ESPN Thematic Report on work-life balance measures for persons of working age with dependent relatives

Slovakia

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Summary / Highlights

The long-term care regime in Slovakia is based on three main forms: informal care at home, formal care provided at home (home care service) and formal care in the form of residential services. Responsibility for long-term care in Slovakia is formally divided between the Ministry of Labour, Social Affairs and Family and the Ministry of Health. The Ministry of Labour, Social Affairs and Family is responsible for social services (benefits in kind) and cash benefits. Social services are provided mainly by local and regional self-governments and financed from local taxes which are supplemented by clients' payments.

Only 14% of long-term care is provided on a formal basis, either institutionally or at home. Thus, informal care represents a dominant part of the long-term care sector in Slovakia. Within the informal care sector, paid long-term care represents a minority. The share of informal carers increased between 2004 and 2013 – it holds true both for informal paid carers (receiving the nursing allowance) and informal unpaid carers. Caring for relatives is a matter for women in Slovakia. According to the Labour Force Survey, in 2010 there were around 62% of women who took care of relatives aged 15 or more in need of care, compared to 37.8% of men.

Informal carers can take a leave and recover from caring duties by using so-called "respite care" service. The aim of the respite care service is to help informal carers by providing a period for recovering and maintaining their mental and physical health. It is provided for 30 days per year and is organised by municipalities. During that period municipalities have to provide substitute social services for disabled persons.

Persons who work are entitled to leave to for care for a sick family member. The leave is provided if a relative is sick and requires care, including sick children, husband/wives, parents or spouse's parents. The leave is provided also to parents who care for a child under the age of 10 because s/he was sent to quarantine or because a school or school facility was closed due to quarantine. During the leave a benefit for care for sick family member is paid at the level of 55% of the assessment base.

Informal carers can claim nursing allowance (care allowance). The condition is that they care for a disabled person aged 6 years and over. The nursing allowance is paid directly to the carer. This does not mean that the informal carer becomes a formally employed carer because the allowance is a (low) social transfer (without obligation to pay taxes and contributions) and not a wage. Its level depends on several factors (for example, on the income of the care recipient). Recipients of the allowance can combine long-term care with work under the condition that earnings from their job must not exceed two times the subsistence minimum for an adult person. An allowance is also paid to carers who increase their qualifications (for example through distance learning at universities or attending courses) if they make sure the dependant is cared for while they participate in the education process.

The amounts of the nursing allowance are quite low, exposing carers to vulnerable living conditions. The amount of the nursing allowance is determined in relation to the subsistence minimum which is not regularly adjusted. Informal carers can use several in-kind benefits: informal education and counselling, respite care service, contributions to old-age and invalidity insurance paid by the state.

The main recommendation relates to the data sources because valid and detailed data are missing. There is a need to define clear expectations for the role of informal carers, their duties and rights. It seems important to define the “work identity” of carers. Support to informal carers should not focus either on income support or on the carer’s labour market attachment should be avoided. Interventions in both areas are needed. More efforts to raise awareness are necessary to tackle information gaps among carers and care recipients. Several commitments mentioned in the “National Programme for Development of Living Conditions of Persons with Disabilities 2014 - 2020” relate to the recommendations in this report.

1 Description of main features of Work-Life Balance measures for working-age people with dependent relatives

1.1 Overall description of long-term care regime

The long-term care regime in Slovakia is based on three main forms: informal care at home, formal care provided at home (home care service) and formal care in the form of residential services. Informal care is provided by family members who can claim a nursing allowance. Home-care services are provided by professional workers who work for public or private providers. Lastly, long-term care can take the form of residential services where long-term care services are combined with temporary or permanent housing. Residential services are offered by various facilities (for example homes for seniors, social services homes, day care centres, nursing care service facilities) which target various groups.

Responsibility for long-term care in Slovakia is formally divided between the Ministry of Labour, Social Affairs and Family (MOLSAF) and the Ministry of Health. Under the auspices of the Ministry of Health, based on public health insurance, various interventions are provided including the use of geriatric clinics, medical and nursing facilities for the long-term ill, nursing care homes, or nursing care agencies. The Ministry of Labour, Social Affairs and Family is responsible for social services (benefits in kind) and cash benefits. Social services are provided mainly by local and regional governments and financed from local taxes which are supplemented by clients' payments.[1]

The provision and extent of long-term care for disabled persons and persons with unfavourable health status is based on an eligibility assessment determining the degree of dependence on assistance by other persons. There are two types of assessment defined by the Act on Social Services: social and health assessment. The **health assessment**, carried out by a health worker who has a contract with the municipality or self-governed region[2], focuses on the health status of the client and its changes. The degree of dependence on assistance is identified according to the list of daily activities that require the help of other persons. The **social assessment**, carried out by a social worker with a contract with the municipality or self-governed region, focuses on evaluation of individual predispositions (ability and willingness to solve the unfavourable situation), family background (ability to help the dependent person and the extent of this help), and the context, which is important for social inclusion (for example, housing conditions or access to public services). The health and social assessment results in a final document on a person's dependence on social services which contains information on the degree of dependence, the list of daily activities requiring assistance and the number of required hours, recommended type of social service, and timing of the next health and social re-assessment.

In 2014, 4,935 workers paid by municipalities provided home care services to 12,152 persons.[3] 4,074 persons received home care services carried out by 111 private providers. Expenditure on home-care provided by municipalities was EUR 28,184,927 in 2014. The amount of income from payments for home care services was EUR 5,105,442. Thus, the difference between expenditure on home-care services and income from payments was more than EUR 23 million. This amount had to be paid by municipalities from their budgets. The income of non-public providers was EUR 8.87 million, while their expenditure reached EUR 7.61 million.

[1] Provision of social services is sometimes also supported by government subsidies.

[2] When assessing health status and its changes, the health worker is supposed to cooperate with a social worker employed by the municipality or self-governed region.

[3] All data in this section come from the Report on the social situation of population in 2014 (MOLSAF, 2015).

36,441 people received long-term care in the form of residential social services in 995 facilities in 2013.[4] It represented approximately 83% of all clients in social services facilities. The total number of places in all social services facilities amounted to 42,794 in 2013, places related to long-term care social services represented 91% of them.

According to Radvanský and Lichner (2013: 5), only 14% of long-term care is provided on a formal basis, either institutionally or at home. Thus, informal care represents a dominant part of the long-term care sector in Slovakia. Within the informal care sector, paid long-term care represents a minority. It also means that a greater part of long-term care is provided at home. Provision of paid informal care will be discussed in section

1.2 Description of carers' leaves

In order to take leave informal carers can use so-called respite care services (see section 1.4). There is no other special leave for persons caring for disabled children/adults or for the elderly.

Persons who work are entitled to leave to care for sick family member (for a maximum of 10 calendar days per year). The leave is provided if a relative is sick and requires acute care, including sick children, husband/wives, parents or spouse's parents. The leave is also provided to parents who care for a child under the age of 10 because s/he was sent to quarantine or because a school or school facility was closed due to quarantine. During the leave a benefit is paid at the level of 55 % of the assessment base.[5] The benefit is not granted to persons who receive:

- income replacement during temporary work incapacity ,
- sickness benefit,
- maternity benefit or
- parental allowance.

A need for long-term care is partially taken into account in the parental leave scheme. In general, parental leave allowance is provided up to the child's age of 3, but can be extended to up the age of 6 if the child has a long-term negative health status.

1.3 Description of carers' cash benefits

Two allowances are discussed in this section: the nursing allowance and the personal assistance allowance. The first one is paid directly to informal carers who care for dependent relatives, and the second one is paid to dependent persons in order to support their independence from their relatives and autonomy. Personal assistance is provided mainly by personal assistants who are not relatives.

Provision of the benefits does not vary with the age of the dependent person. Thus, conditions of persons caring for disabled children (aged 6 years and over) and, for example, the elderly, are the same.

1.3.1 Nursing allowance (Care allowance)

Informal carers can claim the nursing allowance.[6] The condition is that they care (intensively) for a disabled person aged 6 years and over who - according to an official

[4] Data for 2014 and 2015 are not available.

[5] The calculation of the assessment base takes into account gross earnings in previous years, with a ceiling 1.5 times the monthly average wage.

[6] Several different labels are used for this benefit. In the MISSOC tables (http://www.missoc.org/INFORMATIONBASE/informationBase.jsp) the expression "attendance service benefit" is used. Some experts on long-term services use the term "care allowance" (Bednárik – Brichtová – Repková, 2011). The Report on the social situation of the population of the Slovak Republic prepared by the MOLSAF contains the term "allowance for nursing". Following the Report prepared by the MOLSAF we use the term "nursing allowance"

assessment - relies on nursing. Reliance on nursing is defined by the Act on Social Services. The nursing allowance is intended for the relative of dependent person. It can, however, be paid to another person if s/he lives with dependent person (i.e. they have a common address of residence).

The nursing allowance is paid directly to the carer in the form of a social transfer (paid by the offices for labour, social affairs and family).[7] Its level depends on several factors (see Table 2 in section 2.1.2). If long-term care is provided only to one person, it amounts to 111.32% of the subsistence minimum (for an adult person) per month. If two or more dependants receive informal long-term care, the nursing allowance equals 148.42% of the subsistence minimum. The allowance is increased by EUR 49.98 per month if a person cares for one or more severely disabled children. The nursing allowance can also be claimed if the dependent person uses day care services or attends a school facility. In this case, it amounts to 98.33% of the subsistence minimum (139.15% for persons caring for two or more dependants). Carers who receive old-age pensions, early pensions, or invalidity pensions, are entitled to 46.38% of the subsistence minimum (61.22% if two or more dependants are cared for).

Combining long-term care with paid work is allowed. Carers who work are entitled to the nursing allowance too. The condition is that earning from the job do not exceed two times the subsistence minimum for an adult person. An allowance is also paid to carers who increase their qualifications (for example through distance learning at universities or attending courses) if they make sure the dependant is cared for while they participate in the education process.[8]

The nursing allowance is income-tested. It depends on the income of the care recipient (severely disabled person). This income may come from the disability benefits and various financial compensations that are offered to people with severe disability. If the nursing allowance recipient cares for a severely disabled person who has an income above a certain threshold (1.4 times of the subsistence minimum for an adult person), the level of the allowance is reduced. In case of a severely disabled child the threshold is higher (three times the subsistence minimum for an adult person). Income testing is not applied to recipients receiving various types of pensions.

The nursing allowance for carers cannot be paid if the dependent person receives the personal assistance allowance.[9] Furthermore, it cannot be combined with provision of (formal) home care exceeding 8 hours per month, and with weekly or yearly residential services.

In 2014, the average monthly number of nursing allowance recipients was 58,992 persons (58,941 persons in 2013). On average, they cared for 60,697 persons monthly. The average monthly sum of the allowance was EUR 142.55 (EUR 144.46 in 2013).[10] Women represent the majority of the recipients (see Table 4).

1.3.2 Personal assistance allowance

The personal assistance allowance is granted to severely disabled persons aged between 6 and 65 years who are dependent on personal assistance. Persons older than 65 years are entitled to the allowance only if they received it before reaching the age of 65 years. Dependence on personal assistance is defined according to the list of daily activities which require the assistance of other persons.

[7] It is the only allowance related to disabled people support which is given directly to caregiver.

[8] The Act on Direct Payments for Severe Disability Compensation contains a caution, however, that the allowance is paid only for days when long-term care was provided.

[9] The personal assistance allowance is provided to a dependent person on condition that his/her relatives don't apply for the nursing allowance.

[10] Data from the MOLSAF (2015).

Unlike the nursing allowance, the personal assistance allowance is subject to taxation (taxes are paid by the personal assistant). The total amount of the allowance depends on the extent of activities provided by the assistant (and partly on income[11]). The basic hourly rate for calculation of the personal assistance allowance is 1.39% of the subsistence minimum for an adult person. In 2014, the rate for one hour was EUR 2.76. The average extent of personal assistance amounted to 140.04 hours. The average monthly number of recipients represented 8,956 persons with disability.

1.4 Description of carers' benefits in kind

Informal carers can take leave and recover from caring duties by using so-called "respite care" services. The aim of the respite care services is to help informal carers by providing a period for recovering and maintaining their mental and physical health. It is provided for a maximum of 30 days per year and is organised by municipalities. During this period municipalities have to provide substitute social services for disabled persons. During this "break" carers continue receiving the nursing allowance. The usage of respite care services is low in Slovakia (see Table 1 in section 2.1.1).

The state supports persons who care for disabled dependants and receive the nursing allowance by paying contributions to old-age and invalidity insurance schemes.

Informal education is provided through consultations with health care workers. There is the possibility to take part in the social counselling arranged by the offices of the local state administration and the regional and local governments (Bednárik – Brichtová – Repková, 2011: 15).

Informal carers can combine receiving the nursing allowance with (limited) help from the external environment. They can receive the nursing allowance and use day care services to a certain extent (the level of the allowance is reduced in this case). Furthermore, there is the possibility to combine receipt of the allowance with home care which, however, cannot exceed 8 hours per month.

[11] The amount of the allowance is reduced or denied for high-income disabled persons (with income above quadruple the subsistence minimum).

2 Analysis of the effectiveness of work-life balance measures for working-age people with dependent relatives

2.1 Assessment of individual measures

As stated above, informal long-term care plays a dominant role in the long-term care sector in Slovakia. Moreover, the share of informal carers increased between 2004 and 2013 – this holds true both for informal paid carers (receiving the nursing allowance) and informal unpaid carers (Radvanský – Lichner, 2013: 13). In this context, the possibility of combining care and work is crucial.

2.1.1 Carers' leaves

Informal carers may benefit from two measures. Respite care service has a stronger potential to contribute to the balance between caring duties and the carer's own health and well-being. It is not, however, intended as a "standard" work-life balance measure supporting informal care and paid employment. Moreover, the use of the respite care services is very limited in Slovakia. Only 114 (severely disabled) persons benefited from it in 2014 (114 persons in 2013). The respite care service was provided mainly in nursing care service facilities, day centres and through home-care services.

Table 1: Usage of respite care services in 2013 and 2014

Forms of respite care service	Number of recipients of respite service	
	2013	2014
Home-care service	33	26
Facilities for the elderly	12	16
Nursing care service facilities	33	51
Social service facilities	2	4
Day centres	34	77
TOTAL	**114**	**174**

Note: Number of recipients refers to the severely disabled persons who benefited from the respite care service (not to carers who used this period for recovering). Source: Website of the Central Office of Labour, Social Affairs and Families of the Slovak Republic

Leave to care for sick family members aims directly at reconciling work and family responsibilities. In 2014, there were 112,464 (social insurance based) payments for persons who cared for sick relatives. The average monthly amount of payment reached EUR 78. Data on non-take up of the leave are not available.

2.1.2 Carers' cash benefits

The nursing allowance represents the only benefit available for informal carers. It allows for combining care and working to a certain extent. This extent is limited by the earnings ceiling set at the level of two times the subsistence minimum for an adult person per month. Taking into account that the monthly amount of the subsistence minimum for an adult person equals EUR 198.09 (since 2013), the person receiving the nursing allowance cannot earn more than around EUR 396. It is quite close to the minimum wage which was EUR 352 in 2014 and EUR 380 in 2015. According to available estimates, only 2% of carers had paid (mainly part-time) jobs (Repkova, 2008).

Another form of limitation is represented by the fact that - according to the Act on Direct Payments for Severe Disability Compensation - the job of the nursing allowance recipient shouldn't be at odds with the aim of nursing and its extent. Discovering serious shortcomings in the quality and extent of nursing may lead to loss of entitlement.

The amounts of the nursing allowance are quite low, exposing carers to vulnerable living conditions. The fact that they are determined in relation to the subsistence minimum makes them dependent on its adjustment, which however does not occur regularly. In 2014, for example, it was not changed and thus the amounts of the nursing allowance remained the same in 2013 and 2014. Table 2 offers more details on the situation in 2014.

Table 2: Amounts of nursing allowance in 2014 (EUR)

Condition	Amount (EUR)
A. Carer does not receive any statutory pension benefit	
Care for one severely disabled person	220.52
Care for two or more severely disabled persons	294.01
Care for one severely disabled person who spends more than 20 hours per week in a social services facility	194.79
Care for two or more severely disabled persons who spend more than 20 hours per week in a social services facility	275.65
Care for one severely disabled person who spends more than 20 hours per week in a social services facility and - at the same time - care for the second severely disabled person who does not attend the facility or spends a maximum of 20 hours in the facility.	286.66
B. Carer receives some statutory pension benefit	
Care for one severely disabled person	91.88
Care for two or more severely disabled persons	121.88

Source: Ministry of Labour, Social Affairs and Family (2015: 85).

The levels of nursing allowance varied because the overall amount paid to a carer depends on several factors and the allowance is subject to means-testing of the income of the cared-for. The average level of the nursing allowance in 2014 was EUR 142.55, as Table 3 shows. The majority of nursing allowance recipients consisted of working-age persons who didn't receive any statutory pension (61%). On average, they received EUR 177.22 per month. Compared to 2013, the average amount for working-age carers decreased by EUR 3 (MOLSAF, 2015). It was the result of the indexation of the benefits received by severely disabled persons (whose income is taken into account when the level of nursing allowance is calculated) and the absence of change in the subsistence minimum amounts that we mentioned in the previous paragraph.

The average sum of the nursing allowance for working-age carers is low. It probably reflects the conviction that the carers may benefit from the financial help which is received directly by the disabled dependant. In Slovakia, disabled dependants are entitled[12] to several benefits which help them to maintain a decent living standard and social inclusion. According to estimates of the Academic Network of European Disability Experts (Grammenos, 2014), 12.2% of people with disability were at risk of poverty in 2012. The at-risk-of-poverty rate for disabled persons (11.8%) is only slightly higher than the poverty rate for people without disability (11.9 %), indicating that deterioration of their income conditions does not deviate significantly from that of majority. The

difference between people with and without disabilities in Slovakia is among the lowest in the EU.

Taking into consideration that the equivalent household income (i.e. income adjusted to the size and composition of household) is used for the identification of poverty, one may conclude that persons living in households with disabled persons don't face significantly above-average risks of poverty.

On the other hand, Slovak experts on the living conditions of people with disability (Ondrušová – Kešelová – Repková, 2016: 16-17) argue that families with disabled child/children face great risks in Slovakia because one of the parents is usually at home (not in a job) caring for the child. According to the experts, it is very difficult for one-earner households to cover all co-payments for the services related to disability. Single parent households with disabled child/children face even higher risks.

Table 3: Structure of nursing allowance provision in 2014

	Average monthly number of allowance recipients	Average monthly number of care recipients	Average monthly amounts of allowance (EUR)
Carer receives pension benefit	22,239	22,650	89.21
Carer does not receive pension benefit	35,705	36,967	177.22
Carer receives nursing allowance according to transitional conditions[13]	1,048	1,080	93.13
Total	58,992	60,697	142.55

Source: Ministry of Labour, Social Affairs and Family (2015: 90).

The majority of nursing allowance recipients are women aged 25 – 59 years. In 2015, approximaley 27,400 women in this age category received the nursing allowance, compared to approximately 6,700 men. But women aged 65 years and older are also represent a very significant proportion of informal carers. And the proportion increased between March 2015 and 2016. On the other hand, the number of young carers is low. More details on the age structure is provided in Table 4.

Table 4: Number of nursing allowance recipients by age in 2015 and 2016

	2015 (March)	2016 (March)
Men		
18-24 years	313	254
25-59 years	6,669	6,319
60-64 years	2,014	1,923
65 years and over	3,098	3,325

[13] Persons in this category still receive the allowance under the conditions defined by the (previous) Act on Social Assistance, valid until December 2008. Their number is small and continually decreasing.

Women		
18-24 years	602	517
25-59 years	27,383	25,428
60-64 years	7,273	7,042
65 years and over	10 044	10 444

Source: Data provided by the Minsitry of Labour, Social Affairs and Family

2.1.3 Carers' benefits in kind

From the work-life balance point of view, benefits in kind play a rather minor role, except for respite care which is briefly discussed in the section devoted to the leave schemes. In terms of carers' well-being, the fact that the state pays a contribution to old-age and invalidity insurance schemes may help carers in later stages of the life cycle.

2.2 Assessment of overall package of measures and interactions between measures

Primary responsibility for the support of severely disabled dependants devolves to the immediate family in Slovakia. According to the Act on Family, all family members shall help each other and, depending on their abilities and possibilities, contribute towards improving the material and cultural level of their family. Thus, the state commitments play a supplementary role, either when the family is unable to provide support or in policies for the provision of direct financial and practical support to informal family carers (Triantafillou et al, 2010).

Caring for relatives is a matter for women in Slovakia. According to the Labour Force Survey ad hoc module on reconciliation x between work and family life (see Statistical Annex in Synthesis report on Work-life balance measures for persons of working age with dependent relatives), in 2010 there were around 62% of women who took care of relatives aged 15 or more in need of care, compared to 37.8% of men. Both women and men who regularly took care of relatives were predominately aged 25 – 49 years (55.8% of women; 58.6% of men).This similarly holds true for intensive caring for dependent relatives. According to the European Quality Life Survey (EQLS) (see Statistical Annex in Synthesis report on Work-life balance measures for persons of working age with dependent relatives), 9.6% of women were involved in caring for their elderly or disabled relatives every day in 2012, compared to 2.4% of men. There is a social gradient in the involvement in intensive care. While everyday caring is provided by 8.1% of persons in the lowest income quartile and 9.6% in the second lowest level, among people in the highest quartile it is markedly less frequent (2.1 %). Weak involvement in intensive caring may result from the ability of rich households to purchase necessary care services in the market.

Disabled persons tend to live in jobless households more often than the rest of the population. In 2012, 15.6% of persons with disabilities lived in households with very low work intensity (Grammenos, 2014). This percentage was well below the value for the EU (24%). On the other hand, the percentage of persons without disabilities that lived in households with very low work intensity was significantly lower (4.9%).

The extent of supporting measures is quite limited. It includes financial benefit with the possible use of respite care services, leave for care for a sick relative, and some in-kind benefits. The work-life balance perspective is missing in the support of informal carers. Existing measures support informal care per se (with the aim of helping dependent persons), not its interconnection to the labour market. Combination of work and caring is also hindered by the fact that the part-time sector, which would offer opportunities to take part in paid employment, is underdeveloped in Slovakia. Moreover, the employment rate of women (58.6% in 2014) who represent the majority of carers is persistently lower than the employment rate of men (73.2%).

According to Radvanský and Lichner (2013: 13), the number of long-term care workers almost doubled over the last decade and a great deal of this increase can be attributed to the increasing number of persons in need of care who receive informal care. They warn that continuity of this trend will lead to distortions in the Slovak labour market. The fact that the majority of long-term care is informal and its share is increasing makes work-life balance interventions a necessary condition for future economic and employment growth.

2.3 Policy recommendations

The most urgent recommendation relates to the data sources. Although there are initial efforts to identify the extent of long-term care and related problems, valid and detailed data are missing. In addition to the data on the structure of the long-term care demand and supply and related expenditure, data on processes *within* the families would be of great importance. They would offer a valuable picture on the sharing of responsibilities, decisions, preferences, etc. They would also reveal how people perceive their own duties in relation to relatives, external help, either in the form of professional workers or residential services.

Work-life balance measures could attract more policymakers' attention if there were clear expectations about the role of informal carers, their duties and rights. It seems to be important to define the "work identity" of carers and then, according to the definition, implement relevant measures. Choices between either supporting the income of informal carers or their labour market attachment should be avoided because interventions in both areas are needed.

Previous studies have shown that actors often lack information on opportunities and limits (Bednárik – Brichtová – Repková, 2011: 26) which is related to low inter-sectoral communication (between the social and health care sectors, governmental and non-governmental sectors, state administration and self-governed sectors, public – private sectors).

The majority of these recommendations appeared in the approved National Programme for the Development of Living Conditions of Persons with Disabilities 2014-2020. The document contains commitments related to a broad range of areas, as well as the list of concrete tasks and responsible actors. It will allow for judgement of policy development in the future.

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