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

WORK Package 6:

Governance and Finance

Slovak National Report

Rastislav Bednarik, Lydia Brichtova, Kvetoslava Repkova
Institute for Labour and Family Research, Slovakia

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European Centre for Social Welfare Policy and Research (AT) • Ecole d'études sociales et pédagogiques (CH) • University of Southern Denmark (DK) • National Institute for Health and Welfare – THL (FI) • Institut de Recherche et Documentation en Economie de la Santé – IRDES (FR) • Institut für Soziale Infrastruktur (DE) • Wissenschaftszentrum Berlin für Sozialforschung – WZB (DE) • CMT Prooptiki ltd. (EL) • University of Valencia – ERI Polibienestar (ES) • Studio Come S.r.l. (IT) • Stichting Vilans (NL) • Institute for Labour and Family Research (SK) • Institute of Public Health (SI) • Forum for Knowledge and Common Development (SE) • University of Kent – CHSS (UK) • University of Birmingham – HSMC (UK)

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Table of contents

1 Introduction and background

2 Main contextual factors

3 Governance and financing of long-term care services for older people

4 Key barriers

5 Key enablers

6 The funding of long-term care services

7 Financial sustainability

8 Good practice

9 Ongoing tension

10 Embedding good practice in everyday practice

References

1 Introduction and background

The National Report deals with the system of financing and governing services of long-term social and health care for older people dependent on others for help due to their health disabilities or functional limits resulting from older age. The Report contains some selected information processed by the INTERLINKS team in Slovakia within the preparation of particular materials in the first year of the project implementation (Vignette, LTC Slovakia poster, WP5 National Report on Informal Care in the Long-term Care System).

While preparing the Report, the team intensively collaborated with members of the NEP-Slovakia, and was inspired by the discussion on the report preparation in the NING environment, especially regarding the approach to describing and analyzing good practice examples.

The final version of the Report was discussed with members of the NEP-Slovakia in February 2010 and updated in April 2011.

2 Main contextual factors

By the 40s - 50s of the 20th century, the care for older people dependent on others for help in common daily and instrumental activities was provided on the charity and voluntary basis in the former Czechoslovak Republic following the traditions of Christianity teaching about loving one's neighbour and helping one another. Based on this principle, shelters were built, later institutions for the poor and the abandoned were opened (Repková, 2005).

The 50s brought along expansion of residential care for dependent persons organized under the new legislation in the area of social provision (1956 Act on Social Provision et seq.). For the first time, this Act governed also the system of social care for older persons, severely disabled persons and other socially vulnerable groups, and provided for the responsibilities of the state (welfare state) to help dependent individuals and groups. The next development was marked by the following factors:

1. *Different level of legal protection in the area of health and social care.* Since 1 January 1993, the demands in the area of health care have been based on the principle of public health-care insurance guaranteeing an access to health care to everybody regardless of his/her income, wealth status and general family background. To the contrary, social interventions were part of social care, later of social assistance, financed based on a redistributed principle from direct taxes (from the state budget). Individual legal claims in this area (financial allowances, social services) have been and are means tested against the income and the property, taking into account commitments of given family in providing for care. Implementation of the declared interest in an integrated health and social care for dependent persons has thus been initially complicated by various mechanisms of financing and by competencies of relevant bodies belonging to two different sectors.

2. *Substitutive nature of the relation between formal and informal services.* In Slovakia, a majority of care for older dependent persons has traditionally been provided in domestic environment on an informal basis (see WP5 National Report on Informal Care in LTC System). In spite of the existence of legal possibilities to combine domestic care with formal services (e.g. by combining the care provided by the relatives receiving care allowances with the services of daily centres), these possibilities have been and are used minimally. The relation between formal and informal services is thus mainly based on a substitutive rather than complementary basis (older persons receive care either at home or in facilities of year-round operation, and not based on a combined or communal principle).

3. *Various but poorly coordinated competencies in the area of long-term care.* As a fundamental contextual change in the area of long-term care for dependent persons, de-etatization and decentralization in the area of social services for dependent persons can be mentioned. From the beginning of this decade, it concerns a gradual definitive transfer of original competencies and responsibilities of the state in the area of social services onto the regional and local self-governments (the process culminated by adopting Act No 416/2001 Coll. on transfer of some competencies from state administration bodies to communities and higher territorial units, Act No 448/2008 Coll. on social services and related fiscal decentralization) that provide for the social care through public providers of social services. Measures of long-term care in form of financial allowances (e.g. care allowance, direct payments to adaptation dwellings, direct payments for increased costs related to

severe disability) continue to remain in the original scope of the specialized state administration, which complicates, in some cases, the continuity of help, and leads to mutual transfer of responsibilities between local state administration bodies and local self-governments. The measures of integrated social and health long-term care have still not been implemented more effectively (e.g. long-term care in institutional health-care facilities is still unsatisfactory; complications in providing health care in facilities of social services persist).

3 Governance and financing of long-term care services for older people

In Slovakia, long-term care is provided mainly through the system of social services complemented by increased attention paid to older persons in the health care system. Nevertheless, the main burden lies on family and informal care-givers. Therefore, social services are organized so that they would help persons receiving long-term care and their families as much as possible (and for the state and the self-government to a financially acceptable extent).

Regarding the system of health care, it concerns provision of prevention (in particular in form of regular preventive check-ups of older persons), inclusion into dispensaries as well as provision of institutional health care and domestic nursing care to persons dependent on long-term care. In the system of health care, also general hospitals, agencies of domestic nursing care, departments or medical institutions for long-term ill persons, hospices or nursing houses are used for the needs of long-term care.

Financing of health care (and within it also the segment of long-term care) is provided for by the system of public health care insurance (in which three health insurance companies operate), and the performance of health care providers is paid by this system (at least to the extent of the public minimal network of providers). Participation of private resources is low.

Important competencies in the field of long-term care are held by the Ministry of Labour, Social Affairs and Family of the Slovak Republic, and the relevant infrastructure (bodies of specialized state administration, communities, towns, higher territorial units, providers of social services). Financial allowances to compensate social impacts of severe disabilities as well as care allowances are provided from the state budget through Offices of Labour, Social Affairs and Family, and also through bodies of specialized state administration. Key actors in providing social services are, however, communities and self-government regions (local and regional self-governments). Communities and self-government regions assess client's dependency on social services (depending on classification by relevant degree of dependency) and at the same time, they assure, establish and provide for social services. Clients of social services providers include, however, not only older dependent citizens but also younger, severely disabled persons and some other categories of the population.

At the local level, long-term care for older persons is enabled by facilities for seniors, facilities of nursing services, as well as by providing in-the-field nursing services, transportation services, relieving services or basic social consulting. At the regional level, long-term care for older persons is enabled by homes of social services, specialised facilities, interpretation service and basic social consultation delivery. Within the system of supporting services, it is possible to provide older dependent persons and their families with services of monitoring and signalization of help need, and services in daily centres, catering facilities, centres of personal hygiene, or laundry centres. The Act enables to delegate, on the basis of an agreement, the competencies held by the community and higher territorial units in the original scope in the area of social services upon another legal or natural person, i.e. an non-public provider, if the client has chosen it.

Slovak social legislation does not specify a special mechanism of coordinating social services. An important role is played by a social worker (of given community or higher territorial unit) that provides basic social consulting, and is in contact and cooperates with health care facilities, social services facilities, other communities or higher territorial units, relevant Offices of Labour, Social Affairs and Family, the Social Insurance Agency, churches or other institutions involved in the field of health and social services.

Social services guarded and provided by communities or self-government regions are financed from budgets of communities and regions; however, some selected facilities are financed from the state budget. These means are complemented by payments from clients themselves, by gifts, finances of associated communities, means of the public health insurance, or other resources (e.g. also from the EU structural funds, or government subsidies).

When considering the area of supporting mutual cooperation between bodies and institutions involved in the system of long-term care, creation of new legislative conditions for interconnection of social and health care within the residential care system must be mentioned. In selected social facilities (for seniors, in social service homes, in facilities of nursing care) it is possible to provide and finance some selected performances of medical care (from the system of the health insurance), but also vice-versa, in institutional health facilities, it is possible to provide social services financed by the self-government. In the case of providing long-term care in domestic environment, such an interconnection is complicated by the fact that the responsibility for the medical care (including organizing and financing) is exclusively borne by the health care sector (e.g. through an agency of medical care), while nursing care is an exclusive responsibility of the social sector (communities and towns).

In the system of long-term care, public providers of social services (communities and higher territorial units, and legal persons established or founded by communities and higher territorial units) carry a significantly greater weight than non-public providers. It is obvious also in the case of care in facilities of social services when of the total number of 636 facilities, 431 of them (almost 2/3) fall within the scope of communities and self-government regions; 66 facilities fall within the scope of churches, and 139 facilities are owned by other legal or natural persons (Source: Statistical Office of the Slovak Republic, data for 2009). All these facilities depend on financing from public resources. In Slovakia, social services provided on a business (profit) basis and without any support from public finances are rather rare, especially because of insolvency of clients and their families as prices for services in this type of facilities are clearly beyond their financial possibilities.

4 Key barriers

4.1 Structural barriers

In Slovakia, long-term care measures do not comprise a uniform system governed by special legislation. On the opposite, they are rather "scattered" in the systems of health and social care that are weakly coordinated.[i] Generally, it may be stated that the basic structural barriers listed below determine the existence and the nature of the barriers also in the area procedural, financial and professional. In Slovakia, creation and functioning of a coordinated or integrated system of long-term care services (for more see Pillinger, 2001) are complicated mainly by the following:

- various organizing and financing of health and social interventions, hindering continuance of long-term care for older persons across the sector (including their executive components), and holding back providers and financial mechanisms,

- insufficient coordination of legislation in the area of health and social care, preventing from practical application of provisions focused on integrated services of long-term care (e.g. a possibility to provide a health care to the extent of nursing in the facilities of social services),

- an effort to preserve a relative independence of long-term care measures focused on disabled persons, and measures focused on older persons. This effort has been maintained in spite of the fact that more than a half of persons (63,3% in 2010) that were and are acknowledged as persons with severe disabilities at the same time were and are also older persons (aged 60 and more; Central Office of Labour, Social Affairs and Family, March 2011). There may be a problem of continuity of the help when some measures are consistently tied to persons with severe disabilities, while these persons gradually get older and simultaneously become older persons with severe disabilities (e.g. an allowance to purchase an automobile).

4.2 Procedural barriers

Various and uncoordinated sector competencies in the area of long-term care lead to the following:

- a variety of legal and institutional systems of assessing needs and legal entitlements in the area of long-term care for older dependent persons and their families (a special assessment for the purpose of health care system, old-age pension provision, allowances to compensate different disadvantages, or social services),

- a lack of interconnection between databases of dependent older persons in particular systems (also because of a high extent of personal data protection), which prevents from rationalizing the process of submitting documentation for various legal entitlements to be assessed. This absence of interconnection of databases and accesses is also related to protraction of proceedings in connection with social services or financial allowances,

- the weak tradition of involvement of clients and their families in creation of social services plans at the communal and individual levels may also be included in the procedural barriers, even though authors of communal policies of social services and social services providers are directly bound thereto by the Act on Social Services.

Taking into account the low rate of flexibility and sharing of data on persons by various institutions responsible for implementing tasks of the public administration, the conceptual intention to build a *National Register of Disabled Persons* on the ground of an all-society interest can be judged positively. The concept was discussed in December 2009 by the Council of the Government of the Slovak Republic on Disabled Persons. The intention follows up the commitment of the state expressed in the Concept of Informatization of the Public Administration (passed in May 2008), according to which a citizen is to submit information for the public administration bodies only once (in line with the principle „Once Is Enough“), and the public administration is to further distribute the information to its particular components.

4.3 Financial barriers

Even though the provision of needed health care is guaranteed through the system of public health insurance, almost a half of Slovaks mentioned in the special Eurobarometer on health and long-term care in the EU (2007) that health services in households of dependent persons were accessible with problems, and that they could not afford them (QA4.5, QA5.5). Also in the survey by Repková (2006), high prices for medicaments and health services showed to be one of the main factors for which disabled persons evaluated their economic and life situations as worsened.

As for the accessibility of social services, directly the Act on Social Services, entered into force in January 2009, confirms the principle of right to provision of a needed social service. In practice, however, the users point out the problems with accessibility of social services (e.g. long waiting periods for services in social services facilities, insufficiently covered needs of persons in the area of nursing services). On the other hand, towns, communities and regions as exclusive guarantors of providing social services and the holders of original competencies in this area, point out insufficient financing of social services primarily coming from share taxes intended for territorial self-governments (local and regional).

The primary monitoring of implementation of the Act on Social Services confirms the continued existence of the largest interest of older persons and their families in nursing services and in services provided by facilities for senior that fall within the original scope of communities and towns (Koláčková, Repková, 2009). However, towns and communities underline the unsustainability of their financing as under the valid fiscal decentralization only 5 % of the share tax is earmarked for the overall (not only long-term) care for citizens older than 62 years. Especially the area of financing residential social services (facilities for seniors) faces problems. Through the Association of Towns and Communities of Slovakia (ZMOS), towns and communities require from the Government of the Slovak Republic to change the principle of financing through the fiscal decentralization by increasing share taxes so that they would be able to perform tasks given to them by law in the field of social services for older persons. Their requirement is backed up by the Memorandum on Cooperation between the Government of the

Slovak Republic and ZMOS, signed in February 2009 (for more see Part 7). In different circumstances, they propose that the residential care be provided by bodies of regional self-government that, in line with valid rules, has available 32% of share tax for care for persons older than 62 years.

Creation of a coordinated and continual approach to saturating needs of long-term care for older persons is complicated by the fact that the assigned part of share tax to satisfy social needs of older persons is not bound by specified purposes. This increases risks that financial means may be used also for purposes other than social services organized by a community.

4.4 Professional barriers

The different status of the systems of health and social services in/directly influences also the positions of individual experts involved in the field of long-term care for dependent older persons and their families. In Slovakia, the high status of health-care workers (GPs, specialists, nurses), especially as perceived by the older generation, has its tradition. It is confirmed also by some surveys (e.g. Repková, 2006), according to which the life quality of disabled persons and their families is mostly influenced by the accessibility of information services and medical care provided for by doctors and other health-care workers.

Social work, (re)introduced in Slovakia in the last decade of the 20th century, seeks to professionally single out from the mainstream disciplines (in particular medicine, law or sociology) and to get a mediator-like position in multidisciplinary teams focused on care for older persons (e.g. at the level of specialized state administration, or local and regional self-governments). Certain problems are caused by different approaches to assessing needs of dependent older persons and their families by medically and socially oriented experts (individual-medical vs. social-legal model).

When initiatives of non-governmental sector are also considered to be part of the system of long-term care for older persons (see WP5 National Report), then an important question arises regarding the relation between institutions of the public administration (specialized state administration, public legal institutions, regional and local self-governments) and civic associations of disabled persons or seniors. Some surveys point out a low level of trust between the organizations of civic and public sectors. As the results of a 2001 survey by Repková et al. (Repková, 2002) show, up to 80% of civic associations provide social consulting to disabled persons and their families, and try to improve their awareness of socially relevant issues, while only 11% representatives of the local state administration assessed this activity positively. Later findings do not sound more favourable either. For example, according to the results of a survey by Reháková and Pavlíková (2007), only one third of adult disabled respondents think that experts at the self-government level use any available information and possibilities to make their decisions, including the information from representatives of the civic sector.[ii]

4.5 Issues of status and legitimacy

The main barrier to effective financing and governing of the system of integrated social and health services for older persons is the unequal position of the health care and the social care. In this place, we will specially refer to some other aspects that reduce the stability of the intentions to develop social services in individual communities and towns, and of their providers:

- the unequal legal position of public and non-public providers of social services. As mentioned above, the non-public providers are supported from public resources to a minimum extent. Bodies of the local self-government seek (also on the ground of generally insufficient finances) to finance, in the first place, providers established under their own spheres of authority. Non-public providers provide their services for market prices, which makes them uncompetitive against public providers, even though they are often able to provide much more flexible services and more tailor-made for clients' needs. The last amendment of the Act No. 448/2008 Coll. on Social services (has entered into force on 1st March of 2011) created legal conditions for clients to apply the principle of free choice of social services provider. Now the position of both the public and non-public providers of social services is equal. But because lack of financial means of municipalities and Upper Regional Units, the mentioned right of clients and non-public providers is currently problematic to apply in praxis.

- possibilities to influence personal strategies of social services facilities (the structure of the top management) by political interests advocated on the side of the regional self-government, as directors of the facilities are appointed for these positions, and thus they can be recalled at any time without giving a reason.

5 Key enablers

5.1. Shared vision

In the previous period, a number of practical measures were taken by the government as well as self-governments to improve the development of the long-term care for older persons in Slovakia. So far the main emphasis has been put on the development of social services and provision of means to finance the system of compensation of severe disability social consequences in form of financial allowances. In the area of social services, an important incentive of their development was the transformation of the existing facilities of social services, particularly through their decentralization and de-etatization, which is documented in, e.g., the *Summary Final Report on the Social Services Transformation Project* (2008).

Currently, the vision of developing social services as drafted in the *National Priorities of Social Services Development* (2009) is applied. The document is based on the actual situation in providing social services, marked by their partial inaccessibility and unsatisfactory material and technical conditions of their provision. Therefore, the primary goal is to improve the availability and accessibility of social services for each citizen dependent on them, and to achieve sustainability of their financing. Also the task of local and regional self-government bodies in developing social services is emphasized. The development of the social services segment assumes cooperation and exchange of good experience among enablers in this area – the Ministry of Labour, Social Affairs and Family, communities, self-government regions, social services providers as well as research. The National Priorities were drafted with an aim to frame and support the enablers to develop their activities in this area. They are a direct starting point for establishing binding *Concepts of Developing Social Services* prepared by self-government regions (the regional level), and binding *communal plans of social services* prepared by self-government bodies of communities and towns (the local level). The regional concepts and plans of communities and towns will serve as instruments to develop social services at the self-government level.

5.2. Clarity of roles and responsibilities

Simultaneously with clarifying the procedure of improving long-term care for older persons (especially through the development of social services) in conditions of regions and communities of Slovakia, also the idea of using the health-care system and the voluntary sector is developed. For now, a relatively clear role (though not throughout the spectrum of the long-term care system) is played by the social services enablers.

Being a transitive country, Slovakia transformed its health-care system five years ago (see the six acts listed in References), however, without any direct interconnection to long-term care. As part of a national discussion on the health-care system integrating in the long-term care system, a *Proposal of Social and Long-term Care Concept in the Slovak Republic* was made in 2004. The document reckoned with the existing provision of both, health and social services to persons having the need of long-term care. This proposal failed to win a general support due to its high financial expectations, when it assumed a transfer of the weight from public upon private sources to finance long-term care. Currently, legislative interventions to enforce the care in the system of long-term care for older people are again

under consideration (see *Analysis of Health Care for Seniors in the Slovak Republic as of 31 August 2009)*.

Regarding the voluntary sector in the system of long-term care for older people, its role is still indistinctive in Slovakia, as also suggested by experts´ opinions (e.g. Hegyi, Balogová, Šiková, Konečný, within the preparation of the WP6 National Report). Volunteers get more involved in the care for young children, and the situation is also complicated by the fact that there is no systematic legal regulation of performing, organizing and financing their work. Currently only the proposal of Act on Volunteering is ready which will be in a short time submitted in legislative process.

5.3. Appropriate incentives and rewards

The problems with financing the services of long-term care for older people are not connected only with a lack of finances for the services themselves, but also with rewards for employees performing these services. When comparing the wages development, it is obvious that in the long term, the social care sector shows a lower wages level compared to the national average wages. For example, in 2010 in the health care and social assistance resort, the average nominal monthly wages were EUR 698, while the national economy average was EUR 769 (source: data of the Statistical Office of the Slovak Republic). Average monthly gross wages in facilities of social services has achieved in 1st half of 2010 even only EUR 531.29 (see Trexima, Wages (Ministry of Labour, Social Affairs and Family of Slovak Republic) I-02 *Analysis of average earnings of residential Social services facilities employees, Ist half of 2010*).

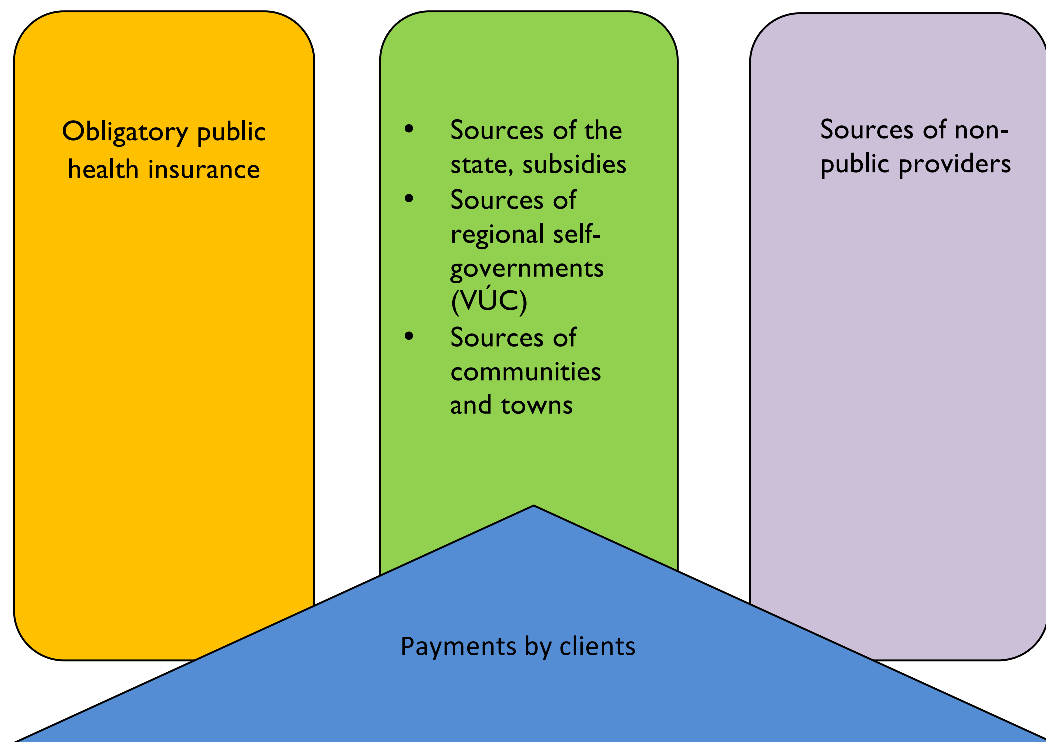
5.4. Accountability for joint working

Both, social and health legislations make effort to improve their cooperation in providing long-term care. As shown by the *Analysis of Health Care for Seniors* (2009)[iii], the provision of long-term care as part of domestic care takes place with a support from general practitioners, specialized doctors, and agencies of domestic medical care. These are involved also in the facilities for seniors. As yet, long-term care is not provided in institutional health-care facilities. New possibilities under the new legislation, the Act on Social Services (provision of social services in facilities of institutional care and vice-versa, medical care provided in the facilities of social services) have not been used in practice.

6 The funding of long-term care services

The funding of long-term care for older people in Slovakia can be divided into the expenses of the health care system (the scope of the Ministry of Health of the Slovak Republic) and the expenses of the social care system (the scope of the Ministry of Labour, Social Affairs and Family of the Slovak Republic and its relevant sector infrastructure). In the former case, it is contributory funding, while in the latter case, it is non-contributory funding. In the case of health care, the sources consist of collected insurance payments for public health insurance by health insurance companies (paid by employers, employees, self-employed persons and the state which pays for about 3 mil. persons, particularly for children, pensioners, unemployed persons and others), unlike the social care which is funded from the revenues of the state, self-government public entities and non-state entities. Figure 1 summarizes the funding system consisting of several sources.

Figure 1: Multiple-source funding of long-term care



Source: authors

In 2008, the total costs of health care (according to *Health-care Yearbook of the Slovak Republic*) amounted to EUR 3.131 billion (4.65% GDP). However, for long-term care for persons older than 60 years, only EUR 0.041 billion (following the data internally requested from health insurance companies). Health insurance companies included into costs of long-term care also costs of hospices, medical institutions for long-term ill persons, as well as hospital wards for long-term ill persons.

Costs of long-term care in the system of social care in 2008 (according to the statistics of the Ministry of Labour, Social Affairs and Family of the Slovak Republic) amounted to EUR 0.516 billion (0.77% GDP), while the costs paid for citizens older than 60 years account for about EUR 0.299 billion. It can be detailed as follows:

- financial contributions paid for compensations (including care allowance) amounted to EUR 0.178 billion (for persons older than 60 years, in the amount of about EUR 0.086 billion),
- for care in facilities of public providers, EUR 0.246 billion (for persons older than 60 years, about EUR 0.155 billion) was paid,
- for nursing services, EUR 0.026 billion (for persons older than 60 years, about EUR 0.016 billion) was paid,
- costs of non-public providers amounted to EUR 0.049 billion (for citizens older than 60 years, about EUR 0.031 billion),
- for insurance of informal caregivers paid by the state, EUR 0.018 billion was paid (in connection with care of persons older than 60 years, it was about EUR 0.011 billion).

These costs do not include further costs needed to perform informal care provided in families of the older dependent persons.

7 Financial sustainability

The issue of financial sustainability of long-term care in Slovakia has two aspects. On one hand, it is necessary to find additional sources to improve the existing situation, while it is necessary to solve up also the organizational framework of providing long-term care. On the other hand, it is needed to take into account also needs of future periods, for which particularly demographic indicators signalize an increase in the number of persons dependent on long-term care. As of 31 December 2009, the population of Slovakia numbered 5,435,273 persons, out of which 51.4%2,629,804 were women (source: Statistical Office of the Slovak Republic). The age category 65+ included 248,290 men (9.4 % of the male population), and 416,845 women (14.9 % of the female population). *Prognosis of Population Development in the Slovak Republic by 2025* (2007) suggests intensive aging of the population, when already in 2015, the average age of the population will exceed 40 years (now it is 38.5 years) and in 2025 it will be 42.6 years. Aging index (the number of people aged 65+ per 100 people aged 0 – 14) will likely reach the value 100 already before 2025 (for men, 102, and for women, 150). The number of people older than 65 will be in 2025 more than 1,047,000 (429,000 men, and 618,000 women). People older than 65 will account for 19%, and people older than 80 will account for 3.66%.

The current legislation covers the funding of the minimal network of health care providers and the network of social services providers falling under the scope of self-governments. Problematic is funding of social services provided by non-state entities (when self-government bodies get some money from share taxes). A sufficient guarantee of financial sustainability of long-term care (e.g. in funding, self-governments emphasize especially provision of technical infrastructure) is still not ensured. Document *National Priorities of Developing Social Services* (2009) recommends communities, self-government regions and other providers of social services to use also additional financial sources from grant programmes, structural funds (in particular of the European Social Fund – Operational Programme: Employment and Social Inclusion), from the Regional Operational Programme (priority axis Infrastructure of Social Services, Social Legal Protection and Social Curatelle) or government funds (especially the Ministry of Labour, Social Affairs and Family of the Slovak Republic).

Discussions of experts in Slovakia, however, point out the need of a more substantial solution to the financial sustainability of the system. In a representative survey (Repková, 2010), 56% of the respondents said that they fully or rather agreed with that the funding of long-term care for dependent persons would improve by introducing a new type of obligatory contributions by which people would „save“ for a future situation of dependency on care. Only 25% of the respondents refused this method of solution. The results will be used for a wider national discussion on the intention to introduce a new type of insurance as well as for drafting an act on long-term care.

8 Good practice

In spite of the above contextual problems in introducing, funding and governing the system of long-term social and health care for dependent older persons, it is possible to identify some elements directing to the creation of such a system:

- *Elements of an integrated long-term care system under the new legislation*

  From January 2009, a new act on social services is valid in Slovakia (Act No 448/2008 Coll. on social services) that defines legislative conditions to provide medical care in facilities of social services (Article 22 of the Act on Social Services), and vice-versa, conditions to provide social services in health facilities of the institutional health care (Article 70 of the Act on Social Services) provided that the health facility has been registered as a provider of social services.

- *Qualified work force and quality of social services*

  The Act on Social Services explicitly defines qualification preconditions to perform various activities related to social services (in the area of medical and social assessments, performance of specialized activities in social services in a direct contact with the client and his/her family or community). The intention is to improve the professionalism of social services performance as a part of the concept of evaluating quality in social services.

- *Establishing a work group for long-tem social and health care of the Council of the Government of the Slovak Republic on Seniors*

  In July 2008, the Government of the Slovak Republic approved establishment of its consulting body, the Council of the Government of the Slovak Republic on Seniors. The Council consists of representatives of central bodies of the state administration (all the relevant ministries and other central bodies), regional self-governments, the non-governmental sector, research & development, academic circles as well as public media. Also based on the participation of Slovakia in the INTERLINKS project, the request to establish a subgroup of the Council for long-term health and social care for seniors within the group was successful.

- *Financial support of local self-government in providing for new competencies in the field of social services*

  Following the fact that the new legislation on social services entered into force at the time of the start of the global financial and economic crisis, the Government of the Slovak Republic signed with the Association of Towns and Communities of Slovakia (ZMOS) a “Memorandum on Cooperation to Solve Impacts of Financial and Economic Crisis on the Slovak Society” in February 2009. By the Memorandum, the Government committed, among others, to refunding the local self-governments (towns and communities) the costs they incur as a result of introducing new competencies in the field of social services. For this purpose, the Ministry of Labour, Social Affairs and Family of the Slovak Republic, as the guarantor of fulfilling the national priorities in the area of social services, established a system of monitoring costs (for more details, see Part 10).

9 Ongoing tension

In the system of long-term care, an insufficient capacity and variability of those social services that are demanded most still persists – it concerns nursing services and facilities of social services. Another problem is a lack of finances of towns, communities and self-government regions to provide for social services, which is caused by an insufficient allocation of percent share of costs for these activities (it should be higher).

Based on the SWOT analysis of the situation in providing social services in Slovakia, published in the *National Priorities of Developing Social Services* (2009), the Weaknesses include also the undeveloped system of communal planning (in communities, towns or regions) that should help to solve also a problem of the persisting, insufficiently ensured continuity of health and social care for citizens dependent on long-term help by another person.

According to the same analysis, an unsatisfactory technical state and furnishing of the facilities of social services continues to persist together with the absence of systematic improvements of qualification of workers in this area, insufficient field social work in the natural and open environments, missing quality standards of social services, and others problems.

In the health care system – following the *Analysis of Health Care for Seniors in the Slovak Republic* (2009) – the persisting problem is the insufficient capacity to provide for professional health care for handicapped patients in their domestic environments, and to provide for surveillance over risk groups of older persons; there are not enough facilities providing day care for patients with mental dementia; in some regions, the level of providing geriatric care in hospitals is rather low. The analysis also states that seniors do not sufficiently take advantage of preventive examinations and of consulting services on healthy way of life.

All these problems are multiplied in connection with impacts of the financial crisis, and endanger the whole gradually built system of long-term care in the future, when it is expected that the demand for long-term care will grow as a result of the growing share of older people in the population.

10 Embedding good practice in everyday practice

In several places in this document it has been stated that in Slovakia there is a relatively significant gap between legislative possibilities of introducing integrated social and health services of long-term care, and the social and political practice. Below are listed some institutions that are determined for gradual enforcement of legislative possibilities (described as good practice) in everyday practice:

- *Intention to draft an act on long-term care*

  In October 2009, the Council of the Government of the Slovak Republic on Seniors discussed and approved document *Analysis and Report on Provision of Health Care for Seniors, and Proposal of Measures of Solution* (selected information and recommendations resulting from the document are included in the appendix). Following the statements on basic shortcomings in providing long-term social and health care for older people, the document proposes, among others, to draft an act on long-term care. Because of the time of adopting this intention (before the parliamentary elections in June 2010), it is reasonable to assume that its implementation will depend on decisions (priorities) of a new Slovak Government during years 2010 - 2014.

- *Evaluation of quality conditions in providing social services*

  The evaluation is provided for by the Ministry of Labour, Social Affairs and Family of the Slovak Republic in cooperation with external experts. The evaluation subject includes procedural, personnel and operational aspects of provided social services, while a special emphasis is put on creation of an individual development plan of the beneficiary of the social service, as well as on flexibility of measures, protection of rights of social service beneficiaries and their families, including the right to express one's (dis)satisfaction with the social service as a basis for its further provision or, as the case may be, its change. The quality concept includes also creation of a space for further growth of employees involved in various special activities comprising an integral part of social services. Through the quality aspects in the system of social services, their communal organization, cooperation with families and establishment of various institutions engaged in providing social services is preferred.

- *Monitoring of implementation of the Act on Social Services, and additional funding of new social services.*

  Since the beginning of 2009, it has quarterly been provided for by the Ministry of Labour, Social Affairs and Family through the Institute for Labour and Family Research. The aim is to identify the costs of communities and towns incurred in the monitored period in connection with new tasks in the field of social services for the purpose of their refunding from the state budget. At the same time, implementation problems are identified at the regional (upper territorial units) and local (communities) self-governments that are bases for adopting needed changes. It has been assumed that the measures resulting from the Memorandum would be temporarily defined for the period of 2009 -2010. Persistent problems with social services financing has led to the fact that another financial means to self-governments will be provided also in 1st quarter of 2011 and it is considered also next reimbursement to cover missing costs within social services during the whole year 2011.

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NOTES

[i] Because of this, it is possible to positively evaluate the intention to draft and adopt an act on long-term care in Slovakia, as it was discussed by the Council of the Government of the Slovak Republic on Seniors.

[ii] In terms of creation of policies of long-term care, it is possible to suggest that crucial is the operation of the Council of the Government of the Slovak Republic on Disabled Persons (in various forms, it has been functioning since 1995) and the Council of the Government of the Slovak Republic on Seniors (functioning since 2009) as consulting bodies of the Government of the Slovak Republic working based on the principle of an equal partnership between various enablers engaged in issues focused on welfare of older persons, disabled persons and their families.

[iii] The above mentioned document states that the system of providing health care for seniors in Slovakia has been working for 30 years, and is based on the Concept of Geriatric Care (as last amended in 2007). A geriatric health-care network was established, and experts in this field are regularly trained. Currently, there are about 150 doctors specialized in geriatrics in Slovakia.

Annex

Analysis of Health Care for Seniors in the Slovak Republic as of 31 August 2009 – selected parts

(prepared by a special working group of the Council of the Slovak Republic on Seniors, focused on health issues of seniors, 2009)

4. Positives and short-comings in providing health care for seniors

The major **positive aspect** is the care system that has been in place in Slovakia for 30 years, and is based on the Concept of Geriatric Care. The currently valid concept was adopted in 2007. Following the Concept, a network of geriatric health care and a system of continuous training of experts were launched. Now there are about 150 geriatric doctors - specialists in Slovakia. In spite of the existing legislation, there is a whole range of **shortcomings** in providing health care to senior citizens.

Shortcomings

Based on the findings of the Health Care Surveillance Authority, the Chief Expert of the Ministry of Health of the Slovak Republic, and regional geriatrists, it results that in health care for seniors there are some serious shortcomings.

1. Out-patient health care

1.a. The real medical work-loads of geriatrists are about 23.0 l.m., while the amendment 751/2008 of the Government Decree on public minimal network of health-care providers in geriatrics defines only 22.0 l.m. for out-patient geriatric practice for the whole Slovakia. This only confirms that unfavourable situation when the contracts with health insurance companies are signed so that the geriatrists are forced to have a part-time job in another field. The main reason for this situation is insufficient rewarding the performance component in geriatrics. Almost all the geriatrists run also internal medicine out-patient practice in addition to their geriatric out-patient practice. The number of out-patient geriatric practices in the Slovak Republic was 59. In some regions, the accessibility of out-patient geriatric care was not provided.

1.b. Health care in many senior homes is sporadic, and is limited to prescribing medicaments.

1.c. There is a lack of facilities providing daily care to patients with dementia.

1.d. There is a lack of nurses providing care in the community, and there is a lack of surveillance of the observance of the treatment regime, as well as surveillance of older persons with some risks.

1.e. Problems in providing special care for immobile patients living in their homes persist.

2. Institutional health care

2.a. In some regions, specialized emergency geriatric care in not available or accessible only with difficulties.

2.b. A lack of doctors results in problems with providing consulting services at non-geriatric wards with senior patients.

2.c. In spite of the valid methodological instruction on qualification preconditions for performing leading positions, a number of head doctors of geriatric facilities do not have completed the geriatric specialization.

2.d. A number of hospitals suffer a lack of paramedic specialists (psychologists, speech therapists, therapeutic pedagogues). Therefore, speech therapy and ergo-therapeutic care for patients with acute vascular brain accidents is not available. Patients with disorders of swallowing do not get, either, the proper care.

2.e. The fact that the attending staff is overloaded with work often results in violation of human dignity of the older persons.

2.f. Nursing care for patients with urinary incontinence is often replaced by application of catheters which increase the risk of infections of urinary tract. Mortality rate of patients having catheters due to their incontinence is twice as high as that of patients treated by other incontinence aids.

2.g. Availability of nursing aids is insufficient which significantly deteriorates the care for immobile and incontinence-suffering patients. This leads to a frequent occurrence of decubituses.

2.h. The level of oral health of seniors is still very poor.

2.i. Unsuitable architectonic solutions comprise a group of other problems. The architectonic solutions of a number of wards are not appropriate for patients mobile only with difficulties. Furniture used in hospital makes it more difficult for the patients with mobility disorders to move around. The number of toilettes and bathrooms is insufficient, which makes the situation worse for the patient with mobility problems. Rooms are small and there is often no space for using a portable toilette (moreover, the number of portable toilettes is insufficient). Toilette assistance is often replaced by using diapers. The lack of space worsens handling of patients, and special armchairs for patients to sit down are not available in a sufficient number. Those that are available are not suitable as it is impossible to get the patient secured against a fall. In some wards, alarm signalization does not work, and thus the patients have problems to get help.

2.j. The lack of space in social care facilities does not enable to increase the number of beds, which means that patients are often released prior to their full treatment, or patients are often admitted into the hospital only after several examinations at the Central Admission.

2.k. The cooperation with the resort of social care is impaired also by the long period the self-governments have available by law to assess the dependence on assistance (30 days).

2.l. So far the long-term geriatric care has failed to be solved in the resort of health care system.

3. Prevention

3.a. Seniors rarely undergo preventive examinations by their general practitioners, and likewise, men do not undergo examinations by their urologists as often as they should.

3.b. Flu vaccination rate is relatively good every year, though it still does not meet requirements of the WHO. The polyvalent pneumococcal vaccination rate is a bit lower. The biggest shortcomings are recorded with the tetanus vaccination rate.

3.c. Seniors get the information about a healthy life style mostly by means of media. The activities of the Health Consulting Centres must be assessed positively, even though their activities only refer to a few thousands of the total number of more than 900,000 old-age pensioners. There are a lot of problems and shortcomings in the practical implementation of the healthy-life style education. In the area of education on good health, all the doctors and medical workers are or should be involved. Until recently, the institutional provision of the education on good health was the responsibility of Regional Offices of National Health (RÚVZ). In the past two years, almost all the good-health education departments at the Regional Offices of National Health were closed. In fact, the most important role in spreading information on good health and healthy life style is played by media today, even though a relatively few media workers have at least basic education related to health care issues. However, in media, negative phenomena in the health care system are very often discussed, which disturbs the relations between patients and health care workers. Internet expansion gave people a possibility to get information; however, not all the information is relevant. Very active are pharmaceutical companies that offer their products. A common person is not in the position to judge their actual benefit. One of the most serious consequences of these phenomena is the decrease of patient’s compliance.

4. Proposed measures

4. a. To create conditions to improve the domestic care for seniors

4.b. To support the development of daily care facilities for seniors

4.c. To extend the provision of specialized out-patient care by geriatrists

4.d. To provide for availability of out-patient as well as institutional geriatric services in all regions of Slovakia

4.e. To draft an act on long-term care

4.f. To use the possibilities given by Act No 448/2008 for providing social services in health-care facilities

4.g. To consistently require geriatric specialization of head-doctors of geriatric wards and clinics; departments and medical institutions for the long-term ill, and after-treatment departments.

4.h. To increase the quality and availability of physiotherapeutic services for seniors by developing speech therapeutic and ergo-therapeutic services

4.i. To improve the furnishing of geriatric wards and departments with various aids

4.j. To improve architectonic solutions of geriatric wards and departments, with special attention paid to the size of rooms, the number of beds, furniture, toilettes, bathrooms, alarm signalizations, etc..

4.k. Because of the high morbidity rate of the age group of 70+, it is proposed to amend Act No 576/2004 Coll. so that preventive examinations performed by general practitioners and paid by the public health insurance are made once a year in the age group of 70+, while preventive examinations by urologists are performed once a year in the age group of 65+.

4.l. We recommend monitoring and improving the provision of dispensary care particularly in connection with the group of patients with cardiovascular diseases.

4.m. To improve the flu vaccination rate and the polyvalent pneumococcal vaccination rate for seniors.

4.n. To support the development of good health education.