ESPN Thematic Report on Challenges in long-term care

Slovakia

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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Summary

Responsibility for long-term care in Slovakia is formally divided between the Ministry of Labour, Social Affairs and Family (MLSAF) (provision of social services and cash benefits) and the Ministry of Health (geriatric clinics, medical and nursing facilities for the long-term ill, nursing care homes, and nursing care agencies). Long-term care takes three forms: formal care in the form of residential services, formal care provided at home (home care services), and informal care at home.

A social and health assessment of the applicant's personal situation is the basis for any intervention in the field of long-term care. It determines their degree of dependence and thus the extent of need for assistance. Provision of financial benefits relies on assessment of their income situation.

The most frequent form of long-term care is represented by residential social services provided in an external environment (mainly elderly care). Among home care services for dependent persons, delivered by public and non-public actors, publicly run services are the most important.

Persons who care for long-term dependent relatives can claim nursing allowance (*príspevok na opatrovanie*). It is paid directly to caregivers in the form of a social transfer (paid by the offices for labour, social affairs and family). Nursing allowance is income-tested in relation to the care recipient's income. Provision of long-term care may be combined with paid work, on condition that earnings from work do not exceed twice the subsistence minimum for an adult person.

Severely disabled persons aged between 6 and 65 years who are dependent on personal assistance are entitled to personal assistance allowance (*príspevok na osobnú asistenciu*). 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 a list of daily activities which require the assistance of other persons. Unlike nursing allowance, the personal assistance allowance is subject to taxation.

One of the greatest challenges with regard to long-term care provided at home is the adequacy of income support to caregivers. It is limited from two sides: by limits imposed by reference to the care recipient's income (means-testing) and by limits imposed on the potential work earnings of the caregiver. As regards access to social services, there are some indications that there are waiting lists for long-term care in residential services. This evidence is far from complete, however. To collect such data more systematically remains a challenge both at regional and national level.

From September 2019 a system of quality assessment will be launched in the social services sector. Introduction of the system (based on legally defined standards) has been delayed due to the fact that many providers were not able to fulfil all the quality assessment criteria in the context of existing levels of financial support.

The long-term care sector in Slovakia suffers from low wages. There is quite a large category of carers (women) who work abroad, especially in Austria and Germany, in order to earn an adequate income. This problem was publicly articulated in 2017 by representatives of these workers, supported by the president.

In order to ensure financial stability, higher public subsidies are planned, based on a positive prognosis for economic development. From 2018 the state provides financial contributions to providers of social service facilities, which are intended to counter low wages in the sector. There is also an increasing interconnection between health and social long-term care, in the form of an increased use of health insurance resources (i.e. a gradual expansion in the number of diagnoses covered by health insurance to long-term care clients). Higher contributions from clients are seen as another way to improve the system's financial stability.

More effort is needed in order to improve monitoring and evaluation of long-term care interventions. We propose four indicators that can be used in the context of Slovakia.

1 Description of the main features of the country's long-term care system

Long-term care has increasingly become a focus of policy-makers in Slovakia. The need for a comprehensive, integrated approach has been recognised, which is reflected in ongoing preparation of a new legislative initiative aimed at establishing an integrated system of long-term care. As this new initiative is still only in the form of a proposal, in this section we focus on a description of the existing features of long-term care. An analysis of the new proposals will be provided in the section on future challenges.

Long-term care consists of three forms: formal care in the form of residential services; formal care provided at home (home care services); and informal care at home. Residential services are offered by various facilities (for example, homes for seniors, social services homes, and day care centres) which are aimed at various groups. Home care services are provided by professional workers who work for public or private providers. Informal care is provided by family members, who can claim the nursing allowance. Responsibility for long-term care in Slovakia is formally divided between the Ministry of Labour, Social Affairs and Family (hereinafter MLSAF) and the Ministry of Health. Under the auspices of the Ministry of Health, various interventions are provided based on public health insurance, including the use of geriatric clinics, medical and nursing facilities for the long-term ill, nursing care homes, and nursing home care agencies. The MLSAF is responsible for social services (benefits in kind) and cash benefits. Social services are provided mainly by self-governing local and regional authorities and financed from local taxes, which are supplemented by clients' payments. Cash benefits are paid either to the caregiver or the care recipient. They are funded from general taxation.

The provision of social services and financial benefits is contingent upon satisfying various conditions. A social and health assessment of the applicant's personal situation is the basis for any intervention in the field of long-term care. It determines the degree of dependence and thus the extent of need for assistance.[1] Provision of financial benefits relies on an assessment of the person's income situation. Both the level of income and its sources are taken into account. Social services are not income-tested. On the other hand, recipients pay some fees that cover a (limited) part of social services costs. The quality of social services is guaranteed by quality standards defined in legislation (Act on Social Services). A regular evaluation of the quality of services with regard to these criteria will start from September 2019 (more details in Section 2).

1.1 Social services

The most frequent form of long-term care is represented by residential social services, provided in formal, external institutional settings. In 2016, there were 43,847 residential places in the social services facilities that were used for long-term care, representing 92% of all places in social services facilities.[2] A majority of clients were elderly persons of pensionable age. However, these data should be interpreted with caution, because the term 'long-term care' used in the MLSAF report on the social situation of the population refers here to the period during which social services are provided. It includes that

[1]The health assessment, carried out by a health worker contracted by the municipality or self-governing region, focuses on the health status of the client and changes in it. The degree of dependence on assistance is identified according to a list of daily activities that require the help of other persons. The social assessment, carried out by a social worker contracted by the municipality or self-governing region, focuses on: evaluating 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 assessments result 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; the number of required hours of care; the recommended type of social service, and the timing of the next health and social (re)assessment.

[2] The latest available data refer to 2015.

number of long-term care clients, including persons with disabilities, in need of long-term care; as well as persons who stay in social services homes for long periods, but without the need for intensive care (a proportion of those in homes for seniors). Therefore, according to the methodology of the report, residential social services providing long-term care include, for example: homes for seniors (355 facilities and 16,255 clients in 2015); homes for adults with multiple disabilities (201 facilities; 9,476 clients); specialised facilities (89 facilities; 5,077 clients); homes for people with mental and behavioural disorders (64 facilities; 3,733 clients); and homes for physically disabled adults (23 facilities; 582 clients); but it also includes day care centres, which are not intended to provide long-term care in the strict sense.[3]

Home care services for dependent persons are delivered by public and non-public actors. Publicly run services are the most important. In 2016, home care services were provided by 5,590 municipal workers to 13,155 persons. Compared wtih 2015, the number of workers grew by approximately 15% and the number of clients by 6%. According to the MLSAF, this was the result of an ESF-funded national project aimed at improving the accessibility of home care (in the period 2014–2015 conflicting processes took place: a decrease in the number of workers and an increase in the number of clients).[4] Home care services were supplied by 173 private providers to 3,594 clients: compared with 2015, the number of providers grew by approximately 33%, while the number of clients fell by 23%).

Expenditure on home care provided by municipalities was EUR 35.3 million in 2016. Revenues from payments for home care services was EUR 6.2 million, an increase of 15% in relation to 2015. The growing volume of revenues was caused by an increased number of service recipients, whose total payments of fees/costs rose by 12%. Despite this development, a huge gap between expenditures and revenues still exists and has to be covered from the budgets of municipalities. This persistent gap represents one of the big challenges for the sustainability of long-term care services. Moreover, taking into account the variability in financial capacities between municipalities, it may contribute to regional differences in access to long-term care services. Unfortunately, there are no data that can be used to verify this hypothesis.

In the non-public sector, a financial balance was achieved at the aggregate level: revenues were EUR 14.8 million, and expenditure reached EUR 14.4 million.[5] The revenues of non-public providers came from various sources, including payments from municipalities, payments from clients, and transfers from the EU structural funds.

Fees for long-term care services (and social services in general) are set by public providers (municipalities, self-governing regions) and non-public providers, taking into account eligible costs and revenues from financial subsidies that were provided in previous year. The Act on Social Services (§ 73) defines a minimum amount of income that must remain at a service recipient's disposal after deducting fees for services. For example, after paying charges for home care services, a recipient's income must be equal to at least 1.65 times the subsistence minimum (for an adult person). After paying fees for residential service provided for a whole year, a recipient's income must in no case be less than 25% of the subsistence minimum.

[3] Moreover, the numbers include residential social services for children with physical or mental disabilities. These services represent, however, a smaller part of residential long-term care.

[4] Ministry of Labour, Social Affairs and Family (2017): *Správa o sociálnej situácii obyvateľstva na Slovensku* [Report on social situation of population in 2016], page 100.

[5] These data don't reveal the real financial situation of each of the providers.

1.2 Financial benefits for informal carers

Persons who care for long-term dependent relatives can claim nursing allowance (*príspevok na opatrovanie*).[6] The condition is that they care intensively for a disabled person who is aged 6 years and over who – according to an official assessment – relies on nursing. Nursing allowance is intended for the relative of a dependent person. It can, however, be paid to another person if they live with the dependent person (i.e. they have a common address of residence). Health and social insurance contributions for nursing allowance recipients are paid by the state.

Nursing allowance is paid directly to caregivers in the form of a social transfer (paid by the offices for labour, social affairs and family). Its level depends on several factors. If the long-term care is provided only to one person, the allowance amounts to 125% of the subsistence minimum for an adult person (EUR 249.35 per month). If two or more dependants receive informal long-term care, the allowance equals 162% of the subsistence minimum (EUR 323.36). The allowance is increased by EUR 49.80 per month where a person cares for one or more severely disabled children. Nursing allowance can also be claimed if a dependent person uses day care services or attends a school facility. In these cases, it amounts to 112% of the subsistence minimum (153% for persons caring for two or more dependants). The amounts of nursing allowance also depend on whether the caregiver receives a statutory pension benefit or not (more details in Table 1).

Nursing allowance is means-tested by reference to the care recipient's income. This income may come from the disability benefits and various other financial compensations that are offered to people with a severe disability. If a someone cares for a severely disabled person who has an income above a certain threshold (1.7 times the subsistence minimum for an adult), the level of the allowance is reduced. For carers of severely disabled children the threshold is higher (three times the subsistence minimum for an adult). Income-testing is not applied to recipients receiving various types of pensions.

Table 1: Amounts of nursing allowance in 2017 (EUR, vaild since 1.7.2017)

Condition	Amount (EUR) per month
A. Caregiver doesn't receive any statutory pension benefit	
Care for one severely disabled person	249.35
Care for two or more severely disabled persons	323.36
Care for one severely disabled person who spends more than 20 hours per week in a social services or school facility	223.44
Care for two or more severely disabled persons who spend more than 20 hours per week in a social services or school facility	304.87
Care for one severely disabled person who spends more than 20 hours per week in social services or school facility and - at the same time - care for a second severely disabled person who doesn't attend such facility or spend more than 20 hours in the facility	315.96
B. Caregiver receives some statutory pension benefit	
Care for one severely disabled person	92.52
Care for two or more severely disabled persons	122.13

Source: Website of Ministry of Labour, Social Affairs and Family

[6] In MISSOC tables the expression 'attendance service benefit' is used. We prefer the term 'nursing allowance', as it is often used in academic and research praxis in Slovakia.

Provision of long-term care may be combined with a paid work, on condition that earnings from work do not exceed twice the subsistence minimum for an adult person. The allowance is also paid to caregivers who increase their qualifications by an external form of study, on condition that they ensure care for the dependant by another person.[7]

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

In 2016, the average monthly number of nursing allowance recipients was 54,666 (56,572 in 2015). The average monthly sum of the allowance was EUR 136.70 (EUR 139.13 in 2015). 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 occurs very rarely. As the subsistence minimum remained unchanged in the period 2013–2016, the amounts of the nursing allowance also remained the same. In addition, the upper limit for earnings from work makes a combination of long-term care provision and labour market participation very difficult.[9] The next table offers more details on the situation in 2016 (data for 2017 are not available).

In 2016, the majority of nursing allowance recipients consisted of working-age persons who didn't receive any statutory pension. On average, they received EUR 170 per month. Persons receiving pension benefits constituted the second largest group of caregivers: 20,042 persons on a pension cared for 22,426 dependent persons, receiving on average EUR 89 per month.

Table 2: Structure of nursing allowance provision in 2016 and 2015

	Average monthly number of allowance recipients		Average monthly number of care recipients		Average monthly amounts of allowance (EUR)	
	2016	2015	2016	2015	2016	2015
Caregiver receives pension benefit	22,042	21,941	22,426	22,334	89.48	89.34
Caregiver doesn't receive pension benefit	31,960	33,832	32,955	34,982	170.19	172.52
Caregiver receives nursing allowance according to transitional conditions[10]	664	799	679	823	92.18	92.94
Total/average	54,666	56,572	56,060	58,139	136.70	139.13

Source: Ministry of Labour, Social Affairs and Family (2017: 98).

[7] 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 is provided.

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

[9] On the other hand, informal carers can take leave under the so-called 'respite care' service. The aim of the service is to help informal carers by providing a period for recovering and maintaining their mental and physical health. It is provided for a maximum period of 30 days per year and is organised by municipalities. During the period of leave municipalities have to provide substitute social services for disabled persons. During this 'break' carers receive the nursing allowance. But usage of the respite care service is low in Slovakia.

[10] 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 aged 25–59 represent a majority of nursing allowance recipients. In 2016, approximately 25,400 women in this age category received it, compared with approximately 6,300 men. Women aged 65 years and older also represent a very significant proportion of informal caregivers. On the other hand, the number of young caregivers is low.

Table 3: 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
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 Ministry of Labour, Social Affairs and Family. Newer data are not available yet.

1.3 Financial benefits for dependent persons

Severely disabled persons aged between 6 and 65 years who are dependent on personal assistance are entitled to personal assistance allowance (*príspevok na osobnú asistenciu*). Persons are 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 a list of daily activities which require the assistance of other persons. Personal assistants provide services on the basis of a contract (with the disabled person or a personal assistance agency). Provision of personal assistance is subject to a maximum of ten hours per day.[11] Family members can deliver personal assistance for a maximum of four hours per day (and can only help with selected daily activities of the disabled person). The total amount of the allowance depends on the extent of activities provided by the assistant (and partly on income[12]). Unlike the nursing allowance, the personal assistance allowance is subject to taxation (taxes are paid by the personal assistant). The old-age pension contributions of a personal assistant are paid by the state on condition that the personal assistant: provides services for at least 140 hours per month; has permanent residence in the Slovak Republic; is not covered by an old-age pension scheme due to other reasons (as an employee, or through self-employment); is not of pensionable age; and does not receive an early old-age pension or invalidity pension.

[11] The limit doesn't apply if personal assistance is provided to a disabled person who is not in a permanent or temporary care residence.

[12] The amount of the allowance is reduced or denied in the case of high-income disabled persons (with income of more than quadruple the subsistence minimum).

2 Analysis of the main long-term care challenges in the country and the way in which they are tackled

2.1 Access and adequacy challenge

According to Eurostat data (Table 4), 1.3% of the population reported using home care services in 2014, compared with 4% in the EU as a whole. Elderly persons were highly overrepresented among service users (6.9% of persons aged 65 years or over). Unfortunately, as there is no similar information on the use of other long-term care services, it is very difficult to estimate the size of the total population of service recipients.

Table 4: Self-reported use of home care services (% of population, 2014)

	Slovakia	EU-28
Total population	1.3	4.0
Sex		
Men	0.8	2.9
Women	1.7	5.0
Age group		
From 15 to 44 years	0.0	2.0
From 45 to 64 years	0.4	2.3
65 years or over	6.9	10.6
75 years or over	10.9	17.4
Degree of urbanisation		
Cities	0.8	3.9
Towns and suburbs	1.5	3.8
Rural areas	1.4	4.3

Source: Eurostat website.

Information on the accessibility of long-term services is also limited. Although access to residential long-term care has been a subject of public discussion for a long time, systematic empirical evidence is still lacking. Some information is provided by data on the number of beds in long-term facilities. As Table 5 shows, the number of beds in nursing and residential long-term care facilities has grown over recent years. Between 2013 and 2014 (the latest available data) it jumped by approximately 9% (3,370 beds). The number of beds has also increased in relation to the size of the population.

Some indices of limited accessibility can be obtained from statistics published by self-governing regions that relate to facilities under their auspices. Unfortunately, not all regions conduct this exercise. On the other hand, we know that there are waiting lists for long-term care in residential services in the Bratislava and Trenčín regions.[13] Here, the number of applications exceeds the number of available places in various social services homes for adult and children. Collecting such data more systematically remains a challenge both at regional and national level.

[13] See, for example, regularly updated data on waiting lists in Trenčín self-governing region: https://www.tsk.sk/socialna-pomoc/egov-sluzby-ziadosti-a-podania/zoznam-cakatelov-a-volnych-miest-v-zss-tsk.html?page_id=92374.

Table 5: Beds in nursing and residential long-term care facilities

	Number	Per hundred thousand inhabitants
2014	42,374	782.00
2013	39,004	720.51
2012	35,647	659.20
2011	32,808	607.74
2010	32,848	607.32
2009	31,780	586.50
2008	30,548	565.01

Source: Eurostat website.
Note: Data refer to beds in 'social service' facilities, including social service homes, specialised facilities, residential homes for seniors, rehabilitation centres and residential nursing facilities.

One of the greatest challenges with regard to long-term care provided at home is the adequacy of income support. Nursing allowance, which is paid to caregivers, depends on the income of the care recipient. As the threshold at which the allowance starts to be reduced is set at a very low level (1.7 times the subsistence minimum), the allowance is provided only to caregivers who care for persons in a very bad financial situation. Moreover, the sum of the allowance is quite low, leaving room for significant improvement. When looking at adequacy, it is also relevant to consider the limited amount of earnings that can be earned by caregivers in the labour market. We showed that a significant proportion of caregivers who receive nursing allowance consists of pension benefit recipients. But for caregivers who don't receive pension benefit and thus can work, their earnings may not exceed twice the subsistence minimum. As result, the adequacy of income support to caregivers is limited from two sides: by limits imposed by reference to the care recipient's income and by limits imposed on the potential work earnings of the caregiver. It is important to stress that nursing allowance is primarily intended for caregivers who are relatives of dependent persons. It means that they often live in the same household. In reality, nursing allowance represents a source of help in the very last resort, in situations where a household faces the most urgent financial problems.

2.2 Quality challenge

As mentioned in the first section of this report, the Act on Social Services defines the standards of quality for social services. They apply also to long-term care services. Although they were defined as long ago as 2008, a regular assessment of social services quality has not happened to this day. According to the last statements from the representatives of the MLSAF, a system of quality assessment will be launched in September 2019. Postponing quality assessment (based on legally defined standards) has resulted from the fact that many providers were not able to fulfil all the criteria of the quality assessment system in the context of their existing levels of financial support.[14] Despite this, partial evidence on some quality challenges[15] comes from the process of preparing for quality standards implementation in 2015 and from the assessment procedures carried out within an ESF-funded national project in 2016. However, these findings relate to social services in general, not just to long-term care services. Among several problems mentioned by Repková (2016: 68-84), we select the following ones which have wider implications.

[14] http://www.teraz.sk/slovensko/b-ondrus-kvalita-socialnych-sluzieb/285629-clanok.html.

[15] Repková, K. (2016): *Kvalita v kontexte transformácie sociálnych služieb* [Quality in the context of social services transformation]. Inštitút pre výskum práce a rodiny.

- In relation to human rights, standards of quality were perceived by providers as something 'additional', i.e. as something that doesn't belong intrinsically to the provision of social services.
- In relation to conditions of social services provision, there was a lack of focus on the individual needs of care recipients, and insufficient social activation of clients.
- In relation to the organisation of social services, there was a lack of public datasets of providers, an absence of a code of conduct, unclear rules for staff, and a devaluation of the education and professional development of professional workers.

The quality of long-term care is discussed in a draft background document to the planned Act on long-term care and support for the integration of disabled persons.[16] According to the document, the capacity and quality of long-term care services don't correspond to the needs of older persons. This is a result of a failure to coordinate health and social interventions in the field, and to integrate them in a coordinated system. In order to increase quality of life among elderly persons with a disability, the document proposes several new measures, including: continual monitoring of clients' needs; giving citizens the right to choose between various alternative forms of provision according to their own individual needs; and stricter control of the quality of services and the effective use of resources.

2.3 Employment challenge

The impact of informal care on participation in the labour market can be estimated from data on the reasons given for economic inactivity and part-time employment. As Table 6 shows, family/caring responsibilities significantly contribute to economic inactivity among women and to the fact that they do not seek employment. In 2016, 28% of inactive women said that they were not seeking employment due to family or caring responsibilities in some form – in the vast majority of cases, 'looking after children or incapacitated adult'. This figure increased each year between 2013 and 2016, although in terms of the total population (active and inactive) the proportion was relatively stable. There is a strong gender bias in the allocation of caring and family responsibilities: men are disproportionally less likely than women to be inactive due to caring for relatives. While care for relatives plays an important role in keeping women out of the labour market, its impact on part-time employment is rather weak (Table 7).

Table 6: Reasons for economic inactivity and not seeking employment (% of inactive population aged 15-64 years)

	Family/caring responsibilities		Looking after child(ren) or incapacitated adult		Other family or personal responsibilities	
	Women	Men	Women	Men	Women	Men
2016	27.6 (9.6)	4.5 (1.0)	26.2 (9.1)	2.0 (0.4)	1.4 (0.5)	2.5 (0.5)
2015	27.1 (9.7)	3.6 (0.8)	25.1 (9.0)	1.5 (0.3)	2.0 (0.5)	2.0 (0.5)
2014	26.2 (9.7)	2.9 (0.6)	24.3 (9.0)	1.5 (0.3)	1.9 (0.7)	1.4 (0.3)
2013	25.6 (9.6)	2.8 (0.6)	24.1 (9.0)	1.2 (0.3)	1.6 (0.6)	1.5 (0.3)

Source: Eurostat website.

Note: Figures in brackets include incidence of reasons expressed as percentage of total population (active and inactive).

[16] This proposal is still under preparation within the Ministry of Health, but was provided to the authors of this report.

Table 7: Reasons for part-time employment among women (% of part-time employees aged 15-64 years)

	Looking after child(ren) or incapacitated adult	Other family or personal responsibilities
2016	5.4	3.1
2015	5.5	2.6
2014	6.4	n.a.
2013	4.3	n.a.

Source: Eurostat website.
Note: Men are not included in the table due to the very low values of the indicator.

The long-term care sector in Slovakia suffers from low wages. There is quite a large category of carers (women) who work abroad, especially in Austria and Germany, in order to earn an adequate income. According to the Labour Force Survey (in 3rd quarter 2017) there were approximately 34,000 women working abroad in the field of health and social assistance. This represents a problem, as the absence of these (often experienced) workers from Slovakia means that demand for long-term care cannot be satisfied. This problem was publicly articulated in 2017 by representatives of these workers, supported by the president.[17] An association of caregivers has been established, with the aim of promoting the return of caregivers and health care assistants from abroad to Slovakia.

2.4 Financial sustainability challenge

The lack of financial sustainability in long-term care is a fact recognised by all relevant stakeholders. In order to ensure greater financial stability, higher public subsidies are planned, based on a positive prognosis for economic development. From 2018 the state provides financial contributions to providers of social service facilities, which are intended to counter low wages in the sector.[18] Furthermore, health and social long-term care are increasingly connected, through the increasing use of health insurance resources (i.e. a gradual expansion of the number of diagnoses paid from health insurance to long-term care clients). Higher financial contributions from clients are seen as another way to stabilise the system. This is reflected in the growing market for life insurance, where insurance for care for dependent persons is attracting attention.

The draft background document to the planned Act on long-term care and support for the integration of disabled persons (see above) sets out some contours for financing a new, integrated system of long-term care. It is proposed to establish integrated accounts of the financial resources devoted to long-term care in health insurance agencies. It should collect resources from the state budget and health insurance agencies in order to increase effectiveness facilitate control of their use.

Policy recommendations

The biggest challenge for public policy is to set up a comprehensive, coordinated and sustainable system of long-term care that would meet (growing) population needs through high-quality services. In addition to this macro- and long-term goal, there are several steps that should be considered:

- reform of the health and social assessment process in order to improve the identification of long-term care clients;

[17] https://www.prezident.sk/article/kiska-sa-stretol-s-opatrovatelkami-slovensko-nie-je-socialny-stat/.

[18] An analysis of the financial costs of social services facilities in 2016 (Bednárik, R. – Tumpach, M., 2016) showed that, despite low wage levels, total wage costs represented approximately two thirds of the total costs of social services facilities.

- establishing conditions for a sustainable and balanced multi-sourced financing of long-term care; and
- improved monitoring of social services facilities and of their personal and material resources, along with improved accessibility and quality of data relating to long-term care.

3 Analysis of the indicators available in the country for measuring long-term care

We recommend four indicators for measuring long-term care in Slovakia. Firstly, there is the indicator 'self-reported use of home care' from Eurostat, which is based on EHIS data (see Table 4 in Section 2). Its advantage is that it provides a 'direct' reflection of the use of home care services in a given year, and offers several analytically interesting breakdowns (by sex, age, degree of urbanisation). The EHIS data allow further analytical insights into this indicator, using variables referring to health status, limited activities, etc. Among the weaknesses of the indicator, there is a low frequency of data collection; and there are difficulties in ensuring its validity in relation to long-term care services (i.e. separating the use of long-term care services from other forms of home care).

Secondly, we recommend the indicator that is regularly collected by the Statistical Office of the Slovak Republic referring to the number of beds in nursing and residential long-term care facilities (Table 5 in Section 2). In addition to the number of beds, the ratio of beds to inhabitants is published (the second row of the table). It allows the capacity of residential services to be tracked in the context of changing demographic conditions. Its weakness is a time lag in publication (on a comparable basis via Eurostat): in 2018 we still have to refer to data from 2014.

The third indicator relates to waiting lists (rejected applications) for places in facilities that provide residential social services. As stated above, such data are not published at national level, and only some regions engage in this activity. But it is our conviction that such information does exist (although not necessarily published). The number of rejected applications (with a breakdown by number of inhabitants in a given age category, for example) reveals the capacity of services and as such is directly relevant to policy-making. Its strength lies in the possibility of producing up-to-date information – provided self-governing regions and other actors can be motivated to do so.

Lastly, we would like to draw attention to the indicators of adequacy. Comparing existing amounts of nursery allowance (or total real incomes of caregivers) with various poverty thresholds can reveal existing gaps.[19] In addition, simple monitoring of valorisation (yes/no in given year) can show how the conditions of caregivers are changing.

[19] Nursery allowance rates are published regularly on the website of the Ministry of Labour, Social Affairs and Family. Poverty thresholds can be obtained from the Eurostat website.

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