home environment.
- **Social housing** assists persons whose level of dependence is categorised as at least V (on the six-grade scale), or those who are blind or practically blind and their level of their reliance is at least III. In social housing such individuals receive physical help, nursing care, personal equipment and allowances specified by ordinance. Children can also be cared for at such facilities (with education and other necessary services).
- **Specialised facilities** also assist clients whose level of dependence is categorised as at least V and who also suffer from medical diseases – usually Parkinson's, Alzheimer's, pervasive development disorders, sclerosis multiplex, schizophrenia, dementia, blindness, deafness and AIDS. Besides basic social care their services include personal assistance, nursing care, personal equipment and allowances specified by ordinance. Again, children can also be cared for at such facilities (with education and other necessary services).
- **Day care/stationary facilities** offer social care to dependent individuals who only need help for part of the day. These facilities assist with meals, work and social therapy, and offer leisure activities. Social counselling or help is also available to individuals and their families at these facilities, which ensures support for those who are reliant on help in the home environment.

Other complementary and home social services include the following:

- **Nursing care** is available to clients whose level of dependence is categorised as at least II and who are reliant for help with personal care, household chores and basic social activities. The range of activities provided is based on the decision of the social advisory committee and the number of hours is set by the municipality. The minimum range of social nursing care cannot be less than that set for the level of dependence.
- **Transport** is a social service provided to persons with profound disabilities who are reliant on individual transport with a motor vehicle or those with disabilities and limited movement or orientation.
- **Guide services** are available those who are blind or partially sighted and persons with mental impairments. Reading services can be also provided to blind persons.
- **Interpreting services** are available to deaf persons in gesture, sign or tactile language.
- **Other complementary social services** can help with the procurement of personal assistance, interpreting and administrative support. The lending of technical aids is an important secondary form of help.

Informal home care is usually given usually by a family member or close contact of the dependent person and is not covered by any legal agreement. The caregiver receives a social contribution for home care according to Act. No. 447/2008 on financial allowances.

The quality assurance of services is mandatory for all facilities providing long-term care, including formal home care.

1.3.1 Who is eligible?

The legitimate basis for access to a selected form of social or medical help is determined by the category of care recipient. The legislation makes distinctions between receiving LTC in the social and medical spheres and by the various types of care provided.

Based on the current legislation, LTC services are determined by individual need and the patient's health status. Health status is considered by the medical doctor/specialist. Every citizen has a right to receive an individual plan and to its periodic medical review. Costs are covered by the obligatory health insurance with a possible excess paid by the care recipient.

Persons with profound disabilities have a right to receive financial support for selected services (transport, modification of housing, etc.) in accordance with Act No. 447/2008.

A needs assessment is provided under Act No. 448/2008 to persons who are in unfavourable social or health conditions, or as a step in the prevention of social exclusion. The examination of a person with a serious disability or who has an unfavourable health status for the purpose of accessing social care (also linked to LTC) is performed by a medical examiner, who also determines the level of disability (in terms of ADLs). The individual's needs, family background and living conditions are assessed by the social worker. Based on the medical expertise and social expertise, a common view on social dependence is elaborated, which will define the level of dependence on assistance, the level of disability and proposed social services.

1.3.2 Which services?

In the previous sections we have described the types of medical and social care provided. An overview of the usual types and length of services in selected facilities is presented in Table 2.

Table 2. Overview of the social and medical services provided in the Slovak Republic

	Type of service			Length of service			Institutional or home	
	Medical care	Social care	Nursing care	Daily care	Short term	Long Term	Institutional care	Home care
Facilities for institutional medical care	X				X		X	
Stationary/day care (nursing)		X	X	X			X	
Agency of home nursing care	X			X				X
Mobile hospice	X		X	X				X
Hospital (general, specialised)	X				X		X	
Ambulatory (primary, specialised)	X			X			X	
Sanatorium	X		X		X	X	X	
Hospice	X		X		X	X	X	
Nursing care facility		X	X		X		X	
Facility for supported living		X				X	X	
Facility for seniors		X	X			X	X	
Rehabilitation centre		X	X	X	X		X	
Social service housing		X	X	X	X	X	X	
Specialised facilities	X	X	X		X	X	X	
Other complementary social services		X		X				X

Source: Authors' compilation.

1.4 Management and organisation (role of the particular participants)

Dependent persons with chronic somatic or psychiatric diseases as well as those with health, sense, mental or psychiatric impairments are deemed to need LTC. Without this help they cannot perform common daily activities (such as eating, dressing, personal hygiene care, communication, etc.).

A key role in the provision of LTC is played by the patient's family and close contacts, who may provide long-term care and may in turn be affected by any other care provided. LTC consists of different proportions of medical (nursing) and social care (nursing, housekeeping, social contacts, etc.).

LTC can be provided at home as informal care by the family, relatives or close contacts of the patient or as formal care by professional nursing or personal assistance services. It can also be received at community facilities (stationary/day care, rehabilitation centres, care/management provided by municipalities). Another aspect is the long-term care at institutional facilities. Several facilities that integrate long-term social and medical care are to be established. Also newly integrated facilities are to be extended.

Besides providing services, a key aspect of the LTC system is the financial aid and contributions (for family members assisting their parents) to caring, personal assistance and compensation of the social consequences of clients' disabilities.

The objective of LTC for individuals dependent on the help of others is to secure the best possible quality of life with as much independence as possible, social and work integration,

satisfaction and human dignity. There is general legislation on LTC at all levels of state administration. The main providers are the Ministry of Health and the Ministry of Labour, Social Affairs and Family.

Only local and regional administrations can effectively take responsibility for providing LTC to abandoned persons who do not have the ability to apply for care. For this reason, social services are managed at several levels. The exact division of tasks among the various levels of administration is specified in Act No. 448/2008 on social services.

The Ministry of Labour, Social Affairs and Family may help determine national priorities and supervises providers of social services.

Municipalities (local administrations) develop and approve community plans for social services in their areas and they set local policy for social services at facilities for seniors, nursing care facilities, stationary/day care facilities, taking into account reliance on nursing care and transport services. They are responsible for funding these services in their respective regions. Municipalities may also contract for the provision of social care and contributions.

Self-governing regions (regional administrations) manage and approve the conception of social service development in their respective territories and set policy for social services provided at facilities for supported housing, rehabilitation, social services and specialised care. They are likewise responsible for funding these services in their regions. Regional administrations may also contract for the disbursement of financial contributions for the care of dependent persons and support for non-governmental organisations offering social services to them. The central responsibility of local and regional administrations is capacity planning for the social facilities.

The main governmental institution covering medical services is the **Ministry of Health**. The Ministry of Health supervises medical facilities and the medical services provided in the Slovak Republic. This ministry also determines national priorities and strategies in the medical field. Some duties are delegated to the regional administrations with responsibilities and financial subsidies from the central government.

Supervision and inspection of social service providers is a responsibility of the **Ministry of Labour, Social Affairs and Family**. This ministry is also able to impose fines for violations. The social services provided and their financial management are monitored by the local or regional administration.

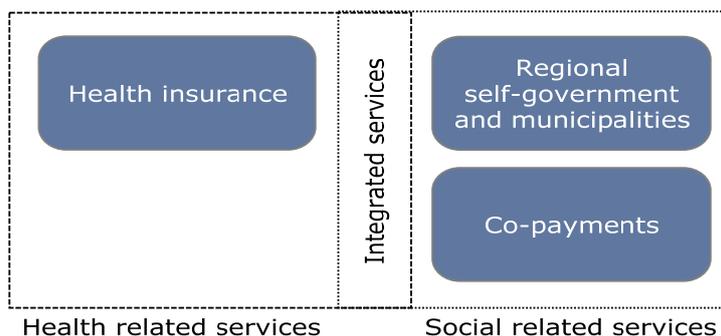
1.5 Integration of LTC

The main problem nowadays in the Slovak LTC system is that social and health services are not really integrated. The integration of the medical and social parts of the LTC system is the next objective. Nevertheless, since January 2009 there has been the possibility for integrated care providers to establish themselves if they fulfil the requirements for providing both types of services.

2. Funding

The financing system for LTC in Slovakia is mixed. Long-term care is funded from two sources, depending on the type of LTC provided (Figure 3). Health-related services are fully funded by health insurance. For health-related services there are no co-payments by the recipient. Home nursing care does not require any co-payments either. Social care is funded by the regional and local administrations (through taxation). These resources cover about two-thirds of the expenses of social care. About one-third is made up of co-payments by patients. This applies to both institutional and home care.

Figure 3. Funding scheme for the LTC system in Slovakia



Health and social insurance are mandatory. The contributions to insurance are shared by the employee and the employer. The state pays these contributions for children until they finish school, for parents taking care of a child under age 6, pensioners, disabled persons and individuals providing informal home care for a patient dependent on this care.

The institutions providing social care (public or private) receive a contribution for each patient according to the patient's degree of dependence (see section 1.2). The private provider is eligible for this contribution only if it has a contract with the local or regional administration. The maximum levels of the contribution are stated in Act. No. 448/2008 on social services, and are shown in Table 3.

Table 3. Maximum contributions for the care of dependent patients

Degree of dependence	Max. contributions for ambulatory social care per month (€)	Max. contributions for home social care per month (€)
II.	62.21	89.82
III.	124.41	179.68
IV.	177.65	269.47
V.	248.82	359.29
VI.	310.99	449.18

Source: Act. No. 448/2008 on social services.

This cost sharing is income-related, i.e. each recipient has to pay for the services. The amount of payment must allow the individual to save a multiple (1.3) of the subsistence (living) wage.

The total costs for LTC in Slovakia are around €130 million, which represents around 0.2% of GDP. Unfortunately, there is a lack of more detailed financial statistics about the LTC system in Slovakia.¹

¹ OECD, Health Statistics Database 2009, OECD, Paris, 2009 (www.oecd.org).

3. Demand and supply of LTC

3.1 The need for LTC (including demographic characteristics)

Slovak legislation provides the basis for universal access to LTC services for every person in need. Like most countries, Slovakia has problems with the increasing share of older persons in society – population ageing.

An illustration of the future development of age groups is revealed Tables 4 and 5. Until 2015 the pre-productive age group (0-14) will continue to decrease and will reach its minimum at around 15% of the total population. At this time, the productive age group will slightly rise from 56% in 2015 to nearly 62% in 2025. A nearly critical situation will arise among the age group 65+, with the share of this group growing from nearly 12% in 2005 to 19% in the next 20 years. The share of very old persons in this period will double.

Table 4. Demographic forecast for selected age groups

	2000	2005	2010	2015	2020	2025
Population	5,400,679	5,387,285	5,423,703	5,471,653	5,510,225	5,521,745
Pre-productive age (0-14)	1,210,798	1,053,386	906,823	820,187	827,994	853,365
Productive age (15-64)	2,580,223	2,684,915	2,864,970	3,077,306	3,265,048	3,408,341
Post-productive age (65+)	617,516	630,927	675,883	775,472	921,798	1,047,470
Very old persons (80+)	102,737	130,609	153,337	167,911	179,048	202,109

Source: Demographic Research Centre, Statistical Office of the Slovak Republic (www.statistics.sk) (2008).

Table 5. Demographic forecast for selected age groups, shares of the total population (%)

	2000	2005	2010	2015	2020	2025
Pre-productive age (0-14)	22.4	19.6	16.7	15.0	15.0	15.5
Productive age (15-64)	47.8	49.8	52.8	56.2	59.3	61.7
Post-productive age (65+)	11.4	11.7	12.5	14.2	16.7	19.0
Very old persons (80+)	1.9	2.4	2.8	3.1	3.2	3.7

Source: Demographic Research Centre, Statistical Office of the Slovak Republic (www.statistics.sk) (2008).

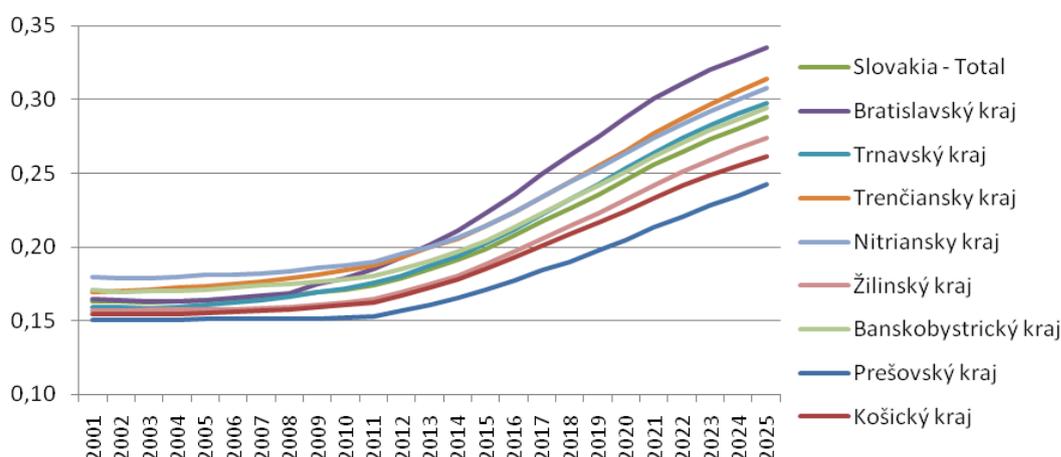
According approximations of the Slovak Ministry of Labour, Social Affairs and Family, about 183,000 persons are in need of LTC and nearly half of them are older than 65. More than 38,000 receive formal institutional care, more than 70,000 receive some kind of formal home-based care and around 60,000 receive some form of informal care.² By these rough estimations, about 20% of persons in need do not receive any kind of LTC.

² These are the authors' expert estimations based on data published in the OECD's Health Database and the health statistics yearbooks published by the National Health Information Center (www.nczisk.sk), along with consultation with Lydia Brichtova (Director of the Department of Social Services at the Ministry of Labour, Family and Social Affairs) as well as Martina Šmýkalová (Department of Medical Care at the Ministry of Health).

According to the European Commission's (2009) *Ageing Report*, the estimated number of persons in need is even higher (around 230,000, among whom more than 31,000 receive formal institutional care). This amount will more than double in the next 25 years.

The old-age dependency ratio characterises the demographic development of the population older than 64 relative to the population of productive age (15-64). Until 2008, this indicator rose very slowly. Since 2008, elder persons born in the post-war baby boom, which entailed a very large cohort, have retired. Old-age dependency will rapidly rise in the near future and will more than double in the next 15 years. The highest old-age dependency ratio is expected to be in the economically stronger, western part of Slovakia (Figure 4).

Figure 4. Old-age dependency ratio, NUTS 3 regions in Slovakia



Sources: Demographic Research Centre, Statistical Office of the Slovak Republic (www.statistics.sk) and own calculations.

3.2 The role of informal and formal care in the LTC system (including the role of cash benefits)

In Slovakia, several kinds of benefits are provided in connection with both social and health care. Everyone is entitled to receive benefits under the Slovak LTC system, but an assessment of the income of the beneficiary is needed. There are binding guidelines for the assessment process. Institution-based care solely provides benefits in-kind, while other forms of care (home care and nursing care) may be linked to both benefits in-kind and in cash.

During the past several years a wider discussion has begun about support for informal care. The role of informal care in the LTC system is inevitable and is usually carried out by the family. The Ministry of Labour, Family and Social Affairs does not legally cover this kind of social care.

Since January 2009, it has been possible for a family member or close contact of the dependent person to provide the subsidised informal care (previously only professionals could receive remuneration for this service). This kind of personal assistance can be done by a family member for a maximum of four hours. The amount of personal assistance contribution is set at 1.39% of the subsistence level per hour of care. In 2009, this contribution represented about €2.58. Another kind of contribution is the care allowance, which is €206.16 per month and is fixed on the condition that informal care is provided by a family member or close contact of the

dependent person for at least 8 hours per day (level V on the scale of disability in ADLs). The average monthly contribution for social care is approximately €150.

3.3 Demand and supply of informal care

Informal care is the most commonly used help in the LTC system. Almost everyone reliant on help receives some form of informal care. Nowadays, there are around 200,000 persons needing LTC in Slovakia, which represents about 3.6% of the total population. An intensive form of informal care is provided to approximately to 57,000 persons.³

3.4 Demand and supply of formal care

There are no exact data on the number of persons seeking LTC. As noted earlier, an estimation based on the number of persons requiring any kind of LTC assistance is about 183,000 persons. Owing to a continual ageing of the population we expect a significant increase in the demand for LTC. Over the next ten years the growth in demand for LTC through population ageing could be 50%.

The estimated number of employees in the Slovak LTC system is around 32,000. Around 22,000 work in institutional care and more than 10,000 are caregivers or nurses in home-based care.⁴ The number of places in selected facilities is shown in Table 6.

Table 6. Number of places in selected social care facilities

	2001	2002	2003	2004	2005	2006	2007	2008
Number of facilities – Total	670	590	680	730	775	797	824	873
No. of places in seniors' homes	13,374	12,922	12,666	13,214	13,277	13,258	13,758	13,922
No. of places in social service homes for handicapped adults	6,569	8,330	9,627	9,902	10,839	12,444	12,833	13,249
No. of places in social service homes for handicapped children	3,668	3,749	3,636	3,659	2,961	2,345	2,088	2,371

Source: Statistical Office of the Slovak Republic (www.statistics.sk).

3.4.1 Institutional care

Institutional care in Slovakia is composed of several types of facilities. Together there are more than 38,000 beds in the entire LTC system.⁵ This number is not sufficient, however, mainly with respect to the long-term care facilities for elderly persons. For some facilities, the waiting periods can last several years. More than two-thirds of all beds are in state facilities and the remaining are private. The majority of private facilities have been established to offer social care.

3.4.2 Home care

Home care is a priority for individuals with a stable social situation and is least stressful. The most important part of home care is the informal care, most often given by family members or

³ Ibid.

⁴ Ibid.

⁵ Ibid.

close contacts of the care recipient, but which is available to all persons requiring a certain level of LTC. Under certain conditions this type of care can be financed by state contributions as an income supplement. The second type of home care is formal home and nursing care. In 2007 around 70,000 persons received some kind of formal home care. Among this number, more than 40,000 were aged 65 and older.⁶

3.4.3 *Semi-institutional care*

A minor part of the LTC system is made up of the institutional facilities providing mostly temporary care, on a daily basis through stationary/day care, mobile hospice and ambulatory care.

4. LTC policy

4.1 Policy goals

The state's strategy for health policy determines the basic aims to be followed. The general strategy for health development in the sense of defined goals is to support and strengthen the health of healthy persons; protect the health of persons threatened by biological, chemical or physiological factors in the environment; and restore the health of persons with weakened or damaged health. There are several objectives related to LTC. The main ones are fostering healthy ageing (such as the objectives of the national programme for the protection of elderly persons), developing palliative care and medical ethics, and improving mental health.

In general, future needs are incorporated into the aims of the LTC system. The national strategy contains basic LTC principles. A further legislative basis for LTC will take into consideration the **following principles and needs** (the national priorities for social and medical LTC are common in this area):

- the predominance of home care over community and institutional care;
- the development of ambulatory health and social facilities with weekly residence opportunities;
- the priority of community care over institutional care;
- an emphasis on the direct private financing of long-term care over indirect financing from public sources; minimal, redistribution of public finances;
- the responsibility of clients themselves and their families for long-term care-giving. The public sector should take responsibility only if an individual cannot take care of him/herself, and the family is unable to do so;
- the mutual independence of the permission, control, financing and executive parts of the LTC system;
- an increase in the quality and humanisation of the services provided; and
- the education of employees in the area of social and medical care.

The main problem of the current Slovak LTC system is that **social and medical services are not integrated** (neither organisationally nor financially). Previous analysis⁷ has shown several drawbacks of the present system, which resulted in new key aims:

⁶ Ibid.

⁷ This refers to the Conception of Social and Long-Term Care in the Slovak Republic (Government of the Slovak Republic, 2005b).

- For the target group of children with physical disabilities and chronic diseases, the system needs to be reformed to meet their medical, educational and social needs, together with parents and experts in this field.
- For the target group of citizens with physical, sensory and mental impairments, long-term care needs to be connected with integration in society, with policies supporting the motivation to work, self-sufficiency and full participation in the life of society for the greatest number of clients possible.
- For the target group of citizens with mental impairments and behavioural problems, in cooperation with psychiatrists, reform of psychiatric care in the Slovak Republic should be added to regional plans for integrated care. Here again the aim should be integration in society, including the labour market, for the greatest number of clients possible.
- For the target group of the elderly, informal care at home should be supported to expand community forms of integrated health and social care.

The Conception of Social and Long-Term Care (Government of the Slovak Republic, 2005b) and the Strategy of Health Care for Geriatric Patients and Long-Term Patients in the Slovak Republic (Government of the Slovak Republic, 2005a) also showed **additional needs** in three areas:

- preventive care
- ambulatory care
- institutional, geriatric health care.

Preventive care is focused mainly on national preventive programmes (the national cardiovascular programme, oncologic programme, diabetologic, etc.), and free vaccinations for older persons. For preventive care, the key future necessity is to continue preventive programmes based on actual needs, expand the knowledge bases within primary preventive care and give attention especially to the preventive care of infectious diseases. In addition, there is the need to secure preventive care that is free from obligatory health insurance.

Ambulatory care is provided as primary care and specialised medical care. The needs in ambulatory care are as follows:

- Practitioners should improve care for patients with chronic diseases in better cooperation with home nursing care agencies and with links to social care.
- For specialised ambulatory care, to ensure accessibility to health care by geriatric specialists in all 79 counties of Slovakia, the network of geriatric ambulances needs to be reconsidered and the education system in the field of geriatrics needs to be adjusted.
- Given the rise in the number of geriatric patients, the number of facilities providing services of daily care (which cannot be provided at home and does not require hospitalisation) is also increasing. In such facilities mostly diagnostic, therapeutic and rehabilitation services can be provided.
- Following the diagnosis and rising incidence of mental illnesses among geriatric patients it is necessary to enlarge the network of gerontopsychiatric medical offices and daily psychiatric interns.
- The Ministry of Health, within the scope of the new categorisation of medicinal drugs, will seek an adjustment to prescription regulations, in light of the frequent cases of polymorbidity and the immobility of geriatric patients.

Institutional, geriatric medical care is provided for urgent cases in the geriatric and gerontopsychiatric departments of hospitals and in sanatoria for patients with chronic, long-term

diseases. Institutional geriatric care is also provided through palliative care and by hospices. In this field, the following needs have been identified:

- The range of services provided for urgent, institutional geriatric care should develop according to the increasing needs of a growing group of geriatric patients. The future profile of this kind of care will also depend on the number of specialists; it is notable that more recently some geriatric patients have been successfully treated by the intern departments of hospitals.
- A rise in the number of beds and facilities for palliative care is needed, as is support for building hospices and other institutions offering palliative care.
- The Ministry of Health will recommend that at least one geriatric department in each of Slovakia's eight self-governed regions fulfils the international criteria of EU medical specialists (UEMS) for accreditation in a gradual increase of geriatric specialists.
- The Ministry of Health should continue to work on a conception of social medicine, given the continually unresolved problems in the transfers of patients from urgent, institutional medical care to sanatoria for patients with long-term diseases. In cases where after receiving such treatment patients cannot return home, they need to be transferred to social service facilities.

These needs are described in several conceptions, which have been changed a number of times during last decade. The needs in relation to improving informal care are not really included in these conceptions and are more or less covered in the Act on social services.

4.2 Integration policy

Generally, we can say that a high degree of readiness on the part of both the Ministry of Health and the Ministry of Labour, Social Affairs and Family to prepare and implement an integrated model of social and long-term medical care does not have at its base a holistic approach for Slovakia. Rather, it comes from the expectations of improvements in the situation by both ministries. The social sphere needs to find resources for expanding the services provided, which are still insufficient. The medical sphere, on the other hand, needs to take another necessary step to rationalise/reduce the supply of institutional medical care. A rough comparison of supply and demand for services in both domains shows an interconnection and partial substitution between them. Efforts to complete the integration of LTC services were stopped in 2005. Nowadays, there is a possibility to provide LTC services in integrated facilities, but under the authority of both ministries. In the last nine months, none of the facilities in Slovakia have fulfilled these criteria.

4.3 Recent reforms and the current policy debate

Establishing the current arrangements for the LTC system in Slovakia has involved several steps over the past 10 years and is still not finished. In August 2000, in the context of the International Year of Elderly People (1999), the central government approved the **National Programme for the Protection of Older People**. This programme takes a complex view of the needs of older individuals. In the state's policy (also the Commission Decision Nos. 91/544 and 93/417), the **principle of care** is defined, which includes and distinguishes the help of family and society, and determines access to health care, social and legal services, as well as access to institutional care. It also defines the need for improvements in **nursing care**, seen as one of the most progressive and humane methods for helping older persons who are dependent on the help of others.

In November 2000, the government approved **State Policy of Health in the Slovak Republic** (Government of the Slovak Republic, 2000). This framework briefly describes the core future strategy and principles for health care. The state policy defines health as a key factor of society's development. In this document, three LTC-related priorities are defined: enhancing healthy ageing, developing palliative care and medical ethics, and improving mental health. The document also includes future legislative strategy in this field.

In 2004, a legislative act on the long-term care and support of disabled persons was prepared, but this act has never been approved. In 2005, new LTC principles and aims in this field were described in the **Strategy on Health Care for Geriatric Patients and Long-Term Patients** (Government of the Slovak Republic, 2005a) and the **Conception of Social and Long-term Care in the Slovak Republic** (Government of the Slovak Republic, 2005b).⁸ Both documents were approved by the government, but the legislative process concerning the proposals for an act was stopped in 2005.

In 2009, the Ministry of Labour, Social Affairs and Family (2009) prepared the **National Priorities for the Development of Social Services**.

Nowadays the arrangements for long-term care services are a little complicated and disorganised. The reform of the public administration in 2001 led to a partial transfer of competencies to local authorities, which include funding for the social services provided. The main difficulties have arisen from the lack of integration of the social and health services. In both systems, many changes have occurred in past years and in some areas the respective competencies are still unclear. A unified proposition for an integrated LTC system in Slovakia is still lacking.

Ordinance No. 640/2008 on a **minimal public network of health care providers** also determines the minimal network of facilities providing medical care (including medically related LTC facilities).

4.4 Critical appraisal of the LTC system

Currently, the LTC system in Slovakia is not very transparent. This is also the main problem from a legislative standpoint. Particular aspects of medical and social care for patients with long-term needs are governed by several acts and regulations, which are not always linked and sometimes do not cover the situation entirely. Several conceptions and proposals for LTC have been introduced in Slovakia in the past. Even with respect to medical reforms, the proposal for an act on long-term care services was prepared, but was not approved for political reasons.

Recently, the problems of population ageing and increased demand for LTC services have been receiving consideration and become a crucial problem for society. The future final shape of the LTC system in Slovakia is still questionable. These days we can say that particular parts of the LTC system in Slovakia (which is treated as a framework in national strategies), incorporate several definitions and plans that are similar to proposals of the World Health Organization on LTC services. The biggest problem today from our point of view concerns informal LTC services, which are not at all thoroughly regulated by legislation.

The Act on social services (No. 448/2008), valid from January 2009, allows the joining of social and medical care in the same way as was valid 15 years ago. The most important feature is that nurses employed in social care facilities are allowed to provide medical care. Until December 2008, another nurse from a medical facility had to be called in to provide medical services to the clients of a social facility.

⁸ These documents are available on the website of the Ministry of Health of the Slovak Republic (<http://www.health.gov.sk/>).

Several barriers to accessing LTC have arisen in the Slovak LTC system. The main ones are financial, geographical (an unbalanced distribution of providers) and organisational (sometimes the waiting periods for social care for the elderly are several years). Moreover, in Slovakia there is a wide range of facilities providing LTC services. The system is in need of simplification.

LTC services are currently undergoing a transitional phase. Future needs are being defined; it will be important to specify tasks and priorities for the provision of informal care. From the viewpoint of evaluation, there are different opinions about future needs and the optimal mix of LTC services at the national, regional and local administrative levels, as well as those offered by service providers.

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Legislation

- Government Decree No. 910/2000 on state health policy in the Slovak Republic.
- Government Ordinance No. 640/2008 on a minimal public network of health care providers.
- Ministry of Health Regulation No. 770/2004, on the characteristic signs of classes of the individual medical facilities.
- Ministry of Health Regulation No. 364/2005, on the scale of nursing services provided by nurses independently and in cooperation with physicians and the extent of birth assistance services provided by birth assistants independently and in cooperation with physicians.
- Act No. 576/2004 on health care and services related to providing health care.
- Act No. 578/2004 on providers of health care, medical workers and medical professional associations.
- Act No. 447/2008 on financial allowances for the compensation of several disabilities and on social services.

Websites

- Government Office of the Slovak Republic (www.vlada.gov.sk)
- Ministry of Health of the Slovak Republic (www.health.gov.sk)
- Ministry of Labour, Social Affairs and Family of the Slovak Republic (www.employment.gov.sk)
- National Health Information Center (<http://www.nczisk.sk/>)
- Statistical Office of the Slovak Republic (www.statistics.sk)

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ANCIEN

Assessing Needs of Care in European Nations



FP7 HEALTH-2007-3.2-2

L launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

- 1) How will need, demand, supply and use of LTC develop?
- 2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (<http://www.ancien-longtermcare.eu>).