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Research Article

The Slovak Long-Term Care System

Gerda Schmahl

Faculty of Management, Comenius University in Bratislava, Slovakia
schmahl1@uniba.sk

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Abstract

Declining relative size of the working-age population, decreasing family-based care supply due to higher female labor force participation, and reduced family size will increase the demand and cost of long-term care (LTC). Governments in European countries have responded differently to these challenges. A European comparison reveals striking differences in the construction and design of the national systems. While research on the Slovak LTC system is in its beginnings, this paper aims to contribute to the acquisition of more knowledge about LTC systems within the European Union and, in particular, to present how the social and financial risk of LTC dependency is covered in the Slovak Republic. The paper organizes existing literature on organization, access, infrastructure and financing of LTC, and uses it to analyze the economic, policy and behavioral forces that underpin the observed equilibrium. Slovakia presents a family-based LTC system with a social security system in the process of being established. The lack of services and the financing of the LTC system are insufficiently prepared for the demand, which is expected to rise in the coming years concurrent with the aging of Slovakia's population.

Keywords: Long-Term Care, Access, Financing, Slovakia

Introduction

Long-term care (LTC) is defined as a range of services and supports for people who, as a result of mental and/or physical fragility and/or disability, require assistance in the activities of daily living (ADL) for an extended period of time (Social Protection Committee 2014, p. 58). In contrast to protection against "classic" social risks such as illness, maternity protection and unemployment, protection in the case of long-term care does not look back on an international or an international legal tradition. This backlog is due to the fact that the need for LTC as a social risk is of comparatively recent origin (Schulte 2009, p. 6). It was not until the late 1970s that a few countries, among them France and the present Czech Republic and Slovak Republic, recognized the need for third-party support for people in need of LTC and provided special services for this purpose. Up to that time, the need for LTC was not considered an independent phenomenon or a particular risk (Lipszyc, Sail & Xavier 2012, p. 9). The risk concerns dependency in old age and the need for constant assistance to perform basic ADL (Golinowska & Sowa 2013, p. 9).

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According to article 34 of the Charter of Fundamental Rights of the European Union (FRCh) (European Union 2010), the European Union (EU) nowadays recognizes and respects the entitlement to social security benefits and social services providing protection in cases such as maternity, illness, industrial accidents, old age, loss of employment and dependency. Social security in the event of the need for LTC is expressly recognized here as a state task (Schulte 2009, p. 6). With the Lisbon Treaty coming into force in 2009, the European Charter of Fundamental Rights has become legally binding, and its implementation must be mandatorily observed (European Union 2012).

In European comparison, there are striking differences in the construction and design of care systems (Wingenfeld, Büscher & Schaeffer 2007, p. 33), which are exacerbated by the mostly federal organization of LTC. The answer to the question, what LTC is and who is responsible for its provision, depends on the cultures and evolved structures of the respective welfare states (Backes, Wolfinger & Amrhein 2011, p. 15). This is due to the fact that the individual member states have developed their own systems in accordance with subjective needs, social traditions, their cultures and the financial means available (Social Protection Committee 2014, p. 13). The difference in the way in which social security for LTC is handled in the individual member countries alone is highly interesting as they are facing the same future challenges (Lipszyc, Sail & Xavier 2012, p. 9).

Declining relative size of the working-age population, decreasing family-based care supply due to higher female labor force participation, and reducing family size will increase the demand and cost of LTC in the coming decades (Costa-i-Font & Courbage 2012, p. 17). In recognition of these factors, there is growing concern in Europe that the current mechanisms for financing LTC will not be sufficient to adequately protect people from the risk of requiring LTC (Comas-Herrera et al. 2003, p. 4). While research on the Slovak LTC system is in its beginnings, this paper aims to contribute to the acquisition of more knowledge about LTC systems within the EU and, in particular, to present how the social and financial risk of LTC dependency is covered in the Slovak Republic.

The Slovak Long-term Care System

The LTC system in Slovakia can be characterized by family orientation, residualism, welfare orientation, and a comparatively low level of service provision (Costa-i-Font & Courbage 2012, p. 240). LTC is not regulated in a legally separate social insurance (Golinowska & Sowa 2013, p. 11) and does not consist of a unified social and health care system (Social Protection Committee 2014, p. 230). The responsibility for legislative and oversight of LTC is divided between two bodies - the Ministry of Labor, Social Affairs and Family (MoLASF) and the Ministry of Health (MoH) (Nádaždyová et al. 2013, p. 3). Individual benefits are covered by multiple regulations and laws (Radvanský & Páleník 2010, p. 1), which address different conditions and/or risks, including old age, invalidity, social security, and health care (Social Protection Committee 2014, p. 230). In Slovakia, the term LTC is not seen as a combination of health- and social care that is provided on a regular and long-term basis. The public perception of these two components is strictly separated. Health care is legally and formally provided by the state, while social care (including care for the elderly, disabled or chronically ill) is partially provided by the state, regions, non-profit and private institutions (Radvanský & Páleník 2010, p. 1). In the former socialist countries, the care for needy elderly people was considered a predominantly medical activity. Therefore, not only the medical LTC component, but also the social LTC services were within the scope of the MoH. Between the years 1948 and 1989, LTC was institutionalized. Services were provided mainly in hospitals or in other health care institutions. A paradigm shift took place in the 1990s along with general systemic changes. In the former socialist country, social care was separated and to an appropriate extent "removed" from the

health sector (Golinowska & Sowa 2013, p. 11). In the early years of transition, the objectives of the social policy agenda were decentralization and pluralization. While the health sector (including the medical LTC component) remained centralized, responsibilities for the provision and financing of the social sector were increasingly shifted to the state and local levels. This has further reinforced the division of the health and social sector (Österle 2010, p. 470). In practice, the confusing separation led to difficulties in coordinating measures (Golinowska & Sowa 2013, p. 12). The combination of limited experience in the establishment of a social sector and a lack of financial resources that would have supported the decentralized authorities led to years of restrictions in the modernization and development of the infrastructure. This delayed the emergence of comprehensive social protection in Slovakia (Costa-i-Font & Courbage 2012, p. 241). Throughout the period from 1990 until a few years ago, LTC did not play a prominent role in social policy reforms and was largely ignored as a social risk (Golinowska & Sowa 2013, p. 5). Therefore, it is not surprising that the current level of social protection beyond family or other informal networks is much less developed than in other parts of Europe. In recent years, awareness of LTC as a social risk has grown (Costa-i-Font & Courbage 2012, pp. 236-241) and is increasingly moving into the focus of policy makers (Gerbery & Rastislav 2018, p. 5).

Access and Care Services

The Slovak legislation does not contain a definition of LTC (Lamura 2014, p. 19). Eligibility criteria for social benefits are defined differently within each of the various welfare sectors (MISSOC 2020, p. 2). As a result, social protection may differ significantly for people with similar health problems (MoF SR & MoH SR 2019, p. 109). Access to state LTC benefits is based on an assessment of the applicant's personal situation (Gerbery & Rastislav 2018, p. 5). The evaluation of need for care is performed by a commission composed of physicians (medical assessment activity) and social workers (social assessment activity) (MISSOC 2020, p. 3). Each patient is evaluated individually. The degree of dependence of a patient is considered according to a six-level scale. Law No. 448/2008 on Social Care defines 12 criteria (e.g., eating, drinking, sitting, walking, hygiene, washing, orientation, etc.) for which an individual is assessed (from 0-10 points) according to the performance of his/her personal ADLs. The total sum indicates the level of care needed. If the category determined ranges from level II to VI, the patient is classified as needing care (Radvanský & Páleník 2010, pp. 3-4). The social assessment focuses on the evaluation of individual prerequisites. These are the ability to solve unfortunate situations, family resources and housing conditions (Gerbery & Rastislav 2018, p. 5). Based on the outcome of the assessment, the amount as well as the type of care required and thereby the benefits granted are determined (Schulz & Geyer 2014, p. 147). In Slovakia, both benefits in kind and cash benefits are available. There is a free choice of services and providers. During the receipt of benefits in kind, the person in need of LTC is obliged to contribute to the costs. In an inpatient care facility, the costs incurred must be paid by the recipient according to his income, up to 25% of the subsistence level per month. For home care services, the recipient must at least maintain 165% of the subsistence income (MISSOC 2020, pp. 6-7). Typical recurring state care payments are cash benefits of home care (which are authorized only to a relative or informal caregiver living in the household) and the care allowance (which is granted to disabled care recipients aged six to 65 for employing an unrelated caregiver) (Social Protection Committee 2014, p. 231). Eligibility for cash benefits is means-tested. The recipient's income and assets are taken into account when determining entitlement to public benefits (European Commission 2019, p. 460). Cash benefits of home care (Peňažný príspevok na opatrovanie) are granted for care needs level five and above (MISSOC 2020, p. 3), with a minimum care duration of eight hours per day (Radvanský & Lichner 2013, p. 3). It is a social transfer paid to the caregiver in the amount of maximum €430.35 per month (MISSOC 2020, p. 8).

The provision can be combined with paid work under the condition that the earned income does not exceed the subsistence minimum twice (Gerbery & Rastislav 2018, p. 4). If the caregiver is a pension recipient, the benefit is not subject to a means test and is paid as a lump sum. The amount is €215.18 per month. Care allowance (Peňažný príspevok na osobnú asistenciu) is paid to professional providers for assisting severely disabled persons with a 50% impairment in their physical, sensory, and mental capacity at the rate of €3.82 per hour up to a maximum of 7,300 hours per year (MISSOC 2020, pp. 2-6). Cash benefits decrease as income increases (European Commission 2019, p. 460). If the income is above 5 times the subsistence level, then the amount is withheld (MISSOC 2020, p. 7). This means that the granting of cash benefits is limited from two sides. It is limited according to the income of the person in need of care (means testing) and to the earned income of the caregiver (Gerbery & Rastislav 2018, p. 4). Moreover, social care services offer different financial compensations for the disabled. These include cash benefits to assist with mobility, communication, and orientation (Smatana 2016, pp. 146-147).

Care Infrastructure

Responsibility for LTC in Slovakia is formally divided between MoLSAF and the MoH (Gerbery & Rastislav 2018, p. 4). The MoLSAF is in charge of determining national strategy and supervising providers of social services. The role of municipalities is to provide LTC. They bear responsibility over social services in terms of developing municipal plans, defining a local policy, contracting with service providers, and even determining contributions. The MoH is responsible for medical services and defines the national strategy in the medical field (Radvanský & Páleník 2010, p. 9). Social care is separate from health care. They are insufficiently aligned, as LTC is only partially provided in both systems. Thus, an integrated model of care is not in place (Smatana 2016, p. 145).
By December 31, 2015, there were 5,426,252 residents in the Slovak Republic of whom 50,165 (0.92%) received social services in 1,255 institutions (MoLSAF SR 2017, p. 103). Formal LTC in social facilities can be provided in retirement homes, social residential homes, special care homes, assisted living homes, nursing homes, day care centers, rehabilitation centers, etc. (Smatana 2016, pp. 146-147). The most common type of social LTC in inpatient care took place in retirement homes (Gerbery & Rastislav 2018, p. 4) with 36%. In 2015, 83.5% of all care recipients were in full-time care, 1.3% were in weekly care, 9.6% were in day care, and 5.6% were in short-term care (MoLSAF SR 2017, p. 103). Informal caregivers are eligible to use public support services such as respite and short-term care for their dependents. The low aforementioned utilization rate of these services suggests that their use is modest, as informal care is the major provider of care (European Commission 2019, p. 461). Social services are provided by a mix of public (municipalities) and private providers (nongovernmental organizations, private companies, and church-based organizations) (Smatana 2016, pp. 146-147). Among home care services for persons in need of LTC, public operated services are the most relevant with 78.5% (Gerbery & Rastislav 2018, p. 4). From a historical perspective, the provision of inpatient care was the main and often the only public response to LTC in Slovakia. Given the lack of alternative care arrangements outside the family, inpatient care remains an important alternative even today when informal care networks are not available (Österle 2010, p. 468). This is also confirmed by Eurostat data: In 2014, only 1.3% of the population reported using home care services, compared to a total of 4% for the EU average (Gerbery & Rastislav 2018, p. 10). The strategy for deinstitutionalizing social services and strengthening care, adopted by government resolution at the end of 2011, provides for a systematic transition from institutional to community-based care (European Commission 2019, p. 461). The expansion of home care is thus an intentional and encouraged trend (MoLSAF SR 2017, p. 102).

Services provided by the healthcare sector for LTC are found in the inpatient sector (in special facilities and in departments of general hospitals) as well as in the outpatient sector (Costa-i-Font & Courbage 2012, p. 240). Inpatient follow-up care serves as an "intermediate stage". It occurs between hospital admission to an acute care unit and discharge to outpatient medical care. Post-inpatient health care is provided primarily in hospital long-stay, post-acute, geriatric, and palliative care units, but is also provided in hospices and sanatoriums. According to the definition, care must be provided until discharge to outpatient care, but only up to three months after admission to inpatient care. Currently, inpatient follow-up care capacity in Slovakia is insufficient, resulting in redundant readmissions (MoF SR & MoH SR 2019, p. 111). It is estimated that more than 20% of inpatient hospitalizations in Slovakia are "ambulatory care-dependent," meaning that they are preventable and could potentially be treated in ambulatory care facilities (Kuenzel & Solanič 2018, p. 7). In 2019, the government passed an amendment to the Health Care Act. According to it, inpatient follow-up care capacity is to be increased (MoF SR & MoH SR 2019, p. 111), by transforming acute care beds into LTC beds (Kuenzel & Solanič 2018, p. 7). The lack of capacity in home care leads to long waiting lists for places in social inpatient care (OECD 2017, p. 132). In 2016, there were a total of 7,699 applicants for the provision of social services in facilities. This represents an increase of 1,699 candidates compared to the previous year (MoLSAF SR 2017, p. 104). The number of people on waiting lists in nursing homes for the elderly and in specialized facilities exceeds the number of available places by 30%. In a survey conducted by the Association for the Protection of Patients' Rights in Slovakia (AOPP), 20% of respondents waited longer than a year for their care recipient to be placed in a social care facility. Only 40% of respondents were able to place the dependent in an institution within two months (MoF SR & MoH SR 2019, p. 112). Demand for LTC has increased significantly, but the system still relies on informal caregivers (Smatana 2016, p. 122). Most services (about 60%) are provided through informal home care (OECD 2017, p. 134). The shortage of formal care capacities is replaced by informal caregivers. This form of care is not sufficiently supported in Slovakia. In 2018, 54,700 people received financial compensation for providing care to a person in need of LTC, which amounts to an average of €215 per month for one person in need of care. According to the AOPP survey, 71% of respondents reported taking care of their relatives themselves. Of these, only 20% were entitled to care benefits (MoF SR & MoH SR 2019, pp. 112-113). At the same time, only 2% of informal caregivers who received cash benefits were employed (European Commission 2019, p. 461). This system of insufficient formal benefits has a negative economic impact on caregivers and their families, as the majority cannot work in the labor market but must provide unpaid care (MoF SR & MoH SR 2019, pp. 112-113). The LTC sector in Slovakia suffers from low wages (Gerbery & Rastislav 2018, p. 4) and employs relatively few people providing LTC services compared to other OECD countries (Giorno & Londáková 2017, p. 36). The remuneration of professional care workers is significantly below the average of the economy. Median monthly salary of employees of social care institutions in 2012 was €580 (72% of the national economy average wage) and professional caregivers/nurses earned €516 per month (64% of the average wage) (Social Protection Committee 2014, p. 234). A high proportion (estimated by 65%) of caregivers trained in the Slovak Republic work abroad especially in Germany and Austria, where there is a high demand for these workers (OECD 2017, p. 134). This problem was publicly expressed in 2017 by representatives of employees, supported by the president (Gerbery & Rastislav 2018, p. 4).

Financing

In the Slovak Republic, a mixed financing system for LTC is in place. It is financed from two public sources, depending on the type of service provided (Österle 2010, p. 470). The medical LTC component is

financed through the statutory health insurance (Nádaždyová et al. 2013, p. 3). Thereby the regulations of the social insurance apply (Österle 2010, p. 470). Health-related services are fully reimbursed by the health insurance company. No additional co-payments are charged for home nursing. The social LTC component is financed through taxes (Radvanský & Páleník 2010, p. 9). Social welfare principles are applied in this scheme (Österle 2010, p. 470). Social services, such as formal LTC services and cash benefits, are provided by several tax sources. The in-kind services are financed by the regional municipalities through local taxes and (Nádaždyová et al. 2013, p. 3) cash benefits are provided through the state´s central budget (Giorno & Londáková 2017, pp. 36-37). Health and social insurance are mandatory in Slovakia (Radvanský & Páleník 2010, p. 10).

The Slovak LTC system suffers from chronic funding problems which have worsened under the influence of the economic crisis which began in 2009 and budget restrictions imposed by regional authorities. These difficulties forced the central government to intervene in the social sector with occasional bailouts to prevent the closure of several care centers (OECD 2017, pp. 133-134). As a result, an amendment to the law came into force on March 1st, 2012, determining a direct state participation in the financing of certain types of social services (mostly LTC) (European Commission 2019, pp. 460-461). At present, social services are partially subsidized through the state´s central budget (Nádaždyová et al. 2013, p. 3). In 2016, the MoLSAF granted funds for a participation in the financing of social services in the amount of €85.9 million. Expenditure was €9 million (12.6%) higher than in 2015 due to an increase of applicants for financial assistance (MoLSAF SR 2017, pp. 104-105). Furthermore, deficient and heavily indebted healthcare institutions required rescue from impending insolvency by the government on several occasions. As an example, debt relief by the government took place in the spring of 2018. In the first phase, financial liabilities of hospitals were reduced by €339 million. A second phase is currently being prepared by the MoH (Kuenzel & Solanič 2018, p. 5). Both sectors are under budgetary pressure, which not only increases financial stress within the segments, but also creates incentives for stakeholders to shift responsibilities and costs to other sectors (Österle 2010, p. 470). Beneficiaries of social LTC services were asked to contribute directly to its financing, which created social tensions given the low-level of pensions (OECD 2017, pp. 133-134). Public funding covers around two-thirds of expenditure. About one-third is supplemented by private co-payments from recipients. This applies to both institutional and home care (Radvanský & Páleník 2010, p. 9). On average, private co-payments amount to €320-350 per month (Smatana 2016, p. 146). All social services, with a few exceptions such as counseling services and social rehabilitation, are subject to cost-sharing. For private care services, private co-payments are defined directly by the providers (Nádaždyová et al. 2013, p. 3). The cost of private facilities is generally considered to be very high (European Commission 2019, p. 31). Institutions providing social services (public or private) receive a fixed contribution for each patient, based on the patient's level of care and the type of service used. A private provider is entitled to this contribution only if a prior contract with the local or regional administration has been negotiated (Radvanský & Páleník 2010, p. 10).

Public spending on LTC in 2016 amounted to 0.9% of the country's GDP, therefore lying considerably below the EU average of 1.6% (European Commission 2019a, p. 31). Expenditure on social services in LTC institutions amounted to €358.3 million. This corresponds to a share of 97.2% of all social institutions' total spending (MoLSAF SR 2017, p. 103). As no additional sources of financing (for example, a new contribution or increased taxation) have been defined to cover public LTC costs, expenditures are financed from health insurance as well as social welfare funds. The spending level of the health- and social care sector is relatively low compared to

the EU average. Therefore, it is not surprising that LTC funding from the modest resources of both sectors is low (Golinowska & Sowa 2013, p. 33). Slovakia appears to have a below-average use of cash benefits compared to EU averages (European Commission 2019, p. 460). In 2016, the average monthly number of recipients of cash benefits was 54,666 and the funds spent on it amounted to €99.4 million. Thus, in 2016, cash benefit recipients received an average of €140.80 per month for their service (MoLSAF SR 2017, p. 94). Only 11% of public spending on LTC is actually incurred by cash benefits. In comparison, the EU average is 15.6%. The bulk of public spending on LTC is hence accounted for by in-kind contributions at 89% (European Commission 2019, p. 460). In 2016, the municipalities spent a total of €35.3 million on the provision of home care. Local government revenues from co-payments by beneficiaries for home care services amounted to €6.2 million in 2016, an increase of €834 thousand over the year of 2015. The reason for the higher income compared to the previous year is the rising number of beneficiaries who are obliged to contribute to the costs of home care (12%). Private co-payments account for 17.8% of current expenditure on home care services. The difference between revenues and expenditures for home care services was €28.5 million in 2016. The municipalities were obliged to pay this amount from their own budgets (MoLSAF SR 2017, p. 102). In Slovakia, the structure of spending on LTC services is diverse and volatile. A comprehensive evaluation of LTC expenditures requires numerous estimations, as the amount of spending on LTC services is not distinguished (reported separately) in either the health or social sectors. This complicates the breakdown of financial data for LTC and demonstrates that the sector is still in a developing state (Golinowska & Sowa 2013, pp. 28-29).

Conclusion

The financing of the LTC system is insufficiently prepared for the demand, which is expected to rise in the coming years concurrent with the aging of Slovakia's population (OECD 2017, pp. 133-134). Projections show that the number of people in need of LTC will increase from 510 thousand in 2015 to 770 thousand in 2070. This represents a change of 52%, which is higher than the increase of 25% in the EU (European Commission 2019, p. 459). Significant investments will be required to meet the increasing demand for LTC (European Commission 2019a, p. 31). To ensure improved financial stability, higher public subsidies are planned based on a positive forecast for economic development. Since 2018, the state has been paying financial contributions to social care providers to help counteract low wages in the sector. In addition, there is an increasing interconnection between health- and social LTC in the form of increased use of health insurance funds (Gerbery & Rastislav 2018, p. 4). Since 2014, social care institutions have been able to receive reimbursement for nine medical services from the health insurance fund (Smatana 2016, pp. 146-147). Increased client contributions are seen as another option to improve the financial stability of the system (Gerbery & Rastislav 2018, p. 4).

It is expected that there will be an even larger "care deficit" in Slovakia in the next few years. The nature of the "Slovak care deficit" results from the fact that many elderly people in need of LTC do not receive any social assistance. However, this is not due to a shortage of local (national) workforce, but to inadequate funding and efforts to meet LTC needs primarily through family members (Nádaždyová et al. 2013, p. 6).

The fragmented organization of the LTC system makes it difficult for beneficiaries to access and use. The multiple channels for assistance administered by different agencies make the system non-transparent and difficult for users to navigate. The bureaucracy involved in assessing the need for care is burdensome, and the various types of assistance are poorly coordinated (Giorno & Londáková 2017, pp. 36-37).

The social care sector is considered an appropriate context for the provision of

LTC, but the relevant infrastructure in this sector is far from sufficiently developed (Costa-i-Font & Courbage 2012, p. 240). There is a lack of home-based care capacity and the few existing nursing homes are considered inadequate due to low personnel resources. This is mainly due to the lack of funding (Smatana 2016, p. 145).

The evidence shows that institutional models do not have much impact when needs' assessments are conducted and countries rely heavily on private cost-sharing to build the demand for services (Costa-i-Font & Courbage 2012, p. 6). The Slovak Republic presents a family-based LTC system with a social security system in the process of being established (Schulz & Geyer 2014, p. 138).

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