Ad-PHS
Advancing Personal and Household Services

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COUNTRY REPORT SLOVAKIA

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EASPD IMPROVING SERVICES IMPROVING LIVES
EFSI European Federation for Services to Individuals
UNI global union europa
EFFAT
IWAK Institut für Wirtschaft, Arbeit und Kultur Zentrum der Goethe-Universität Frankfurt am Main
diesis
EFFE EUROPEAN FEDERATION FOR FAMILY EMPLOYMENT & HOME CARE

Introduction

Slovakia has joined the EU in 2004 and the Schengen agreement in 2007. The country has around 5,5 million citizens and together with Poland, Czech Republic and Hungary, it forms the Visegrád group. So far, and with regard to PHS, the integration of social care and medical care in the Slovak Republic is not systematically regulated by national legislation. And since the country has inherited a Socialist healthcare system, which was very good at providing acute care and curative treatment, new policy initiatives on, for instance, long-term care, but also policies addressing informal carers are yet to be elaborated. Another challenge is the circular migration of experienced (informal) care workers from Slovakia to neighbouring countries such as Austria and Germany, aggravating an already labour force shortage in (long-term) care professions.

Factors supporting the growth and development of the field of PHS

Main demographic changes in the Slovak Republic in the first half of the 21st century include a halt in population growth and an ageing society. The Slovak society has to prepare for an increased share of elderly people, the integration of a higher number of foreigners, often from very different cultures, and increased tensions in inter-generational relations. Therefore, new approaches in social, economic and migration policies will be required. Slovak authorities intend to observe other countries dealing with similar problems in order to draw best practices from them.[1]-[2]

Another challenge to the Slovak society is undeclared work. There are no recent national estimates of the size of the shadow economy, but a non-representative survey carried out by the Institute for Labour and Family Research among representatives of relevant public authorities estimated the size of the hidden economy at 21.4 per cent of the GDP in 2014, an increase compared to 18.3 per cent of the GDP estimated in a similar survey in 2007.[3]

According to a representative survey carried out by Infostat in 2014, 18.1 per cent of respondents stated to have carried out some form of undeclared work in 2013, of which 7.4 per cent worked illicitly in their main job and 10.7 per cent in their second job. The share of positive answers has not changed much compared to 2007, when a similar survey undertaken by Infostat found that 18.5 per cent of the respondents were performing undeclared work. However, the relative share of women participating in undeclared work has increased since then, which is in line with the supposed rise of undeclared work in the services sector.[4] A

[1] Infostat (2002).
[2] Statistical Office of the Slovak Republic (2015).
[3] European Commission (2017).
[4] European Commission (2017).

survey conducted in 2014 showed a significant share of respondents, i.e. 41.3 per cent, identifying undeclared work in the services sector.[5]

In 2016, control authorities detected 1,311 employers, making up 5.6 per cent of all controlled employers, who illicitly employed 2,924 persons, i.e. 4.8 per cent of all controlled persons. Controls have been conducted mainly in small businesses with up to nine employees, where the highest number of irregularities have been suspected.[6]

Another challenge on the Slovak labour market is gender equality. The employment rate among people aged 20 to 64 years is 60 per cent for women versus 75 per cent for men, with a total employment rate of 68 per cent. The gender gap in the employment rate is the same when the number of hours worked is taken into account. The full-time equivalent (FTE) employment rate of women is around 44 per cent, as compared to 60 per cent for men. 8 per cent of women work part-time, compared to 4 per cent of men. 9 per cent of working-age women versus 0.3 per cent of working-age men are either outside the labour market or work part-time due to care responsibilities. Gender segregation in the labour market is a reality for both women and men: 27 per cent of women compared to nearly 5 per cent of men work in education, human health, and social work activities (EHW), while about five times more men (37 per cent) than women (7 per cent) work in science, technology, engineering and mathematics (STEM) occupations.[7]

The share of workers with high-level qualifications is expected to increase to 36 per cent in 2030, 4 percentage points below the EU-28 average. The share of medium-qualified workers is expected to decrease to 59 per cent in 2030, 14 percentage points above the EU-28 average, however starting from a very high value. The share of low-qualified workers is expected to remain broadly stable at 5 per cent over time, 10 percentage points below the EU-28 average. A detailed analysis of occupational groups shows that most of the new jobs are expected to be created in legal, social and cultural related professions, in business and administration related professions and in personal services, with the latter group expected to have the highest number of total job openings.[8]

Definition and development of PHS instruments

Integration of social care and medical care in the Slovak Republic is not systematically regulated by national legislation. In 2005, a law proposal on the long-term care and integration of persons with disabilities was presented by the Ministry of Health with a conception of an integrated so-called Long-Term Care System. The act was not approved, so that the system of providing social and medical services separately was reinforced. Nowadays, single parts of the LTC system are included in several regulations and acts.[9]

[5] Eurofund (2017).
[6] European Commission (2017).
[7] EIGE (2018).
[8] CEDEFOP (2018).
[9] Radvanský/Páleník (2010).

Provision of care services for older people is underdeveloped in the Slovak Republic, as long-term care for the elderly has not been a central policy concern. Only as of the late 1990s, long-term care has slowly been acknowledged as a policy concern in its own right. But so far, care for older relatives has been understood to be a family's responsibility. Hence, care services for older people are either still not available or poorly developed. Similar to childcare benefits, public financial support for long-term care needs is tailored to economically poorly situated people without a family or social network. Residential care homes can be found in urban areas, while rural areas are rather scarcely serviced. Moreover, home care services are rarely available and often underdeveloped.[10]

Home care is a new type of care in the Slovak Republic, developing since 1995.[11] The sector is divided according to the type of services. **Formal medical related services** such as home nursing care are covered by health insurance and **formal social related services** are provided via a social system, with expenditures covered by lower-level administrative bodies, i.e. municipalities and regions, via taxation and co-payments of the care receiver. Major principles of the availability of social care, social nursing care, and social palliative care are described in Act No.448/2008 about social services.[12]

Home care is provided usually via family members or a person close to the family. **Family members or close persons** providing intensive home care can be supported by **benefits or social contributions**. Other types of informal care are not covered by any legal agreement and are therefore not financially supported.[13]

An important instrument in the PHS sector is the **child tax bonus**. It is a tax bonus granted to a taxpayer with a maintained child or dependent child such as an own child, an adopted child, a child taken into care replacing the parental care, or a child of the second spouse. The amount of the tax bonus is EUR 21.56 per month for each dependent child living with the taxpayer in the same household. The income tax is reduced by the amount of the tax bonus.[14]

Another instrument is the **childcare allowance**. In order to cover the costs necessary for childcare, the state contributes to the parent or to a natural person to whose care the child was placed by means of the childcare allowance. The childcare is provided in the child's family environment (so either by the parents or to by natural person providing childcare) or in an environment specifically designed and adjusted for the sake of providing childcare (such as nurseries, crèches etc.). The term child refers to the following: a child until three years of age; a child until six years of age suffering from a long-term adverse health condition; or a child whose care is provided by a person to whose foster care the child was placed (the benefit is paid for a maximum period of three years from the date when the decision on placing the child into care entered into force).[15]

The amount of the childcare allowance per calendar month is provided as follows: up to a maximum amount of EUR 280 for costs as proved by an entitled person;[16] up to a maximum amount of EUR 80 for a child in the care of a nursery school registered in the System of Schools

[10] Bauer/Österle (2016).
[11] Lezovic et al. (2011).
[12] Radvanský/Páleník (2010).
[13] Radvanský/Páleník (2010).
[14] IOM (2017a).
[15] IOM (2017b).
[16] IOM (2017b).

and Education Facilities of the Slovak Republic, which is established by municipality;[17] or a maximum amount of EUR 41.10 for a child either cared for by another natural person (such as a grandparent), given that this person does not receive parental allowance, or cared for by a parent who performs gainful activity and who does not provide for the child care in any other manner.[18]

Furthermore, there is another type of benefit, the **parental allowance**. It is a type of state social benefit paid by the state to the entitled person for providing due care to the child. The entitled person to receive parental allowance can be the parent of a child (or the spouse of the child's parent, if living with the child's parent in a common household) or a natural person to whose care the child was placed as a replacement to parental care. The granting of the entitlement is conditioned by the provision of due care (such as care for the mental and physical development of the child, especially the child's adequate nutrition, hygiene, raising), which can be performed in person or through another person. The amount of the parental allowance is EUR 220.70 per month (since January 2019). If the entitled person provides due care to two and more children born at the same time, the parental allowance is increased by 25 per cent for each subsequent child born at the same time as the first child. If the entitled person is receiving maternity benefit or other benefits similar to maternity benefit in a member state at an amount lower than the amount of parental allowance, the parental allowance is calculated as the difference between the amount of parental allowance and the amount of maternity benefit or other benefits similar to maternity benefit in a member state.[19]

Besides that, the state provides **care allowances** or **nursing allowances for informal carers**. In the Slovak Republic, informal carers of persons with severe disabilities can receive care allowance or nursing allowance. The carer must be older than 18 years and capable of providing care, must have the consent of the person they are taking care of, and must have legal capacity.[20] The condition is that they care for a person with disabilities aged 6 years and older. 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.[21] A beneficiary of care allowance may be concurrently employed, but their income is monitored.[22] In 2001, care allowance for informal carers was introduced as an original responsibility of local governments covered by tax revenues. Recipients of care allowance automatically became health insured and, since August 2006, also became eligible for statutory old age and disability pensions as well as for the reserve solidarity fund. Social insurance contributions are covered by the state budget. Care allowances stipulate on average a payment of about EUR 2,500 per year (EUR 206 per month) and per person, paid to an entitled informal carer. The individual entitlement can be lower for individuals, as care allowances are means-tested.[23] Its level depends on several factors (such as the income of the care recipient).[24] If the care is provided only to one person, the allowance amounts to 125 per cent of the subsistence minimum for

[17] IOM (2017b).
[18] IOM (2017b).
[19] IOM (2017c).
[20] UNECE (2019).
[21] European Commission (2016a).
[22] UNECE (2019).
[23] Eurostat (2019).
[24] European Commission (2016a).

an adult person (EUR 249.35 per month); if two or more dependants receive informal care, the allowance equals 162 percent of the subsistence minimum (EUR 323.36 per month). The allowance is increased by EUR 49.80 per month where a person cares for one or children with more severe disabilities. Nursing allowance can also be claimed if a dependent person uses daycare services or attends a school facility. In this case, allowance amounts to 112 per cent of the subsistence minimum (153 per cent for persons caring for two or more dependents). The amounts of nursing allowance also depend on whether the caregiver receives a statutory pension benefit or not.[25] [9] The amount of the nursing allowance is determined in relation to the subsistence minimum which is not regularly adjusted; it can be quite low, thus exposing informal carers to vulnerable living conditions. 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.[26] Carers who are pensioners receive a flat rate of approximately 50 per cent of this amount in addition to their old age pension.

The care allowance increases if the person cared for is a child. Attending school and/ or enjoying other social services does not prevent persons living with a disability from benefitting from the care allowance. The contribution is provided from the state budget on the principle of discretion. **Informal carers do not have the status of employees; however, the state covers their health and social insurance contributions**.[27] For compulsory social insurance, the state contributes about EUR 925 annually for each informal carer to the pension fund and about EUR 420 per year for health insurance (as of 2011).[28] 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.[29]

Furthermore, there are respite periods for informal carers. 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.[30] Since 2009, informal carers are entitled to take time off for a maximum of 30 days per calendar year. During the informal carer’s respite period, municipal social services provide substitutive social services according to the care recipients’ own choice, such as formal home care services (theoretically also 24 hours per day) or temporary residential care. In case an informal carer stays at home during the respite time, formal carers provide care for the older person in need of care in their own or in the informal carer’s home. On average, costs for residential care amount to about EUR 650-700 per recipient. This sum may vary depending on the type of residential service chosen.[31]

[25] European Commission (2018a).
[26] European Commission (2016a).
[27] UNECE (2019).
[28] Interlinks (2011).
[29] European Commission (2016a).
[30] European Commission (2016a).
[31] Interlinks (2011).

Landscape of users

Nursing allowance for informal carers: 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). 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.[32]

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. Women aged 25–59 represent a majority of nursing allowance recipients. In 2016, approximately 25,400 women in this age category received pension benefits, 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.[33]

Respite periods for informal carers: A qualitative study conducted half a year after the introduction of respite care into legislation and practice showed that only 5 out of 30 interviewed carers had heard about the availability of this service. Only 9 informal carers welcomed the service theoretically, but the majority of interviewed persons underlined the barriers for taking up respite care, namely: the relationship between the person cared for and the caring person being too close; cared recipients and caregivers feeling uneasy with the presence of "strangers" (professional carers) in their households; no tradition to combine intensive family care with formal care services; informal carers tending to underestimate the negative impact of intensive long-term care on their own health conditions; and a generally low trust in professional care.[34]

According to other surveys,[35] in 2009 only 253 informal carers/ care allowance recipients from 824 monitored towns and municipalities were provided with respite care services, less than 2 per cent of all potential recipients of the monitored local units. In 81 per cent of all cases, home care services were provided through substitutive social services for older persons during the respite time of the informal carer.[36]

Financing of the main instruments and associated prices

Medical related services: Home nursing is usually free of charge for the patient and reimbursed by the patient's health insurance company, while home rehabilitation is

[32] European Commission (2018b).
[33] Interlinks (2011).
[34] Interlinks (2011).
[35] Bednarik (2010a; 2010b).
[36] Bednarik (2010a).

reimbursed only by some of them. Home assistance provided by agencies is financed by the patient.[37]

Municipal home care services: 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 per cent 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 per cent. 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.[38]

Private home care services: 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. The revenues of non-public providers came from various sources, including payments from municipalities, payments from clients, and transfers from the EU structural funds.[39]

Respite care services: Costs related to the implementation of respite care services are covered primarily by local government (municipal) budgets.[40]

Informal care allowance: The major part of public money spent for support of informal carers is provided by the state budget.[41]

Work arrangements

Informal home care is provided usually via family members or close persons and is not covered with any legal agreement. The family member gets social contribution for home care according to the Act. No. 447/2008 on financial allowances.[42] Inquiries show that as many as 90 per cent of citizens prefer to have health and social care provided within their own home settings.[43]

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. Family/ caring responsibilities significantly contribute to economic inactivity among women and to the fact that they do not seek employment. In 2016, 28 per cent 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, they were instead “looking after children or incapacitated adults”. This figure increased each year between 2013 and 2016, although in terms of the total population 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

[37] Lezovic et al. (2011).
[38] European Commission (2018a).
[39] European Commission (2018a).
[40] Interlinks (2011).
[41] Interlinks (2011).
[42] Radvanský/Páleník (2010).
[43] Lezovic et al. (2011).

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.[44]

Landscape of intermediaries and quality management

Skilled home nursing is part of the healthcare system in the Slovak Republic. It is provided mainly by a single type of organization, namely home care and nursing agencies (agentúry domácej ošetrovatel'skej starostlivosti, ADOS). The latter agencies are part of primary healthcare and belong to the system of healthcare services. They provide complex special nursing care for clients/ patients, families, and communities within their own habitat. It is a self-contained functional unit allowing the provision of nursing care including prevention, therapy, rehabilitation, counselling, healthcare as well as social and educational care. In 2011, there were 162 home care agencies in the Slovak Republic. Most of the agencies provide nursing care exclusively by means of qualified nurses. The emphasis is mainly on technical nursing of sick people at home. Some agencies also include rehabilitation provided by qualified physiotherapists. Others provide home assistance such as housework, shopping, cooking, and feeding.[45] In 2014, 4,074 persons received home care services carried out by 111 private providers; and in 2016, home care services were supplied by 173 private providers to 3,594 clients. Compared with 2015, the number of providers grew by approximately 33 per cent, while the number of clients fell by 23 per cent.[46]

For the non-medical home care sector, there seems to be no formal training or certificates. Also, there does not seem to be any labels or brands for intermediaries. 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 Ministry of Labour, Social Affairs and Family, 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. Despite this, partial evidence on some quality challenges 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.[47]

[44] European Commission (2018a).
[45] Lezovic et al. (2011).
[46] European Commission (2016a).
[47] European Commission (2018b).

Landscape of employees and degree of professionalisation

Formal carers: Only 14 per cent of long-term care is provided on a formal basis, either institutionally or at home.[48] 4,935 workers paid by municipalities provided home care services to 12,152 persons in 2014,[49] while 5,590 municipal workers provided home care services to 13,155 persons in 2016. The increase was a result of an ESF-funded national project aimed at improving the accessibility of home care.[50]

Informal carers: Between 57,000 and 59,000 adults worked as informal carers in 2011, of which more than 65 per cent were people above the age of 65. 19 per cent of the total population of the Slovak Republic are informal carers;[51] the share of informal carers increased between 2004 and 2013,[52] and informal carers represent 8.7 per cent of the working age population.[53]

Caring for relatives is a matter for women in the Slovak Republic. According to the Labour Force Survey, in 2010 among the informal carers there were around 62 per cent of women who took care of relatives aged 15 or more in need of care, as compared to 37.8 per cent of men.[54]

Personnel within residential care: Circa 18,000 employees worked in permanent residential care in different types of social services for adults and seniors; [55] short-term services (care on a daily or weekly basis) are used only occasionally.[56]

Long-term carers: The long-term care sector in the Slovak Republic suffers from low wages. There is quite a large category of carers, mainly women, who work abroad, especially in Austria and Germany, in order to earn an adequate income. According to the Labour Force Survey, 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 experienced workers from the Slovak Republic means that demand for long-term care at home cannot be satisfied.[57]

[48] European Commission (2016a).
[49] European Commission (2016a).
[50] European Commission (2018b).
[51] Interlinks (2011).
[52] Interlinks (2011).
[53] European Commission (2018b).
[54] European Commission (2016a).
[55] European Commission (2018b).
[56] European Commission (2016b).
[57] European Commission (2016b).

Wages

The national gross minimum wage in 2019 amounted to EUR 520.[58] The average gross monthly salaries in the medicine and social care sector amount to EUR 1,012 sector-wide, EUR 615 for a carer or personal assistant, and EUR 651 for a caregiver.[59] The average gross monthly salaries in the service industries amount to EUR 908 sector-wide and EUR 815 for a housekeeper.[60]

Social dialogue in the field of PHS

A tripartite structure of the social dialogue is not constituted at all at the national level. Collective agreements are negotiated every year across the board for staff working in the public interest and in the civil services. Collective bargaining takes place at the enterprise level, where trade unions operate. The trade unions within the tripartite structure as well as the Slovak Trade Union of Health Care and Social Services operate in various committees, working groups, and councils of government at the national level in the social services sector, namely: the Committee on Equal Opportunities for women and men and equal opportunities at Ministry of Labour, Social Affairs and Family of Slovakia; the Working group for legislative changes in the field of social services at the Ministry of Labour, Social Affairs and Family; the Expert Working Group for the preparation of methods and methodologies for evaluating the quality standards of social services provision; the Regional Council of the Confederation of Trade Unions in 8 HTUs (Higher Municipality Authority Units); and the Sectoral Economic and Social Council at the Ministry of Health of Slovak Republic.[61] A main social partner involved in the dialogue is the Slovak Trade Union of Health Care and Social Services.[62]

Policy process

The legislation for social services was introduced in 2008 during the administration of Iveta Radičová. The governing coalition consisted of "Slovenská demokratická a kresťanská únia - Demokratická strana" (Slovak Democratic and Christian Union - Democratic Party), "Sloboda a Solidarita" (Freedom and Solidarity), "Kresťanskodemokratické hnutie" (Christian Democratic Movement) and "Most-Híd" (Bridge).[63]

[58] Eurostat (2019).
[59] Platy Slovakia (2020a).
[60] Platy Slovakia (2020b).
[61] Tenenet (2015).
[62] See: http://www.sozzass.sk
[63] European Commission (2018a).

Before 2001, informal carers in the Slovak Republic were not systematically mentioned in social welfare legislation; they did not qualify for social insurance, and respite services, as well as economic support for informal carers, were lacking. Over the past decade, several legal amendments have therefore been introduced to close this gap. By doing so, both national and local government levels are contributing within their area of competence. During the last decade, the Slovak Republic has gradually introduced various legal measures with the aim to improve social protection of informal carers (care allowance recipients). This has been realized by sharing responsibilities between different government levels. Recent initiatives for informal carers have also introduced the legal right to take time off (respite care) in order to keep or regain their physical and mental health conditions. Respective regulations in the Social Services Act (Act No.448/2008, in force since January 2009) stipulate a maximum of 30 days respite per year without losing care allowance entitlements.[64]

The childcare allowance is overseen by the Ministry of Labour, Social Affairs and Family,[65] the parental allowance by the Ministry of Labour, Social Affairs and Family,[66] and the care allowances / nursing allowances for informal carers by the Ministry of Labour, Social Affairs and Family.[67]

Commonalities across countries

The Slovak Republic has inherited a Socialist healthcare system. This system was very good at providing acute care and curative treatment. Because of this healthcare style, a lot of death and dying took place in hospitals.[68] In order to change this, the Department of Palliative Care was created in 1995. It is the mission of this organization to raise awareness about palliative care and how it can benefit many suffering patients at the end of life. During this period of time, the Slovak Republic intended to provide a slow release of opioid medications, create a network of home care agencies, and continue to promote the value of palliative care.[69]

The introduction of the informal care friendly provision by the Social Services Act No.448/2008 into the Slovak legal system was initiated by the Ministry of Social Affairs after a visit of some representatives to the Australian social administration, where detailed information on the Australian respite care scheme was collected.[70]

[64] Interlinks (2011).
[65] IOM (2017b).
[66] IOM (2017c).
[67] UNECE (2019).
[68] Sadovská, (1997)
[69] Krcmery (2017).
[70] Interlinks (2011).

Previous instruments

As described above, informal carers in the Slovak Republic were not systematically mentioned in social legislation before 2001; they were not entitled to social security, and there was a lack of respite services and economic support for informal carers. The instruments mentioned above are the first tools in the sector.

Promising practices

The Institute of Health Policy of the Ministry of Health currently cooperates with the Ministry of Labour, Social Affairs and Family to prepare a strategy for long-term care (LTC). The strategy aims to create an optimal integrated model of LTC care. The National Programme for Active Ageing 2014-2020, which was approved by a government resolution in 2013, gives the possibility to eventually introduce insurance for LTC by the Ministry of Labour, Social Affairs and Family in cooperation with the Ministry of Finance by 2020.

The strategy of deinstitutionalisation of social services and strengthening of care, approved by a government resolution in 2011, foresees a systemic transition from institutional to community-based care. It includes limits on the capacity of institutions and restrictions on the year-round provision of care in certain types of facilities. In addition, new types of services aim to support the independent living of persons with disabilities and strengthen social prevention and early intervention.[71]

The absence of experienced workers from the Slovak Republic means that the demand for long-term care cannot be satisfied. This problem was publicly articulated in 2017 by representatives of these workers, supported by the president. An association of caregivers has been established, with the aim of promoting the return of caregivers and health care assistants from abroad to the Slovak Republic.[72]

[71] European Commission (2016b).
[72] European Commission (2018a).

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