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Integrative Elderly Care Model as a Part of a Changing Long-Term Care and Welfare State in Slovakia

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Abstract

The aim of this article is to describe and discuss the key challenges of social and healthcare services in Slovakia, focusing on the Integrative Elderly Care Model as part of a changing welfare state. It also examines the opportunities and challenges related to the transformation of community-based social and healthcare services. The Slovak welfare state has undergone several revisions during the last decade; so too has the elderly care sector, which is a combination of public and non-government organisations. Elderly citizens, however, remain in a precarious situation. The trend toward marketisation and re-familiarisation of elderly care ‘go towards the EU average’, indicating an increase in public social expenditure directed towards aging.

Keywords: welfare state, Slovakia, Integrative Care Model, elderly, elderly care.

Introduction

The welfare state plays a key role in people’s lives in developed societies and is one of the forms of social organisation which ensures economic equality (Greve, 2014, Van Lancker & Van den Heede, 2021). Demographic aging is at the centre of the public health policy debate, and management of welfare and

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long-term care (LTC) policies lead to a shifting of responsibilities across public sectors (eg. from health to social care and from national to localised provision) and across sectors (eg. from state to private or third sector provision) (Rummary, 2021). Long-term care has a major impact on public spending and political leaders search for solutions to keep public finances sustainable and allow for population aging. Health care and long-term care systems aim to provide timely access to good quality medical care, and contribute to human well-being in the context of an aging society (Gusmano & Okma, 2018). Care policy, socio-economic and structural issues in developed welfare states lead to discrepancies between supply and demand in the provision of social and healthcare services in many countries. Many European countries have implemented major LTC reforms since the 1990s (Aidukaite *et al.* 2021; Albesa Jové, 2021; Fischer *et al.* 2022), and there have been three main trends: a) readjustments to the LTC policy mix – specifically, moves away from residential care towards home and community care; b) efforts to enhance financial sustainability; and, c) improving access and affordability of care, including improving the status of informal carers (Spasova *et al.* 2018). The Slovak Government approved the first Long-Term Care Strategy in Slovakia in September 2021 due to the projected long-term trend of intensive aging of the Slovak population (Statistical Office of the Slovak Republic, 2019). This strategy sets out measures for the introduction of Integrated Social and Health Care (Ministry of Labour, Social Affairs and Family, 2021).

LTC includes a broad array of services provided to disabled persons – particularly elderly with chronic illnesses or disabilities - at home, in nursing homes, and in assisted-living facilities to improve personal functioning and quality of life (Freeman *et al.* 2017). Integrative care is a strategy for improving patient care through better coordination (Craftman *et al.* 2018; Zhu *et al.* 2020), and the integrative care model responds to the needs of people suffering from diseases, and their families (Czerska & Skweres-Kuchta, 2021). The integration of social and healthcare is a complex process that is dependent on a plethora of factors (WHO, 2016; McGilton *et al.* 2018). Current research provides evidence that integrative care can lead to positive patient outcomes (Liljas *et al.* 2019; Trukeschitz *et al.* 2021).

The aim of this paper is to describe and discuss key challenges of the social and healthcare services in Slovakia, focusing on the Integrative Care Model for the elderly care sector as part of a changing welfare state.

Description of Slovak demographic changes and long-term care system

The aging index has been increasing in Slovakia in the last decade. The historical turning point was 2018, when the number of seniors exceeded the number of children for the first time - 102 people aged 65 and over for every 100 children. The latest population forecast points to a continuing increase in the aging index until 2060 (up to 220 people aged 65 and over per 100 children under the age of 15). Current research indicates that the most significant demographic trend will be at the regional level (Bleha *et al.* 2018; Repková, 2020). Slovakia spends less on health than most other EU countries; in 2015, €1,538 per capita was spent on health care (6.9% of GDP) compared to the EU average of €2,797 (9.9%). According to the report 'State of Health in the EU/Slovak Republic', some 80% of health spending in Slovakia is publicly funded, which is close to the EU average. (Statistical Office of the Slovak Republic, 2020).

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 (Gerbery & Bednarik, 2018).

Since 2012, Slovakia has begun the process of transforming social services to create and secure conditions for citizens dependent on assistance in their natural social environment, including transferring selected competences to the local and regional level, ensuring the principle of social subsidiarity and supporting the community character of the provision of social services. There is currently an unconnected multi-level system of long-term care services in Slovakia; individual services in favour of addressing individual needs are not coordinated. Health care and social services are two separate systems, governed by their own legislation and standards. Support services are traditionally fragmented in two areas: (1) *System of social services* – regulated by the Social Services Act no. 448/2008, with the last actualisation from 2021. Social services are aimed at preventing, solving or mitigating the unfavourable social situation of a person, their family or community. Currently, social services for seniors are provided mainly in senior living facilities, specialised facilities and social service centres. Outpatient social services are provided for seniors mainly through home care services; (2) *Health care system* – care for seniors is also provided within the structures of the health system (Act 576/2004 Coll.), primarily aimed at persons with chronic diseases and elderlies in need of special geriatric care. This is mainly provided through home nursing agencies - ambulatory care and institutional care (long-term care departments, geriatric and palliative departments in hospitals) - and in specialised

healthcare facilities, especially in long-term care facilities, psychiatric hospitals, nursing homes and hospices. All these types of healthcare are financed by health insurance companies, mainly on a flat-rate basis.

The Integrative Elderly Care Model in the Slovak Republic

The ‘Global Strategy on Integrated People-Centred Health Services 2016-2026’ (WHO, 2016 & 2017) defines integrated health services delivery as an approach to strengthen people-centred health systems through the promotion of the comprehensive delivery of quality services across the life-course, designed according to the multidimensional needs of the population and the individual and delivered by a coordinated multidisciplinary team of providers working across settings and levels of care.

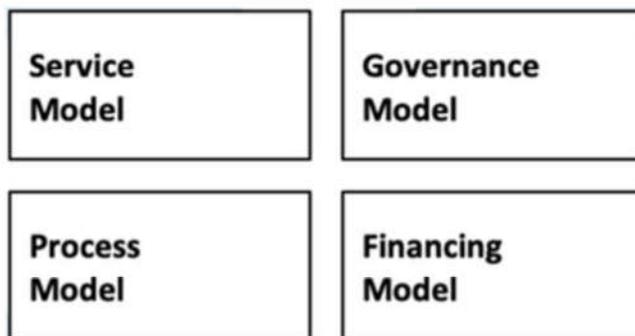
Since 2020 Slovakia has been implementing an integrative elderly care model via the project “*Community - Based Social Service Centres as a Tool of Multilevel Partnership for Providing Long-Term Care in Slovakia*”. The aim is to create a functioning model of community-based social service centres for the elderly with an innovative approach to long-term care provision. This integrative elderly care model is one part of reshaping the future of the welfare state. The centres will serve as a platform for integrating the social and health services of various providers both geographically and structurally, potentially achieving a more coordinated and targeted system of flexible and sustainable services covering preventive activities, outpatient and residential social services, and long-term care services. The aim is to bring social services directly to the elderly in their home environment, whenever their health conditions permit. The proposed activity covers the design of the integrative elderly care model in three small regions, with the possibility of applying the model to other territories of Slovakia. The results of this model will be analysed and evaluated within the working group with the participation of the Ministry of Labour, Social Affairs and Family of the Slovak Republic, as a basis for setting criteria for further legislative processes and long-term care reforms in Slovakia. Horizontal interconnection of adjacent municipalities and systematic support from experts will build up personnel and knowledge capacities necessary for the high-quality provision of long-term social and health care services. Vertical interconnection of different providers at local, regional and national level will create a professional multi-level platform that will ensure better adjustment of provided services directly to the client with an emphasis on outpatient and ambulatory services. An integrative elderly care model will improve cooperation and the flow of information between social and health service providers under the administration of local, regional and national organisations, promoting sustainable multi-level partnerships between individual founders and providers of social services and legislators. Measurement of the impact of the integrative elderly care

model, as well as experience with its enactment, will serve as a basis for setting the criteria for further use of EU funds and national implementation.

Integrative Elderly Care Model Principles and Components

The model is based on the following principles (World Bank, 2020): (1) *Integration of care* - bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion, with the goal of achieving higher efficiency, effectiveness, and a seamless care experience of individuals, including simple communication channels and a coordination of individual services (MacAdam, 2008); coordination of the health and social care service provision, which are currently provided by the various service providers under several financing schemes and regulated by various principles; (2) *Person-centred approach* - focusing care service provision on individuals, families, and communities. It is necessary to understand the person's life, values, priorities and preferences (Šolcová *et al.* 2020). This approach is more focused on the needs and expectations of individuals than on their problems; (3) *Community-based care* - this allows individuals with health limitations or disabilities to retain their independence in their own environment and in connection with the local community. Community-based supports and services (CBSS) are designed to help community-dwelling elderly people remain safely in their homes and delay or prevent institutionalisation. (Wieland & Boland *et al.* 2010); (4) *Suitability to the current legal framework of the Slovak Republic* - working under the separate systems of the provision of health and social services, with divided parallel schemes of financing.

The proposed Integrative Elderly Care Model consists of four core components (Figure 1): The Service Model, Governance Model, Process Model and Financing Model. The core model components are harmonised and supported by additional extensions (World Bank, 2020).



Source: World Bank (2020).

Figure 1. Core Model Components

The *Service Model* component analyses existing social and health services and proposes improvements to spatial distribution, availability, and integration of health and social services in the target area. The *Governance Model* defines institutional structure for integrated care. It proposes optimal distribution of roles and responsibilities among the key providers and their interrelations. Options for optimal legal arrangements are analysed. The *Integration Process Model* lays the practical foundations of care integration, and identifies the main functions, range of activities and processes that need to be introduced and managed by the entity responsible for integration of services. The *Financing Model* describes the current and proposed future models of financing social and health services, their integration, and an estimate of costs and contributions needed (World Bank, 2020).

Scope of the Integrative Elderly Care Model

To achieve integrated care for the elderly it is necessary to solve the service provision issues beyond integration of care (e.g., availability of healthcare services that are not present within a reasonable distance or travel time for a lot of the residents). Since most healthcare services are not specific to the elderly, the focus should be on services provided to the general public and not limited to the elderly (e.g., specialist doctors). The scope of the model could therefore be broader than just integrating care for the elderly. Figure 2 provides a visual representation of the activity areas that are critical for building a fully functional and efficient integrated elderly care system. It clearly shows that while integration of services for the elderly is the main objective and core component of the proposed model, questions related to development of services (including for the general public) and broader mechanisms of care integration need to be recognized as important components of a functional integrated elderly care model (World Bank, 2020).



Source: World Bank (2020)

Figure 2. Model Scope

Key challenges of the Integrative Elderly Care Model

Based on the current review of health and social care systems in Slovakia, the following key characteristics and challenges of the existing system need to be considered when developing the Integrative Elderly Care Model.

Key challenges and characteristics from a Social Care perspective

(a) Social services and care systems are decentralised towards municipalities and regions; (b) The founders of social services are municipalities, self-governing regions and other private organisations and non-governmental organisations; (c) The current system offers a good spectrum of social services types and forms – outreach, outpatients, and residential services; (d) Currently, the self-governing regions and municipalities have a legal responsibility to fund diverse types of services; (e) Divided responsibilities for ensuring social services and lack of their fulfilment result in a complicated system of funding; (f) Existing social services are not focused on preventive and community support, but rather on institutional care. Thus, community services in Slovakia are in short supply; (g) The legal framework contains person-centred standards of quality of social services, but monitoring of the services is only in the preparation phase; (h) Municipalities and self-governing regions have an obligation to do community planning; (i) The existing legal framework allows partnership projects for the provision of social services based on the collaboration of different suppliers - for example municipalities and private providers, and combining several types of services (World Bank, 2020).

The key challenges identified include: (1) lack of funding in the social care and services system; (2) shortage of trained professionals in social services in Slovakia, especially in less-developed regions; (3) low wages of personnel in social services, including allowances for non-formal care; (4) lack of integration between social and health services in Slovakia.

Key challenges and characteristics from the Health Care perspective

(a) The payment mechanisms for health services are highly fragmented; providers have little incentive to integrate health services and promote a person-centred approach. Moreover, the providers' ownership and control are also fragmented. Health and Social systems are harmonised neither on the legislative level nor on the level of service provision; (b) A blend of publicly and privately-owned providers with different governance principles is in place; (c) An organisation focusing on population health, accessibility of the services or the interests of the citizens / patients is missing from the system; (d) Entities closest to the people locally or regionally (municipalities and self-governing regions) have almost no say in the health service provision or policy; (e) Health insurance companies do not have an obligation to offer services to the client if there is insufficient provider capacity

in the region; (f) Health promotion services and interventions (the responsibility of the Regional Public Health Authority) are dramatically underfinanced; (g) There is a lack of data on the current and expected health status of the population, including pertinent data related to the districts and municipalities; (h) No public information is available about any significant epidemiological studies or health needs assessments; (i) The official statistics are focused on services provided or patient registered, and based on statistical reporting of service providers; (j) LTC and other non-core health services (rehabilitation, palliative care, home care nursing, inpatient nursing, and geriatrics) are under-financed, under-developed, low capacity and thus not accessible (World Bank, 2020).

The key challenges identified include: (1) systematic information on more extensive epidemiological studies or health needs assessments in the region and in Slovakia as a whole; (2) identification of suitable investment opportunities and preparation of applications for non-repayable financial support.

Key challenges and characteristics from the Integration of Care perspective

To date there has been no systematic programme of care integration and no localised effort focused on inhabitants of a specific region or catchment area in Slovakia, except for the investment in the integrated health care centres; these, however, failed to achieve the declared goal and have not resulted in a substantial integration of services. The successful cases of care integration refer to individual privately-run facilities or establishments. Aside from the lack of funding, social care and healthcare fall under different founding competences and are subject to different legislation. While LTC is provided in both healthcare and social fields, there is no systemic service coordination or integration between the two. Social care is mainly focused on prevention and relief in social deprivation, and its function is preventive at most. In many cases, patients are discharged from hospitals in a condition requiring further nursing care. There is no timely assessment of the patient's need for follow-up health or social care and the organisation and provision of follow-up care, especially in the case of infirm patients. Follow-up care for an infirm patient is handled by close relatives, who are often surprised by the situation itself; they lack professional help in organising follow-up care, and the knowledge to assess real needs and the availability of services (World Bank, 2020).

To overcome the systemic separation of health and social systems and highly fragmented payment mechanisms there is a need for a new process, which would work hand-in-hand with health and social services provision – care integration services. Care integration services should serve as a key enabler to achieving integrated care.

Care integration services could determine the following challenges, which are not currently identified: (1) Mapping the needs of population; (2) Planning

regional health, social and integration support service development, investment, and transition; (3) Training existing and new health and social workers in integrated care (physicians, nurses, carers, coordinators of care, case managers, public health specialists, health promotion specialists and other non-medical health specialists etc.); (4) Ensuring a detailed health and social data collection and exchange on a regional level; (5) Facilitating the cooperation of the stakeholders such as health and social services providers, physicians, nurses, carers, municipalities, public health authorities, non-Government organisations etc.

Other identified challenges and characteristics related to the implementation of the Integrative Elderly Care Model in Slovakia

The national system does not prohibit integration of care; however, without institutional financial support for integration from the national level it is down to regions and municipalities to design and fund processes to support integration of care. The possibility of integration is confirmed by existing non-public providers combining the provision of health and social services in the form of outpatient care in the case of Centrum Memory, and residential care in the case of Dom Rafael in Bratislava (Slovakia). Locally designed systems should address the shortcomings in service provision based on the needs of the local population. Challenges in care supply require a thorough analysis of population needs and a location-specific approach to address the shortcomings in the existing service provision. The local systems of elderly care must address both the integration of care and the development of currently insufficient services. Besides integration, better availability of services in rural areas is the main challenge. Local models of elderly care should prioritise community care, and outreach and ambulatory services where possible. The national system is overly dependent on institutional care; the gap that needs to be filled on the local level is mostly in care models that can help people extend their independence and keep them in their communities. While individual municipalities do not have sufficient capacity to fulfill responsibilities associated with elderly care provision, the establishment of local elderly care systems (integrating care, health, and social services) should be the joint responsibility of a group of municipalities under a partnership arrangement. A good example of quality management and prioritising community-based services can be seen in Slezská Diakonie (Czech Republic), showing that municipalities need not have sole responsibility for providing services; they can arrange / ensure provision through other entities. It is recommended that there is one separate responsible entity for integration of services; current health and social service providers usually do not have capacity to deliver such services, or the legal competency to require cooperation from others.

The simplification and dissemination of the integration of care on a national level will entail national legislation, introducing a separate financing stream for the integration of care and population health management on a national, regional, micro-regional and community level, and furthermore introducing more flexible legislation on patient data exchange between service providers while respecting the protection of personal data. This data exchange would also apply to health and social services planning, development, and integration. The proposed model is expected to establish a new precedent in elderly care provision in Slovakia and introduce national reforms. The model relies on the joint effort of municipalities expressed in the formal partnership provision of additional services that enable and support the integration of all types of care and people-centred community-based approaches. Experience from the pilot model could set up the base for the development of national legislation, and lead to further scaling up of elderly care integration across the first pilot region, and then other parts of Slovakia. The establishment of Integrated Social and Health Services Centres will strengthen citizens' rights as enshrined in the European Social Charter, Part I, point 13 - Everyone without adequate resources has the right to social and medical assistance; point 14. - Everyone has the right to benefit from social services; point 15 - People with disabilities have the right to independence, social inclusion and participation in society. Mann *et al.* (2004) pointed out that a variety of barriers and challenges can slow the process of integration, including limited personal financial and temporal resources, negative peer opinion, legislative hindrances, and reimbursement shortfalls. According to Ee *et al.* (2020) the advantages and challenges of integrative health and social care, collaborative models of care, review of research highlights of select integrative approaches, and comment on potential cost advantages are currently under discussion. Ignatti & Nakamura (2021) described that despite advancements in policy development, there remain political and operational challenges to its implementation and expansion; these should be overcome to fully implement complementary and integrative practices in health and social care. Slovakia is also going through this changing process with the aim of improving care, especially for the elderly, in the next decade.

Conclusion

Long-term health and social care for the elderly in Slovakia does not meet the current needs of the population. Slovakia lags significantly behind in the capacity of community and home care, as well as in the number of informal carers. The inefficiency of long-term care is reflected in a duplicate assessment system, weak prevention of dependency and confusing management and financing of long-term care. The Integrative Elderly Care Model is not directly defined in the valid laws. The provision of quality, accessible and comprehensive assistance and support with the need and long-term care will also increase the inclusion of

people with disabilities and the elderly in accordance with the Convention on the Rights of Persons with Disabilities. Change and improvement of social and healthcare services requires the coordination of stakeholders from the national to the regional and municipal level. Mutual harmonisation of social care for the elderly, both formal and informal, in such a form that is naturally available to citizens, is a priority.

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