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Assessing Needs of Care in European Nations

THE SLOVAKIAN LONG-TERM CARE SYSTEM

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1. The LTC system of Slovakia

1.1. Overview of the system (summary) (including the philosophy of the system)

Long term care is provision of complex medical, nursing and custodial services for a long term period, in some cases as a permanent care. Slovak legislation does not define term “long term care” as a combination of social and health services provided on a regular and long term base. Also in public perception these two systems of care are strictly divided. Health care is legally and also formally provided by the state and social care including care of elderly, disabled or chronically ill people is partly provided by state, regions, charity and private institutions.

Integration of the social care and medical care in the Slovak Republic is not systematically regulated by the national legislation. Besides it, the approach to the Long Term Care (LTC) system as a long-term social and medical care in Slovakia has gone through several major changes during last 15 years. In 2005 a proposition of an *act on the long term care and integration of persons with disabilities* was presented by the Ministry of Health with a conception of integrated LTC system. This act was not approved and conception was changed back to providing separate social and medical services.

Nowadays single parts of the LTC system are included in several regulations and acts. The LTC is interpreted in two ways of needs – social care and medical care. This includes the LTC from the point of view of disabled persons and problems of their needs and their social inclusion. The second part is related to a care for older and elderly people with chronic diseases. Main principles are continuously incorporated in several national health-care and social strategies. More transparently, parts of the Slovak LTC system are presented in Chart 1.

Chart 1 – Development of long-term social and healthcare facilities

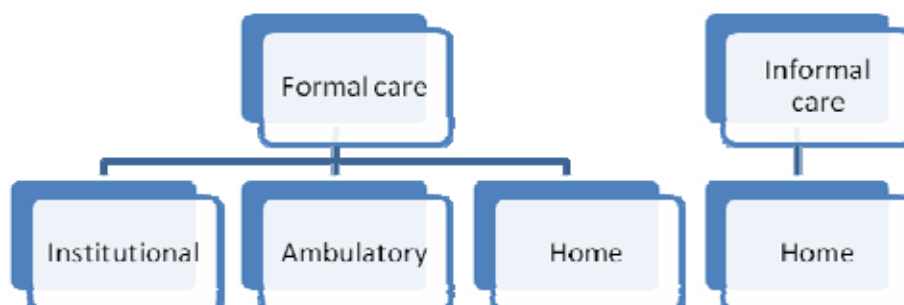
Current system is vertically divided into three types of facilities and has lack of home care services		
Facilities of social services	Facilities with mixed social and nursing services	Hospitals providing social services (currently transforming to nursing facilities)
It is suggested to create a network of integrated facilities, providing horizontal services at home in every facility providing long-term services. Level of care is set by independent expert review team for long-term care. (There are separate review teams for elderly, psychiatric clients, etc.)		
Social services with basic nursing care		
Social services with medium nursing care		
Social services with widened nursing care		

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

Main acts and regulations covering current LTC principles are:

- Regulation No. 910/2000 on **State health policy** in the Slovak Republic, which provides basic guidelines to LTC legislation
- Act No. 576/2004 on **health care and services related to providing the healthcare**
- Act No. 578/2004 on **providers of healthcare, medical workers and medical professional associations**
- Government ordinance No. 640/2008 on **minimal public network of healthcare providers**
- Regulation No. 770/2004 of Ministry of Health, which determines **characteristic sign of class of the individual medical facilities**
- Regulation No. 364/2005 of Ministry of Health, which determines **scale of nursing practice provided by nurse independently and with cooperation with physician and extent of birth assistance practice provided by birth assistant independently and in cooperation with physician**
- Act No. 447/2008 on **financial allowances to compensation of several disabilities** and about changes and addition of some regulations, which determines given financial support to persons in needs.
- Major principles on availability of social care, social nursing care and social palliative care are described in Act No. 448/2008 about **social services**. This act also describes providers of long-term social care. It replaced several previous acts about social services and brings a possibility of providing integrated services to the system. Social related facilities can provide medical services in limited way (have to obtain licence from Ministry of Health and have medical personnel).
- Care for disadvantaged persons and social inclusion is part of Programme declaration of Slovak Government in 2006.

Chart 2 – Overview of LTC system in Slovakia



Both social and medical LTC services in Slovakia can be divided between formal and informal care – see Chart 2. A formal care is provided via public network of social and healthcare facilities or private medical facilities. An institutional care is provided on an institutional basis (longer than 1 day) and also via ambulatory care and home/nursing care. The ambulatory care can be provided on daily base and is usually medically related. A formal home care is divided according to the type of services.

Medical related services as home nursing care are covered from health insurance. Social related services are provided via social system; expenditures are covered by lower level administration (municipalities and regions) via taxation and co-payments of care receiver. Informal home care is provided usually via family member or a close person. Family member or close person providing intensive informal care can be supported by benefits in cash or similar (social contribution can be paid to care giver). Other types of informal care are not covered with any legal agreement and are not paid, in usual.

The ambulatory care is provided as primary care (by a general practitioner) and in a form of specialized medical care.

An institutional geriatric medical care is provided at urgent beds in geriatric department of hospitals, at urgent beds in gerontopsychiatric departments of hospitals and chronic beds in sanatoria for patients with long-term diseases. The institutional geriatric care is provided also within a palliative care and hospices. Types of the Slovak institutional care will be described in detail in the next chapter.

One of the basic principles of the health system is a free opportunity to choose the provider. Considering LTC system, it is applied also to the social services, but there are some funding limitations. Social services are provided by a local administration. If the patient selects a service in another region, this will be provided only for a full price without any right to get a contribution.

In 2006 the share of older persons at age 65+ in the population was 11,8 %, what represented approximately 640 thousands persons. The share of old persons over age of 60 was about 814 thousand persons, what represented the share about 15 % of the population. According to the Ministry of Health 38 % of the population of pensioners is relatively healthy and 32 % of them having some kind of chronic disease with a provided healthcare. Remaining 21 % are endangered with organ decompensation and 9 % have serious illness or is reliant on long-term care and help of others.

1.2. Assessment of needs

Formal LTC services in Slovakia are provided in wide types of facilities. Services are provided according to the level of person disability (ADL). Entitlement to receive services is general, conditioned by the disability level. There is an assessment to determinate the kind and amount of provided benefits. The assessment is being carried out by an advisory committee comprised of physicians and social workers by the necessity. Each patient is assessed individually according to a set of strict guidelines, which are given by a special legislation. Results of this assessment will be used for selection of the most suitable type of the LTC provided. The expenditures on social services are usually covered by local or regional administration with co-payment of reliant person.

The level of reliance of a patient is being considered according to the 6 grade scale. The Act No. 448/2008 on social care defines 12 criteria (e.g. eating, drinking, sitting, walking, hygiene, washing, orientation, ...) where the individual score of a particular personal activity is assessed by points 0-10. Total sum gives the degree of reliance according to the table 1:

Table 1 – Degrees of reliance of a patient on care of other person

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

The advisory committee is established by the municipality or region in a form of a contract with an assessment physician and social worker. The assessment physician scores the health status of the patient according to the above mentioned table. When the degree is II. – VI., the patient is assessed as reliant to assistance.

Social and family situation of the patient is afterwards being assessed by the social worker according to the 4 criteria (e.g. self service, household activities, basic social activities, supervision) and result is a written statement. Based on the medical assessment and social statement, an expert report is issued, which states a proposal of a most suitable social service for the patient.

1.3. Available LTC services

Institutional LTC is provided in following facilities (medical related):

- Medical facilities, which include:
 - 1. Facilities of institutional medical care,
- Facilities of ambulatory medical care, which includes
 - 2. Stationary (facility designated to short-term care with medical care),
 - 3. Agency of home nursing care,
 - 4. Movable hospice (home palliative care).
- Facilities of institutional medical care (licences are approved by self-governing region):
 - 5. hospital:
 - general,
 - specialized – licences approved by the Slovak Ministry of Health
 - 6. Sanatorium,
 - 7. Hospice (palliative care),
 - 8. Nursing care house,

1. **Facility of institutional medical care** is designated to provide medical care to persons whose state of health requires continuously medical care with anticipated staying in bed in medical facility longer than 24 hours.

2. **Stationary** is designated to give ambulatory medical care to persons whose state of health requires repetitively day ambulatory medical care always link-up with institutional or ambulatory medical care.
3. **Agency of home nursing care** provides complex home nursing care and assistance to persons by whom it is anticipated that their state of health will not require continuous medical care in any institutional healthcare facility, or to persons which refused given institutional medical care facility
4. **Mobile hospice** is home based palliative care provided by a professional employee of the hospice.
5. **Hospital** continuously provides a requisite medical care and specialized medical care with a link-up with ambulatory care and pharmaceutical care in hospital pharmacy.
 - a. At a **general hospital** an institutional medical care is given in different specialized departments
 - b. At a **specialized hospital** an institutional medical care is given mostly in one specialized medical field, possibly also in departments linked-up with main specialized medical field
6. At a **sanatorium** a specialized medical care is given, with orientation mainly on health disorders of chronic character with prolonged progress of treatment.
7. At a **hospice** a medical care is given to patients with incurable and also advanced and active progressive disease, which usually leads to death (palliative care). Aim of medical care given in hospice is to improve quality of life, reduction of suffering ill persons and stabilization of their health status. Part of hospice also might be used as a facility for providing ambulatory medical care including home based medical care in the residence of ill person.
8. At a **nursing care house** a continuous nursing care and rehabilitation is provided to persons, which health status does not require continuous medical care provided by the physician. This includes providing necessary linked-up ambulatory medical care with orientation to providing nursing care. Part of this facility can be used as nursing stationary.

Ambulatory care is provided as a **primary care** and a specialized medical care. Primary medical care is given to geriatric patients via the network of practical medicine doctors for adults, who cooperate with specialists in relevant medical areas. Necessary part of primary medical care are **agencies providing home nursing care**, which provide complex medical care mainly to group of geriatrics patients, which is usually provided in cooperation with nursing care provided by organs of state social care.

A specialized ambulatory care is provided to geriatric patients on request of a practical doctor for adults by specialist in area of geriatric care and specialists in other areas. A specialized ambulatory geriatric care includes preventive and dispensary care provided under current legal regulations. Geriatric ambulatory care also provided care for patients with dementia. Ambulatory care for gerontopsychiatric patients is provided via the net of gerontopsychiatric departments and daily stationeries that are being established (as nowadays there is rather a lack of them).

Facilities and services of a long-term social care (according to the act 448/2008 on the Social services) providing social services related to LTC are described in part five of the Act on the Social services. This part is about services provided to solve a poor social situation arisen due to a heavy

disability and worsen health due to reaching the retirement age. Slovakia has very elaborate and wide system of social care facilities. In future, it is planned to simplify this system and also integrate them with medical facilities of the LTC.

Institutions of social care provide general social consulting and social rehabilitation and also accommodation in facilities with long term care. Other provided services in social care facilities are (besides daily stationary and facility of supported housing) laundering, cleaning and cooking. Specific services are listed below, together with the description of particular facilities. Facilities for persons reliant on help from other person and for retired are:

- **Facility of supported living**, where a social service is provided to person reliant on another person's help or reliant on supervision, under which they can lead independent life. At the facility is mainly supervising provided, social care, accommodation and conditions for cooking.
- **Facility for seniors** provides a social service to pensioner or to person, which reach retirement age and is reliant on other person's help and who needs help in this kind of facility from other serious reason. At facility for seniors, there are, besides basic social services, nursing care and spare-time and cultural activities provided.
- **Facility of nursing care** provides a social service to adult person for shorter period, reliant on help of other person and it is not possible to provide another service. At the facility of nursing care a physical help from other person, nursing care and basic social services are provided.
- **Rehabilitation centre** provides a social service to person reliant on help of other person, who is sightless, deaf or which is strong hearing-impaired. In the rehabilitation centre also physical help from other person is provided. If only ambulatory care is provided in a rehabilitation centre, there is no need to provide cooking, accommodation, ironing and laundering in this type of facility. If an accommodation is provided, this can be done only for selected period. In rehabilitation centre it is given also social consulting to family or person who secures help to person reliant on help in home environment, from purpose to help in rehabilitation.
- **House of social services** provides a social service to person reliant on help of other person and level of their reliance is at least V (from six-grade scale), or person, which is blind or practically blind and level of their reliance is at least III. At the house of social services there is a provided physical help from other person, nursing care, personal equipment, allowances given by ordinance. In this type of facilities also children can be treated (with education and other necessary services).
- **Specialized facilities** provide a social service to person reliant on help of other person and level of their reliance is at least V and also has medical disease, usually Parkinson disease, Alzheimer disease, pervasive development disorder, sclerosis multiplex, schizophrenia, dementia, blind-deafness and AIDS. In the specialized facility it is provided besides basic social care a help from other person, nursing care, personal equipment, allowances given by ordinance. In this type of facilities also children can be treated (with education and other necessary services).
- **Daily stationary** provides a social care to person reliant on help of other person, but their need of reliance is only for a part of a day. In the daily stationary it is provided a help of other person, cooking, work and social therapy, leisure activities. In this facility it is also given social

consulting or help to family or person, which secures help to person reliant on help in home environment, for a purpose to help in rehabilitation.

Other complementary and home social services

- **Nursing care** is a social service provided to persons reliant on help of other person and level of their reliance is at least II and is reliant on daily activities about self-care, activities of treating household and basic social activities. Range of activities is provided on the base of decision of the social advisory committee and it is set by the municipality in hours. Minimal range of social nursing care cannot be less than the set level of reliance.
- **Transport care** is a social service provided to person with heavy disability, reliant on individual transport with motor vehicle or person with disability and limited movement or orientation.
- **Guide care** is a social service provided to person who is practically blind or blind and person with a mental disability. Reading can be also provided to blind persons.
- **Interpreting** is a social care provided to deaf people in gesture language, sign or tactile language.
- **Other social complementary services** like procurement of personal assistance, interpreting and help on administration etc. Important secondary type of help is lending of aid tools.

Informal home care is provided usually via family member or close person and is not covered with any legal agreement and the family member gets social contribution for home care according to the Act. No. 447/2008 on financial allowances.

Quality assurance of services is mandatory for all facilities providing the long-term care; there is also formal home care is included.

Who is eligible?

The legitimacy to use selected type of social and medical help is determined by type of a care receiver. The legislation distinguishes between receiving the LTC independently from social and medical care and by the type of provided care.

On basis of the current legislation, LTC services are assigned by the individual needs of patient health status. Health status is considered by the medicine doctor – specialist. Every citizen has a right to receive individual plan and its periodic medical examination. Expenditures are covered by the obligatory health insurance with possible excess of receiver.

Persons with heavy disability has right to receive financial support to selected services (transport, modification of housing etc.) according to the act No. 447/2008.

The assessment of needs is provided under the act No. 448/2008 to persons, which are in unfavourable social or health situation, or as prevention of social exclusion. Examination of person with a serious disability or in an unfavourable health status to get the social care (also linked with the LTC) is performed by a medical examiner, who will determine also the level of disability (ADL). The individual needs, family background and living conditions are assessed by the social worker. Based on the medical expertise and social expertise a common expertise on social reliance is elaborated, which will define the level of reliance to assistance, the level of disability and proposal of the needed social services.

Which services?

In previous parts we have described types of provided medical and social care. Overview of the usual types and length of provided services in selected facilities are presented in **Error! Reference source not found.**

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

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

1.4. Management and organisation (role of the particular participants)

Persons of every age with a long-term dependence on help of third persons need the LTC. Without this help they cannot perform common daily activities (like eating, dressing, personal hygiene, communication with social environment etc.). This concerns persons with chronic somatic or psychiatric diseases, with health, sense, mental or psychiatric disabilities.

Key part in the LTC is family and closeness to the patient / client, which provides long-term care and which are back influenced with provided care. The LTC consist of different shares of medical (nursing) care and social (nursing, housekeeping, social contacts etc.) care.

The LTC is provided at home (as informal care of family, relatives and close to patient or formal – professional nursing care or personal assistance). It can be also provided in community facilities (daily stationeries, rehab centres, care – management provided by municipalities). Another part is long-term institutional care at facilities providing long term care. Several facilities providing long-term care facilities of integrated social and medical care will be created. Also new integrated facilities will be built-up.

Besides providing services the key part of the LTC is also the financial aid and contributions (at children contribution to their parents) to caring, personal assistance and compensation of social consequences of clients' disability.

Objective of the LTC for individuals reliant on help of other person is to secure the best possible quality of life with as much independency as possible and social and work integration, satisfaction and human dignity. General legislation on LTC is created at all levels of state administration. Main providers are the *Ministry of Health* and *Ministry of Labour, Social Affairs and Family*.

Only local and regional administration can effectively take responsibility to provide LTC to abandoned persons without ability to apply for care. From this reason, social services are managed at several levels. The exact division of tasks between various level of administration is mentioned in the Act No. 448/2008 on Social services.

The Ministry of Labour, social affairs and family is eligible to determine national priorities and keep supervision on providers of social services.

Municipalities (local administration) develop and approve community plans of social services in their own territory and they are governing institutions in proceedings about reliance to social services in facilities for seniors, facilities of nursing care, daily stationeries and reliance on nursing care and transport services. They are also responsible for funding of these services in the own region. Municipalities also sign contracts about providing social care and contributions.

Self-governing regions (regional administration) manages and approves conception of social services development in their territory and is a governing institution in proceedings about reliance to social services in a facility of supported housing, a rehabilitation facility, in a house of social services and in a specialized facility. They are also responsible for funding of these services in the own region. Regional administration also signs contract about providing financial contribution to help of other person (if this person is reliant on this kind of help) and financial support to non-public organization providing social services to such person. Main responsibility of local and regional administration is the capacity planning of the social facilities.

Main governmental institution covering medical services is the **Ministry of Health**. Ministry of Health provides supervising on medical facilities and medical services provided in the Slovak Republic. The ministry also determines national priorities and strategies in medical field. Some duties are transferred to regional administration with responsibility and financial subsidies from central government.

Supervision and inspection of the social services providers is a responsibility of the Ministry of Labour and social affairs. The ministry is also eligible for awarding fines for violations. Control of level of provided social services and financial management is controlled by the local or regional administration.

1.5.Integration of LTC

Main problem in Slovak LTC system is that social and health services are not really integrated nowadays. Integration of medical and social part of LTC system will be the next objective. Despite this, since January 2009, integrated care providers can be established, if they fulfil requirements for providing both types of services.

2. Funding

Financing system of the Slovak LTC is mixed. Long term care is funded from two sources; differed by type of provided LTC. Health related services are fully funded from the health insurance. In health related services there are no co-payments from the side of receiver. Social related care is funded by the regional and local administration (taxation). It covers about 2/3 of expenses of social related care. About 1/3 comprises co-payments of patients. This includes both institutional and home care. The home nursing care also does not require any co-payments.

Health and social insurances are mandatory. The contributions payments are shared by the employee and the employer. The state pays these contributions for children until finishing school, parent taking care of a child under age 6, pensioners, disabled pensioners, persons providing informal home care for patient reliant to this care.

The institution providing the social care (public or private) gets a contribution for each cared patient according to his degree of reliance (see chapter 1.2). The private provider is eligible for this contribution only if he has a contract with the local and/or regional administration. The height of the contribution is stated in the Act. No. 448/2008 about Social services:

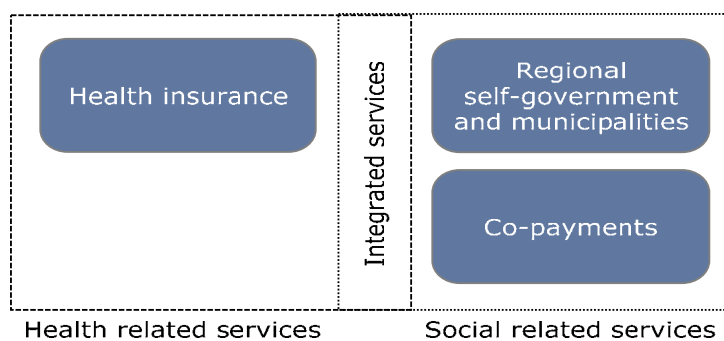
Table 3 – Height of contribution for care of patients on reliance

Degree of reliance	Height of contribution for ambulatory social care per month	Height of contribution for home social care per month
II.	62, 21 EUR	89, 82 EUR
III.	124, 41 EUR	179, 68 EUR
IV.	177, 65 EUR	269, 47 EUR
V.	248, 82 EUR	359, 29 EUR
VI.	310, 99 EUR	449, 18 EUR

This cost sharing is income related, i. e. – each receiver has to pay for the services. The amount of payment must allow him/her to save 1,3 multiple of the subsistence (living wage).

Total costs concerning the LTC in Slovakia are around 130 mil. Euro, what represents around 0,2 % of GDP. There are lacks of more detailed financial statistics about LTC system in Slovakia.

Chart 3 – Funding scheme of Slovak LTC system



3. Demand and supply of LTC

3.1. The need for LTC (including demographic characteristics)

Slovak legislation secures a universal access to the LTC services for every person in need. Slovakia like most countries has problems with increasing share of older people in population – ageing.

The best illustration of future age groups development is in table 5. Till 2015 the preproductive age group (0-15) will decrease and will reach its minimum at around 15 % of total population. In this time the productive age group will be slightly increased from 56% in 2015 to nearly 62 % in 2025. Nearly critical situation will arise in age group 65+, where share of this group will rise from 50% in 2005 to 62% in next 20 years. Share of very old persons in this period will be doubled.

According approximation of the Slovak Ministry of Labour, Social Affairs and Family, there is about 183 thousand people in need of LTC and nearly half of them are older than 65. More than 38 thousand receive formal institutional care, more than 70 thousand receive some kind of a formal home based care and around 60 thousand people receive some kind of informal care. By the rough estimation about 20 % persons in need do not receive any kind of LTC.

According to the EC Ageing Report in 2009 the estimation of persons in need is even higher (around 230 thousand people, of which more than 31 thousand receive formal institutional care). This amount will be more than doubled in next 25 years.

Table 4 – Demographic forecast for selected age groups

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

Source: Slovak Demographic Research Centre, 2008

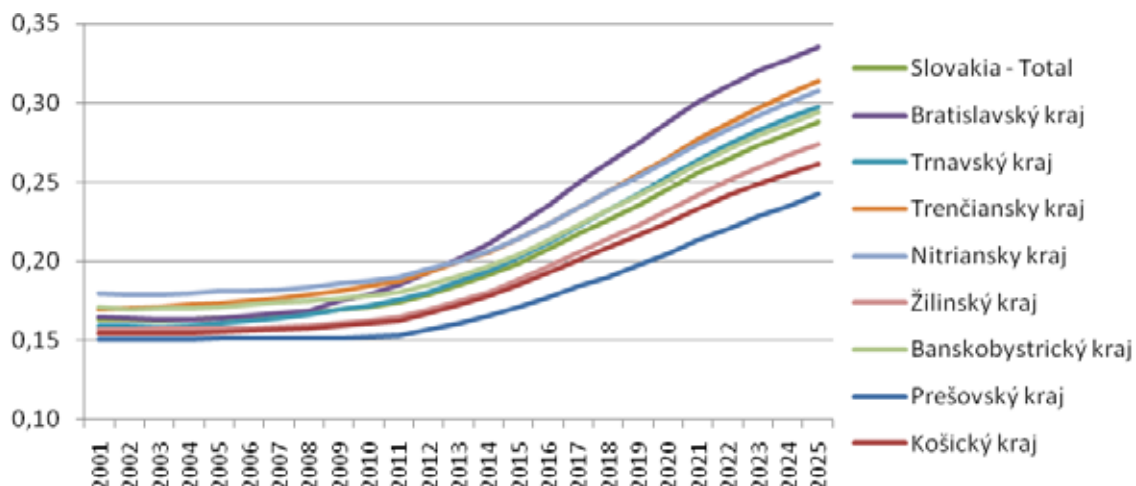
Table 5 – Demographic forecast for selected age groups, shares on total population

	2000	2005	2010	2015	2020	2025
Preproductive age (0-14)	22,4 %	19,6 %	16,7 %	15,0 %	15,0 %	15,5 %
Productive age (15-64)	47,8 %	49,8 %	52,8 %	56,2 %	59,3 %	61,7 %
Poproductive age (65+)	11,4 %	11,7 %	12,5 %	14,2 %	16,7 %	19,0 %
Very old persons (80+)	1,9 %	2,4 %	2,8 %	3,1 %	3,2 %	3,7 %

Source: Slovak Demographic Research Centre, 2008

Old dependency ratio characterizes demographic development of population older than 64 to population in productive age (15-64). Until 2008 this indicator has risen very slowly. Since 2008 elder persons born in post World war baby boom, which had very strong cohorts, became retired. Old dependency will rapidly rise in near future and will be more than doubled in next 15 years. Highest old dependency ratio will be in economically stronger western part of Slovakia (Graph 1).

Graph 1 – Old dependency ratio, Slovak NUTS 3 regions



Source: Slovak Demographic Research Centre, own calculations

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

In Slovakia, several kinds of benefits are provided in connection with both social and health care. Everybody is entitled to receive benefits in the system of Slovak LTC, but an assessment of the income of the beneficiary is needed. There are binding guidelines for assessment process. Institutional based care provides only in-kind benefits and the other kinds (home care and nursing care) are the benefits in-kind and also benefits in cash.

During several past years a wider discussion was started about support of the informal care. The role of informal care in LTC is inevitable and is usually covered by family. Slovak Ministry of labour, family and social affairs does not legally cover this kind of a social care.

Since January 2009 the paid informal services can be provided also by a family member, or close person (until this date only professionals could receive remuneration for this service). This kind of personal assistance can be done by a family member in maximum of 4 hours. The amount of personal assistance contribution is set to 1,39 % of subsistence level per hour of care. In 2009 this contribution is represented by amount of 2,58 Eur. Other kind of contribution care allowance is 206,16 EUR per month, which is fixed on condition that informal care must be provided by a family member or a close person at least for 8 hours per day (level 5 on scale of disability – ADL). Average month contribution concerning the social care is approximately 150 Eur.

3.3.Demand and supply of informal care

Informal care is most used help in LTC system. Almost every person reliable on help receive some kind of informal care. According to different sources, there is about 200 thousand persons needed LTC in Slovakia, which represents about 3,6 % of total population. An intensive informal care is provided approximately to 57 thousands of people.

3.4.Demand and supply of formal care

There are no exact data about number of people demanding the LTC. Estimation based on number of persons requiring any kind of LTC assistance, is about 183 thousands of people. By a continuous ageing of population we expect a significant increase of demand for the LTC. In following 10 years the increase of demand for LTC caused by ageing of the population could represent 50 %.

Estimated number of employees in Slovak LTC system is around 32 thousand. Around 22 thousand works in institutional care and more than 10 thousand are care givers or nurses in home based care.

Table 6 – Number and places in selected social facilities

	2001	2002	2003	2004	2005	2006	2007	2008
Number of facilities - total	670	590	680	730	775	797	824	873
No. of places in seniors homes	13374	12922	12666	13214	13277	13258	13758	13922
No. of places in social service homes for handicapped adults	6569	8330	9627	9902	10839	12444	12833	13249
No. of places in social service homes for handicapped children	3668	3749	3636	3659	2961	2345	2088	2371

Source: Slovak Statistical Office

Institutional care

Institutional care in Slovakia is composed of several types of facilities. Together there is more than 38 000 of beds in the whole LTC system. This number is not sufficient mainly in the long term care facilities for elderly people. In some facilities the waiting periods last even several years. More than 2/3 of all beds are placed in state facilities and the remaining are private. Majority of private facilities are established for social care.

Home care

Home care is a priority for people with secured social background and is least stressful. The most important part of the home care is an informal care from family, close persons, which is provided to all persons requiring a certain level of LTC. Informal care is mainly provided by the family or close persons. By certain conditions this type of care can be financed by state contributions as an income supplement. Second type is a formal home care and formal home nursing care. In 2007 around 70 thousands of people received some kind of this formal home care. From this number more than 40 thousand are persons older than 65years.

Semi-institutional care

Minor part of the LTC system are the institutional facilities providing mostly temporal care based on daily basis as daily stationary, mobile hospice and ambulatory care.

4. LTC policy

4.1. Policy goals

The strategy of the state policy of health determines basic objectives as followed: Basic strategy of health development in sense of defined objectives is to support and strengthen the health of healthy persons, protection of health of persons threatened by biological, chemical or physiological factors of environment and return health to persons with a weakened or damaged health. There are several goals which are related to the LTC. These main goals are healthy ageing (such as goals of National programme of protection of elderly people), development of the palliative care and medical ethics, improvement of mental health and others.

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

- Dominance of the home care over the community and institutional care
- Development of the ambulatory health and social facilities with weekly residence
- Dominance of the community care over the institutional care
- Dominance of direct private financing of long-term care over indirect financing from public sources. Minimal public finance redistribution.
- Responsibility of clients themselves and their families for the long-term care giving. Public sector has to take responsibility only if person or his/her family cannot take care of themselves
- Mutual independence between permissions, controlling, financing and executive part of LTC system
- Increasing quality and humanization of provided services
- Education of employees in the area of social and medical care

Main problem of the current Slovak LTC system is that **social and medical services are not integrated** (neither organizationally nor financially). Previous analysis¹ shows several problems in the Slovak LTC system, which resulted to key requirements:

- For target group of children with physical disabilities and with chronic diseases - it is needed to do a revision of the system in order to satisfy their medical, educational and social needs, together with parents and experts in this field.
- For target group of citizens with physical, sense and mental disabilities - it is necessary to connect long-term care with the integration to life, with policies supporting motivation to work, be self-sufficient and fully participate in the life of society for the large possible clients.
- For target group of citizens with mental disabilities and behaviour failures - in cooperation with psychiatrists, the Reform of psychiatric care in SR should be added into the regional

¹ Conception of social and long-term care in the Slovak republic

plans of an integrated care with the aim of integration into the society including the labour market for the largest possible number of clients.

- For the target group of elderly people - informal care at home should be supported to enlarge community forms of integrated health and social care.

The *Conception of social and long-term care* and *Conception of Health Care for Geriatric patients and long-term disabled* in the Slovak republic also showed **further needs** in three groups:

- Preventive care
- Ambulatory care
- Institutional geriatric health care

Preventive care is focused mainly on national preventive programs (national cardiovascular program, oncologic program, diabetologic...), free vaccination for older people and prevention. In preventive care future needs can be concluded, as:

- To continue in preventive programs based on actualized needs, widen the knowledge bases of primary preventive care and focus especially on preventive care of infectious diseases. The main future need in preventive care is to secure a free preventive care from obligatory health insurance.

Ambulatory care is provided as primary care and specialized medical care. The needs in ambulatory care are following:

- Practitioners should improve care for patients with chronic diseases mainly in better cooperation with agency of home nursing care – ADOS, with link-up to social care.
- In specialized ambulatory care, to secure accessibility to healthcare by geriatric specialists in every 79 counties of Slovakia, reconsider network of geriatric ambulances and adjust education system in the field of geriatrics.
- Following the increasing number of geriatric patients, the number of facilities providing services of daily care, which cannot be provided at home and do not require hospitalization, increases. In one-day-care facility mostly diagnostic, therapeutic and rehabilitation services can be provided.
- Following the presence and increasing number of mental illnesses by geriatric patients it is necessary to enlarge the network of gerontopsychiatric medical offices and daily psychiatric stationaries.
- Ministry of Health of the SR will secure in scope of new categorization of medicinal drugs an adjustment of prescription regulations for geriatrists, with regard to often polymorbidity and immobility of geriatrics patients.

Institutional geriatric medical care is provided at urgent beds in geriatric department of hospitals, urgent beds in gerontopsychiatric departments of hospitals and chronic beds in sanatoria for patients with long-term diseases. Institutional geriatric care is provided also within palliative care and hospices. In this field following needs are defined:

- Range of urgent institutional geriatric care will develop according to increasing needs of growing group of geriatric patients. The further profile of urgent beds will depend on number of specialists, because, in recent days, part of geriatric patients has been cured in intern department at hospitals.
- To enlarge the number of beds and facilities of palliative care and to support building of hospices and other institutions of palliative care.
- The Ministry of Health will recommend that at least one geriatric department in self-governed region (8 regions in Slovakia) will fulfil international criteria of EU medical specialists (UEMS) of accreditation in post-gradual rising of geriatrics specialists.
- The Ministry of Health will continue at work on conception of social medicine due to continuous unsolved problems with transfers of patients after provided institutional medical care on beds of urgent care to sanatorium for patients with long-term diseases. In cases when patients after this treatment cannot be returned to home conditions, it is needed to transfer them to facilities of social services.

These needs are described in several conceptions, which have been changed several times during last decade. Needs concerning improvement of informal care are not really included in these conceptions and are more or less covered in the act about social services.

4.2. Integration policy

Generally, we can say that high readiness of both resorts (Ministry of Health and Ministry of Family, Social Affairs and Work) to prepare and implement integrated model of social and long-term medical care does not have origin in holistic approach in Slovakia. Rather, it can be found in expectations of improvement of the situation of both resorts. The social resort needs to solve sources for widening provided services, which are still insufficient. The medical resort on the other way needs to do another necessary step to rationalisation / reduction of supply of institutional medical care. Rough comparison of supply and demand for services in both resorts show interconnection and partial substitution in both spheres. Efforts to complete the integration of LTC services were stopped in 2005. Nowadays, there is a possibility to provide LTC services in integrated facility, but under authority of both ministries. In 9 months, there still has not been any facility in Slovakia which fulfils these criteria.

4.3. Recent reforms and the current policy debate

Creation of current status of the LTC system in Slovakia has several steps in past 10 years and still is not finished. In August 2000 the Government of the Slovak Republic, in context with the International year of elderly people (1999), accepted the **National programme of protection of older people**. This programme contains complex view on needs of older people. In The state policy (also the Commission decisions No. 91/544 and 93/417), **principle of care** is defined, which determines and includes help of family and society, access to healthcare, social and law services and access to

institutional care. It also defines needs of improvement in **nursing care** as one of the most progressive and humane method of help to older people reliant on help from others.

In November 2000 the Government of the Slovak Republic accepted the **State policy of Health in the Slovak Republic**. This framework briefly describes main future strategy and principles in healthcare. The state policy defines health as key factor of society development. In this document three LTC related priorities are defined: healthy ageing, development of palliative care and medical ethics and improving of mental health. Document also includes future legislative strategy in this field.

In 2004 a legislative framework of act about the long term care and support of disabled people was prepared, but this act has never been approved. In 2005 new LTC principles and aim in this field were described in the **Strategy of health care for geriatric patients and long-term patients²** and the **Conception of social and long-term care in Slovak republic**. Both materials were approved by the Government of the SR, but legislative process about proposition of act was stopped in 2005.

In 2009 the Ministry of Labour, Social Affairs and Family was preparing the **National priorities of development of social services**, which was published in 2009.

Nowadays the situation in the long term care services is a little complicated and disorganized. The reform of the public administration in 2001 led to partial transfer of competencies to local authorities, also in funding of provided social services. The main problems arose from non-integrated social and health services. In both systems many changes occurred in past years and in some areas there are still not clear competencies. There is still no unified proposition about the LTC system in Slovakia.

The government ordinance No. 640/2008 about a **minimal public network of healthcare providers** also determines the minimal network of facilities providing medical care (also medical related LTC facilities).

4.4. Critical appraisal of the LTC system

The current situation in the LTC system in Slovakia is not very transparent. This is also main problem from the legislative point of view. Particular parts related to the medical and social care for patients with long-term needs are treated in several acts and regulations, which are not always linked and sometimes do not cover the whole related area. Several conceptions and proposals about the LTC were introduced in Slovakia in the past. Even among the medical reforms, the proposition of act about long-term services was prepared, but it was still not approved for political reasons.

Recently the problems of ageing and increased demand for the LTC services are being concerned and become a crucial problem in the society. The future final shape of the LTC system in Slovakia is still questionable. Nowadays we can say that particular parts of the LTC system in Slovakia, which is treated as framework in national strategies, has several definitions and plans, which are similar to propositions of the WHO on the LTC services. The biggest current problem from our point of view is the solution of the informal LTC services, which is not complexly treated at all by legislative.

² Documents are available at the Ministry of Health of the Slovak Republic, <http://www.health.gov.sk/>

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

Several barriers to access the LTC occurred in the Slovak LTC system. Main of them are financial barriers, geographic barriers (non-balanced distribution of providers) and organisational barriers (sometimes the waiting periods for social care of elderly people are several year). Moreover, in Slovakia there exist wide types of facilities providing LTC services. There are needs to simplify this system.

LTC services are recently situated in a transitional phase. Future needs are being defined; it will be important to specify tasks and priorities of providing the informal care. From the point of view of evaluation there are different opinions to future needs and an optimal mixture of provided LTC services between national, regional and local administration and services providers.

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ANCIEN

Assessing Needs of Care in European Nations



FP7 HEALTH-2007-3.2-2

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

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

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

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

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

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

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