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The Health Assistance in Hospital and at Home

The Slovak Situation

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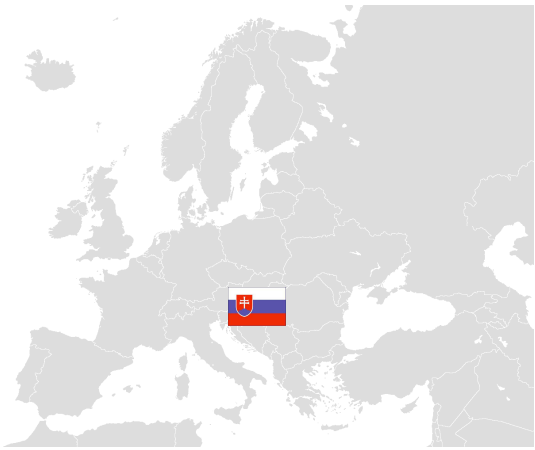

Lifelong Learning Programme

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The Health Assistance in Hospital and at Home
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Hrivňáková štefánia, juraj dúbrava
Transfer Slovensko
Bratislava, Slovak Republic
transfer@transfer.sk, juraj.dubrava22@gmail.com

Abstract

Health care system in Slovakia has long history. Following the velvet revolution in 1989 transformation process has started. The decentralization and the transfer of state monopoly to regional levels with the option of various providers of social and health care emerged. The special medical treatment for elderly people or people with disabilities or those who are in need of long-term care is separated from social treatment (selfservice, allimentation, homemade activities, transportation and social counselling), while the former belongs under administration of Ministry of Health and latter of Ministry of Labor Social Affairs and Family. This segregation is administratively demanding for providers. Increasing ageing of population calls for new approaches how to satisfy the demand for increased need of care. At present 66% of all capacities in institutional care belongs to elderly and the rest to people with disabilities or chronically ill. Still 18 000 elderly people are on the waiting list to retirement houses or houses of social services. The development of home care with more complex services was challenge from nineties and each year new agencies are established into operation. The staff of agencies besides nursing, has also educational role to teach family members how to treat the patient. These agencies grow in numbers each year and play important role in nursing care. Several types of providers both from the social domain and also from the health care are described with the division to social and health care institutions and home care and health care agencies.

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1. Introductory Overview

Slovakia is located in the very heart of Europe, covering 49 035 km. It borders the Czech Republic to the west (252 km), Poland to the north (547 km), Ukraine to the east (98 km), Hungary to the south (669 km) and Austria to the southwest (106 km). It is mostly mountainous with a mixture of continental and oceanic climates characterized by four distinct seasons. The capital of the Slovak Republic is Bratislava. According to the results of the Population and Housing Census conducted in May 2001 (the first since Slovakia's foundation in 1993), Slovakia's population was 5.4 million of whom 51.4% were women. In comparison with the previous census conducted in 1991, the Slovak population had increased by 105 000 and the percentage of women had increased even more, according the Census in 2010 the number of population increased to 5, 6 million. [1] Between 1991 and 2001 the number of economically active persons increased by 48 000. Though their share in the total population remained unchanged, they composed almost half of the total population (49.6%). The number of women in the economically active population increased slightly from 46.9% in 1991 to 47.7% in 2001. Slovaks accounted for 85.8%, Hungarians 9.7%, Roma 1.7%, Czechs 0.8% and others 2% . However, according to the World Bank's 2002 report, Slovakia has one of the largest Romani populations in Europe – informal estimates suggest that there are between 420 000 and 500 000 Roma in Slovakia, or between 8% and 10% of the population. This estimate suggests that a large proportion of the Romani population tends to report another nationality. According to the 2010 census the share of the total population with any religious affiliation had increased from 73% to 84% since 1991. The share of persons reporting the Roman Catholic Church increased from 60% to 69%, Evangelical Church of the Augsburg Confession affiliation increased from 6.2% to 6.9%, Greek Catholic Church increased from 3.4% to 4.1% and the Reformed Christian Church increased from 1.6% to 2%.

1.1 Political History and administrative Structure

The Slavic tribes from which the Slovaks derive their ethnic origin settled in the area of the current Slovakia in the 5th and 6th centuries. The Great Moravian Empire (833–907) became one of the most important cultural, historical and political milestones in Slovak history. After its collapse, Slovaks became part of the Hungarian Kingdom for almost 1000 years. In 1918 after the breakdown of the Austro-Hungarian monarchy, Slovaks and Czechs created the Czechoslovak Republic. In 1939 the first Slovak Republic was created under the pressure of the German national socialist regime. In 1945 the Czechoslovak Republic was restored. The communists' assumption of power in February 1948 affected Slovakia's development for more than 40 years. The 1968 invasion by Warsaw Pact troops ended efforts to reform the totalitarian communist regime. The Czechoslovak Socialist Republic's change into the Czech and Slovak Federal Republics in 1968 and the following period of normalization had symbolic rather than practical significance for Slovakia. The velvet revolution in November 1989 led to the fall of the communist regime. Political, economic and social reforms towards a democratic market- oriented economy in the Czech and Slovak Federal Republic were accompanied by Slovak efforts to gain more political and economic autonomy in their part of the Federal Republic. In September 1992 the Constitution of the Slovak Republic was adopted by the Parliament of the Czech and Slovak Federal Republic. From January 1993 the Czech and Slovak Federal Republic was divided constitutionally into two independent successor countries. Since that time Slovakia has been an independent state: a republic with a multi-party parliamentary democracy and a social market economy. The National Council of the Slovak Republic, the parliament at national level, has a single chamber of 150 members. The current President of the Slovak Republic was elected in the 2004 direct presidential election for a period of five years. The President appoints and dismisses the Prime Minister and other members of the Government. The President can return for repeated consideration the legislation accepted by the parliament but if this is passed through parliament a second time it is adopted automatically. Since 1996 Slovakia has been divided administratively into 8 regions and 79 districts. In 1999 the Government adopted a new public administration reform strategy aimed at strengthening a dual-element public administration system consisting of state and territorial administration. The state administration currently operates at regional level. The heads of the regional offices that correspond territorially with the self-governing higher territorial units are appointed directly by the Government. Following adoption of Act No. 302/2001 on self-governing regions, the territorial administration operates on two different levels. At local level municipalities act as self-governing bodies – this system was reinstated immediately after the collapse of the communist regime in 1989.

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The mayors and members of municipal councils are elected directly in local elections for four-year periods. At regional level there are eight higher territorial units, with borders identical to those of the eight administrative regions. The higher territorial units established by the 2001 Act are represented by their chairmen and local parliaments, both elected directly for four years. The functions of the territorial administration have been expanded in recent years and now they perform most functions connected with social care and the daily lives of the citizens.[2]

1.2 Socioeconomic Development

In 1991 the radical transformation of a centrally planned and controlled economy towards a free-market oriented economy started with four introductory steps: price liberalization, internal convertibility of the currency, a policy of macroeconomic stabilization and extensive privatization. After a severe downturn at the beginning, the Slovak economy developed rather dynamically during the period 1993–1998 with an average annual increase of 5% in GDP and an inflation rate that decreased from 25.6% in 1993 to 5.6% in 1998. Nevertheless, the foundations of this economic development proved to be unsound, especially from 1996 to 1998, and unsustainable. In 1998 the economic situation worsened and by the end of that year the growth in GDP was only 0.1%. Final domestic demand fell by nearly 10% between 1998 and 2000. Meanwhile, core inflation – which excludes administered prices and indirect taxes – slowed slightly and the current account deficit was halved to less than 4% of GDP. A significant positive contribution from external demand enabled Slovakia to avoid a recession, however, with output growing by 2% annually in 1999 and 2000. In December 2000 this period of sluggish economic growth was followed by Slovakia's accession to the Organization for Economic Co-Operation and Development (OECD). Since the early 1990s, real GDP has shown a continuous increase that was – except for stagnation between 1998 and 2000 – also reflected in international purchasing power parities (PPP)). In 2002, Slovakia's GDP was about SKK 1096 billion (€25.3 billion). Per capita, purchasing power adjusted (PPP) GDP accounted for US $12 256, which was well above the EU-10 average, but still just about half of the OECD average. Unemployment fell from 14.4% in 1993 to 11.6% in 1997, but then increased to 17.8% In 2003 the unemployment rate was 17.1% compared to the EU-25 average of 9.1% as documented by Eurostat. State policy based on a comprehensive social security scheme to systems of social insurance, state social support and social assistance. In 1993 the National Insurance Agency was established to cover social, sickness (i.e. sick pay) and health insurance systems. In 1995 the health insurance system was separated from social and sickness insurances. From 1996 both social and sickness insurance were administered by the Social Insurance Agency and a voluntary complementary pension insurance scheme was introduced. In 1998 a new Act on Social Assistance limited substantially state benefits and the number of eligible recipients.

Table 1: Macroeconomic indicators

Indicator	1992	1995	1996	1997	1998	1999	2000	2001	2002
GDP at current prices (billion SKK)	349.9	576.5	638.4	712.7	781.4	844.1	934.1	100.9	109.6
GDP per capita in US $ PPP	6 703	8 114	8 821	9 303	9 802	10 008	10 680	11 371	12 256
Annual inflation (CPI) (%)	10.0	9.9	5.8	6.1	6.7	10.6	12.0	6.5	3.4
Rate of registered unemployment (%)	11.4	13.8	12.6	12.9	13.7	17.3	18.3	18.3	17.8
Public social expenditure (% GDP)	–	13.0	13.0	12.7	13.1	13.5	–	–	–
– on old age pensions (% GDP)	–	4.9	5.0	4.9	5.0	5.1	–	–	–
– on unemployment (% GDP)	–	0.3	0.4	0.5	0.6	0.8	–	–	–

Source: OECD Health Data, 2004.

Note: GDP: gross domestic product; billion: one thousand million; CPI: consumer price index.
SKK: Slovak koruna=€0.02.

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1.3 Demographic Trends and Health Status

The main demographic characteristics in Slovakia are low rates of birth, fertility and population growth. Slovakia's population is ageing (Table 2). In comparison with 1991, the number of persons of pre-productive age declined by 298 000 and reached 1 015 million in 2001 – their share in the total population declining by 6% to 18.9%. The number of persons of productive age increased by 303 000 (5.3%) and reached 3349 million persons (63.1%) in 2001, of whom 48% were women. The post-productive age population increased by 0.7% to 967 000 in 2001 and the proportion of women was 66.1%). In consequence, the average age of the population extended to 36.3 years and the ageing index (defined as the population aged 65+ compared to the children aged 0–14) reached a value of 98.5 in 2001, well above the current European average of 73.

Table 2. Age structure of the population (%), 1961–2001

Census data	Permanently resident population in the age group[a]		
	0–14	15–65	66+
1961	31.5	54.8	13.7
1970	27.2	56.3	16.5
1980	26.1	57.5	16.4
1991	24.9	57.8	17.3
2001	18.9	63.1	18.0

Source: Statistical Office of the Slovak Republic.

Note: [a] including persons of unknown age.

Between 1989 and 2010 the population grew from 5.1 to 5.6 million, mainly due to a decrease in mortality. At the same time the negative trend of the birth rate continued. The number of live births decreased from 15.3 per 1000 inhabitants in 1989 to 9.5 in 2002, when it ranked above the EU-10 average (9.2) but below the EU-15 average. In recent years due to political and social actions the birth rate increased and reached the EU-15 average.

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2. Historical Background

2.1. The Early Developments

By the end of the nineteenth century, the Austro-Hungarian monarchy had passed the first acts on social insurance covering accident and sickness insurance for certain groups of the population. After the creation of the Czechoslovak Republic in 1918, the Bismarck type of health care system based on social insurance was developed further. Sickness insurance became mandatory for wider groups of the population in accordance with Act No. 221/1924. However, this was restricted to employees in privileged services and in certain high-risk occupations (e.g. miners) rather than others such as peasants or the unemployed. The sickness insurance scheme included reimbursement of curative medical services only but various insurance funds offered different contribution terms and services for different groups. Some funds, mostly profession-oriented, owned their own health care facilities. An additional system of private health care providers, mostly family doctors, provided their services for direct payments. In parallel the system of public health services was built up to combat infectious diseases and other public health problems but did not receive appropriate political and financial support. Generally the quality of medical services and their accessibility were dependent on ability to pay. Act No. 221/1926 widened the social insurance system to include disability and pension benefits.

2.2. From 1948 to 1968

Radical changes occurred in the health system after 1948. All health care facilities were nationalized and placed under the ownership of the state, Act No. 99/1948 on national insurance unified all types of insurance, e.g. sickness, disability and pension. This began the health system's transformation into a Soviet-type system. Following Act No. 103/1951 on Unified Curative and Preventive Care, outpatient and inpatient services were integrated into hospitals with polyclinics. Based on Soviet experience, Act No. 4/1952 on Hygienic and Anti-epidemic Care led to the establishment of hygiene stations and research institutes and introduced doctor-hygienists. It was a priority to improve health statistics and health education services. A system of chief experts from important medical specialties was introduced to advise the Ministry of Health. These new elements were developed further and some survive to this day, as shown later. The new system of health care covered over 95% of the population. During the 1950s there was significant success in controlling infectious diseases, particularly tuberculosis. Act No. 20/1966 on Health Care for the Population was another important milestone in the development of the socialist type of health system. The insurance system was replaced by general taxation and the state assumed responsibility for financing and managing the provision of health care. All health services, including drugs and medical aids, became free of charge for all citizens. There was further unification of the organization and structure of the health system. Health care facilities, hygiene stations and other health institutions were integrated into the hierarchical structure of the regional, district and local national institutes of health. This represented vertical and horizontal integration of all health services. At a local level, health centers consisted of a team of health professionals: a "territorial" physician and a nurse for adults, a pediatrician and a nurse for children (aged up to 15), a gynecologist and a nurse for women, and a dentist with a dental assistant. Doctors for adults had to pass a specialization exam in internal medicine or surgery. These teams served a population of 3200 to 3800 residents who were assigned to their primary health care physicians according to domicile. These health centers worked with hospitals with type I polyclinics to form a local institute of national health, providing basic health services to a population of 30 000 to 50 000. Type I hospitals had four departments: internal medicine, pediatrics, gynecology and surgery. Other services were provided by hospitals with polyclinics of the higher type II. Together with three to four local institutes of national health, a district hygiene station and other specialized health institutions, these formed the district institutes of national health and provided comprehensive health services for a population of 150 000 to 200 000. Three regional institutes of national health completed the hierarchical organization of integrated health care provision. Type III hospitals provided highly specialized services for a larger population: 1 to 1.5 million inhabitants. This also included teaching hospitals (9). State-allocated financial resources were paid, according to the plan for the development of the national economy, to the national institutes of health through the district and regional national committees. This was the only source of income for the health care facilities.

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2.3. From 1968 to 1989

In 1968 the Ministry of Health of the Slovak Socialist Republic was established, following the adoption of the federal organization of Czechoslovakia. Its task was to ensure the unified provision of health care services. The basic principles of socialist health care were: state responsibility for, and ownership of, the health care system and care for health of the whole society; unity of science and practice; planning; a unified system for the provision of health care services; focus on prevention; universal coverage and free of charge access to services; and citizens' active participation in health protection. Yet the scarce resources allocated to the health sector were insufficient to cover all the needs of health care providers. According to the literature, the state allocated 5% of its budget to the health sector but lack of transparency in this allocation resulted in a general lack of necessary capital investments, obsolete equipment and facilities, drug shortages, low salaries for health personnel and inequitable development of health services. The socialist health system's indicators of success were the numbers of graduated physicians and nurses as well as hospital beds, hence the widespread construction of hospitals observed from the 1960s. This resulted in a relative oversupply of health personnel, dominance of hospital care and prevalence of so-called specialist culture. Patients tended to be hospitalized extremely often for routine conditions and became passive objects of the health care services. In contrast to the state's commitment to preventive care, this underuse of primary health care providers lowered health personnel's social status and reduced morale and caused overall low prestige of th e health sector. In addition, state paternalism encouraged the population to hold passive attitudes towards their own health. Although the system provided universal coverage of free of charge comprehensive health services, this did not result in desirable outcomes in the health status of the population. For example, the gap in life expectancy between Slovakia and the western European countries has increased since the mid 1960s, mainly due to no communicable diseases. Radical political, social and economic changes triggered throughout Czechoslovakia in November 1989 also brought about reforms in the health sector. After 1989, there were slow but sure differences in the development of the health systems in the Czech and Slovak Republics.

Table 3: Mean life expectancy and average growth of mean expectancy per annum

		1960	1970	1980	1990	2001	2002
Mean life expectancy at birth	males	67.70	66.73	66.75	66.64	69.51	69.86
	females	72.47	72.92	74.25	75.44	77.54	77.63
Average growth in mean life expectancy per annum	males	..	–0.10	0.00	–0.01	0.29	0.03
	females	..	0.05	0.13	0.12	0.21	0.01

Source: (Statistical Yearbook of the Slovak Republic 2003)

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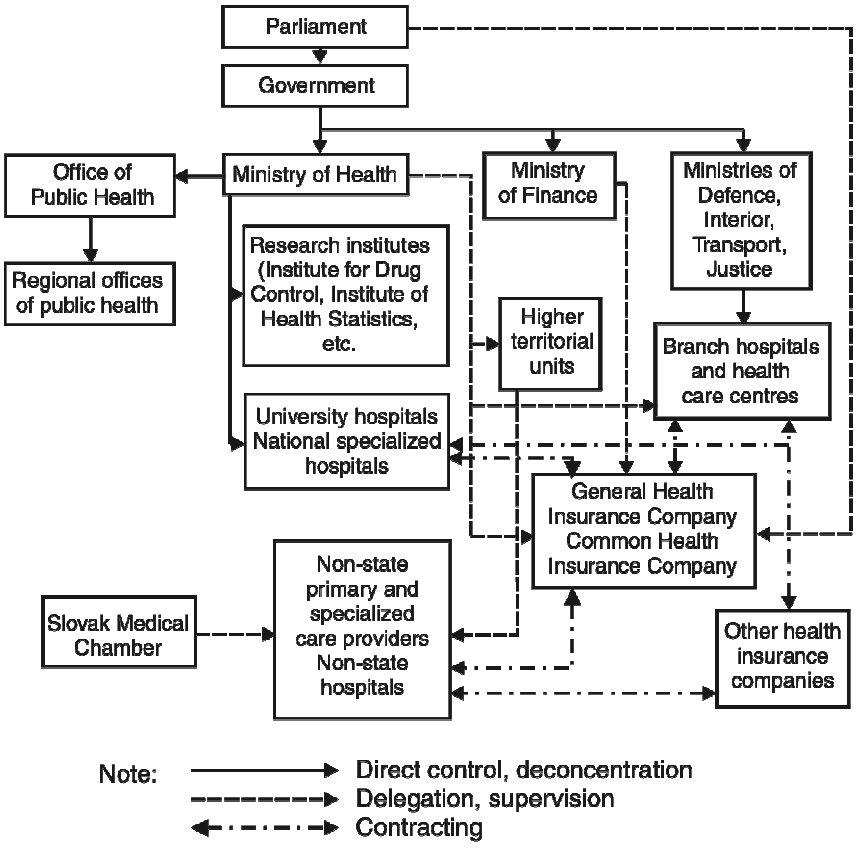
3. Organizational Structure of the Health Care System

The organizational structure of the health care system has changed radically since the communist era. During the 1990s the integrated health care system was stepwise replaced by a social health insurance system with multiple funds. The integrated purchaser-provider function of public administrations with a three- tier hierarchical organizational structure at local, district and regional level was abolished. Most providers of primary health care and many specialists providing secondary care went into private practice. Thus health care delivery became fragmented, based on separated health care providers operating mostly alone. Also, the links between primary health care providers and secondary health care weakened. Until 2001 all but three hospitals continued to be owned and operated by the Ministry of Health and their employees remained civil servants. There were few strong administrative imperatives to manage these facilities effectively and efficiently. Indeed, no hospitals were closed or liquidated for debts and no directors sacked for financial mismanagement, neither were there any significant reductions in staffing levels. In other words, Slovakia's health sector still was shaped by many of the same forces as before 1990 and the devolution of some health service responsibilities to the newly established self-governing regions in 2001 was no panacea. Thus, although Slovakia had achieved a relatively painless transition from socialist central planning to a pluralistic health insurance-based health care system, the grim reality was that a variety of financial and organizational difficulties remained. After the 2002 elections this resulted in the government declaring its objective to increase the health care system's responsiveness to population needs, having regard to the finance available. The Government intends to increase the efficiency of the use of finance allocated for health care, mainly in the mandatory health insurance and, as a priority, to ensure the protection of individuals particularly in the provision of expensive health care services that realistically cannot be covered by an individual. The current organization of the health care system builds upon a mixture of decentralized and centralized structures.

Table 4: Health care structure



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3.1 Ministry of Health

Despite the intention to transform the Ministry of Health into a body focusing mainly on its regulation functions, its status has changed rather slowly over the last decade. As the main state executive body responsible for health care and health protection, the Ministry of Health proposes the principal directions and priorities of state health policy and prepares and submits the appropriate draft legislation to the Government. Based on the Act on Health Care, the Ministry of Health is responsible for the regulation of health care providers to ensure that everyone has equitable access to health care services. It issued licenses for all non-state health care providers until this was delegated to the regional state physicians in 1996. Since January 2002 (based on Act No. 416/2001 on Transfer of Competences from state administration to self-governing regions and municipalities) a major part of the Ministry of Health's powers to issue licenses to health care providers has been decentralized to local territorial administration – self-governing regions (higher territorial units). In 2003 the management of 44 hospitals was transferred to the regions. Of these, 16 hospitals with type I polyclinics were transferred to the municipalities and 28 hospitals with type II polyclinics were transferred to the higher territorial units. Following adoption of the "Transformation" Act No. 13/2002, another 14 hospitals became non-profit organizations. Until 2004 the Ministry of Health also took responsibility for capital investments in the health care facilities owned by the state. This activity has practically stopped and the health care providers have to cover their investments from their own sources. The Ministry of Health also bears responsibility for the postgraduate, continuing and secondary education of health personnel, as well as for the recognition of diplomas and certificates for professional qualifications obtained abroad. However, while the previous HiT on Slovakia noted that the Ministry of Health owned and operated the secondary nursing schools, these schools are now under the management of the self-governing regions. On 1 September 2002 the former Slovak Postgraduate Academy of Medicine was transformed into the Slovak Healthcare University (Slovenska zdravotnicka univerzita). Through the State Office of Public Health of the Slovak Republic, the Ministry of Health ensures surveillance and control of communicable diseases; food safety; safe and healthy working and living conditions; and other public health functions regulated by the Act on Health Protection. 36 regional offices of public health following a devolution process in 2004 carry out most surveillance and control activities.

3.2 Decentralization of the Health Care System

Among the key strategic objectives of the health care reforms in Slovakia were reduction of the state monopoly and decentralization of health care delivery. While the state monopoly has been reduced by the massive privatization of health care providers, particularly primary health care physicians and pharmacies in the mid 1990s, the process of decentralization went nowhere until the beginning of the new millennium. During the reform process, it became obvious that the abolition of the national health institutes resulted in an undesirable centralization of health care facilities' management functions at ministerial level. Although considered to be a transition stage enabling later privatization, centralized management of inpatient facilities prevailed until recently. The reasons were twofold. First, initially the municipalities rejected responsibility for the hospitals due to a fear that they would be unable to manage, finance and sustain them. Second, the Government was reluctant to allow the privatization of inpatient health care facilities. As a consequence, 161 health care facilities (practically all hospitals, polyclinics and specialized therapeutic institutes) and 69 more control and reference institutions (such as the State Institute for Drug Control, National Health Promotion Centre and Institute for Health Information and Statistics) remained under the direct management of the Ministry of Health for decision- making and regulation in 2000. Inevitably hospitals had very little discretionary power over their own resources, the minister appointed the hospital directors thereby guaranteeing dependence and full control. The idea of a hospital governing board comprising representatives of the health insurance companies, state administration, municipalities, patients, private sector and others, was not practiced. In short, it was an inefficient system of management since the Ministry of Health could not possibly oversee the day-to-day operation of more than 90 hospitals. Also this operational burden obstructed its more important strategic role as regulator and policy-maker. However, there had been progress for polyclinics and local health centers providing outpatient care. Responsibility for these centers was devolved to the regional offices of the state administration or to the municipalities and some of the Ministry of Health's administrative tasks were passed to district and regional state

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physicians. This was decentralization by deconcentration. Regional state physicians were authorized to issue licenses to private outpatient care practices. They were responsible for the organization of outpatient health care provision in their territories and involved in the analysis and development of the provider network. In addition, insurance contribution rates, health service prices and In June 2001 Government Resolution No. 577 approved the second phase of privatization for health care facilities. This included 36 local health centers, 13 sanatoria, 2 rehabilitation institutes for children, 1 long-term care facility, 27 hospital pharmacies, 49 polyclinics, 1 natural spa treatment centre and 7 specialized therapeutic institutes. Government Resolution No. 101 in February 2002 added another 3 polyclinics and 1 long-term care facility. Finally, 6 more local health centers, 9 sanatoria, 1 rehabilitation institute for children, 3 long- term care facilities and 20 more polyclinics were included by Government Resolution No. 274 in March 2002. In January 2003 the legislation transferring the ownership of several health care facilities from the Ministry of Health to higher territorial units and municipalities came into effect. This applied to the majority of the previously mentioned health care establishments determined either for privatization or transformation into not-for-profit organizations. Owing to the legal contradiction that only the possessions of the state (not self-governing regions or municipalities) can be privatized or transformed, it was impossible to privatize and transform any health care facilities whose transfers were unfinished at the end of 2002. New legislation on the ownership of higher territorial units and municipalities was adopted in late 2003. This gave them more competencies to manage their health care institutions and in early 2004 the management of some institutions owned by higher territorial units was transferred to private institutions on a contractual basis. [3]

3.3 Fees for Health Care Services

Most medical services in Slovakia are free of charge for those who qualify, but some services are only subsidized and citizens must pay part of the cost. Co-payments exist for some prescription drugs, some dental treatment and medical devices. Non-essential treatments like cosmetic surgery, treatment abroad and acupuncture and excluded from cover. Prescription medicine for those who suffer from chronic illness or those who belong to the medically vulnerable groups e.g. pregnant women, war veterans, diabetics and tuberculosis patients are exempt from all charges. Drugs are divided into three groups, with the first category consisting of essential drugs, which are fully reimbursed by the insurance companies. The second category are partially subsidized and the third group receive no subsidy at all. Appointments with a doctor and referrals to a consultant are free.

3.4 Private Healthcare

Few people take out additional health insurance, which is offered by the five insurance companies. Those that do use it either have no state cover or use it to supplement the state healthcare in areas not covered by the basic care package. Voluntary coverage does reimburse treatment abroad. Doctors and Health Centers: Doctors fall into one of three groups in Slovakia; general practitioners for adults, general practitioners for people under eighteen, gynecologist-obstetricians. GPs provide basic examinations, diagnoses, preventive care, prescriptions, referrals, home visits and emergency health services. GPs tend to work in one-man practices, which are predominantly private. However, private doctors rent their rooms and equipment from the state facilities and make contracts with the health insurance companies. Most doctors employ at least one nurse in their practice. Citizens can register with the doctor of their choice and have the right to change their GP every six months. Most people select their GP according to their proximity to the workplace. People seeking state medical care must make sure that their doctor is contracted into the state scheme through one of the insurance companies. Doctors in Slovakia still take under-the-table payments, which are not authorized by law. Doctors are obliged to inform their patients about the possibility of receiving drugs free of charge. Many doctors rent their rooms from the polyclinics and health centers. These facilities are responsible for outpatient healthcare. Medical services provided include, general practice, maternity care, child healthcare and dental care. They also provide emergency medical aid as well as laboratory, radiology, and other diagnostic services. Qualified doctors and nurses staff health centers: Some polyclinics are private. Waiting times to see doctors vary and it is recommended that you make an appointment in advance. If you need urgent help, you may go to the doctors' surgery on speculation, but be prepared for a long wait. Consultants: Many patients ignore their GP as the first point of contact and self refer to specialist doctors. Consultants are senior doctors who have completed a higher level of specialized

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training. GPs refer patients to a consultant if he believes that a patient may need specialist help and diagnosis. There are numerous specialist fields of medicine in Slovakia like gynecology, oncology, pediatrics and dermatology. Many consultants work out of the state facilities. Hospitals: There are 44 hospitals in Slovakia that are managed by the regions. Hospitals have been under-funded in recent years and are in need of new equipment and technology. Sometimes hospitals have been unable to purchase certain drugs and medical devices, although the situation is improving. Hospitals and clinics exist in all major towns and cities. Their doctor admits patients to hospital either through the emergency department or through a referral. Once a patient is admitted, treatment is controlled by one of the hospital doctors. There is a waiting list for some non-emergency treatments and services. Emergency Care: Emergency care is available free for everyone including those without state health insurance. However, once your condition is stabilized they will want proof of your insurance status. Emergency treatment is provided at the emergency room of all hospitals. Emergency departments are open non-stop all year. You may use their services if you need immediate attention, or if your GP refers you to them, or if there is no GP service available. Private Clinics: Most doctors and specialists are private practitioners in Slovakia. They operate out of rented offices in public facilities funded by the doctors themselves and by additional voluntary private insurance contributions. Private health is only used by a limited percentage of people, often as a top up to the basic state healthcare and to cover them for the services deemed non-essential. Dentists: Dental care in Slovakia is mainly private and dentists are paid on a fee for service basis. Some dental treatment is available through the state healthcare system, but it only covers routine visits and check-ups. Citizens must pay themselves for more detailed dental treatment like crowns and bridges. Pharmacies: Dispensing chemists sell medicines and only doctors and consultants can prescribe medicine in Slovakia. Prescription medicine is only available from a qualified and registered chemist or from a hospital pharmacy. Non-prescription drugs are priced higher than prescription drugs. Under this system, you may pay less for a packet of aspirin if your doctor has prescribed it. Costs for prescription drugs are reimbursed through the national health system.

3.5 State Owned Large Hospitals in Slovakia

Large hospitals are of two kinds: faculty hospitals and regular hospitals. Currently 8 of the large hospitals range as faculty hospitals, others 14 hospitals are state owned and some for them functions as stock exchange companies with majority state share (as e.g. Poprad hospital). The effort to rearrange the legal status of state owned hospitals in recent year was met with strong resistance on the part of doctors and the responding with strong opposition and strike. The transformation of hospitals to stock exchange companies was halted, although all materials and administration for transformation was prepared and the lost expenses for this unsuccessful process counts 30 M €. [4]

3.6 Health Insurance Companies in Slovakia

During the Reform of health care system in Slovakia 5 health insurance companies were established with the aims to manage the patient and to compete. Their legal status allows them to generate profit, what is in the undercapitalized health care system rather strange arrangement. The General Health Insurance Company covers the majority of the population. The Common Health Insurance Company is the second largest and both are guaranteed by the state. Citizens are able to change insurance company at any time, but there is little competition between the insurance companies, although more recently insurance companies have attempted to attract people to their funds. There appear to be no identifiable benefits for the public in having such a choice of companies. The money collected by each insurer is paid to the state run General Health Insurance Company for rationalization. Health insurance is mandatory for all income-earners. The government pays contributions for those citizens who are exempt for contributing like the unemployed, old age pensioners and people on long-term sickness benefit, maternity leave, job seekers, those on disability benefits and reservists. Employers must register their employees with one of the health insurance funds when a new employee starts work. Employees pay 4 percent of their basic income into the fund, whilst employers pay 10 percent. Employed disabled people need only contribute 2.6 percent of assessed income because the state makes up the remainder. Self-employed citizens must pay the full 14 percent contribution, which is calculated as 50 percent of the income on which they paid tax in the previous year. The minimum wage for healthcare contributions is approximately 91 EUR and there is a top limit whereby you do not

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need to contribute any more to the insurance funds, which makes this a system biased towards high-income earners. The list of health care insurance companies:

- General Health Insurance Company
- Dôvera Health Insurance Company
- Apollo Health Insurance Company
- Union Health Insurance Company
- Common Health Insurance Company

3.7 Health and Social Care

Social care services include long-term inpatient care, day care centers and social services for the elderly, patients with chronic illness or other groups with special needs such as those with learning disabilities, mental illness or physical disabilities. Legislation in Slovakia defines this as subsequent, special, and community care respectively. Health insurance companies finance subsequent and special care while community care is financed either by the state budget or through direct payments. Subsequent care follows acute care and includes nursing, rehabilitation, psychological and spa treatment. In 1994 there were 6 institutes with 665 beds for the long-term ill, mainly for elderly people. By 1997 they had increased to 14 with 1122 beds. In 2002 there were only 10 long-term care institutes with 685 beds but 49 long-term care departments with 1958 beds. Despite the provision of another 1978 long- term care beds since 1994 still there are not enough and patients sometimes have to wait months to be admitted. Also, demand is greater as the social care institutes charge fees so families use the institutes for the long-term ill to secure more affordable care (only marginal payments are charged) for their elderly and disabled relatives. In 1997 there were 6 rehabilitation institutes with 511 beds but these had been reduced to 3 with only 294 beds in 2002. The number of convalescent (recovery) homes decreased from 13 with 820 beds in 1994 to 12 with 702 beds in 1997 and 49 day and night sanatoria with 1462 beds in 1994 were reduced to 38 with 1095 beds in 1997. In 2002 there were 41 establishments, including 10 rehabilitation sanatoria, with 1137 beds as well as 6 sanatoria for children with 403 beds. Many of these were privatized. The number of curative spas increased from 46 with almost 11 000 beds in 1994 to 55 with 12 326 beds in 1997, but reduced to 30 spa facilities with 12 666 beds in 2002. All spas were privatized. Currently, Slovakia funds spa treatment through the health insurance scheme with patient co-payment. Special health care includes psychiatric care and care of persons with alcohol or drug dependency. In 1994 there were 11 psychiatric institutes with 3215 beds, compared with 12 psychiatric facilities with 3310 beds in 1997. In 2002 there were 6 psychiatric hospitals with 2300 beds and 5 psychiatric institutes with 900 beds including one children's psychiatric institute with 90 beds. The number of psychiatric departments within hospitals was 29 with 1384 beds. Care of alcohol and drug addicts was delivered in 5 specialized inpatient care departments of psychiatric hospitals with 420 beds and 9 centers for the treatment of alcohol and drug addictions with 146 beds in 2002. The Needles and Syringes Exchange project, the Programme of Vaccination against Hepatitis B for drug abusers and the Methadone Substitution Treatment project were introduced within the framework of the National Programme to Fight Against Drugs. Although the infrastructure of elderly care improved from 195 beds in 1998 to 263 beds in three geriatric institutes and another 856 beds in 21 geriatric departments within hospitals in 2002, it is still not sufficient. Community care has been improved by the introduction of home care agencies that increased from 2 in 1997 to 173 by the end of 2003 and to more than 200 in 2009. Community and home care for the elderly and disabled is supported by the legislation that provides social benefits to the carers of those with disabilities. These forms of community care are increasing. In 1994 the Ministry of Health ran 8 institutions for infants, 12 children's homes and 20 homes for infants. Although transferred to the responsibility of the Ministry of Labor, Social Affairs and the Family, most of these were passed on to the regional state administration authorities. Many institutes for community care were passed to municipalities and are under mixed ownership. Within the framework of the social system there are homes for adults with physical disabilities; adults with both physical disabilities and learning difficulties; persons with impaired senses; and adults with learning difficulties. In 2002 there were 98 with 8330 places. There are also homes for young people with physical disabilities; young people with both physical and learning difficulties; young people with learning difficulties; and young people with

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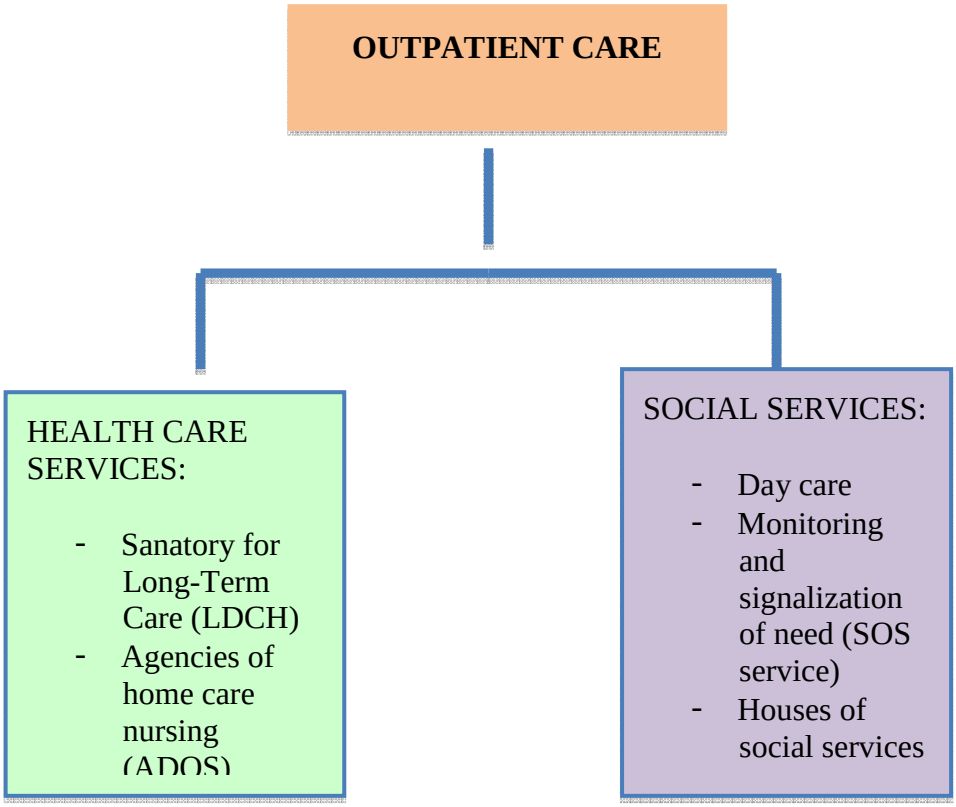
impaired senses. In 65 institutions the capacity was 3749 in 2002. There are also 252 social care institutions with 16 202 places. In summary, the institution- based capacities for social care increased between 1999 and 2002. About 1500 acute beds were transformed into social care and another 1000 hospital beds were transformed into long-term inpatient care. Home care agencies have been promoted since the end of the 1990s. Community-based projects, such as those for harm reduction in drug users, were introduced in recent years. However, home care and community-based services still face financial and legislative hurdles to developing in a way that is appropriate to the changing care priorities and needs of the population. To support the efforts of community care development, the recent amendment of the Act on Health Care Delivery defined the concept of nursing care. [5]

3.8 Long-term care Segregation of Health and Social Services

There exists an unhelpful segregation of health and social care: some of the providers are administered by Ministry of Health (e.g. Agencies of Home Care Nursing – ADOS, etc.) and Ministry of Labor Social Affairs and Family administer other institutions. So in one facility one can find mixed services and mixed reimbursement of expenses. Doctors' and specialists' services with nursing services are under auspices of Ministry of Health, while the social services as self-service assistance, catering, transportation are under Ministry of Labor, Social Affairs and Family. So it can happen that in health care institutions or in home care, the social services are not reimbursed from health care insurance companies. On the other hand there exist social institutions where the health care nursing is provided, which have to be reimbursed from health insurance and it is mostly up to the client and vice versa – if the client in health care institution or agency of home care needs social services, it is up to the patient or family to ask such care for additional payment. The integrated patient oriented approach to the outpatient care for those who are in need of long-term care is missing. Outpatient care can be either institutional or home care format.

Table 5: Outpatient care



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4. Home Care Patients Services Provided Under the Health Care System

In 2004 for the first time in history of Slovak legislature by Act no. 576/2004 Coll.[6] Statutes at large about health care § 8 Ambulatory care Article 5 defines home nursing care as home care provided by nurses or midwives with special competencies in accord with nursing procedures. Home care is a form of outpatient care provided to a person whose health status does not require a continuous provision of health care for periods exceeding 24 or 16 hours. The network of agencies is governed by amendment of Statutory order no. 751/2004 about minimal public network of health care providers and minimal requirements for home care agency to have 1 nurse per 1 000 inhabitants. The expenditures in 2008 for the services were 1.90 billions €, what is 0,5% of all activities of health care insurances and taking into account the agencies are here almost 10 years, the amount of expenditure is considerably low. Reimbursement for the health care services is limited and the agencies work on contractual basis with health insurance companies, those services that are not in the contract reimburses patient or families. In health care institutions it is possible to receive also social care, in that case it is up to the patient or families to reimburse such services.

4.1 Sanatoria for Long-term care (Liečebňa pre dlhodobo chorých - LDCH – institutional care)

Service provided:

Institutional form for long-term care and patients according to specialization of individual sanatoria is provided. In case of LDCH it is gerontology and geriatrics for the patients with long-term disease or multi-diagnoses patients.

Scope of care provided:

Treatment of long-term patients depends on health condition of patients and the type of diagnosis. In majority cases the process of treatment lasts 6 weeks and the hospitalizations can be repeated, if health condition of patient demands the multiply hospitalization. Provided are all services: basic diagnostics, nursing care, rehabilitation, logaoedic treatment, etc

Types of clients –patients:

Services are provided to all ages patients, though the providers are ranged in their specialization among geriatrics. Constituent of this type of provider is Upper Level Regional Unit or Ministry of Health Care. It is possible to establish private sanatoria of this type of health care provision. Except of private sanatoria the reimbursement is by health insurances. Statistical data show that long-term patients with repeated hospitalization is approximately 61%, while the number of psychiatric patients with repeated hospitalization with the same diagnosis counts 42%.

Table 6: The number of hospitalizations in sanatoria (LDCH)

Department	Hospitalizations	Hospitalizations for the diagnoses					
		The first time		Repeatedly		Not specified	
		No.	%	No.	%	No.	%
Long term patients	4 330	1 644	37,97	2 660	61,43	26	0,60
Total	4 330	1 644	37,97	2 660	61,43	26	0,60

4.2 Agencies of Home Care Nursing - Ados

Home care nursing is for individuals who need direct nursing care, but who do not wish to live in a nursing facility. A nurse can visit the home and provide care in that setting. A home health care patient is referred to as a client, and home care can last for a short period of time or an indefinite amount of time. Home Care is an array of services for people of all ages, provided in the home, workplace, schools and other community settings such as clinics, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration and support for the family caregiver. The provision of home care allows persons of all ages the opportunity to recover or manage their health care issues and age at home surrounded by family, friends and their community to which they can continue to make a meaningful

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contribution. Home care services help people with a frailty or with acute, chronic, palliative or rehabilitative health care needs to independently live in their community and co-ordinate and manage an admission to facility care when living in the community is not a viable alternative.

Services provided in the agencies ADOS

Services within home care include nursing, personal support/homemaker, therapy (including physiotherapy, occupational therapy, speech language pathology, social work, nutrition/dietetics), medical supplies and equipment in the home. Home care in Slovakia is delivered by service provider agencies that have to met quality standards given by legislature. Home nursing care is an important and inseparable part of individual long-term healthcare. The need of complex home care in Slovakia has an increasing trend both for clients/patients and for healthcare workers. Inquiries show that as many as 90% of citizens prefer to have health and social care provided within their own home settings. Due to the fact that the number of old people is increasing worldwide, including Slovakia, old people will be the only age group with a growing number of inhabitants in the nearest future. We should be aware of a significant fact that the number of people over 65 years, i.e., of those in need of health and social assistance, is continuously expanding and will form the largest group. As old age is typically associated with advanced stages of chronic diseases requiring treatment in form of follow-up and nursing, the support of complex home care development in Slovakia is of great importance. The aim of home care is to provide complex care in coordination with ambulatory and institution-based care as well as with provision of care services. In 2008, the home nursing care expenditures in Slovakia amounted to EUR 9.3 million and the number of providers counts 173 agencies all over the Slovakia.

The list of Agencies of Home Care in Slovakia:

Banská Bystrica: ADOS Sestrička, Sládkovičova 7/A, Banská Bystrica; ADOS Horná 60
Bardejov: Arcidiecézna charita Košice – ADOS Bardejov, Stocklova 9
Bratislava: ADOS Interrehab, Švabinského 8; ADOS SIGI, Prešovská 39; Harris Slovakia, Haanova 26; ADOS Slnečnica, Parková 31; NZZ SALVUS, s.r.o., Narcisová 5; ADOS – Charita, Heydukova 12; Linda ADOS, s.r.o., Karpatské nám. 11; ADOS MARTA – Stanica zborovej diakonie, Rezedová 3
Brezno: ISIS, s.r.o., Nám. M. R. Štefánika 11
Dolný Kubín: Spišská katolícka charita, ADOS Charitas, Nám. J. Vojtaššáka 1551/1; A.D.O.S. – Nádej, s.r.o., Bysterecká 2066/15
Dunajská Streda: ADOS-DS, s.r.o., Športová 4392/46
Fiľakovo: Medical Fiľakovo, spol. s r.o.- ADOS, Biskupická 24
Handlová: ADOS Erika, Okružná 5
Heľpa: Nezisková organizácia NOVÝ DOMOV, Hlavná 121
Humenné: ADOS – ,,Dubník", Javorová 11; Ošetrovateľské centrum, s.r.o. – ADOS, Lipová 32; Dom ošetrovateľskej starostlivosti, Lipová 32; Denný ošetrovateľský stacionár, Lipová 32; EMPATIA – MO, s.r.o., Staničná 13
Hurbanovo: ADOS ŽIVOT, Komárňanská 104
Ilava: ADOS – Červená, s.r.o., Štúrova 3
Jablonové: Harmónia Života, n.o. – Seniorville Jablonové 439
Jaklovce: ADOS – Srdce, s.r.o., Nová 351
Kežmarok: Spišská katolícka charita, ADOS Charitas Kežmarok, Kostolné nám. 1; ADOS Nádej, s.r.o., Hviezdoslavova 27
Komárno: ADOS – Pomocná ruka, s.r.o., Rákócziho 11; ADOS Oazis – OZ, Kameničná; ADOS Petheoová, Gombaiho č. 7
Košice: Košická ADOS, Pražská č. 4; ADOS EM, s.r.o., SNP 1; Harris Slovakia, Trieda SNP 24; Arcidiecézna charita Košice – ADOS Košice, Južná trieda 2; Asistenčné a opatrovateľské služby, Dénešová 55; ADOS Tereza, s.r.o., Južná trieda 48; BC. Anna Mandzáková – ADOS, Južná Trieda 93
Kováčová: ADOS Nádej Danka Hajková Bc., Tajovského 8
Kremnica: Alzheimerické centrum (Ne)zabúd(k)a, n.o. Kremnica, Dolná 51/25
Kúty: ADOD, Nová č. 1230
Kysucké Nové Mesto: ADOS APEX, s.r.o., Belanského 773
Levoča: Spišská katolícka charita, ADOS Charitas Levoča, Nám. Majstra Pavla 49
Lipany: Arcidiecézna charita Košice – ADOS Lipany, Hviezdoslavova 826
Liptovský Mikuláš: Spišská katolícka charita, ADOS Charitas Liptovský Mikuláš, Nám. Osloboditeľov

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68; ADOS-BH,s.r.o., ADOS, 1. mája 724
Malacky: ADOS Jung, Dubovského 980/33
Málinec: ADOS Málinec 177
Martin: ADOS – Majzlíková, s.r.o., A. Kmeťa 28; ADOS MEDIK. M. s.r.o, Kollárova 5781
Michalovce: SADOS, s.r.o., Námestie osloboditeľov 81; ADOS Charitas – Gréckokatolícka charita Košice, Námestie osloboditeľov; Integra, o.z. – Špecializovaná ADOS pre ľudí s duševnými ochoreniami, A. Hrehovčíka 1
Mýtna: ADOS – Elena, Zvolenská 125
Námestovo: Spišská katolícka charita, ADOS Charitas Námestovo, Priemyselná 572; ADOS Poliklinika, ČK 62/30
Nitra: ADOS Dôvera, s.r.o., Koceľova 29, poliklinika Párovce; ADOS Repiská, Štúrova 21; ADOS Charita, Diecézna charita Nitra, Samova 4; STOMADOS s. r. o., Javorová 643/8
Nové Mesto nad Váhom: ADOS Florence, s.r.o., Odborárska 11/1375
Nové Zámky: ADOS Samaritán, G. Czuczora 1; ADOS Nádej Nové Zámky, s.r.o., Slovenská 37
Partizánske: ADOS Partizánske, s.r.o., R. Jašíka 156/4; ADOS – Jana, Hrnčíriková 222/6
Petrovany: PhDr. Agáta Smelá ADOS, Petrovany 317
Piešťany: Alzheimercentrum Piešťany, n.o., Rekreačná 7; ADOS Vitalis Plus, s.r.o., Rekreačná 4827/2
Poprad: ADOS Zdravie, s.r.o., Lidická 1616/25; Spišská katolícka charita, ADOS Charitas, Alžbetina 372/5
Poproč: Mgr. Zita Baníková ADOS-ATIZ, Východná 23
Poša: ADOS Matta, s.r.o., Poša 169
Považská Bystrica: ADOS Helena, Moyzesova 891/90
Prešov: ADOS Schneider, Čapajevova 23; Harris Slovakia, Nám. mieru 1; Gabriela, n.o. Dom ošetrovateľskej starostlivosti, Lemešianská 21; Gabriela, n.o. Zariadenie opatrovateľskej služby, Lemešianska 21; Kontakt Prešov, s.r.o., Sládkovičova
Prievidza: ADOS RIA – Mária Pipíšková, Ľ. Štúra 5
Púchov: ADOS – Srdce, Pod lachovcom 1727/55
Radošovce: ADOS – OSES Júlia Poláková, Vieska 144
Rimavská Sobota: ADOS ,,Mako" Gabriela Sojková, L. Svobodu 17
Rožňava: ADOS Krištal, spol. s r.o, Vargová Anna, Komenského 26; Edita Bodnárová – ošetrovateľstvo, Špitálska 1
Ružomberok: Spišská katolícka charita, ADOS Charitas Ružomberok, Majere 5
Senica: ADOS – Opora, Sadová 638/43
Sobrance: Arcidiecézna charita Košice – ADOS Sobrance, Kapitána Nálepku 8
Spišská Nová Ves: Spišská katolícka charita, ADOS Charitas Sp. Nová Ves, Hanulova 2; ADOS Monika Kraková, Jánskeho 1
Spišská Stará Ves: ADOS Úsmev, Tatranská 276
Spišské Podhradie: ADOSAN, s. r. o., Prešovská 331/54
Spišské Vlachy: Spišská katolícka charita, ADOS Charitas, Požiarnická 973/49
Stará Ľubovňa: Spišská katolícka charita, ADOS Charitas, Nám. Sv. Mikuláša 12; ŠIAS spol. s r.o. – ADOS, Levočská 1; D.O.M. Nádej, spol. s r.o., Levočská 1
Streda nad Bodrogom: ADOS Helena Horváthová, s.r.o., Hlavná 127
Stropkov: ADOS EVA, s.r.o, Akad. Pavlova 321/10
Stupava: ADOS, Zdravotnícka 1
Svidník: ADOS Ela, MUDr. Pribulu 1
Šamorín: ADOS JANEK, s.r.o., Senecká 4
Tekovské Lužany: ADOS Mgr. Mária Tóthová, Osloboditeľov č.16
Topoľčany: ADOS Abslovakia, Bernolákova 1546/32; ADOS SANAS, Obchodná 2
Trebišov: ADOS Schneider, M. Kukučína 1; Arcidiecézna charita Košice – ADOS Trebišov, Kukučínova 184/1
Turčianske Teplice: ADOS Daniela Šolonyová, Pod Bôrom 277/7
Tvrdošín: ADOS – ALBA, Medvedzie 135
Veľké Orvište: ADOS – IMAG, spol. s r.o., Veľké Orvište 2
Veľký Krtíš: ADOS TOP-MED, Mgr. Katarína Lukáčová, Nemocničná 1
Vranov nad Topľou: ADOS KELZA, spol. s.r.o., Budovateľská 1279; ADOS Mgr. Čačková Anna,

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Budovateľská 1279
Zvolen: ADOS Mária, Kuzmányho nábrežie 28; ADOS Karolina, Obchoditá 1 028 – Očová; ADOS pri NsP Zvolen Vaše zdravie, n.o., Kuzmányho nábr. 28
Želiezovce: ADOS MEDSERVIS, s.r.o., Brezová 9
Žilina: Ľubomíra Hrabušová – ADOS-VITA, Rajecká 17; ADOS Mária, s.r.o., Štefánikova
Bánovce nad Bebravou: ADOS sv. Tadeáša, Radlinského 10

4.3 Hospices – Institutional Care

Services provided:

Hospice provides palliative care, mainly symptomatic treatment and at the same time the patient's psychological, social and spiritual needs are treated. Guarantee for the clients in hospices:

- that they will not suffer unbearable pain
- honesty and humanity of the client respected in all circumstances
- autonomy of the patients as imperative
- respect of individual rights and rights of relatives
- in the final time of life the patient will not be alone.

Hospice includes the time span "ante finem", "in fine" and "post finem". The casual medical treatment is not provided; the aim is to maintain the quality of life till death. Quality of life can be defined as physical (mobility, ability to communicate, removed pain), psychological (joy, harmony without anxiety) and social (family situation, friends, economical aspects) and spiritual (sense of life, values, metaphysical relationship). Quality of life includes also individual aspects based on values. Act no. 578/2004 Coll. on health care providers guarantees outpatient care in hospices.

Scope of the care provided:

- Medical treatment (diagnostics and treatment dealing with pain),
- Nursing care
- Rehabilitation
- Psychological services
- Spiritual services
- Social counseling and supervision (support for families)

Types of clients

Clients with incurable prognosis and who search for quality of life, sense of life and suffering, geriatric patients "prae finem" are the typical clients, to be more specific they are oncological patients with incurable tumor diseases with pain of various types –somatic, visceral, neuropathological, patients with various types of obstructions (gastrointestinal and urophoetical) and neurological and intracranial hypertension, via neuro chirurgic solution unable pain cases, etc.

Description of present situation

Palliative care in Slovakia takes two formats. The new palliative beds are created in hospitals and/or hospices are opened, as it was previously stated. Providing holistic services for terminally ill is not diagnostically and by legislation determined. Main indication is unfavorable health condition of patients demanding control of symptoms in progressing incurable illness in terminal stage. For the admission of patient to hospice demand close relatives, physicians, nursing sister and other institutions (hospitals, retirement houses, social care institutions and other organizations). Each client signs informed agreement of acceptance, or in case of child or person unable to make legal action this agreement sign parents or close relatives.

4.4 Mobile Hospices – Combined Institutional And Home Care

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Mobile hospice provides nursing care for patients with incurable or terminal stage of life in home environment. Service is provided also to families and close relatives in demanding life situation. The service is relatively new based on the regulation of Ministry of Health. [7] Working hours of mobile hospices are daily from 8.00 till 16.00 and longer in case patient need the nursing assistance and on appointment. The goals of mobile hospices are similar to regular hospices concerning the nursing and medical care. However team of physicians and nursing sister strive also for:

- The option for client to stay in home environment
- That the quality and special palliative care is provided
- That the relevant expectations in the domain of bio-psycho-social services are met

That the weak potential of home care is revealed in time and measures are searched

The team of specialist consists of nursing sisters, special doctors and physicians. The main difference between institutional hospice and mobile hospice is more active involvement of family members including their education and training of treatment needed in care for the patient.

4.5 Houses of Nursing Care (Dom Opatrovateľskej Starostlivosti – Dos – Institutional Care)

Houses of nursing care are institutionally based providers and provide nursing and social care.

The delivered Service Quality Conditions/ Standards:

Quality of delivered service / standards		**Evaluation of procedure set**	**Maximum no. of points**
I. Procedural			
1	Procedures, procedural steps and conditions (including time and place) of delivery of service, scope of service and format are determined		5
2	Rules and procedures do attain the purpose of the service delivered are determined and methods, techniques and principles of delivery of service are set		5
3	Individual developmental plans for recipients of service are prepared		5
4	Principles and rules are set to maintain the human rights and freedom for the recipients of the service		5
5	Procedure for the agreement with the recipient of service is set		5
6	Information to the clients on delivery of the services is provided adapted to the capabilities of recipient		5
7	The rules for complaints of clients are set		3
8	Aid in obtaining other social needed service is provided to the client		3
9	The system of satisfaction statement with the services delivery for client is set		3
10	Provider set the criteria assessing if the social services delivered are suitable for the client's needs and with the aims of the service delivered		3
II. Personal			
11	The rules and system set for admission, adaptation and development of staff to increase their capabilities in agreement with the requirements for the service delivered		5

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12	The structure and number of positions and functions, qualification requirements for the positions and compensation set according the § 84 adequate to the numbers of clients served		5
13	The performance appraisal system is set with the goals for individual staff, the development of the staff and delivery of the training needs		3
14	Training needs determined and the supervision set in the environment of provider of service		3
II. Facilities and operations			
15	Without barriers access, material equipment and lavatories and lights comfort in agreement with general obliged conditions		5
16	Social service environment supports human dignity and honesty		5
17	The procedures are set for the cases of emergencies or the endangered situations in the buildings		5
18	Annual reports with complete budgeting reports are prepared		3
19	The rules for donation are set		3
20	The rules for deposits elaboration are set		3
21	The rules for private data maintenance		3
22	The procedures for patients / clients documentation and archive maintenance are set		3
23	The rules and availability of information on the services provided so that the delivery of service is available to others with disabilities or in need of services delivered (web page and other means of communication with public!		3
24	Budget plan for the following year prepared by the end of each year (with planned expenses and coverage of these expanses for the services delivered)		3
TOTAL			100

4.6 System of Study of Nursing Care and Social Care

Nursing care study encompasses 5 years long diploma course (almost master study) or bachelor 3 years long bachelor course and is provided by the 2 universities with the regional affiliations (Univerzita sv. Alžbety, Slovenská zdrtavotnícka univerzita). Diploma nursing care course involves the capabilities and skills: alumnae are able to work in nursing care in the team of health care team or independently in planning, delivery, coordination and evaluation of nursing care in primary, secondary and tertiary health care, social care and in home care. He/she knows the nursing process, has knowledge from humanity sciences related to nursing, performs nursing activities and makes decisions and takes responsibility for the decisions. He performs diagnostics, therapeutical procedures, nursing and rehabilitation as also educational techniques and process, diagnostics methods and procedures to assess health condition and also management of nursing care. Independently solves professional tasks, lead the team and works in team, is bale to perform changes, take risk and be responsible and applies and uses knowledge and skills in practice. Educational program consists of medical, humanitarian and managerial knowledge integrated into holistic nursing aimed at individual person and community in good health condition and in illness.Duration:

- 5 years (10 semesters) - master
- 3 years (6 semesters) – bachelor

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4.7 Study Courses For Social Care

Social care course consists of 220 hours study content. The goal of the course is to prepare student for personal work with the client to ensure his personal needs, activating and social care to support self-sufficiency of the client as long as possible with support of his/her honesty. Course for social care involves capabilities and skills: Social care, organization of work, planning and elaboration of documentation, basics of hygiene and infections. First aid, principles of care for elderly and disabled persons, long term or terminally ill. Basics of physiotherapy, ergotherapy, ergonomics, treatment and transport of clients. Home making and house keeping, safety and preventions of injuries. Psychology of care of elderly and long-term or terminally ill. Communication, conflict handling, basic of social care in individual European countries. In the field social care, agenda and documentation of social client. Providers of the courses are educational organization with accreditation for the delivery of the social care courses issued by the Ministry of Education SR. The courses are organized also with foreign agencies and the certificate is valid in all Europe.

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5. Social Care System in Slovak Republic

There exists social care system divided from health care services, although as it was already mentioned, both systems have institutions and home care system where both – social and health care support is mixed. There were efforts and legislature prepared for unification of both systems with the central focus on patient or client in need of health service often times in need also of social services. However Slovak government did not approve these efforts in prepared legislature.

5.1 Historical Background of Social Care

In 1990 central legislative body Czechoslovak Federal Assembly by Act no. 180/90 Coll. (that was Amendment of Act 100/88 Coll.) overruled State monopoly for providing social services. From that time on the legal subjects other than state can provide social services. In 1992 the Act no.135/1992 Coll. was adopted by Slovak National Council on providing social services by individual persons and by legal organizations. This Act, however, had not specified individual services or type of institutions or facilities. This helped to tackle new risks of transforming country as homeless or drug addiction issues or home violence psychic disturbances, etc. Basic conditions for signing the contract for providing social services and for reimbursement from local state administration was specialization and contract with insurance company for damages. This Act also gave option to restitute state property and to provide service in these facilities.

5.2 Present Situation

At present social services are provided according to Act no. 195/1998 Coll. on social assistance with later amendments of this Act. Social service was defined as one of the tool of social assistance. The Act defines it: "as specialized activities for destitute solution – physical or social destitute. (§ 14, paragraph 1). Social services are:

1. Day care
2. Alimentation
3. Transportation
4. Social care in facilities
5. Social loans.

Act 195/1998 made the enabled decentralization to larger extent and a new social Act was adopted and partially valid from 1.1.2009 up to 1.1.2013. This Act no. 448/2008 Coll. Completed decentralization of social services to upper level units of self-government and also defines interconnectedness with health care services.

Table 7. Founders of the social care facilities before decentralization (year 2001)

Founder	No. of facilities	Capacity of facilities
State – regional administration	369 = 55,1%	27591 = 81,5%
State – district offices	171 = 25,5%	2 263 = 6,7%
Community/ village	25 = 3,7%	1 159 = 3,4%
Church*	54 = 8,1%	1 690 = 5%
Other legal bodies	43 = 6,4%	708 = 2,1%
Individuals	8 = 1,29%	436 = 1,3%
Total	**670 = 100%**	**33 847 = 100%**

*****Church – Slovak Catholic Charity governs 17 charity houses for elderly or ill religious, however since the Church is financed under the Ministry of Culture, these facilities are reimbursed from the budget of Ministry of Culture.

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Table 8: Founders of the social care facilities after decentralization (year 2004)

Founder	No. of facilities	%	Capacity of facilities	%
State - specialized state administration	79	10.8	3 745	10,10
Self government region	305	41,8	21 017	56,6
Community/village	142	19,4	7 075	19,1
Church	67	9,2	1 749	4,7
Other legal bodies	119	16,3	2 801	7,6
Individuals	18	2,5	724	8,9
Total	**730**	**100**	**37 111**	**100**

Resource: Ministry of Labor, Social Care and Family, 2007

5.3 Reimbursement of Expenditure for Social Care Services

Social services after the complete decentralization are reimbursed from the budget of regional self-government to compensate expenditure of providers, from the budget of local self-government and partially from the clients in need of social services, e.g. for day care or payment in retirement houses. Reimbursement can be complete or partial depending on service provided. Act no. 195/1998 Coll. defines conditions of financing/reimbursement of costs for providers of social services as follows:

- Provider is registered as provider of social services
- Provider meets the conditions set by the social legislature
- Social service is missing or is inadequate in the region
- Provider does not generate profit for the provided services
- Provider prepares annual report with budgeting for the registrar body

5.4 Facilities of Social Care for Elderly or for People with Special Needs

Day care at home – social services

People with need of assistance can obtain from the community center – self-government social department unit, assisted care in daily living: assistance in self-service, housekeeping, catering and transportation (social taxi service). The service is partially reimbursed from the self-government (municipality or village) budget, partially paid by the person in need or the family. Many retired people or people with special needs prefer the home care instead of institutional care.

Monitoring and signalization of need (sos service)

Protected work units were established in the framework of local self-government social units with 24 hours working hours to be in emergency help for:

- elderly people
- people with risk diseases
- seriously handicapped people
- people who have experience with falls

This service works on simple principle of Smart Call with pressing the button which is shock-proof or water-proof and pressing the button transfers the signal into unit remote 20 – 40 meters and when the button is pressed the signal is transferred to central work unit and the team performs the measures needed for the person in emergency situation. This service is paid and the expenses are around 12 €/monthly including the equipment and the service needed.

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Houses of Social Services

Regional self-government units administer houses of social services. In the year 2004 the houses for elderly, pensions and houses of social services represented 66% of all capacity of the facilities. The rest were the houses for social services for children, crises centers and asylum houses. At present there is demand for 18 000 places in retirement houses that cannot be satisfied immediately. Upper level regions, or municipalities and the co-financing by clients reimburse public providers. 20% of overall pensions remain to the client and this is legally guaranteed by the legislature. Private providers are only registered, not reimbursed, all the expenses are financing by client or the families.

The number of providers in individual regions:

Banská Bystrica region

- 83 registered providers of social service together with 2 851 individual places
- 41 registered houses for social services with 1 858 places
- At present there is 657 demands for the service.

Bratislava region

- 16 retirement houses with capacity 1 686 places
- 3 houses of social services

Košice region

- 10 retirement houses combined with the houses of social services, out of the number 8 public and 2 private facilities

Nitra region

- 29 facilities of social services

Prešov region

- 27 facilities of social service with capacity 1 782 persons, retirement houses have capacity 1 154.
- Non public providers of social service provide services in 46 facilities with capacity 944 places.

Trnava region

- 3 combined retirement houses, 14 houses are community administered
- 11 non public providers

Žilina region

- 26 providers administered by upper unit
- 8 facilities for seniors are administered by local self-government
- 11 facilities are administered by private providers

Supported Living Facilities

Supported living facilities offer a greater degree of help for the residents compared to an independent living home, but will fall short of the nurse-intensive staffing found at a skilled nursing facility. Residents in SLFs might have semi-private rooms with roommates. They might need help with bathing and dressing or might need supervision in taking prescription medications. Staff provides cleaning and laundry. Most SLF rooms lack private kitchen areas. Residents eat in a facility cafeteria or take meals in their rooms.

5.5 Non Public Providers of Social Services

Besides regional and local governments there are other non-public organizations that provide social

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services. Among the largest belongs:

- Slovak Catholic Charity
- Christian social organizations
- Slovak Red Cross

Slovak Catholic Charity and Dioceses Charities administer:

- 17 charity houses
- 14 orphans houses and adults with special needs and for elderly in need
- 24 providers of day care
- 28 centers for homeless people
- 42 centers for home care

Christian social organizations:

Administer centers for elderly people, homeless and people with special needs, some organizations are network based, some of them functions locally. Evangelical Church has the largest network of providers called Betania.

Slovak Red Cross

Out of 41 affiliations that are legal subjects, 31 regional affiliations provides social services (catering for elderly or homeless people, day care in the form of home care, day care for children with special needs, transportation service, asylum houses for homeless people, etc.

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6. References

1. Slovak Statistical Office, 2001, 2010
2. World Health Organization 2004, on behalf of the European Observatory on Health Systems and Policies, 2004
3. Government Resolution No. 577/2003
4. Slovak Press Agency, January 27, 2012
5. Lezovic, M, Taragelova, B., Beresova, M.: Home Care in Slovakia, Bratislavské lekárske listy 2011, 112 (9)
6. Act no. 576/2004 Coll. on Health Care Providers, services of health care, later amended as Act. No 662/2007 Coll.
7. Decree of Ministry of Health Care, Slovak Republic no. Z45641-2011-OP of August 24, 2011

Relevant Acts:

1. Act 581/2004 Coll. on Health Insurances and Supervision of Health Care
2. Act No. 302/2001 Coll. on Self-governing Regions
3. Act no.195/1998 Coll. on Reimbursement Expenses, Registration of Providers of Social Care
4. Act No. 416/2001 Coll. on Transfer of Competences from state administration to self-governing regions and municipalities
5. Decree of Ministry of Health, Slovak Republic no. Z45641-2011-OP of August 24, 2011 (Mobile hospices)
6. Act no.180/90 Coll. (That was Amendment of Act 100/88 Coll.) Overruled state monopoly for providing social services
7. Act no.448/2008 Coll. on Decentralization of Social Services

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