interlinks

Health systems and long-term care for older people in Europe
Modelling the interfaces and links between
prevention, rehabilitation, quality of services and informal care

National Report on Informal Care in the LTC System

Slovakia

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Foreword

This report is one of the outputs of the first year of implementing project INTERLINKS, within the work package WP5 „Informal Care within the LTC System". Its purpose is to describe the system of long-term care of older persons in Slovakia, with a special emphasis put on functioning of informal care as part of long-term care, and in connection with the informal care, position of persons providing informal care, in particular of family members. The report is structured in line with the template agreed by partners of WP5. The first version of the report was informally discussed within the Slovak National Expert Panel. Based on comments and additional information, the report was amended and submitted for a final discussion by the National Expert Panel held on 3 September 2009 in Bratislava.

In March-April 2011 the report was finally updated to include latest developments in the long-term care and informal care sectors in the period of autumn 2009 - spring 2011.

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1 Introduction and Background

1.1 Informal Care and Formal Care – Definitions, Differences

Hegyi (2007, 2008) defines long-term care as provision of complex medical, nursing and custodial services for a longer period or a long-term period, in some cases as a permanent care. Slovak legislation, however, does not define terms, such as "long-term care", "informal care sector" or "formal care sector". After 2006, the term "long-term care" has explicitly been mentioned only in the document "National Report on Strategies of Social Protection and Social Inclusion", in which it is instrumentally defined as "social services, care allowance and direct payment for personal assistance" (The National Report, 2008: 63). Based on this definition and its components, it is possibly to implicitly derive also definition of formal and informal sectors of care, in particular in connection with older persons. For the purpose of this report, *informal care* is defined as care:

- provided to persons that have been dependent, due to severe disabilities, on help by others for long periods of time so that their needs of daily activities (normal daily tasks of taking care of oneself and one's household, and basic social activities) could be fulfilled,
- provided mainly by the closest relatives at home, or by other persons that live in the households of the persons to be cared for,
- not requiring any special qualification of caregivers.

On the other hand, *formal care* is understood as care:

- provided to persons dependent on help of other persons to assist with their daily living activities (tasks of taking care of oneself or one's household, and basic social activities), or to persons that are in danger due to some serious reasons (e.g. domestic violence, loss of home),
- provided by professional social workers arranged for by local and regional self-governments, or non-public providers,
- provided in form of social services (including social consulting) at home or in a social services facility on daily, weekly or yearly bases,
- the extent of care dependence is minimally two hours a day,
- financed primarily from budgets of local and regional self-governments, by persons cared-for, and/or by other resources,
- requiring qualification skills of social caregivers as defined by law.

Formal and informal care sectors are indirectly distinguished also by identification of persons and entities involved in these sectors. In the case of the informal sector, Act No 447/2008 Coll. on financial allowances to compensate a severe disability refers to the so-called *natural persons* (relatives), or *other natural persons* (friends, acquaintances, neighbours) that provide care. In the case of the formal care sector, the Act No 448/2008 Coll. on social services refers to *public* or *non-public providers* of social services. As public providers of social services are municipalities/towns or higher territorial units or legal persons established or instituted by them. Any legal and natural persons established otherwise are non-public providers of social services.

1.2 Legal Aspects of Care, Responsibilities of Family and State

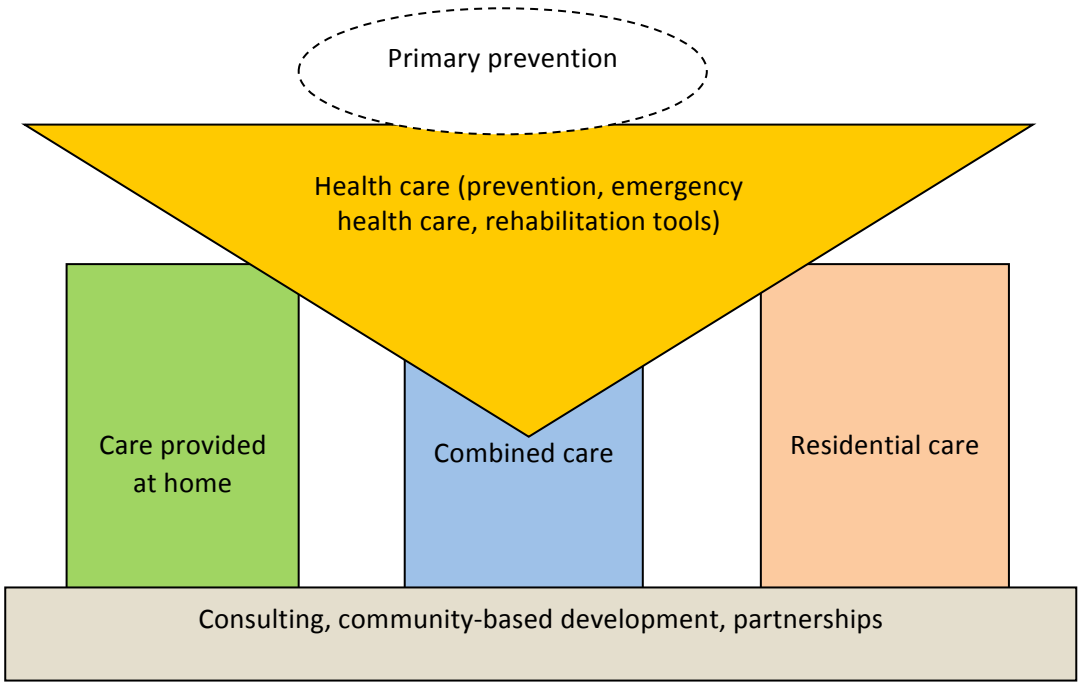
We have stated several times (e.g. Repková, 2007; Brichtová & Repková, 2009) that it is very difficult to operationalize the term "family care" and to quantify the commitments that family members have against their dependent relatives, or to compare them with obligations in the formal care sector. Thereby, we start from the general principle defined in Article 4 of Act No 36/2005 Coll. on family which stipulates that „All the family members shall help each other, and depending on their abilities and possibilities, to provide for improving the material and cultural level of their family". The act on social services and the act on financial allowances, that entered into force in January 2009, take the family of a dependent person as an important entity with which the provider of social and health services is obliged to cooperate for the purpose of activation and enforcing of the self-reliance and dignity of the dependent person and his/her continuance in his/her natural family or communal environment. Obligations of the family are explicitly expressed in the principle of co-financing of financial allowances and social services, when the incomes of the closest relatives (his/her spouse, children) are taken into account, based on their duty to support their family members generally stipulated by the act on family.[i] According to a specialist for legislative issues of the Association of Towns and Villages of Slovakia, it is, however, practically, almost impossible in the area of social services to impose on family members the duty to participate in financial burdens of taking care of their dependent family member. The reason for this lies in the non-explicit wording of support duties of children towards their parents (Konečný, 2009, member of the NEP Slovakia).[ii]

1.3 Main Component Services in National LTC System

In the conditions of Slovakia, long-term care is mainly of curative nature, i.e. it does not take part until a health-social problem arises, and the affected person or his/her family submit a request. There is a lack of more systematic primary prevention to avoid dependency on assistance from another person, or to avoid deepening this dependency (e.g. by regular screening of an older person at home carried out by geriatric nurses). In addition, there is also a lack of continuity of social and health care.[iii] The components of the national LTC system are depicted in the picture below.

In addition to the schematization which is mainly based on environments where care is provided, it is possible, when determining the components of the long-term care national system, to apply also a sector-based approach, as the services are organized and financed also by sectors.

Figure 1 Components of the Slovak National Long-term Care System



1.3.1 Sector of Health Care Services of Long-term Care

In December 2006, the Health Ministry of the Slovak Republic issued a "Conception of Health Care Services in Geriatrics", defining the geriatric care as prevention, detection and registration of persons requiring permanent care and prevention, diagnostics, treatment and rehabilitation of persons older than 65 years. In general, the conception states that "the key question is a need to solve the long-term care that is currently not solved" (Conception, 2006: 4). Health care of older persons is provided in geriatric out-patient departments, daily care centres, hospital wards, and clinics, but also in medical institutions for the long-term sick, or in geriatric centres. Within the long-term care, the geriatric care may be provided also in facilities of social services. At home, older persons may be provided some selected health care services also through home nursing agencies. Based on indications of a specialized physician, the geriatric care of dependent person is provided free of charge, covered by the public health insurance system. The public health insurance systems cover also free-of-charge provision of needed tools (aids) and technical equipment compensating functional limitations of body organs and organ systems.[iv]

1.3.2 Sector of Social Services and Social Interventions of Long-term Care

The social sector provides for various measures of long-term care:

- financial allowances to compensate severe disabilities consequences for persons acknowledged as persons with severe disabilities. They enable the persons to stay in their home environment,

support their social integration and help their family members provide needed care in home environment. They include also a care allowance and free-of-charge social consulting. They are financed from the state budget, and implemented by bodies of a specialized state administration,

- social services provided in - field, on an ambulatory basis, or in form of admission to a social service facility. According to the declared social policy, the priority is to provide social services in - field, on an ambulatory basis, or on a weekly basis. They are financed from regional and local budgets, by payments from clients, or other sources, and are implemented by bodies of local or regional self-governments, and non-public providers,
- subsidy policy for self-governments and the civic sector. It refers to providing subsidies for new types of social services, for rehabilitation and reconditioning stays of dependent persons and persons accompanying them, and other civic activities. It is financed from the state budget (Act No. 544/2010 Coll. on Subsidies provided under responsibilities of the Ministry of labour, social affairs and family of the Slovak republic) but also from donations, foundations, philanthropic programmes of major employers or other important institutions (e.g. banks).

Modern elements of the integrated long-term care for dependent older persons (Pillinger, 2001) were introduced by social legislation that became into force as of 1 January 2009. It refers to providing health care to the extent of nursing care directly in facilities of social care (Article 22 of the Act on social services), and vice versa, providing social services in health care facilities of the institutional health care (Article 70 of the Act on social services) after entering the provider in the register of social services providers.

1.4 Data on Informal Family Carers and Other Informal Unpaid Carers

The support provided at home by close relatives is often “hidden”, i.e. performed based on the principle of the most common family and generation solidarity, and is beyond the reach of social statistics. According to a research by Bodnárová et al. (2005), as many as 82% respondents stated that they provide care for a dependent family member without any financial compensation. Other research projects (e.g. Bednárik, 2004) document that older persons often evaluate the family relations as good, and in the case of a need of help, they preferably rely on the help of their families.

Another analysis of family and other informal carers is based on the results of a unique research focused on mapping characteristics of family carers aged 18-64 years – care allowances recipients for taking care of dependent family members older than 6 years. More than 60% of them take care of dependent persons older than 65 years, mainly older women. In addition to care allowances recipients, we focused also on those who provide their relatives so called personal assistance, within legally stipulated possibilities (Repková, 2008). By their characteristics, these two groups of carers comply most, in conditions of Slovakia, with informal carers on whom WP5 is mostly focused.

Of the total number of 57,034 analyzed care allowances recipients, 82% of them were women, and 18% men. The highest number of them were in the age category of 51-64 years (47%), but also the age category of 36-50 years was represented relatively significantly (36%). The most often relation to the dependent persons was the position of adult child (more than 40%), which shows the fact that the most

often cared-for group in home environment is the group of aging parents. Almost three quarters of carers and cared-for persons live in common households, especially in the case of family carers aged 31-50 years (confirmed also by the research by Bodnárová et al., 2005). Almost a half (45%) of family carers aged 18-64 years started to take care of a family member in the situation when they themselves were unemployed, more frequently in the case of unemployed men (65% of men compared to 41% of women). Even though the valid legislation allows to take care of a family member and at the same time to have a job, this possibility is used only by 2% of care allowances recipients. About 74% of them were employed persons, the others self-employed persons. More than 80% of those who were carers and at the same time they also had a job, were women.

Carers provide a comprehensive assistance with any routine daily living activities, they help with housework, and they also provide assistance with social activities of the dependent persons. The whole day care was a condition for the provision of care allowances by 31 December 2008. From January 2009, there is condition by the dependency of given person at least 8 hours a day, primarily in the area of serving himself/herself.

The research did not provide any information about education and qualification structures of care allowances recipients. Some partial information was given by a bit older research by Ladovičová (2005), in which out of 500 persons providing family care, 64% had completed secondary education with leaving exams.

Available social statistics show that out of the total number of almost 57,000 care allowances recipients, about 2,000 (about 3%) of them simultaneously take care of more than one dependent person (the situation as of December 2010). We expected some changes in the number of beneficiaries of care allowances in connection with the fact that from January 2009 the care allowance may be given also to other persons than relatives. However, in April 2010 only 2,2% of care allowance recipients came from the settings beyond the close family, mainly from wider families, neighbours, or friends (Repkova, 2010).

At the time of performing the research, only 234 persons, about 60% women and 40% men, most often aged 51-64 years, were in the position of family personal assistants. The low representation of this category is caused by strict legislative conditions for performing personal assistance by family members (Repkova, 2008).

1.5 Cultural and Current Political Context

At the beginning of this decade, a political and social discussion took place on the position of a family in providing care to older person, while this discussion focused mainly on issues of *provision of basic income to persons taking care of family members* – social allowances (care allowance), which should traditionally substitute the loss of income due to discontinuation of employment. Solution to this issue was later linked to wider issues of social protection of family carers (in particular, their health and pension insurance) who became the insured of the state for this purpose. In the efforts to support the right of choice of the carer to harmonize his/her working and caregiving commitments, the legislation stipulated also a possibility to provide care and to work with some limitations to the income from the

gainful employment. As part of the *harmonizing policy*, also some legislative measures, within public services of employment, were taken to support disadvantaged job seekers having long-term family responsibilities and commitments. At the end of the last decade, a way how to relieve the closest family members from demanding care-giving commitments started to be sought. In 1999, personal assistance and allowances for personal assistance provided primarily by persons out of the close family were introduced in the conditions of Slovakia. The possibility to provide personal assistance in the household of a person older than 65 years was not legally possible until 2005.

The latest measures refer to the system of *respite care services* for the care-giving members of the family without any negative impact on the provided care allowances. The measures were adopted by the legal system and practice as of January 2009 within the area of social services. Similarly, it was enabled also for other persons than close relatives to get the care allowance, which created a practical option to extend the range of persons engaged in the informal care sector.

2 Main Links and Interfaces between Informal Carers and Health and Long-Term Care System

2.1 Policies for Informal/ Family Carers of Disabled People or Dependent Older People

One of the objectives of the *Programme Declaration of the Government of the Slovak Republic for 2006 – 2010* in the area of social inclusion is a commitment to pay special attention to older persons and disabled persons that are dependent on help from other persons, so that they could stay in their family environment as long as possible, and at the same time, so that the financial situation of their carers would improve.

Another key document is the *National Programme of Protecting Older Persons* (passed by the Government of the Slovak Republic in 1999), which in its concentrated form presents the government policy of older people, including assistance from informal (family) carers. With an aim to harmonize working responsibilities and taking care of an older family member, the document provides for developing a network of respite field social services provided to the senior at the time while his/her family members are at work, or taking holidays. In the area of primary health care, an important commitment is defined to provide information and relevant training to family members so that they could provide health and rehabilitation care to sick older people dependent on the assistance of another person.

An important national document dealing with informal carers is also the *National Programme of Developing Living Conditions for Disabled Persons in All Areas of Life,* passed by the Government of the Slovak Republic in 2001. The part referring to the support of „Family and Integrity of a Person" (Rule No 9 of the National Programme) includes a commitment of the state to provide a respite to family members taking care of a disabled person through a short-term care service provided in the meantime. The commitments of the government in the area of supporting informal carers were reflected

particularly in the legislation on allowances to compensate social consequences of a severe disability (Act No 447/2008 Coll.), and in the legislation on social services (Act No 448/2008 Coll.).

The key issue of supporting informal and family carers is also their *social protection in the health and social system,* as a protection from various types of socially risky situations. In line with Act No 580/2004 Coll. on health insurance as last amended, and Act No 461/2003 Coll. on social insurance as last amended, the state shall pay the health and social insurances for persons that systematically provide a care, while not being employed.

The valid Slovak legislation distinguishes several institutes that have ambitions to support *harmonizing working and care-giving responsibilities* of family carers. These intentions are expressed in the Employment and Social Inclusion Operational Programme by 2013, financed by the European Social Fund.

Part 2.4 of the report deals with particular forms of supporting informal carers in more detail.

2.2 Links and Gaps between Informal Carers and Formal Carers

No systematic long-term researches, studies or other reports are available, that would comprehensively analyze links and cooperation between the formal and informal sectors and care-giving, or the cooperation of families with formal social services providers. Bodnárová et al. (2005) analyzed needs of families with dependent members in the area of social services. The most often requirements of formal social services were the requirements of families taking care of older or disabled persons. 14% of respondents mentioned a need of care services provided in the household of the dependent person (assistance with serving oneself, or household), 10% preferred construction of facilities of permanent care (especially homes for seniors), while 5 % preferred catering centres for pensioners or clubs for seniors, and 4% preferred social services provided on daily or weekly bases. Interesting examples of cooperation of families with residential social services at the local level were brought by the research by Matulayová et al. (2009). In their research, the authors determined an inevitability of interventions by families in the case of providing care in residential facilities of social services, particularly in the case of older facilities. Old architecture of these facilities hinders the movement of elderly dependent clients who can only get out of the premises of these facilities mainly thank to the cooperation with their families.

From practical experience and information provided by carers in the field of social services and other types of social interventions, it results that *cooperation of the formal and informal sectors* takes place mainly as a combination of an informal family care and a care service provided in the household of the older person by professional carers – employees of the community. Professional carers provide care to dependent persons mainly at the time when their relatives are at work or at school (e.g. grandchildren). As the relatives do not provide an intensive daily care for more than eight hours, they do not receive any care allowances. The combination would be possible with an allowance for taking care and nursing in a daily facility of social services. However, this is only as an emerging case as out of the total number of the boarding days in the previous period, only 6% of them were provided in a form of daily care (Správa,

2009). Based on the experience of both public and non-public providers of care services, the most often is the combination of care service and family care when family members cannot and do not want to leave their employments for various reasons, or when the family seeks to save finances for paying costs of the care service, and reduces the service to an absolute minimum (e.g. serving meals, assistance with toilette, delivery of food). The experience with *respite measures* for informal carers is minimal as yet (the measures became valid in January 2009). First information signalizes that when there is a need of a respite service, communities are not able to flexibly provide for a substitute service to a dependent person. Moreover, the application for a respite service needs to be submitted well in advance (1 to 2 months in advance). Communities explain the situation with a lack of professional carers and finances. There is also another problem of providing social services after working hours and at weekends, but also when the social services are required to be provided continuously for 12 hours daily, or when the informal carer needs some help immediately (e.g. in the case of emergent hospitalization of the carer). Another problem is also a lack of vacant places in facilities of social services, mainly in public facilities that are a substitute solution during respite periods too. According to Bednarik´ s survey in a first half of 2010 in totally of 728 monitored towns and municipalities only in 40 cases the respite care for care allowance recipients was provided. In an second half of 2010 the situation did not rapidly changed as of only 51 care allowance recipients were provided with respite care in totally of 935 monitored towns and municipalities (Repkova, 2011).

A special issue is a problem of *maltreatment in care relations*. This phenomenon is understood as a phenomenon of double character (maltreatment of cared-for person by carer, but also vice versa). In Slovakia, there have not been made more systematic researches in this area, and findings of experts are not always consistent. In addition, existing researches more or less deal exclusively with maltreatment of cared-for person, not the other way round.

Based on the results of the research by Lackovičová (2003), older persons did not mention existence of maltreatment against them, even though they admitted that the dependence on carers might increase the risk of such a treatment. On the contrary, Balogová (2007), based on her research but also studies of other authors (e.g. Koval, 2001), makes a conclusion that maltreatment of elderly dependent persons is quite wide-spread in Slovak families (Balogová, 2007:17). In her case studies, maltreatment of elderly dependent persons is often linked to alcoholism of children on whom the dependent person depends, or to economic abuse of elderly relatives. In the case the misuse leads to a bodily injury, health care facilities will arrange for further care of the dependent person either in an institutional health care facility, or in a facility of social services.

The problem of maltreatment of older persons is contained also in the National Programme of Protecting Older Persons. The latest summary report on implementing the National Programme in 2007-2008 informs in Part 8, focused on safety, about activities of the Police Corps in the area of prevention from bad treatment of older persons in their families by distributing leaflets on “Domestic Violation, Abuse in Families”. (Proposal, 2009)

The issue of taking care of older persons with some dementias is a very distinctive problem. Based on the experience of gerontologic psychiatrists, it is a challenge to find a facility of social services which would take care of such a person. Therefore, they are kept in health care facilities (where they are often

seen as a "burden"), or when their families decide to take care of them at home, there is a threat of insufficient care or even maltreatment due to overburdening of family members.

Nevertheless, the phenomenon itself of maltreatment of older dependent persons is admitted in Slovak to a much smaller extent than it is in average in Europe.[v] However, when it takes part, Slovaks link it significantly more often to maltreatment by the closest relatives (children, spouses, siblings, totally 55%) than Europeans in average (totally 36%) (Health, 2007, QA32). On the other hand, it is often the family that prevents from discovering and solving such cases, also in form by public intervention (Balogová, 2007).

2.3 Positive and Negative Aspects of Care-giving

Importance of family's assistance to dependent persons, in spite of the development of high-quality services of long-term formal care, was confirmed by several researches (e.g. Bednárik, 2004; Repková, 2004; Repková, 2006). According to the results of our research (Repková, 2006) focused on living conditions of families with a disabled family member, the respondents with serious disabilities were given assistance with common daily tasks most often by the relatives (almost 70%). In questions regarding provision of assistance with common daily tasks, the respondents expressed the highest rate of satisfaction. However, other researches showed some *negative impacts and consequences of systematic care-giving*. In the research by Pavlíková, and Kondášová (2001) only 18% of 298 responding family carers mentioned that they felt good, in terms of their health. On the contrary, 48% of them had some health problems, and 34% mentioned serious health problems. The worst health condition was mentioned by persons with basic education. Based on experience of the respondents, a presence of a disabled family member in conditions of Slovak families is a huge burden, meaning limitations of other activities, hobbies and contacts, as well as a lack of spare time of other family members, and impossibility to improve their financial situation. The overburdening even leads to increased tension in the family relations. In their research, B. Bodnárová et al. (2005) found out that as many as 87% respondents involved in family care of a dependent family member have the feeling of obligation and duty, and almost a half (46.3%) of them provide for the care because there is nobody else who would be available to do it. In about 70% cases, it concerned a care provided for a long time (from 1 to 10 years), with the highest representation of care provided for 3-5 years (28.6%).

Provision of care by close persons has also some important *economic consequences and an impact on economic welfare of informal carers*. It is a well known fact that fulfilment of family responsibilities is generally perceived as a complication in connection with performing job responsibilities and pursuing a professional career (e.g. research by Kotvanová, 2007). The research by K. Repková (2008) showed that almost a half (45%) of all care allowances recipients started to provide a systematic care for a close person in the situation of their own unemployment (especially in the case of men). On the other hand, the most often reasons for ending the provision of care is death of the cared-for person, not finding a job.

Based on correspondence sent by family carers to central or local bodies of the state administration, or based on personal contacts with them, it is possible to identify other unfavourable consequences of providing a systematic care:

- a lack of relevant and comprehensive information which would enable informed selection regarding provision of care (formal care, informal care, combination of them),
- an absence of systematic peer-based support and counselling, as family carers are not organized in Slovakia (especially concerning provision of care for older dependent persons),
- dissatisfaction of the amount of care allowances, in spite of declaratorily acknowledged social importance of family care,[vi]
- dissatisfaction with differences in amounts of provided care allowances depending on the economic status of the carer (productive age or post-productive age),
- impossibility to share the care allowance with several persons,
- a lack of understanding from the side of employer in creating flexible working conditions to harmonize work and care responsibilities.

2.4 Type, Form and Efficiency of Support for Family Carers

2.4.1 Services in Kind - Information on Services and how to Access; Counselling or the Existence of Mutual Self - help Groups; Respite Care

Allowances in kind provided as a support for family carers can be divided into several areas, depending on the type of support they are focused on:

- *the area of social protection:* in the case that care allowances recipients do not work, the state pays the social and health insurances for them,
- *the area of providing respite periods:* beneficiaries of care allowances can get a substitute for 30 days in a calendar year for their taking a rest, and in addition, 8 days monthly for the purpose of arranging for some operative issues,
- *the area of supporting employment:* informal carers that are out of the labour market for more than 2 years due to their providing care are deemed, for the purpose of active measures of the labour market, disadvantaged job seekers on the basis of which their employer can get various types of support for their re-employment. It refers to, for example, to an allowance to support employment of a disadvantaged job seeker. In 2004-2008, almost 150 persons with family responsibilities were supported within this system (not all of them, of course, provided a care to an older person; based on the material from the Centre of Labour, Social Affairs and Family),
- *the area of employment relations, harmonization of work and care-giving:* it refers to a possibility to use flexible elements of the organization of work in line with the Labour Code (e.g. employment for a certain period, part-time work, work performed at home, and work performed by phone; occasional/extraordinary work at home or at a place different from the usual place of performing work; or flexible working hours),
- *the area of social counselling:* in line with the act on social services, or the act on allowances the counselling is provided for free at the level of the local state administration (Offices of Labour, Social Affairs and Family), regional self-government (higher territorial units), or local self-

governments (communities and towns). Counselling free of charge is provided also by other organizations, particularly *civic associations of seniors and disabled persons*, but also some health-care organizations (providers of health care),

- *the area of supporting civic society*: within the subsidy policy, the Ministry of Labour, Social Affairs and Family of the Slovak Republic annually provides subsidies to civic associations for rehabilitation, reconditioning and recreation stays,
- *the area of tax policy:* civic associations may get 2% of the tax on income of natural persons to provide for their activities, and civil beneficial activities, including project activities focused on supporting informal carers.

For illustration, the table shows the development in using various forms of atypical regimes of work in 2006-2008.

Table 1: Some Employment Facts in Slovakia in 2006-2010 related to Atypical Employment

Indicator	*2006*	*2007*	*2008*	*2009*	*2010*
Economically inactive population 15+ due to keeping household, care (in thousands)	180	193	186,5	208,6	202,2
Part-time job totally in%	2,8	2,7	2,2	4	4,2
Part-time job due to care or other personal or family reasons (in thousands)	4,1	4,6	7	3,8	5,2
Working at home (usually + sometimes) in %	8,4	8,1	7,4	7,7	7,2

Source: Labour Force Sample Survey. Results in the Slovak Republic for the 2nd Quarter. Slovak Statistical Office Bratislava, 2006, 2007, 2008, 2009, 2010

2.4.2 Services in Cash - Care Allowance and/or Fiscal Aids; Working Arrangements; Reimbursement of Costs in Providing Care; Tax Exemptions

The *care allowance* is a contribution to ensure basic incomes of informal carers. The basic amount of care allowance, in the case of providing care to one dependent person, is about € 206 (situation in March 2011). In the case of providing care to two or more persons, the amount is about € 275 monthly. It is income-tested, and its amount depends on the income of the cared-for person, which substantially reduces the extent of real support, particularly in the case of informal carers in their productive age taking care for beneficiaries of old-age pensions (following available statistics, in December 2010, the average amount of care allowance for caring about one person was ca €154, www.upsvar.sk). When it is received by a beneficiary of old-age pension, a lump sum is provided: in the case of taking care of one dependent person, the amount is about € 86 monthly, and in the case of two and more persons, it is about € 113 monthly.

Indirect forms of the financial support for informal carers are any other allowances provided directly to the dependent person that *simplify the performance of providing care.* In the case of taking care of older dependent persons, it refers mainly to allowances for buying, repairing or adaptation of various tools; for barrier-free home/flat adaptation (the most common is replacement of a bath tub by a shower cabin); for getting lifting equipment, or allowance for transportation of older persons. Financial allowances for home/flat adaptation are very much preferred, being used two or three time more often by persons older than 65 years than by younger persons (following the material from the Centre of Labour, Social Affairs and Family).

2.4.3 Training of Informal/Family Carers

Informal care-giving has traditionally been considered in Slovakia as a private issue of given family. Therefore, informal carers are not required to have any special qualification, and thus no training is provided for them.[vii] When informal carers do attend re-qualification training organized by the Offices of Labour, Social Affairs and Family, they attend this training as job seekers (formal care-giving).

Informal education of family carers is provided in the widest sense in a form of individualized instruction by health care workers, social consulting arranged for by offices of the local state administration and the regional and local governments, or in a form of peer consulting and self-help groups within activities of civic associations, as mentioned above.

2.5 Different Forms of Family Carer Support and their Impact on the Care Process (Carers´ and Older Persons´ Outcomes)

In Slovakia, no more systematic studies and reports in the area have been made.[viii] Only partial researches are available, made at universities as qualification papers for master degrees, in particular in the field of social work, focusing on e.g. the importance of personal assistance in the life of disabled persons and their relatives (the papers did not deal exclusively with older people). In the research carried out in 2001 by the Ministry of Labour, Social Affairs and Family of the Slovak Republic regarding the evaluation of the new system of social assistance to disabled persons, the respondents mentioned that personal assistance was very much helpful in that sense that families were happier, their members were healthier, more independent (prepared by Repková, 2001). Also the results of several other researches confirm that personal assistance to family carers helped them get employed, spend more time for themselves and their hobbies. As for the dependent members of the family, personal assistance helped them carry out their plans that otherwise would be unreachable (e.g. Šuniová, 2001; Karlubíková, 2002; Madunová & Duračinská, 2009).

2.6 Participation of Informal Carers in Improving the Care Process (Connotations to Prevention and Rehabilitation Matters)

2.6.1 Promotion of their own and their Older People's Health

The National Programme of Protecting Older Persons states that health care facilities shall provide family members with relevant information about health conditions and rehabilitation of their older relatives. Informal carers are also entitled to be trained and educated how to provide rehabilitation to dependent persons in home environments, and how to use tools that were given to them. The purpose is to optimize conditions of taking care of a dependent older person in home environment. The tasks of this type are not only performed directly by health care facilities, but also offices of public health as part of the agenda of public health (e.g. within the implementation of the project "I am 65+ and I enjoy my healthy lifestyle"). According to the results of the research by Repková (2006), it is the health care facilities and their employees from where disabled persons (including elderly dependent persons) expect most often the assistance with improving conditions of their lives and their families' lives.

2.6.2 Measures to Reduce the Development of higher Levels of Older People's Dependency

The support of independency or not increasing the dependency on assistance from others is one of the core principles and priorities of the National Programme of Protecting Older Persons. However, there are no data on how informal carers contribute to fulfilling the above intention. We include a summary of general measures focused on meeting these priorities:

- providing health tools and equipment, covered by the system of public health insurance, or providing compensation tools covered by the system of social assistance (e.g. allowances for getting, repairing or adaptation tools),
- enabling barrier-free home/flat or garage adaptation, or barrier-free access (allowances for adaptation home/flat or garage, allowances for getting lifting equipment),
- providing social counselling to older persons, and maintaining their mental independence from the closest relatives as much as possible,
- developing possibilities of life-long education (e.g. universities of the third age; in Slovakia, there are currently 12 of them),
- developing social services for older persons, focused on free-time activities (e.g. daily centres),
- emphasizing social rehabilitation as part of social services provided to older persons,
- introducing social services by means of information technologies (monitoring and signalizing needs of help, crisis help provided by means of telecommunication technologies).

One of the forms of participation of family members in creating programmes to support independence of older persons is their active cooperation within *community planning,* establishing community centres and implementation of community rehabilitation (Article 82 of the Act on social services). For this purpose, in line with the Act on social services, family shall cooperate with the community, education institutions, and providers of social services and health care.

2.6.3 Rehabilitation following Acute or Chronic Declines in Health

Health care provided in acute declines in health and following rehabilitation to improve health condition of the older person are included in the system of the public health insurance. It is provided in health care facilities and then in the household of the older dependent person, or in ambulatory form when the older person commutes to the health care facility, or in residential form when the older person stays in an institutional health care facility or in a selected social services facility. When it is provided in the household of the older person, it is mainly provided by workers of home nursing agencies based on a recommendation of the attending physician and after training of the family members. Further assistance with common daily tasks is provided for either by the close relatives, or by the home nursing services of public or non-public providers.

2.7 Involvement of Informal Carers into the Quality of Services Issues

2.7.1 Clinical Outcomes and Quality of Life

No information and data are available on how family members or other informal carers contribute to improving clinical indicators of dependent persons. As it was mentioned in the previous text, one of the tasks of health care workers is to comprehensively train and inform informal carers how to provide nursing in the home environment. Family members are involved in providing social services also through an institute of the so-called *individual development plan*.

2.7.2 Clients' Perceptions: Satisfaction, Knowledge and Empowerment

In connection with home care provided by family members or other informal carers, the issues of quality or standardization of its monitoring are not legally provided or practically performed. Thereby, the assumption is that the family is naturally interested, in each aspect, to provide care and assistance of high quality. The institutes of enforcing and increasing self-determination of older persons include, for example, the following:

- the right that one's own opinions and assumption for deciding about social intervention (the general principle of administrative law) are taken into account,
- inevitability of the older person's acceptance of the person to provide long-term care,
- the right to choose a personal assistant.

Within the system of social services provided in ambulatory form, in-field form, or in residential form, the institutes of enforcing the self-determination include the following:

- the right to choose the type, the form and the provider of social services,
- the right to have available information provided in an easily understandable form,
- the right to have developed an individual development plan of the person dependent on social services, and its active participation in its developing,
- the right to participate in determining the living conditions in the residential facility of social services (e.g. by establishing a council of residents).

The act on social services stipulated for the first time a system of *evaluation of quality of the provided social service.* It is focused on procedural, personnel and operational aspects of the provided social services. It reflects also the requirement of protecting clients and their rights, provision of social services depending on individual needs, abilities and ideas of the recipients, but also their satisfaction with provided social services. Identification of the satisfaction of the social service beneficiaries with all the elements of the provided social services is one of the criteria to evaluate the quality of provided services. Providers of the social services are obliged to establish procedures and rules to identify satisfaction of clients with provided social services, and to inform them about the results. It is expected that as part of preparing the individual development plan for an older dependent person, the questions on the quality of provided social services will be discussed also with his/her relatives.

3 Description of 'Good Practice'

3.1 Good Practice – Definition, Criteria and Models Development, Dissemination, Implementation, Illustration of Good Practice Models

In the Slovak Republic, a uniform system of development, dissemination and implementation of good practice is not established as this term is not defined and standardized. Similarly, there are no criteria specified based on which pilot experience of a social entity becomes good practice which could be inspiring for other entities or which could be generalized in the national legislation and common practice of social entities. The most common method of disseminating new ideas and new forms of work are *pilot projects* carried out by various entities (e.g. non-state sector, bodies of public administration), most often based on experience and knowledge from abroad.

Because of the fact that taking care of dependent older persons has traditionally been considered a private issue of the family, no examples of good practice are available which would explicitly and exclusively focus on supporting families taking care of their dependent members. They are mostly part of wider programmes/projects focused on groups of disabled persons of which more than a half are older than 65 years (data from the Centre of Labour, Social Affairs and Family, April 2006, based on questionnaires) and their family members.

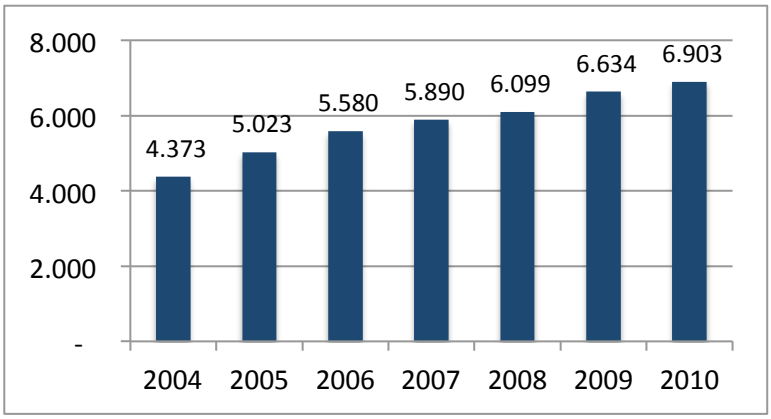
3.1.1 Good Practice 1

As an example of good practice in the area of assistance to family carers may be mentioned *personal assistance*, tested in Slovakia in 1997-1998 within a pilot project implemented in cooperation with the Stockholm Independent Living Institute. The project was primarily focused on supporting the living independence of disabled persons, their ability to identify their own needs in the area of assistance from others, and to manage the work of personal assistants. From the very beginning, however, it was clear that the personal assistance system substantially supports also relatives of the dependent person. The project was mainly initiated by the Ministry of Labour, Social Affairs and Family of the Slovak Republic, and involved also relevant civic associations and their representatives as potential users of personal

assistance, as well as some selected representatives of the state administration involved in the field of social affairs.

The results of the pilot project in 1997-1998 became the basis for establishing financial and legal conditions for personal assistance, and providing personal assistance allowances under the Act of social assistance which finally became effective as of 1 July 1999. The development in the number of recipients of the direct payment for personal assistance (hereinafter "DPPA") in 2004-2010 is given in the graph below.

Graph 1 The development of beneficiaries of direct payment for personal assistance (DPPA) in 2004- 2010 (always as of December of given calendar year)



Source: www.upsvar.sk

The graph shows a gradual and constant growth in the number of DPPA recipients though the interest growth was linked mainly to younger disabled persons. Until 2005, it was namely possible to provide DPPA only to persons younger than 65. It was precisely the representatives of the disabled persons who pushed on the legislators so that this condition perceived by them as age-based discrimination would be cancelled. According to the amendment to the legislation adopted in January 2005, now also persons older than 65 years can be DPPA recipients; however, with a condition of their working activity. This was also the reason why by 2008 the personal assistance was used by dependent older persons only minimally. The available statistics show that in 2005-2008 it was about 1.3-1.4% of all the DPPA recipients. From January 2009, it is possible to provide personal assistance also to persons older than 65 years without any condition of working activity, whereby they were required to become entitled to this form of assistance before achieving the age of 65 years. This option resulted in the fact that in December 2010, the share of such persons in the total number of DPPA recipients accounted almost 5%.

Civic initiatives to improve the system of personal assistance continued. Following the creation of legal conditions for personal assistance allowance, users of personal assistance in various place in Slovakia started to get organized and established *agencies of personal assistance*. At the beginning they operated in a pilot-project manner only. Based on practical experience of these agencies, the national legislation adopted a new social service within the Act on social services effective as of 1 January 2009 – *intermediation of personal assistance* through agencies of personal assistance. Evaluation of personal assistance by users of this service has already been mentioned in the text above (part 2.5.1).

3.1.2 Good Practice 2

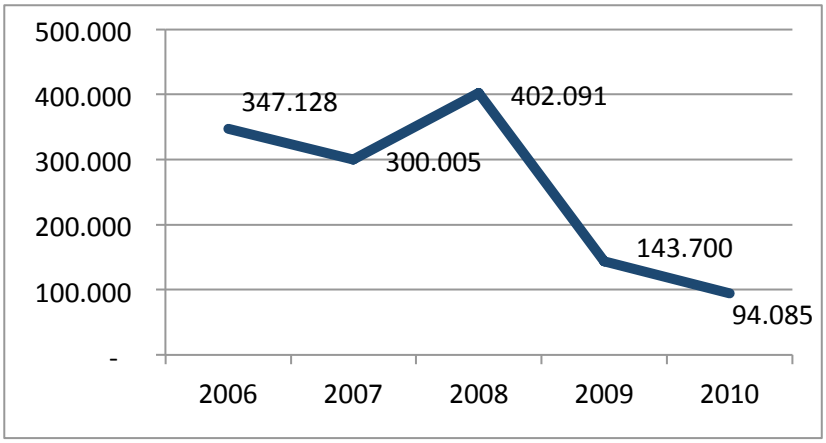
Another example of good practice supporting family carers is *provision of subsidies by the Ministry of Labour, Social Affairs and Family of the Slovak Republic*. The pilot project started in 1991. It always was and still is focused on much wider target age groups, not only older dependent persons and their families. From the very beginning, it was devoted also to supporting project activities for civic associations representing disabled people and seniors, and organizing reconditioning and rehabilitation and integration stays not only for seniors and disabled persons but also for their relatives. The organized stays are attended also by workers from various fields (physicians, rehabilitation workers, lawyers, social workers, experts for compensation tools and barrier-free architecture, etc.). They give dependent older persons and their relatives practical advice, discuss with them the problems of daily life and the care management.

Until 2005, the mentioned subsidies were provided based on internal regulations of the Ministry of Labour, Social Affairs and Family of the Slovak Republic. Experience obtained in the previous period and the intention to make the subsidies more transparent by defining exact rules for all the entities finally led to making a legal norm expressed in the Decree on Providing Subsidies in the Scope of the Ministry of Labour, Social Affairs and Family of the Slovak Republic.

From 2006 to 2009, the subsidies provided to civic associations for the above purposes amounted to SKK 37 million (about € 1.2 mil.). The amount of the subsidies for the mentioned purposes is part of the state budget in the chapter of the Ministry of Labour, Social Affairs and Family of the Slovak Republic. The amount changes every year, and its final volume is approved by the National Council of the Slovak Republic. The development of the provided financial means in the monitored period is given in the graph below.

Graph 2 clearly shows a sharp drop in finances provided for this purpose in 2009 and 2010 as a result of the global economic crisis. Since January 2011 conditions for providing subsidies are stated in the Act No. 544/2010 Coll. on providing subsidies under responsibilities of the Ministry of labour, social affairs and family of the Slovak republic.

Graph 2 Subsidies for rehabilitation stays of disabled persons and their relatives under the subsidies scheme of the Ministry of Labour, Social Affairs and Family of the Slovak Republic 2006-2010 (in €)



Source: Ministry of Labour, Social Affairs and Family of the Slovak Republic

3.2 Mechanisms to Embed Good Practice in the Support of Informal Carers into Everyday Practice

Both examples of good practice have eventually been transformed into a form of national legislation, and uniformly regulated conditions of providing financial support. Based on the example of good practice focused on the system of personal assistance, it is possible to document *the* so-called *layer effect of a good practice.* It comes from the complex, systematic nature of social problems of dependent persons and their families, which means that solving one partial problem causes a follow-up need to solve another related issue. Introduction of the system of personal assistance was from the very beginning connected with a high rate of administrative activities linked to administering the personal assistance and DPPA (e.g. recruiting personal assistants, contractual relations, preparation of time sheets, paying rewards for personal assistance, communication with local state administration). The problems and discomfort of a part of personal assistance´s users in providing for mentioned activities finally led to a pilot project of establishing agencies of personal assistance and subsequent introducing this practice into the national social legislation effective as of 1 January 2009.

As for the inhibitors impeding a wider introduction of good practice for the section of supporting informal carers, at least three groups can be identified:

1) *Area of attitudes:* family care has always been perceived as a private issue, and family members are under high requirements from the society regarding care.
2) *Area of underdevelopment/development of civic sector:* existence of supporting public tools (allowances, subsidies to civic associations) cannot by its own guarantee the support of informal carers. Currently, there is an absence of wider civic initiatives based on which informal carers could be organized, and could uniformly express their requirements against public authorities.

3) *Financial area:* introduction of some practice, tested as pilot projects, into national legislation or a wider social practice can be impeded by a lack of public resources as a result of redistribution processes and rules, especially in the time of the financial and economic crisis and its consequences. Now, the above fact is negatively reflected e.g. in the inability of the government to increase the basic amount of care allowances so that it would be at least at the level of the national minimum wage. Another example of financial restriction is also the dramatic reduction of finances intended for supporting civic associations in organizing reconditioning and rehabilitation stays of dependent persons and their families.

The process of transferring the pilot practice into the national legislation and a wider practice of social entities provides for availability of good practice for wider groups of people regardless of their affiliation to original proprietor of the good practice (the example of personal assistance and DPPA).

In the case good practice is directly reflected in a legal regulation and the national legislation, it is provided to dependent persons in line with specified criteria in form of legal claims. Financial resources for their implementation are provided from the state budget, and the person being legally entitled can make a claim for it also in court.

4 Family Carers´ Private Solutions to Care and their Links with the Formal Health and Long-term Care Systems

4.1 Migrant Workers in the Field of LTC, specifically at Home

In Slovakia, no discussion about providing for long-term care needs by migrant workers is under way now, and therefore, there are no statistics available to document the phenomenon on providing care by migrating workers. We can identify at least three reasons for this: (1) Slovakia has one of the most homogenous labour market in the European Union (foreigners account for less than 1% of the Slovak labour market); (2) the income situation of a large majority of the population does not enable to pay a private carer; (3) restraint of Slovak families in solving the dependence of a close relative by a stranger, let alone a foreigner.

Employment of foreigners (citizens of the so-called third countries, i.e. countries out of the European Union, the European Economic Area and the Swiss Confederation) within the territory of the Slovak Republic is governed by Act No 5/2004 Coll. on employment. Other relevant acts are also Act No 48/2002 Coll. on residence of foreigners, Act No 311/2001 Coll. Labour Code, Act No 461/2003 Coll. on social insurance, Act No 462/2003 Coll. on compensating the income during the employee's inability to work, and Act No 595/2003 Coll. on income tax. From 1 May 2004, employment of citizens of the EU and EEA countries, and the Swiss Confederation is governed by the Community legislation.

Foreign migrants, citizens of the so-called third countries, need residence permits and work permits. Residence permits are issued by the police authority in the place of residence, or the diplomatic office in the third country. Work permits are issued by the Office of Labour, Social Affairs and Family. Foreign

migrants are subject to monitoring of movement seeking job, which is implemented through the reporting duty on the information card about the existence and completion of the employment. This is the obligation to be satisfied by the employer.

Migrant workers could perform care services in several ways. When it refers to a citizen from the European Economic Area, having registered the residence for indefinite time, he/she can provide care in the household of the dependent person in the position of the so-called "other natural persons" (informal carer), and receive a care allowance. However, it is conditioned by the fact that he/she has to share the common household with the dependent person. Another option refers to the performance of formal care service, when it is provided through an organization registered as a social services provider. In such a case, the migrating person is employed by the mentioned organization, and he/she provides care on a professional basis. The third option is to provide care based on the small-business licence, which requires that the migrating worker is registered with the Small-Business Office, and with the Register of Social Services Providers in the relevant higher territorial unit (depending on the place of providing care). When a natural person provides social services based on the small-business licence, he/she needs to sign a contract on providing social services with the recipient of the social services in line with the Act on social services. Up to 2012, no qualification will be required for providing care. In any case, migrating carers are subject to the obligation to pay health and social insurances (sickness pay, old-age pension, unemployment allowance), and to pay income tax. Conditions of providing social care in any of the above methods for migrating workers are not different in any way from the conditions valid for domestic workers.

4.2 Migrating Carers from Slovakia – Slovakia as a Donor Country

Slovakia is a country from where migrating workers have been leaving for the countries of the EU, the EEA and the Swiss Confederation since long. The prevailing destinations are Austria, Germany, Holland, England, Switzerland, and also Italy. Persons interested in this work are motivated mainly by higher earnings in these countries as well as by the fact that in Slovakia there is still no (or only minimal) interest of families with elderly dependent persons to solve the situation by hiring private carers paid by their own sources.

Intermediation of work abroad for carers is offered by several agencies having their seats in all the regions of Slovakia.

- in West Slovakia: Senior Service Agency (intermediating care for seniors in Slovakia and Austria), Huettl and Krisko Agency (intermediating care for seniors and sick persons in Austria), PR Agency (intermediating work in England, Ireland, and Holland), BUWAG Agency (intermediating care for seniors and sick persons, performing housework in Austria and Germany),
- in Central Slovakia: JOB4U Personal Agency (intermediating work), Nathan and Wolf Agency (intermediating care for seniors in Germany, Austria, Holland, Switzerland, Ireland and England), Laura Agency (intermediating work, specializing in care in Austria, Holland and the United Kingdom),

- in East Slovakia: L-Work Agency (intermediating work abroad, particularly auxiliary housework and providing care in Great Britain, Netherland, Cyprus and other EU countries), Apprime Agency (specializing in providing care in Holland), Personal Swk Service (intermediating care in Austria).

It goes without saying that offers to intermediate care for Slovak carers abroad are made also by foreign personal agency, in particular from the Czech Republic (e.g. Elite Agency).

Offers to provide care services in households in developed EU countries are attractive for interested persons from Slovakia. The agencies are usually able to intermediate work also for job seekers without special experience or special training (e.g. for the positions of assistants of professional health-care workers, or as auxiliary workers in households). What is for the interested job seekers important is at least the basic knowledge of the language of the receiving country and an inevitable level of sociability (to be able to get along with people). Several offers include also free-of-charge language courses, and paying costs of travelling to a more distant country. In addition to the wages, several offers include also compensation of boarding in the host family. Providing private care abroad is in several cases also supported by commitments of the intermediating agencies to assist with health insurance (Netherland), or arranging for a small-business licence (Austria).

Also funds of the European Union are used to support special education of Slovak carers. As an example, the project of MOTUS initiated by the German *Institut für Berufsbildung und Sozialmanagement (Erfurt)* can be mentioned. The project is focused on exchange and work mobility of experts in the field of providing social services to seniors in Germany, Italy and Slovakia.

5 Summary of Main Findings and Conclusions

An important feature of a modern/advanced care dependence policy is its double nature: on one hand, it is focused on social rights of dependent seniors (providing health care and social services, and various public interventions to support their self-reliance and social inclusion). On the other hand, it is focused on rights of carers, especially in home environment. The current policy of Slovakia (Programme Declaration of the Government by 2010; National Programme of Protecting Older Persons, 1999, as last amended; National Programme of Developing Living Conditions of Disabled Citizens in All Areas of Life, 2001, as last amended) reflects this fact and seeks to transpose it into the valid legislation or legislation under preparation.

Some important social and political changes in the field of supporting informal carers have occurred since January 2009. It refers mainly to the legislation on social services and compensation policy focused on disabled persons and indirectly also their families. Because the new legislation started to be implemented at the time of the global financial and economic crisis, the Government of the Slovak Republic and the Association of Towns and Villages of Slovakia signed a *Memorandum on cooperation in solving impacts of the financial and economic crisis on the Slovak society* on 13 February 2009. In Article 1 paragraph 4 of the Memorandum, the Government committed to, among others, monitor and quarterly evaluate the financial impact of the introduction of new tasks resulting from the Act on social services for towns and villages. Because of the short time of the implementation period, no complex results of the monitoring were available at the time of drafting this report, which partially complicated the situation for the authors of the report. The situation was also complicated by the fact that in Slovakia there has not been made a long-term systematic research of the living and social situation of informal carers. Therefore, the team of authors often relied on works of regional nature or partial nature, and practical experience of individual players in the social policy.

For the purpose of the national report, the key terms are “natural person” and “other natural persons” that from 1 January 2009 provide informal care in home environment and receive care allowance. Until December 2008, informal carers included, in line with the valid legal provisions, only close persons (family members) that became a basis of our analysis in the report. Of the total number of about 51,000 current beneficiaries of care allowance, more than 60% of them systematically provide care to persons older than 65 years, especially older women. About 4% of informal carers take simultaneously care of several dependent persons. Informal carers are most often aged 51-64 years (47 % of the total number of carers), most often in the position of adult child (more than 40%). About three quarters of informal carers share the household with the cared-for person. Almost a half of carers (47%) started to provide care in the situation of their own unemployment, whereby men more often than women. On the other hand, only about 2 % of informal carers are employed, out of this 80% are accounted for by women, and about three quarters work in the regime of dependent activity (as an employee).

The measures focused on supporting informal carers include mainly free-of-charge consulting by health care providers or public social services providers, care allowances (allowances to contribute for the basic income of carers), a possibility of concurrence of care allowance and limited income; old-age pension insurance and health insurance by leaving the job because of care; respite measures (substitute social services for dependent persons providing informal carers with possibilities to take a rest, recover or arrange for some operative tasks); services of employment for persons that after a longer time spending

by providing family informal care want to go back to work; flexible working conditions (part-time work, flexible working hours, work at home, etc.), and a subsidy policy for civic associations for organizing reconditioning and rehabilitation stays, and social integration stays of dependent older persons and their relatives. Special personal assistance relieving family members from some tasks has been used only minimally in the case of persons older than 65 years. However, based on new legal conditions, the number of older persons using this option started to grow.

A special problem of the position of informal carers is the rate of their financial provision by means of care allowances. Its basic amount currently does not reach the level of the minimum wages, which is only a bit more than a quarter of the average income in the national economy. Thus, informal carers become significantly economically dependent on other members of the family (in particular, on their spouses), with endangering their social certainties in situations of their own disability or old age. Some researches show the fact (e.g. Special Eurobarometer, 2007), that it is the low payment for informal care that can be a source of bad treatment of an elderly dependent person by the closest, which is in Slovakia admitted much more often than in Europe in average.

Valid legislation and the government policy declare a possibility of interconnecting formal and informal services of long-term care of older persons. However, efficiency of such interconnecting is hindered by some facts. Awareness and lack of information is a global problem. We record a relatively low intersectoral awareness and communication (social sector – sector of health care, government sector – non-government sector, state administration sector – self-administration sector, public sector – commercial sector) as well as a low awareness of receivers of long-term care and their families, particularly in rural areas. The problems with access to information at each level is deepened by the instability of the legislative environment. Also financing of long-term care services and setting the rules in formal and informal regimes are a serious problem. It has been long-term confirmed that dependent older persons and their families do not make their decisions based on criteria of service quality (the form, the needed scope, respecting privacy, etc.), but rather pragmatically based on their financial possibilities. Finally, also traditions and position of a family in providing long-term care need to be mentioned. A number of research studies as well as common experience show that the world of family where the informal care of older persons is provided is relatively closed. Even though the valid legislation offers several options to interconnect the informal and formal sectors of care (a respite service, combined family care and ambulatory social services) or the world of work (a possibility to provide care and at the same time to work, flexible working conditions), they are used relatively little. Also our research experience (Repková, 2009) confirms that carers rely particularly on their own capacities, and expect an effective assistance mainly from their own families, and not from formal social services.[ix] This is a fact which for some time will still hinder from penetrating migrating workers to the informal care market in Slovakia.

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*Národný program rozvoja životných podmienok občanov so zdravotným postihnutím vo všetkých oblastiach života (*2000).
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Annex

Annex 1a: Demographic data

Table 1 Population of older people in Slovakia (numbers of male and female; 65+ / 80+)

	1960	*1965*	*1970*	*1975*	*1980*	*1985*	*1990*	*1995*	*2000*	*2005*	*2006*
F 65 +	163760	200422	236734	272588	301711	288800	328700	356388	380746	394147	398706
F 80 +	24156	27967	32009	37355	48683	59888	71576	76536	67526	89165	92375
M 65 +	117278	148617	177867	203067	219249	198470	218456	226573	234610	235145	237434
M 80 +	15370	17721	18979	20664	26167	30842	36562	37750	32269	40136	41070

Source: Huber, M. et al.: Long-term care for older people in Europe: fact and figures (Database), 2009

Table 2 Population of older people in Slovakia (% of total population of male and female; 65+ / 80+)

	1960	*1965*	*1970*	*1975*	*1980*	*1985*	*1990*	*1995*	*2000*	*2005*	*2006*
F 65 +	7,9	9,1	10,3	11,3	11,9	11	12,1	13	13,7	14,2	14,4
F 80 +	1,2	1,3	1,4	1,6	1,9	2,3	2,6	2,8	2,4	3,2	3,3
M 65 +	5,9	6,9	7,9	8,7	9	7,8	8,4	8,7	9	9	9,1
M 80 +	0,8	0,8	0,8	0,9	1,1	1,2	1,4	1,4	1,2	1,5	1,6

Source: Huber, M. et al.: Long-term care for older people in Europe: fact and figures (Database), 2009

Table 3 Specific mortality rates in Slovakia within male older age groups (No. of deaths per 1000 males)

age	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*
65-69	42,1	41,1	42,1	40,8	41,2	39,8	38,2	38,9	36,5	36,8	36,7	35,7
70-74	63,1	63,5	63,1	60,2	60,6	59,2	55,2	55,6	55,7	55,2	55,1	52,4
75-79	82,6	86,2	89,6	90	87,6	82,9	83,8	85,2	84,6	84,2	85,1	82,8
80-84	136,3	131	137,4	127,3	126,8	126,1	122,6	126,3	127,7	133,8	128,4	130,4
80 +	204	202,5	197,8	192,6	195,3	224,6	223,9	224,4	213,3	215,6	210	199,9

Source: Health statistics yearbook of the Slovak Republic, Bratislava, ed. 1996-2007

Table 4 Specific mortality rates in Slovakia within female older age groups (No. of deaths per 1000 females)

age	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*
65-69	19,1	19,2	19,1	18,3	17,8	17	17,1	17,1	16,9	15,8	15,5	15,4
70-74	31,8	33,3	31,8	30,6	31,3	30,2	29,2	29,2	28,9	28,2	28,3	26,3
75-79	55,6	56	57,3	57,9	56,3	54,8	53,1	53,3	52,1	51	50,5	50
80-84	99,4	102	103,6	95,3	97,9	91,1	89,6	92,8	93,8	95,4	93	94,1
80 +	182,8	181,7	182,2	180,3	182,5	199,7	198,4	201,1	187,7	199,2	185	180,2

Source: Health statistics yearbook of the Slovak Republic, Bratislava, ed. 1996-2007

Table 5 Notified cases of malignant tumours in Slovakia within male older age groups (per 100 000 male)

age	*1993*	*1994*	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*
65-69	1900,9	2083,5	2018,7	2154,6	2078,9	2011,1	2057,8		2034,9	2163,8	2176,8	2213,8
70-74	2377,8	2547	2451,1	2628,9	2695,9	2602,8	2571,2		2636	2720,4	2829,5	2964,3
75-79	2703,1	2612,2	2901,8	2765	2945,8	3194,2	3074,5		3112,1	3351,6	3381,3	3629,1
80-84	2790,7	3100,9	3008,4	3217,9	2939,3	3353,6	3032		3458,9	3297,5	3381,7	3759,4
80 +	2134,1	2431,6	2886,5	2980	2714,5	2993,5	2930,6		3371,9	3073,3	3219,3	3645,4

Source: Health statistics yearbook of the Slovak Republic, Bratislava, ed. 1996-2007. Note: for the year 2000 not available data

Table 6 Notified cases of malignant tumours in Slovakia within female older age groups (per 100 000 female)

age	*1993*	*1994*	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*
65-69	997,9	1062,3	1064,2	993,4	1105,5	1117,4	1038,6		1044,4	1189,3	1205	1254
70-74	1262,5	1315,8	1332	1358,6	1320,1	1374,4	1291,7		1351,8	1399,2	1451	1527,9
75-79	1473,6	1531,8	1516,2	1559,7	1581,4	1650,2	1616,9		1653,8	1682,1	1765,1	1820,7
80-84	1620	1691,5	1810,9	1685,5	1820,1	1751,4	1699,1		1749,9	1848,9	1955,3	2000,9
80 +	1353	1746,1	1577	1607,9	1634,6	1627,3	1563,8		1716,2	1744,6	2044,5	1901

Source: Health statistics yearbook of the Slovak Republic, Bratislava, ed. 1996-2007. Note: for the year 2000 not available data

Table 7 Notified cases of tuberculosis in Slovakia within male older age groups (per 100 000 male)

age	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*
65-69	80,6	81,5	73,6	65,8	54	60,3	53,6	55,4	45,3	34,7	38,4	33,4
70-74	126,2	91,5	81,8	104,7	79,3	79,3	87,5	67,4	36,9	62,8	40,4	50,8
75-79	127,5	100,1	132,8	93,5	98,7	71,4	96,8	86,9	59,3	86	62,9	60,3
80-84	132,8	124,4	95,1	149,1	142,3	128,8	149	121,6	60,4	52,9	98,8	67,7
80 +	145,4	113,1	118	76	162,9	120,7	136,7	44	60,9	48,4	56,5	66,4

Source: Health statistics yearbook of the Slovak Republic, Bratislava, ed. 1996-2007

Table 8 Notified cases of tuberculosis in Slovakia within female older age groups (per 100 000 female)

age	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*
65-69	49,2	48,3	33,6	40	34,7	18,9	26,6	42,1	12,5	13,3	15,9	11,1
70-74	78,4	61,7	57,1	43,1	56,9	45,6	43,6	49,4	36,7	29,5	25,7	25,4
75-79	125	100,8	142,3	94,9	98,3	75,2	60,1	61,3	45,1	42,5	47,1	38,6
80-84	138,3	124,5	79,5	100,3	85,9	103,3	111	92,1	61	57,7	39,6	34,4
80 +	188,5	132,8	115,7	102	93	106,9	71,4	67	55,3	65	51,3	51,5

Source: Health statistics yearbook of the Slovak Republic, Bratislava, ed. 1996-2007

Table 9 Life expectancy at birth in Slovakia (No. of years)

	1960	*1965*	*1970*	*1975*	*1980*	*1985*	*1990*	*1995*	*2000*	*2005*	*2006*
Total	70,3	70,4	69,8	70,3	70,4	70,9	71,1	72,4	73,3	74,1	74,4
Male	67,9	67,9	66,8	66,8	66,7	67	66,7	68,4	69,2	70,2	70,4
Female	72,7	72,9	73	74	74,4	75	75,7	76,5	77,5	78,1	78,4

Source: Huber, M. and coll.: Long-term care for older people in Europe: fact and figures (Database), 2009

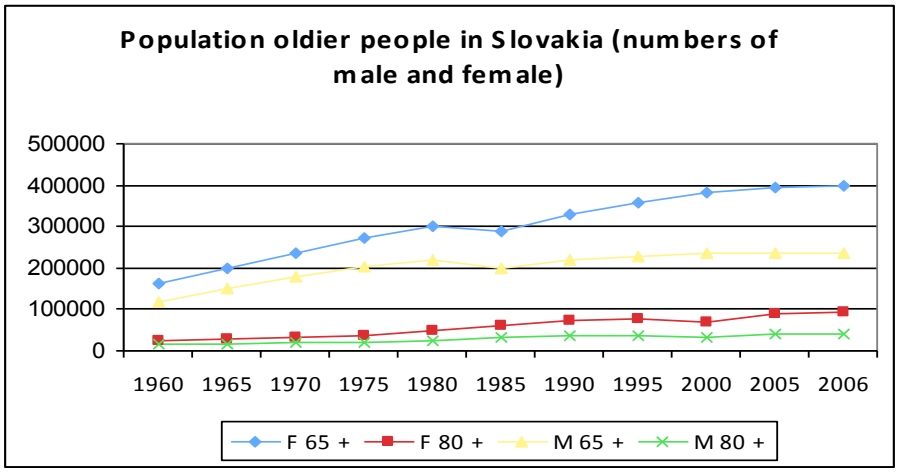
Table 10 Life expectancy at the age 65 in Slovakia (No. of years)

	1960	*1965*	*1970*	*1975*	*1980*	*1985*	*1990*	*1995*	*2000*	*2005*	*2006*
Total	14,0	13,9	13,5	13,9	13,7	14,1	14,3	14,7	15,0	15,5	15,6
Male	13,1	12,9	12,3	12,4	12	12,4	12,3	12,7	12,9	13,3	13,3
Female	14,7	14,7	14,6	15,2	15,2	15,6	16	16,2	16,7	17,1	17,3

Source: Huber, M. and coll.: Long-term care for older people in Europe: fact and figures (Database), 2009

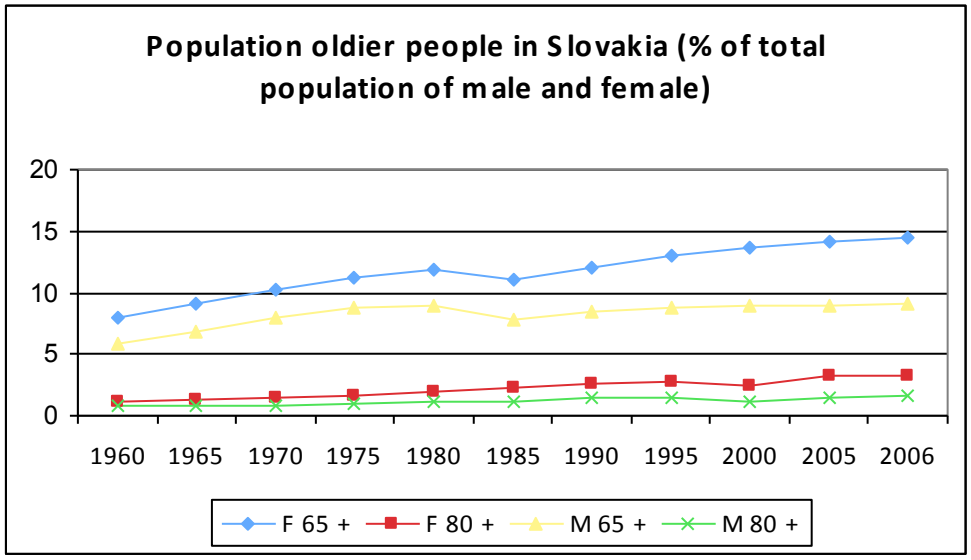
Annex 1b Demographic data – Graphs

Graph 1 Population older people in Slovakia (numbers of male and female)



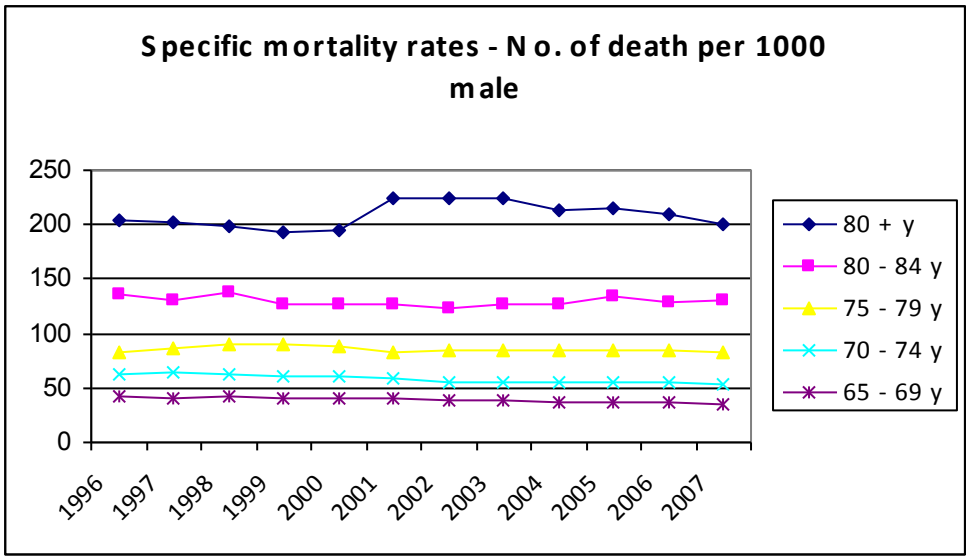
Source: Huber, M. et al.: Long-term care for older people in Europe: facts and figures (Database), 2009

Graph 2 Population older people in Slovakia (% of total population of male and female)



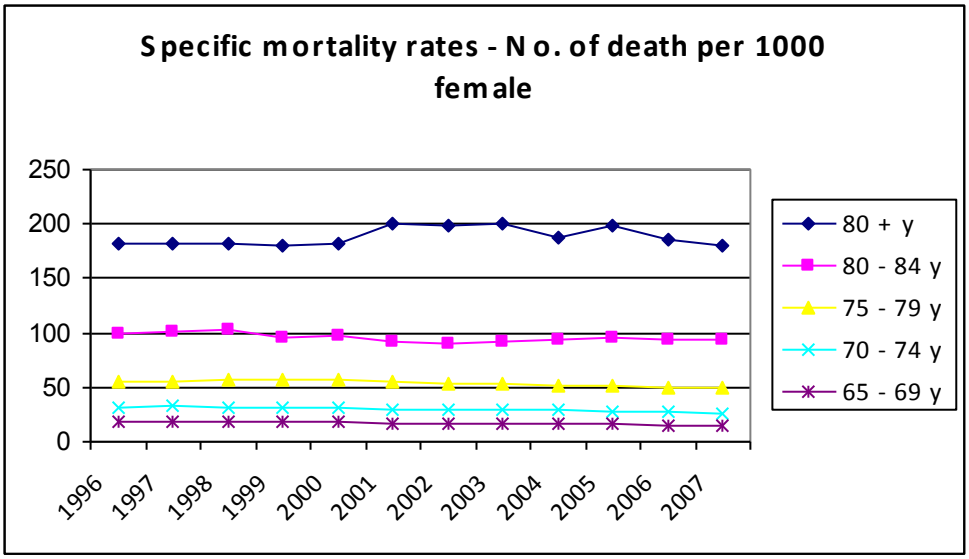
Source: Huber, M. et al.: Long-term care for older people in Europe: facts and figures (Database), 2009

Graph 3 Specific mortality – No. of death per 1000 male



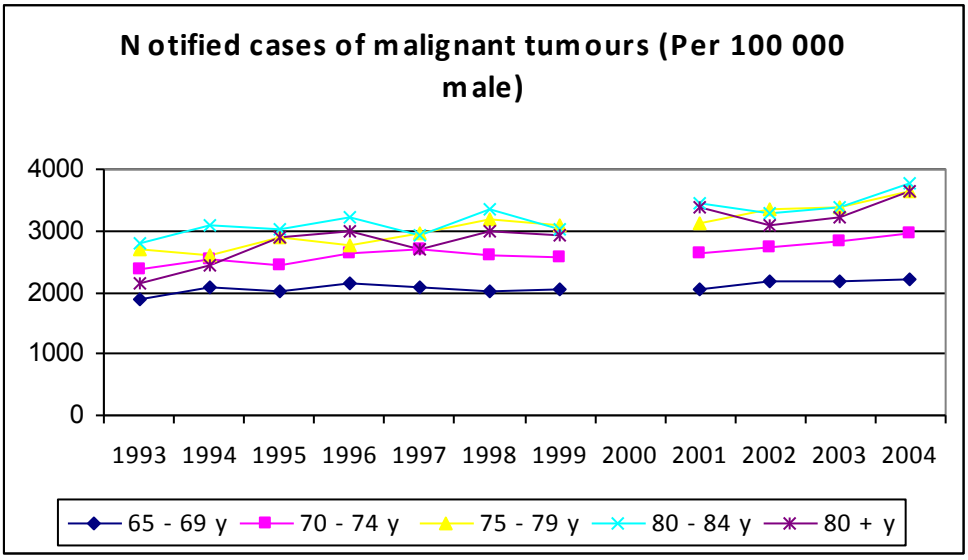
Source: Health statistics yearbook of the Slovak Republic, Bratislava, ed. 1996-2007

Graph 4 Specific mortality – No. of death per 1000 female



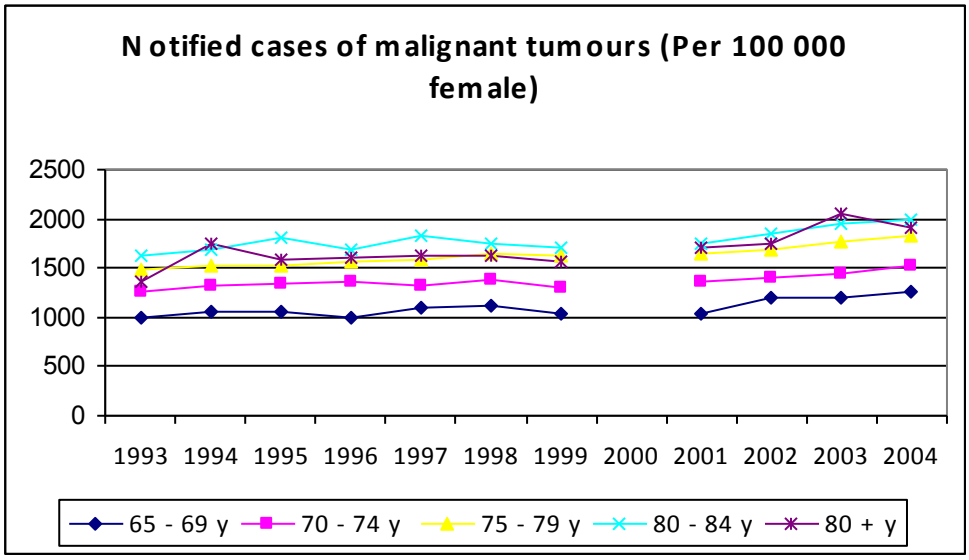
Source: Health statistics yearbook of the Slovak Republic, Bratislava, ed. 1996-2007

Graph 5 Notified cases of malignant tumours (Per 100 000 male)



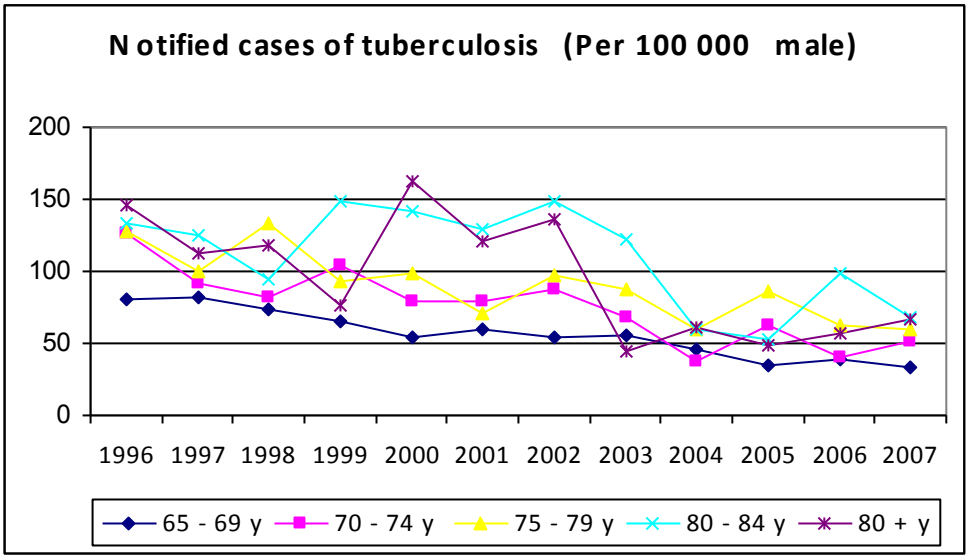
Source: Health statistics yearbook of the Slovak Republic, Bratislava, ed. 1996 – 2007.- Note: no data available for the year 2000

Graph 6 Notified cases of malignant tumours (Per 100 000 female)



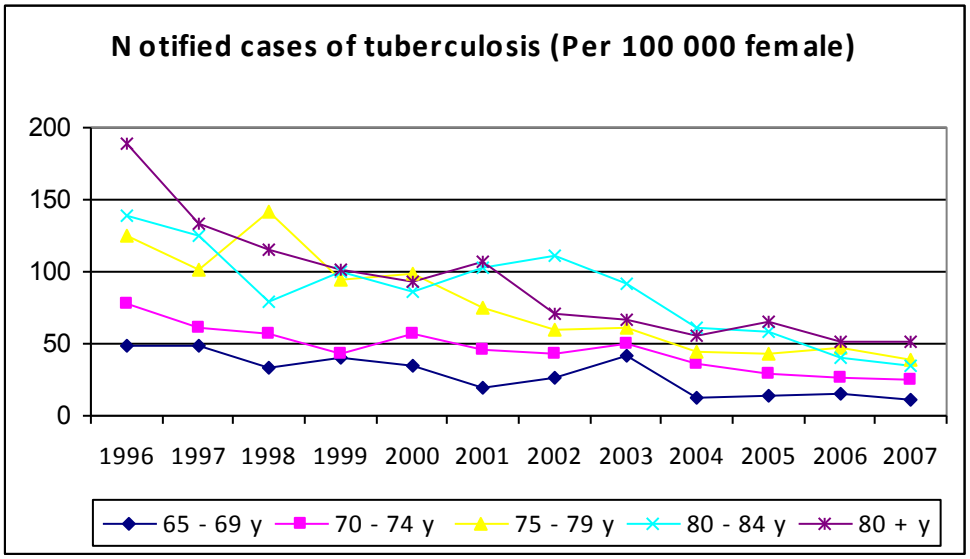
Source: Health statistics yearbook of the Slovak Republic, Bratislava, ed. 1996 – 2007.- Note: for the year 2000 not available data

Graph 7 Notified cases of tuberculosis (Per 100 000 male)



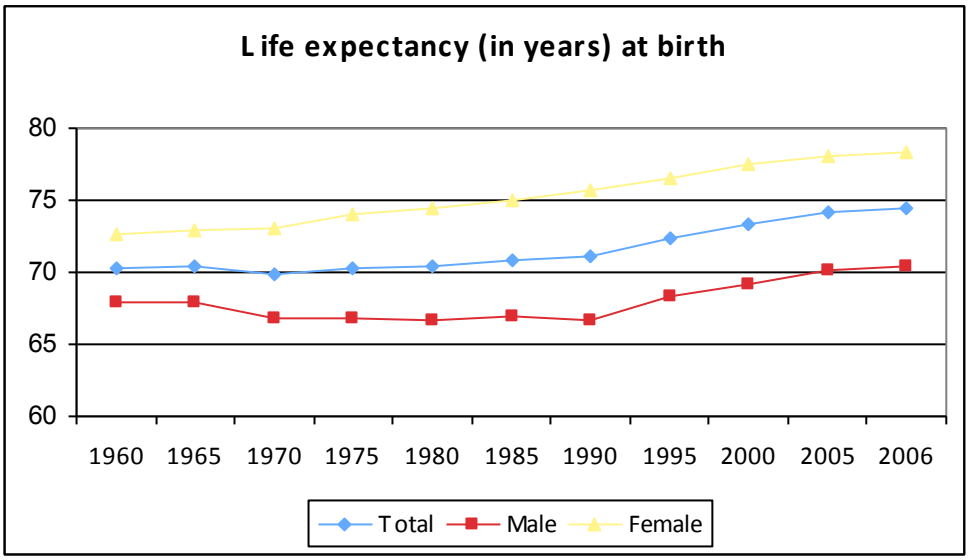
Source: Health statistics yearbook of the Slovak Republic, Bratislava, ed. 1996 – 2007

Graph 8 Notified cases of tuberculosis (Per 100 000 female)



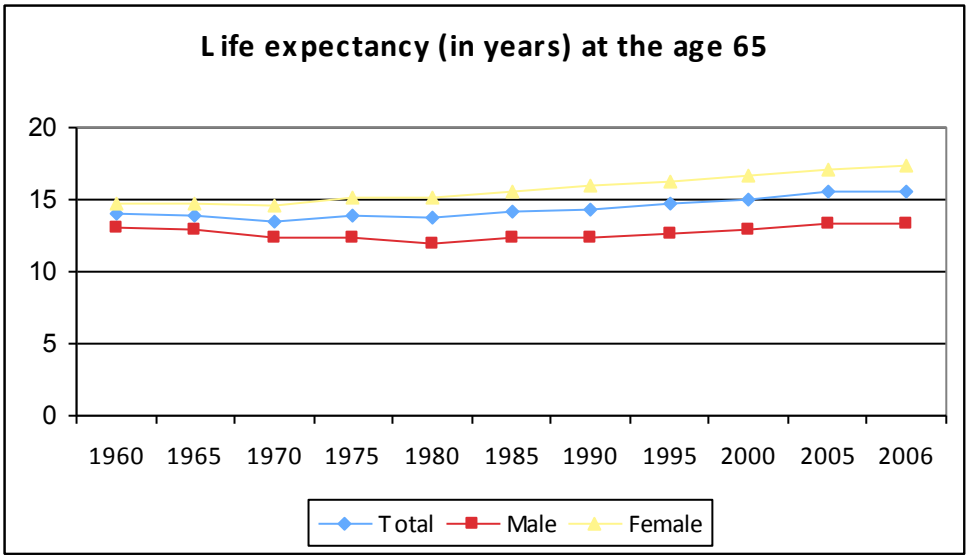
Source: Health statistics yearbook of the Slovak Republic, Bratislava, ed. 1996 – 2007

Graph 9 Life expectancy (in year) at birth



Source: Huber, M. et al.: Long-term care for older people in Europe: facts and figures (Database), 2009

Graph 10 Life expectancy (in year) at the age 65



Source: Huber, M. et al.: Long-term care for older people in Europe: facts and figures (Database), 2009

Notes

[i] Thresholds for co-financing vary according to the type of financial allowances /direct payments.

[ii] In defiance of this position, the Special Eurobarometer 2007 showed (at least declaratorily) a relatively high preparedness of Slovak families to participate in financing costs of care for older persons. While only 37% of Europeans agreed that the costs of care for an elderly dependent person should be borne by close relatives (spouses and children), as many as 68% of Slovaks were in favour of this position (Special, 2007, QA21).

[iii] As the SWOT analysis of providing social services, performed by the Ministry of Labour, Social Affairs and Family of the Slovak Republic and by self-government regions in 2007, showed the insufficient continuity of social and health care in the case of long-term dependency on another person is one of the weakest elements of the system of social services (National, 2009).

[iv] In spite of extensive reform efforts in the system of public health insurance and provision of health care, Slovaks declare that it is much more complicated for a dependent person to have accessible health services in the dependent person's household (the issue of problematic access was mentioned in the Special Eurobarometer by 50% of Slovaks, in comparison to 25% of Europeans in average, QA4.5).

[v] According to the Special Eurobarometer "Health and Long-term Care in the European Union" maltreatment of elderly persons is widespread according to 47% of Europeans in average, but only 20% of Slovaks (Health, 2007).

[vi] Improving financial rewarding for home care as a method of preventing from bad treatment of older persons is perceived by Slovaks much more often than by Europeans in average (39% : 19%, QA33).

[vii] Another situation is in the case of formal care by professional social workers where qualification requirements are directly defined by law, in Act No 448/2008 Coll. on social services.

[viii] In Slovakia, no researches focused on functioning of families with an elderly dependent person or with a dependent child have been made. It is a paradox that, for example, journal Psychology and Patopsychology of a Child publishes articles on life quality of families with a disabled child, but the articles refer to researches made in the Czech Republic.

[ix] Based on our in-field research job focused on harmonization of work and care in June 2009, the respondents did not know about a possibility to use the respite care service, even though this option had been published in the valid legislation for six months. (Repková, 2009)