MATEJ BEL UNIVERSITY
IN BANSKÁ BYSTRICA

Long-term Integrated Care for Older Adults

Andrea Seberíni, Miroslava Tokovská, Anna Vallušová

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Faculty of Economics
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Reviewers
doc. Ing. Stanislav Kološta, PhD.
prof. Hans Jørgen Wallin Weihe

Revision and Proofreading:
Alex Elwood GCLCM

Cover design
HenriMat Photography

PhDr. Andrea Seberíni, Ph.D. https://orcid.org/0000-0002-8531-1611
Doc. PhDr. Miroslava Tokovská, PhD. https://orcid.org/0000-0002-8279-3168
Ing. Anna Vallušová, PhD. https://orcid.org/0000-0001-8861-1102

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To all social and healthcare professionals who are working or supporting the older adult population on a micro-, meso- and macro-level in Slovakia.

Thank you for your effort.

CONTENT

LIST OF ABBREVATIONS

ADL	activities of daily living
BBSGR	Banská Bystrica Self-Governing Region
CBSS	Community-based supports and services
CISH	Centres of Integrated Social and Health
EU	European Union
FA	functional ability
HR	human resource
IADL	instrumental activities of daily living
IC	integrated care
ICOPE	integrated care for older people
ICT	information and communications technology
LTC	long-term care
MLSAF	Ministry of Labour, Social Affairs and Family, Slovak Republic
NGOs	non-public providers
OECD	Organisation for Economic Co-operation and Development
PREMs	person-reported experience measures
SDGs	sustainable development goals
SHARE	Survey of Health, Ageing and Retirement in Europe
V4 countries	The Visegrad Group countries (Czech Republic, Hungary, Poland, Slovakia)
WHO	World Health Organisation

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INTRODUCTION

The world's population is rapidly ageing, and the consequences of this are unprecedented public health challenges for most countries in the world. The need for diverse health care is rapidly increasing, along with the complexities of providing health care to older populations. In the 21st century the population demographics in Slovakia have shifted, yet the system of social and health care is not adapting quickly enough to the new circumstances. Due to the challenges in the formal care system, the number of unpaid carers has been growing fast and now constitutes almost two-third of the provided care.

The health and social care system in the Slovak Republic is struggling, and to a certain extent failing, to meet the care and support needs of older adults. Health issues concerning older people are often managed in disconnected and fragmented ways, and there is little coordination between care providers among different settings and over time at the municipality, community, and national level. Nevertheless, the involvement of numerous health care and social care professionals, and the use of multiple clinical interventions, necessitates a high degree of coordination between professionals and within treatment levels, settings, prevention and health promotion. Additionally, support of the next of kin is an essential measure that brings long-term results. There is a clear challenge for the Slovak Republic to meet the care and support needs of an ageing population, both now and in the future.

The Banská Bystrica Self-Governing Region (BBSGR), within the framework of the European Commission's call to support social innovation and national reforms in the field of long-term care for older adults, is implementing the project 'Community-Based Social Service Centres as a Tool of Multilevel Partnership for Providing Long-Term Care in Slovakia'. The project is being implemented from 2020 by the Banská Bystrica Self-Governing Region in cooperation with: Matej Bel University in Banská Bystrica, Slovakia; Kristiania University Oslo, Norway; the Ministry of Labour, Social Affairs and Family of the Slovak Republic; and the Ministry of Health of the Slovak Republic. The common ambition of all the participating institutions is to create a functioning pilot model of community centres of social services for the elderly, which will serve as a platform for the integration of social and health services.

The project is designed to solve the following problems:

1. improve the connection of social and health care systems for older adults;
2. increase the transfer of responsibility for the provision of field and ambulatory social services to municipalities;

3. provide outreach and outpatient social and healthcare services that increase the quality of life for older adults and, at the same time, represent a lower burden on public finances.

The project aims to create a functioning pilot model of three Centres of Integrated Social and Healthcare Services for older adults at the community level in selected regions. The Integrated Social and Healthcare Centres will serve as a platform for the integration of social and healthcare services in a specific territory of a functional cluster of municipalities in cooperation with the BBSGR. The project has been implemented in three regions: Veľký Potok - Ipeľ, Novohradské Podzámčie and Štiavnicko). These regions (especially Veľký Potok – Ipeľ and Novohradské podzámčie) are among the less developed areas of Slovakia, both economically and in terms of the provision of social services. The regions consist of a number of villages located relatively far from bigger towns and organising the care for older adults in these loose collections of villages can be done from one office. The project makes use of existing cooperation among the villages within the formal associations of the municipalities and establishes pilot operation of joint offices for integrated care. This monograph originated in partial fulfilment, and with support of the project KEGA 040UMB-4/2021 'Diversification of content and didactic forms for teaching economic subjects in Slovak language and world languages' at the Faculty of Economics, Matej Bel University in Slovakia.

The output of the project will be a model of long-term care for older adults, integrating various forms of assistance and support through preventive, outreach, outpatient, and residential social services, as well as healthcare services, which will be financially sustainable.

The intention of the project is:

- to bring social services closer to the citizen in his/her home environment, in his/her community;
- create the conditions for the creation of an efficient and financially sustainable system of long-term care services, with an emphasis on the provision of outreach social services considering local needs;
- strengthen the responsibility and participation of local capacities in solving the problems of older adults.

This monograph summarises the experiences of the implementation of the project. Its aim is to propose a system of community social and healthcare services for small settings which meets the needs of older people while making its provision efficient in terms of human and financial public resources. Several steps were taken in order to meet the aim of the project. Firstly, we made a synthesis of existing literature on the problematics of ageing and long-term

care, which provided the context of the analysed problem. We then performed an analysis of best practice from the Scandinavian countries and from the V4 countries. The Scandinavian countries were chosen to serve as benchmark in this area for their highly developed systems of services for older people, and the V4 countries were chosen due to the fact that they face a similar reality (demographically, culturally, and economically) to Slovakia, and are therefore a source of valuable information. Following this, we used the method of analysis and synthesis to describe the challenge of the current social and healthcare system in Slovakia. In the next step, the method of direct questioning was used to gain the view of the older citizens on their needs for social and healthcare services and the level of their satisfaction. We use a quantitative analysis – a questionnaire was conducted eliciting the level of satisfaction of older people in regard to their needs being met. Finally, this knowledge was applied to formulate proposals for efficient community social and healthcare services in the form of Centres of Integrated Social and Health Care.

The present monograph aims to provide a proposal for the creation of a system of care for older adults in the selected region of Slovakia, based on the experiences of foreign countries and their approaches to managing care for the elderly. Ultimately, it is recommended that Centres of Integrated Social and Health Care (CISHC) are established, allowing local and regional levels of social service provision to pool their knowledge and resources, thus integrating social and healthcare services for the elderly in Slovakia. In view of the above-stated aim, the subject of the monograph is social and healthcare systems in the context of the provision of their services to older adults. The solution to the deficiencies that occur in both systems in regard to the provision of care for older adults is to integrate them and to create a model that aims to bring social services closer to the client in his or her home environment, as far as his health condition allows.

This monograph comprehensively, coherently and systematically discusses the guidance of the development of the integrated care system. The publication summarises examples of possible integration of the social and healthcare services from Scandinavian and V4 countries and presents a new approach to solving the problem of long-term care for older adults through Centres of Integrated Social and Health Care. Space for the development of new theoretical knowledge in this area, as well as for innovative practical solutions that will help to improve the lives of older adults in all regions of Slovakia in the future, is also offered.

KEY MESSAGES

- Social and healthcare services should be reoriented towards person-centred and coordinated models of care.
- The primary healthcare approach has a key role in meeting the holistic needs of older adults.
- The responses to the health needs of older people include supportive policies, plans and regulatory frameworks.
- The continuum of care and integration of services are the two primary goals for transforming and adapting the current disease-oriented healthcare systems to the needs of all older persons.
- In order to face the increasing demands for health care by the growing number of older adults, the fragmented care system must be replaced by person-centred integrated care that has primary care as a central element; this includes:
  - undertaking a comprehensive assessment of the health and social needs of older adults;
  - empowering and engaging individuals, families, and communities in the management of their healthcare systems, decisions about their health care, and their ability to take care of their own health and the health of those they care for;
  - ensuring that actions towards the delivery of integrated care for older adults can take place at all levels of health care;
  - utilising information and communication technologies to help in training healthcare workers to provide personalised care, thus allowing older adults to do what matters most to them in the latter part of their life;
  - integrating care which allows a more appropriate allocation of resources to support the ageing population.

1 THEORETICAL BACKGROUND OF AGEING AND HEALTH IN THE WORLD

People worldwide are living longer. Today most people can expect to live into their sixties and beyond. Every country in the world is experiencing growth in both the number and the proportion of older persons in the population. According to WHO (2022), by 2030 one in six people in the world will be aged 60 years or over; this figure represents 1.4 billion people, an increase from 1 billion in 2020. By 2050, the world's population of people aged 60 years and older will be double that of today (2.1 billion). The number of persons aged 80 years or older is expected to triple between 2020 and 2050 and reach 426 million. While this shift in the distribution of a country's population towards older ages – known as population ageing – started in high-income countries (for example, in Japan 30% of the population is already over 60 years old), it is now low- and middle-income countries that are experiencing the greatest change. By 2050, two-thirds of the world's population over 60 years old will live in low- and middle-income countries.

1.1 Age-friendly world, cities and communities

The proportion of older people in cities and communities in respect of the general population is increasing. The physical and social environments in our cities and communities are powerful influences on the experience of ageing and the opportunities that ageing affords. Cities and communities around the world are already taking steps towards becoming more age friendly.

Active ageing is the process of optimising opportunities for health, participation, and security to enhance the quality of life as people age. In an age-friendly city policy, along with services, settings and structures, will support and enable people to age actively by:

- recognising the wide range of capacities and resources among older people;
- anticipating and responding flexibly to ageing-related needs and preferences;
- respecting their decisions and lifestyle choices;
- protecting those who are most vulnerable;
- promoting their inclusion in, and contribution to, all areas of community life.

An age-friendly environment generally refers to a community in which ageing people are valued and respected. They are involved and supported in basic daily activities, such as moving around and shopping, and accessing and receiving all kinds of public and private services. The World Health Organisation (WHO, 2007) defines an age-friendly city and community as, 'one in which policies, services, and structures related to the physical and social environment are designed to support and enable older people to age actively – that is, to live in security, enjoy good health, and continue to participate fully in society'. Age-friendly environments foster healthy and active ageing (Figure 1). They enable older people to age safely in a place that is right for them, be free from poverty, continue to develop personally, and contribute to their communities while retaining their autonomy, health, and dignity. Because older people know best what they need, they are at the centre of any effort to create a more age-friendly world.

Figure 1 Eight dimensions of age-friendly community, 2017

Source: Centre for Age-Friendly Excellence, 2017.

Remillard-Boilard et al. (2020) identified four priorities that the age-friendly movement should consider developing. Firstly, the negative perception of older age should be challenged, along with raising awareness of the needs of older people; secondly, all relevant parties

(stakeholders) should be involved in drawing up age-friendly programmes; thirdly, the (diverse) needs of older people should be attended to; and finally, the planning and delivery of age-friendly programmes must be continuously adapted and improved. The researchers also highlighted the benefits of conducting more empirical, comparative, and cross-national studies in order to better understand the development of the age-friendly movement. As the movement continues to expand, measuring its progress - and documenting the experience of participating cities - will be essential to demonstrate the benefits of the age-friendly approach, and recommend the direction of future policy and practice. However, it is precisely in this situation that the benefits of adopting an age-friendly approach may become apparent, in particular, helping to ensure that support for older people is maintained and that the voices of those growing old continue to be heard and acted upon. Del Barrio et al. (2018) added that the model envisages a community where older people are not only the beneficiaries, but they also have a key role to play in defining and promoting their distinctive age-friendly features.

The WHO (2017) states that one of the essential conditions for creating age-friendly cities and communities is older people's meaningful participation in all stages of the development process. This last point - where older people are seen as crucial agents of change - is supported by research adopting a participatory approach to involving older people as the key to researching and developing age-friendly communities (Buffel et al. 2012). Such a collaborative approach, in which older people play a central role as co-researchers in developing age-friendly initiatives, has been shown to facilitate community development and change at the local level, which can lead to more hospitable and supportive community environments and increased civic engagement and social capital (Buffel 2018a). Further advances, however, must be made - both in developing strategies to sustain age-friendly work as a collective community building process and in gaining commitments to develop structural solutions with a range of stakeholders. Chung et al. (2021) stressed that in an age-friendly society older people are encouraged to engage in productive activities, such as sharing their knowledge and expertise with younger generations and contributing to their communities through employment or voluntary work. In return, their contribution to society is appreciated and older people are respected.

Families with older adults feel less stress when an age-friendly community provides support and social and health services to older adults. Programmes and policies in this type of city are therefore designed to enable older adults to contribute to their communities. Furthermore, communal facilities are designed to be shared and used by people of different ages and interests, leading to harmonious interactions between different generations. In this

type of community, even the media depicts older people positively and without the use of stereotypes.

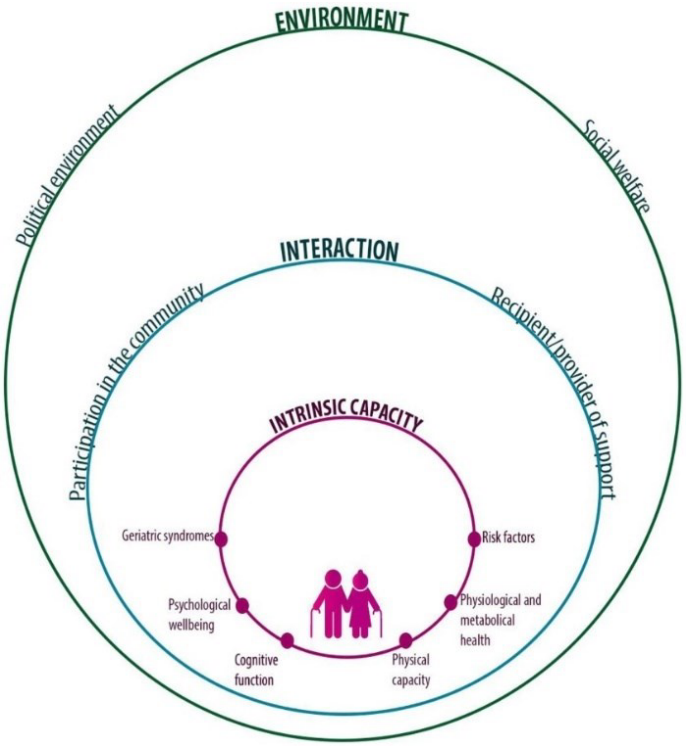
1.2 The concept of healthy ageing

To formulate public health strategies in response to the ageing population, the WHO (2015) has proposed the concept of healthy ageing as, 'the process of developing and maintaining the functional ability required for a healthy life of older adults'. Functional ability is described as, 'the health-related attributes that enable people to be and to do what they have reason to value', and depends on intrinsic capacity and the environment, as well as the interaction between them. Intrinsic capacity refers to the sum of an individual's physical and mental abilities. Evidence shows that focussing on the intrinsic capacity of older adults is more effective than focussing on specific chronic diseases (Beard et al. 2016; Zhou & Ma, 2022). Older adults can achieve a higher quality of life in their later years when they are within a suitable environment and have reached the peak of each health phase, thus reducing the costs on society. The new WHO care model of healthy ageing involves a longitudinal observation of the individual's trajectory, with the goal of implementing active and personalised interventions that improve older adults' intrinsic capacity and functional ability.

A healthy ageing model was developed based on the WHO concept of healthy ageing (Rudnicka et al. 2020). Chalise (2023) noted that healthy ageing is an individually-lived experience that is influenced by healthy behaviours over the course of a lifetime. This includes a person's ability to meet their own basic needs, learn, grow and make decisions, be mobile, build and maintain relationships, and contribute to society. For the promotion of healthy ageing, a healthy lifestyle is important. A healthy lifestyle for older adults includes healthy eating, regular physical activity, staying at a healthy weight, improving mental health, social participation, regular health check-ups and health screening, abstinence from smoking, and taking steps to prevent falls. Rivadenaira et al. (2021) considered three components for healthy ageing: a) the intrinsic capacity, referring to the physical and mental health, b) the social and political environment, and c) the interaction of the older adult with the environment. To determine the intrinsic capacity, six domains were considered: 1) physiological and metabolic health, 2) geriatric syndromes, 3) risk factors, 4) physical capacity, 5) cognitive capacity, and 6) psychological well-being (Figure 2). The physiological and metabolic health domain took into consideration whether the individual has or had cancer, diabetes, hypertension or other

chronic diseases, but made allowances for those under treatment or post-treatment who did not have any limitations to the functional status of being an older person. The geriatric syndromes domain included the absence of urinary and faecal incontinence, the number of falls, and the presence of polypharmacy. In the domain of risk factors we included measurements for cardiovascular risk, consumption of alcohol, tobacco, and measurements of physical activity. The physical capacity domain included compliance with activities of daily living and a self-reported assessment of mobility, while the cognitive ability domain involved an assessment of dementia or cognitive impairment. The absence of physical, sexual, and psychological abuse, as well as absence of depression, were included in the psychological well-being domain.

Figure 2 Multidimensional model of healthy ageing



Source: Rivadeneira et al., 2021.

Cesari et al. (2022) stressed that the concept of Healthy Ageing has initiated a global discussion about the need for shifting paradigms to reorient social and healthcare services towards person-centred and coordinated models of care. In particular, the integration of social and healthcare services is critical to provide the basis for comprehensive information sharing and service delivery to support the evolution of the older person over time. The capability to

monitor and respond to an older person's changing health and social care needs will enable prompt and personalised health and social care plans to be implemented.

The implementation of an integrated care approach involves all the settings where persons age, but also requires a concerted action among micro (clinical), meso (service delivery) and macro (system) levels. The community is of relevance given the primary objective of 'ageing in place'. However, from the perspective of the continuum of care and services acting synergistically, all health and social care settings (including long-term care facilities and hospitals) need to evolve and embrace an integrated way of operating to support functional ability in older people, while maximising resource and information sharing efficiencies.

Gutterman (2023) highlighted that the WHO's 2020 baseline report, with respect to the goals of the Decade of Healthy Ageing strategy, stressed that at least 142 million older persons worldwide were unable to meet their basic needs. The WHO further called for engagement around four action areas to optimise the functional abilities of older persons: 'change how we think, feel and act towards age and ageing; ensure that communities foster older people's abilities; deliver person-centred integrated care and services that respond to older people's needs; and provide access to long-term care for older people who need it'. Specific goals include:

- *Combatting Ageism:* challenging and eliminating negative attitudes towards older people that take various forms, including stereotyping (how we think), prejudice (how we feel) and discrimination (how we act) towards people based on their age.
- *Communities:* creating age-friendly physical, social and economic environments for older persons by removing physical and social barriers and implementing policies, systems, services, products and technologies that address the social determinants of healthy ageing and enable people, even when they lose capacity, to continue to do the things they value.
- *Integrated Care:* creating and maintaining non-discriminatory access to good-quality essential health services that includes: preventive care; promotion of good health; curative, rehabilitative, palliative and end-of-life care; safe, affordable, effective, good-quality essential medicines and vaccines; and, dental care and health and assistive technologies. It should be ensured that use of these services does not cause the user financial hardship.
- *Long-term Care:* provide care to address declines in physical and mental capacity associated with ageing that can limit older people's ability to care for themselves and to

participate in society, including access to good-quality long-term care, to provide those in need of support and assistance with rehabilitation, assistive technologies and supportive, inclusive environments so they can enjoy basic human rights and live.

1.3 Common health conditions associated with ageing

Several factors impact ageing. A longer life brings with it opportunities, not only for older people and their families, but also for societies as a whole. Additional years provide the chance to pursue new activities such as further education, a new career, or a long-neglected passion. Older people also contribute in many ways to their families and communities. Yet the extent of these opportunities and contributions depends heavily on one factor: health. Evidence suggests that the proportion of life in good health has remained broadly constant, implying that the additional years are in poor health. If people can experience these extra years of life in good health and if they live in a supportive environment, their ability to do the things they value will be little different from that of a younger person. If these added years are dominated by declines in physical and mental capacity, the implications for older people and for society are more negative. Although some of the variations in older people's health are genetic, most is due to people's physical and social environments – including their homes, neighbourhoods, and communities - as well as their personal characteristics – such as their sex, ethnicity, or socioeconomic status.

The environments that people live in as children – or even as developing foetuses – combined with their personal characteristics have long-term effects on how they age. Furthermore, physical and social environments can affect health directly or through barriers or incentives that affect opportunities, decisions and health behaviour. Maintaining healthy behaviours throughout life, particularly eating a balanced diet, engaging in regular physical activity and refraining from tobacco use, all contribute to reducing the risk of non-communicable diseases, improving physical and mental capacity and delaying care dependency. Supportive physical and social environments also enable people to do what is important to them, despite losses in capacity. The availability of safe and accessible public buildings and transport, and places that are easy to walk around, are examples of supportive environments. In developing a public-health response to ageing, it is important not just to consider individual and environmental approaches that ameliorate the losses associated with older age, but also those that may reinforce recovery, adaptation and psychosocial growth.

At the biological level, ageing results from the impact of the accumulation of a wide variety of molecular and cellular damage over time. This leads to a gradual decrease in physical and mental capacity, a growing risk of disease, and ultimately death. These changes are neither linear nor consistent, and they are only loosely associated with a person's age in years. The diversity seen in older age is not random; beyond biological changes, ageing is often associated with other life transitions such as retirement, relocation to more appropriate housing and the death of friends and partners. Common conditions in older age include hearing loss, cataracts and refractive errors, back and neck pain and osteoarthritis, chronic obstructive pulmonary disease, diabetes, depression, and dementia. As people age, they are more likely to experience several conditions at the same time. Older age is also characterised by the emergence of several complex health states, commonly called geriatric syndromes. They are often the consequence of multiple underlying factors and include frailty, urinary incontinence, falls, delirium and pressure ulcers.

Effectively managing patients with complex clinical and social needs requires the thoughtful integration of social and healthcare services. Research has shown that patients with multiple clinical and social needs consume a large share of healthcare services. Social services providers, though historically disconnected from the broader health system, play an important role in providing services for these patients (Siddiqi et al 2022, Rosenbloom et al. 2023, Taketa et al. 2020).

On the other side, even though integrated care appears to be a promising approach for organising services more comprehensively around the needs, preferences and capabilities of individual older people, effective implementation of person-centred care is still a challenge. The involvement of older adults in decision-making in regard to their own care and support processes is often limited (Stoop et al. 2020).

Formal social care services are often organised and funded separately from health care or medical services, and this can result in fragmented care for people who need both types of services. A common response is to develop integrated social and healthcare services for older adults with complex needs. Integrated care can mean different things in different settings, but a common feature is that it seeks to improve the quality of care for individual patients, service users and caregivers by ensuring that services are well coordinated around their needs.

1.4 Ageing, health and ageism

Ageing, an inevitable process, is commonly measured by chronological age and (as a convention) a person aged 65 years or more is often referred to as an 'older adult' (Merriam-Webster, 2022; WHO, 2010). However, the ageing process is not uniform across the population due to differences in genetics, lifestyle, and overall health (Levine et al. 2013). There is no typical older person. Some 80-year-olds have physical and mental capacities like many 30-year-olds. Other people experience significant declines in capacities at much younger ages. A comprehensive public health response must address this wide range of older people's experiences and needs. The diversity seen in older age is not random; a large part arises from their physical and social environments and the impact of these environments on their opportunities and health behaviour. The relationship between people and environments is skewed by personal characteristics such as the family we were born into and our sex and ethnicity, leading to inequalities in health. Older people are often assumed to be frail or dependent and a burden to society. Research from the World Health Organisation (WHO) reveals that one in two people hold ageist attitudes towards older people (WHO, 2021). Also, Mikolajczyk (2023) stated that there are many examples of countries and states taking an ageist approach towards their older citizens, including but not limited to mandatory retirement, cut-off social policy entitlements and exclusion from the labour market, and various barriers in access to goods and services. Specific barriers are identified in older persons' access to financial tools and relate to age limits, digitalisation, poverty, or low income. Another area where ageism is prevalent is the healthcare sector; the report indicates the use of dismissive and patronising language in institutions, a lack of curricula on ageing, a lack of expertise in geriatrics and inadequate gerontological culture in general. Finally, older people are not treated seriously by social workers and law enforcement in cases of violence, abuse and neglect, and the redress mechanisms are not easily accessible to older persons who may have particular support needs.

Public health policy should take appropriate steps to prevent ageist attitudes, which can lead to discrimination, and promote training on the legal duties and responsibilities of care providers, healthcare and social workers. It is necessary to influence the way policies are developed in order to afford older people the opportunities they need to experience healthy ageing. In addition, globalisation, technological developments (e.g., in transport and communication), urbanisation, migration and changing gender norms are influencing the lives of older people in direct and indirect ways. A public health response must take stock of these

current and projected trends and frame policies accordingly. Allen et al. (2022) described that commonplace ageist messages, interactions, and beliefs may be harmful to health and that multilevel and multisector efforts may be required to reduce everyday ageism and promote positive beliefs, practices, and policies related to ageing and older adults. Ageism is an important social determinant of health.

The social determinants of health are the non-medical factors that influence health outcomes and include the conditions into which people are born, grow up, and live, as well as the wider set of forces and systems that shape the conditions of daily life. Like all forms of discrimination, ageism generates divisions and hierarchies in society and influences social position based on age. Mikton, (2021) pointed out that ageism results in various harms, disadvantages, and injustices, including age-based health inequities and poorer health outcomes.

1.5 The approach of integrated care for older adults

The integrated care for older people (ICOPE) approach has been developed by the World Health Organisation (WHO, 2019) in the context of populations around the world ageing rapidly. This demographic transition will impact on almost all aspects of society and create new and complex challenges for health and social care systems. From 2015 to 2050, the proportion of the global population aged 60 years and over will more than double. Many of these people are likely to experience losses in their health, including developing multimorbidity, and will live in low- and middle-income settings. At the same time, the world has united around the United Nations 2030 agenda for sustainable development, which pledges that no one will be left behind and that every human being will have the opportunity to fulfil their potential with dignity and equality.

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

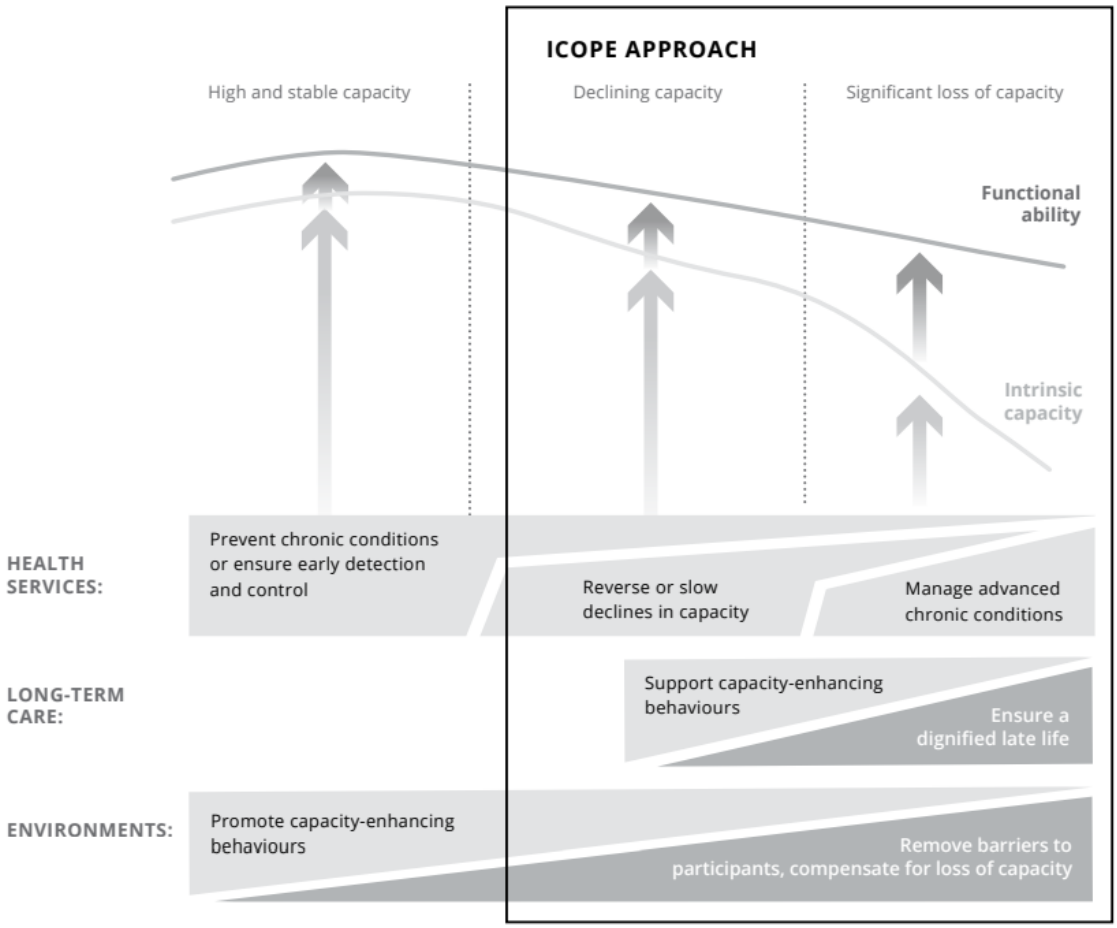
The sustainable development goals (SDGs) within the 2030 agenda demonstrate a renewed global commitment to reinvigorating and reorganising health systems. However, unless structural and social adaptations are implemented and quality care is assured, many of the

ambitions outlined in the SDGs will not be achieved. The WHO world report on ageing and health, and the subsequent global strategy and action plan on ageing and health, help to ensure that societal responses to population ageing are aligned with the ambitious 2030 agenda. Both call for action to ensure the needs of older populations are met by appropriately aligned healthcare and long-term care systems. A transformative approach is needed in the way healthcare systems and the services within them are designed to ensure care is high quality, integrated, affordable, accessible and centred on the needs and rights of older people.

Integrated care, particularly for older people and people with chronic health conditions, is widely accepted as a mechanism to improve health outcomes and system efficiency. In the context of building sustainable long-term care systems WHO defines long-term care as, 'the activities undertaken by others to ensure that people with significant loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity'. According to the WHO report (2016), integrated care is a system and process in which services are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care, all coordinated across the different levels and sites of care within and beyond the health sector, according to their needs throughout the life course. These activities include social care, health care and the contribution of other sectors (such as transport) and should be integrated to ensure optimal coordination and efficiency. Long-term care systems may include a range of paid and unpaid caregivers, and they should be considered in the implementation of the ICOPE approach. The Approach of Integrated Care for Older People is underpinned by four guiding principles:

1. Older people are afforded the same basic human rights as all people, including the right to the best possible health.
2. Older people should be given equal opportunity to achieve healthy ageing, regardless of social or economic status, place of birth or residence, or other social factors.
3. Care should be provided with equality and non-discrimination, particularly on gender, age and ethnicity.
4. Health and social care systems and services need to respond to the unique health and social care needs and goals of older people, which may vary over time, and should address the social determinants of health.

Figure 3 A public health framework for healthy ageing and the opportunities for public health



Source: WHO, 2016.

This approach (Figure 3) is underpinned by the principle that functional ability can be maximised when services and systems integrate health and social care for older people in a manner that responds to their unique needs – that is, in a person-centred manner. Integration does not mean that structures must merge but, rather, that a wide array of service providers should work together in a coordinated way within a system. ICOPE is a community-based approach that helps to reorient health services and build long-term care systems towards this more person-centred and coordinated model of care.

1.6 Strategies to sustainably build long-term care systems

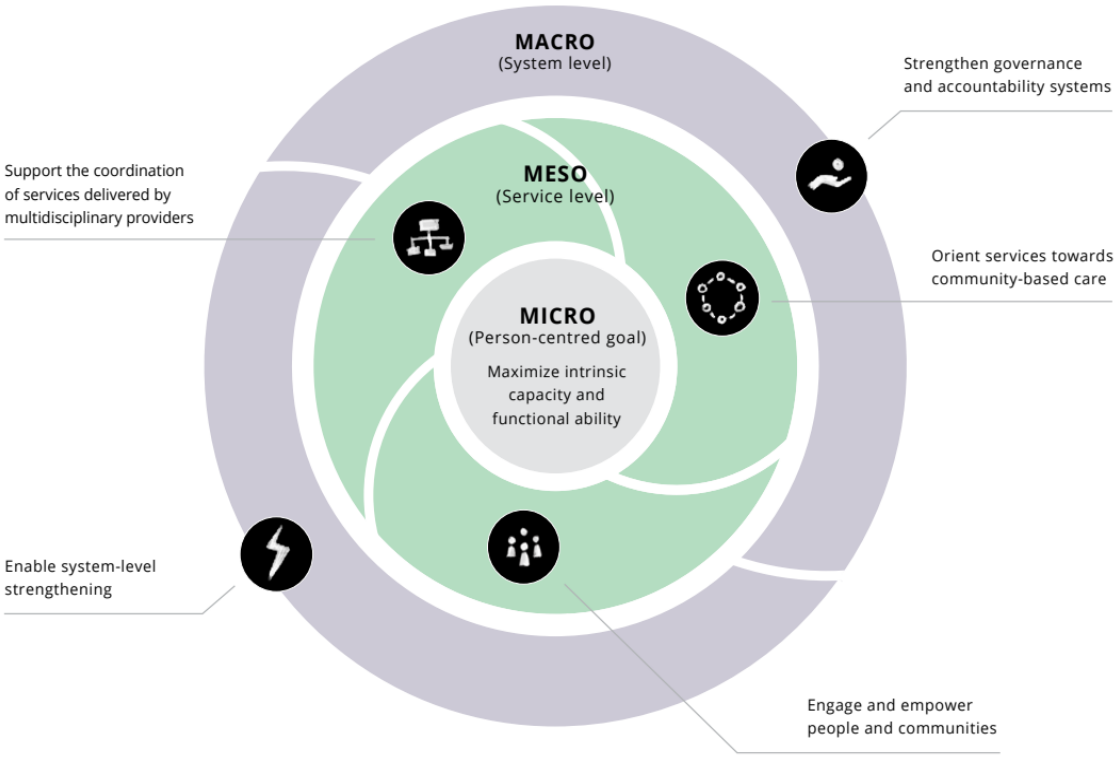
WHO (2016) proposes three strategies to sustainably build long-term care systems: 1) develop and continually improve the system infrastructure through appropriate legislation and sustainable financing mechanisms that enable access to services; 2) build capacity in the paid and unpaid workforce by providing training, support, and career opportunities; 3) ensure the quality of social care services. In order to achieve effective integrated health and social care services and systems for older people there needs to be transformation at the system (macro), service (meso) and clinical (micro) levels.

Facilitating changes and the implementation of any health or social care reform is complex. Considerations and actions are needed at multiple levels for integrated care for older people – from better individual clinical encounters to whole-system changes. While most interventions are targeted at the clinical level, there is a growing recognition for effort and resources to be invested at the service and system levels. The macro-level components of the framework are intended to support policymakers, system-level planners, funders and decision-makers. The meso-level components are intended to support service and programme managers and decision-makers (Figure 4).

The implementation of Integrated Care for Older People is dependent on two parts – one relevant for service managers (the question is: 'What is the capacity of the services to respond to identified care needs?') and the other for system managers (the question is: 'What is the capacity of the system to support integrated services?') It may be used to:

1. identify older people in the community in need of health and social care;
2. assess the capacity of services or systems to deliver integrated care at the community level using the ICOPE approach;
3. initiate an ICOPE implementation plan according to capacity.

Figure 4 Implementation of the approach for integrated care for older people



Source: WHO, 2019.

Service (meso) level

Service actions are directed at supporting the implementation of the ICOPE approach in health and social care services. The actions are intended to assist service and programme managers. Service-level managers will vary according to service designs in each country, but may include roles such as service manager, district manager, programme manager and state health coordinator. Community-based care is a blend of health and social services provided to an individual or their family or caregivers in their place of residence to promote, maintain or restore health, or to minimise the effects of illness and disability. These services are usually designed to help older people remain independent and in their own homes. They can include centres for older adults, transport, meal deliveries or sites for meal congregation, visiting nurses or carers, and adult day-care services. The service actions are grouped into three areas of focus:

1. to engage and empower people and communities;
2. to support the coordination of services delivered by multidisciplinary providers;
3. to orient services towards community-based care.

The engagement of community members and organisations in service delivery takes advantage of untapped resources, helps to ensure healthy and facilitative environments for older people, and helps to decrease caregiver burden. The community may include, for example, families and neighbours, other older people, employers, religious and community organisations. Participation by individuals, families and civil society in health and social care delivery can help to fill care gaps, such as personal care, promote older people's health and well-being and create age-friendly environments. Non-governmental organisations, social enterprises and medical care funds can often provide services that health facilities are unable to offer, such as care coordination, peer support and support for self-management.

Supporting the physical and mental well-being of caregivers and supporting their skills-based care competencies is essential in supporting the care of older people. Caregivers often form a critical component of the unpaid workforce. The mode of training and support for caregivers will differ by setting and should be flexible to suit local needs, capacity and available resources. Services should provide a combination of support for caregivers, including catering for their physical and mental well-being, enabling growth of skills-based care competencies, and providing respite care when it is needed. Services can implement case-finding systems to identify older people in the community (or in a defined geographical area) who need health and social care. In most case-finding initiatives, some level of central coordination for a given geographical area is needed. Home visits within a defined geographical area by health and/or social care workers, or other members of a multidisciplinary team, may be appropriate in some settings.

Person-centred assessments are an essential aspect of personalised care planning when an older person's intrinsic capacity (IC) has declined or is at risk of decline. These person-centred assessments consider (WHO, 2019):

- integrated care (IC) and functional ability (FA), and their trajectories;
- specific health or social conditions, behaviours and risks that may influence IC and FA;
- environmental context;
- social care needs.

Person-centred assessments provide the information needed to prioritise and tailor interventions that are aligned to the holistic, individual needs of the person. Assessments should be shared between multidisciplinary providers to inform a personalised care plan that includes a package of services. Services should support the development of personalised care plans for older people based on a person-centred assessment of their health (e.g., disease management)

and social care needs, as well as their goals and preferences. Where appropriate, care plans should also incorporate advance care planning and be revised as a person's health or social circumstances change. The primary focus of a personalised care plan should be improving intrinsic capacity and functional ability by directly addressing the older person's health and social care needs.

Networks of local health and social care service providers are needed to facilitate timely referrals to appropriate sites and levels of care for older people. This development of networks should include pathways for rapid access to acute care and specialist services when needed (e.g., to a geriatric medicine unit), rehabilitation, or palliative and end-of-life care. These networks can build communities of practice to optimise care delivery and coordination. A referral network to accommodate respite services for caregivers and to maintain their physical and mental well-being is also an important component of service delivery. Care should be delivered through a community-based health and social care workforce, including paid and unpaid roles (e.g., family members), that is supported by an infrastructure for the delivery of safe and effective, clinically appropriate, and feasible care to older people in their home or community. Workforce configurations to deliver such care will vary according to the setting and resources available; for example, it may include a mix of health and social care professionals (e.g., family doctors, dentists, nurses, allied health professionals, social workers) working alongside community health workers and volunteers/peers/family members (e.g., paid and/or unpaid roles). Where unpaid carers are involved, adequate support (financial or in-kind) is likely to be needed.

The physical infrastructure of many healthcare settings may not be well matched to older people's needs or abilities. This may include a lack of accessible toilets, long waiting lines, physical barriers to access (e.g., stairs) and communication barriers resulting from a lack of accessible information for people with hearing loss and/or visual impairment. Social care service infrastructure such as respite care, day-care centres and nursing homes should be made available. Locally available facilities should be used, or local strategies devised, to deliver care in the absence of such an infrastructure so as not to limit service initiation or the delivery of integrated care. Services should deliver safe and effective health and social care that targets functional ability (FA) and is aligned with older people's needs, preferences, and cultural practices. In some settings, this may include traditional or complementary medicine.

Where evidence exists to guide practice, care interventions should be aligned with it (including clinical guidelines such as the WHO guidelines on community-level interventions to

manage declines in intrinsic capacity; WHO, 2017). In some circumstances, assistive devices and environmental adaptations will be needed, and where appropriate and feasible, services should provide assistive products that can accommodate losses in intrinsic capacity (IC) and so maintain FA. Examples include spectacles, hearing aids and mobility aids.

System (macro) level

System actions are directed at supporting the implementation of the ICOPE approach in health and long-term care systems (collectively referred to as 'systems'). The actions are intended to assist system managers. The system actions are grouped into two areas of focus:

1. strengthening governance and accountability systems;
2. enabling system-level strengthening.

While implementing processes to actively engage and empower older people and their families or caregivers, civil society (e.g., non-governmental organisations) and local service providers participate in the development of health and social care policies. These policies may include long-term care systems and services for older people. Providing opportunities to all older people to share their views and wishes, without excluding any level of capacity, is an important component of participatory governance. Examples of strategies to achieve active community participation in policy or service development and its evaluation include: community forums (e.g., face-to-face meetings, online discussion boards); community representation on the boards of health care facilities; and the active participation of civil society in policy and service development by government agencies.

Elder abuse is an intentional act, or failure to act, by a person such as a caregiver in a relationship of trust with an older person that causes harm or creates a risk of harm to the older person. Regulatory frameworks to protect against elder abuse are important given the vulnerability of many older people. Policies, plans and regulatory frameworks should be created or updated to support the integration of care and activities against elder abuse at several levels, including:

- the clinical (micro) level between care teams.
- the organisation/service (meso) level (e.g., primary health care, residential care facilities and hospital-based services);
- the system (macro) level targeting health and social care systems.

Strong political support from older adult leadership can catalyse integrated action against elder abuse at these levels. Support such as this is often needed for more detailed jurisdictional or national-level planning.

Quality assurance and improvement are important components of service development and sustainability. Valuable data on the person-centredness and effectiveness of services are provided by the experiences of people, both consumers and providers, in accessing and interacting with services, and by patient- or person-reported outcome measures (PROMs) and patient- or person-reported experience measures (PREMs). PROMs reveal information about a person's self-perception of their health and may include quality of life, functioning (e.g., intrinsic capacity and functional ability) and self-efficacy. PREMs reveal a person's perception of their experience with a health or social care service. This may include experience with access, waiting times and the ability to participate in shared decision-making. Quality-improvement initiatives using measures such as these should use a culturally sensitive format.

System-level capacity assessments provide important information to a country or region on the gaps and opportunities for delivering integrated health and social care services to all older people, including disadvantaged groups. Assessments of this capacity may be far-reaching, including capabilities in policy, financing systems, infrastructure, workforce and local services. These data are useful for planning and review at the subnational level. This integrated care for older people (ICOPE) implementation framework and scorecard guide the essential and important actions needed within systems and services to implement the ICOPE approach. The present component of the framework evaluates whether systems routinely assess the overall capacity for equitable delivery, while each of the other components prompts users to judge the capacity within the services or systems to enable the implementation of specific elements of ICOPE.

Workforce capacity-building means supporting the development of knowledge and skills in the workforce to undertake person-centred assessments, develop personalised care plans and deliver services that target functional ability (FA), both in the current health and social care workforce and the emerging one (students, trainees and new roles, or roles with extended scope). Capacity-building may be achieved by providing regular training opportunities to develop competency-based skills alongside continuing professional development across the workforce. Initiatives, such as education to develop knowledge and skills in integrated care for older people (ICOPE) and intersectoral collaboration, should be undertaken across providers. This gives cross-disciplinary relevance and supports team-based (e.g., interdisciplinary)

collaborative care. It is important to recognise that the workforce may include, in addition to salaried caregivers, unpaid caregivers and providers such as family members; it is necessary for capacity-building initiatives to accommodate both.

Financing policies and mechanisms to support the integration of health and social care for older people can be established through:

- joint or pooled funding of health and social sectors managed at the system level;
- incentives for effective care coordination at the service level.

In some cases, contractual incentives or joint reimbursement models have been used to motivate health and social care workers to incorporate new practices that promote the coordination of care, such as joint care planning or joint support for self-management (WHO, 2018). Human resource (HR) processes and systems are needed to ensure the paid and unpaid workforce is managed in a fair, transparent and equitable manner. HR systems ensure that the workforce is supported by appropriate processes and procedures (e.g., for promotions, personal development, grievances, and professional advice). Ideally, HR processes should be reasonably standardised across services to ensure equitable approaches to the management of human capital. HR processes should be aligned across services so that there is consistency in (for example) performance-management practices, in the establishment of supervision and advisory roles, and in processes to provide timely feedback on performance. This system action does not necessarily mean that HR processes should be the same for paid and unpaid workers, but both areas of the workforce should be supported and managed by processes that are appropriate to their context.

Where locally acceptable and feasible, systems should implement health information and communications technology (ICT) and processes to facilitate the storage, sharing and communication of information (e.g., health records, prescriptions, consultations) between health and social care services and providers. Examples of this may include e-health records, home monitoring systems, integrated prescription systems, and telehealth. Such systems may also facilitate data collection and auditing – e-health records, for example, can organise information about individuals and entire clinical populations of older people to help identify needs, plan care over time, monitor responses to treatment and assess health outcomes. Many health systems do not have the capability to support e-health systems, although being unable to perform this system action should not prevent integrated care advances in other areas. In the absence of ICT, relatively low-tech options such as telephone and fax can be used to ensure that information is shared appropriately among providers.

Declines in intrinsic capacity (IC) and losses in functional ability (FA) – such as limitations in locomotor capacity, cognitive capacity, psychological capacity, vision, hearing and nutritional status – should be routinely assessed in older age groups within existing health information or surveillance systems; see WHO ICOPE guidance on person-centred assessments and pathways in primary care for further implementation support. Various instruments for measuring IC, including those being developed by WHO, may provide useful starting points for responding to health needs at a primary care level. At the service level, collecting data on IC will facilitate timely responses to declines and better resource allocation. At a system level, collecting these health data offers the opportunity to monitor population health and to evaluate initiatives designed to improve system performance in care integration, quality and safety. Where settings have the resources, infrastructure and policy to support them, digital technologies should be deployed to support older people to self-manage, for example through self-monitoring using mHealth (mobile technologies) or web-based tools. The implementation of such technologies may be easier as technologies evolve and the evidence for their effectiveness and acceptability emerges.

1.7 The long-term care system

The burden of disease worldwide is shifting to long-term conditions. Although advances have been made in effective service delivery major challenges remain, namely, the projected increases in populations aged ≥ 65 years, the increases in demand associated with an ageing population, and government pressure on the necessity for major efficiency savings. In many countries current services are organised around treating and managing single medical conditions, but many people have more than one (multimorbidity), which means that care is often fragmented and unresponsive to needs. Patient and policy consultation around care for long-term conditions has repeatedly emphasised the need for ‘integration’ (European Commission, 2022).

According to European Commission (2014), long-term care (LTC) can be defined as a range of services and assistance for people who, because of mental and/or physical frailty and/or disability over an extended period, depend on help with daily living activities and/or are in need of some permanent nursing care. LTC may be required by people of any age, although the risks of dependency for children, young people and adults of working age may be lower compared

to the risks for older people and are falling as the proportion of people below retirement age shrinks. The goal of long-term care is to ensure that an individual who has a significant decline in physical or mental capacity can maintain the best possible quality of life, with the greatest possible degree of independence, autonomy, participation, personal fulfilment and human dignity. The goal of long-term care also includes the provision of comfort and well-being for individuals and for their families at the end of life. To achieve these goals and attain the vision of an integrated continuum of long-term care, services should uphold certain values; the following six principles optimise and achieve the goal of successful long-term care.

1. Principle - be person centred and aligned with the person's values and preferences. Long-term care activities should be adapted and tailored to the level of capacity of each individual and their values and preferences in a person-centred manner, providing older people or their trusted person (for example, in cases of severe cognitive impairment that prevents independent decision-making) with the education and support they need to make informed decisions in relation to their care. Older people and their carers have the right to, and deserve, the freedom to realise their continuing aspirations to well-being, meaning and dignity, and a good life, even in the event of significant loss in intrinsic capacity or the risk of such a loss. The values and preferences of the people who are involved in care provision (such as carers) also need to be considered.
2. Principle - optimise functional ability over time and compensate for loss of intrinsic capacity. Along with addressing older people's physical and basic needs (such as nutrition and hygiene), long-term care systems should promote their ability to move around, build and maintain relationships, learn, grow, make decisions, and contribute to their communities as much as possible. Long-term care should aim to keep the trajectories of people's intrinsic capacity and functional ability as optimal as possible over time, optimising and rehabilitating temporary functional loss, as well as compensating for permanent losses, to achieve healthy ageing.
3. Principle - be part of and served by the community. Older people and their carers value services and interventions that have the potential to enhance their daily lives and provide practical solutions to allow older people to age in their preferred place of living, whilst participating in and contributing to their families and to their community for as long as possible.

4. Principle - provide integrated services in a continuum. Formal long-term care involves a package of services that include aspects of prevention, promotion, treatment, rehabilitation, palliation, assistive care and social support to varying degrees, depending on the needs of the individual. To maximise the mental and physical capacities and functional ability of older people, and to support their carers, these service components should be delivered seamlessly in a continuum and integrated into service packages to effectively respond to changes in the functional ability of older people.
5. Principle - include services that empower the older person. Long-term care should empower and enable persons to do as much as possible themselves, rather than replace their existing or potential ability with a social service that may ultimately decrease their function and increase care dependency.
6. Principle - emphasise support for carers and care workers. Such support should ensure they do not endure the negative impact of caring on their physical, emotional, social, and financial well-being (European Commission, 2014).

The WHO (2017) defines long-term care systems as, 'national systems that ensure integrated long-term care that is appropriate, affordable, accessible and upholds the rights of older people and carers alike'. Long-term care systems do not need to constitute a new and separate system but can, and ideally should, be built within the existing care workforce, health systems and social care systems of each country if they contribute to optimising the physical and mental capacities and abilities of their users. Integration in long-term care means the seamless integration of both the health and social systems, from governance to information systems and care delivery, so that long-term care can be provided and received in a non-fragmented way. A continuum in long-term care emphasises a continuum of care that is inclusive of prevention, promotion, curative, rehabilitative, palliative and assistive care, and social support. It also highlights the importance of coordination across health and social sectors, a seamless transition across settings (homebased, community day-care centre, residential facility care), and harmonised management across various care roles (for example, health and care workers, caregivers and family), spanning all levels of intensity of care and providing care in a timely manner. A long-term care system – which can mirror the health system – consists of all the organisations, people, and actions whose primary intent is to promote, restore or maintain the health or abilities of those who have significant limitations in functional ability

and are in need of care, or are at risk of needing care. This includes efforts to influence the determinants of the health of people in need of long-term care, as well as their carers.

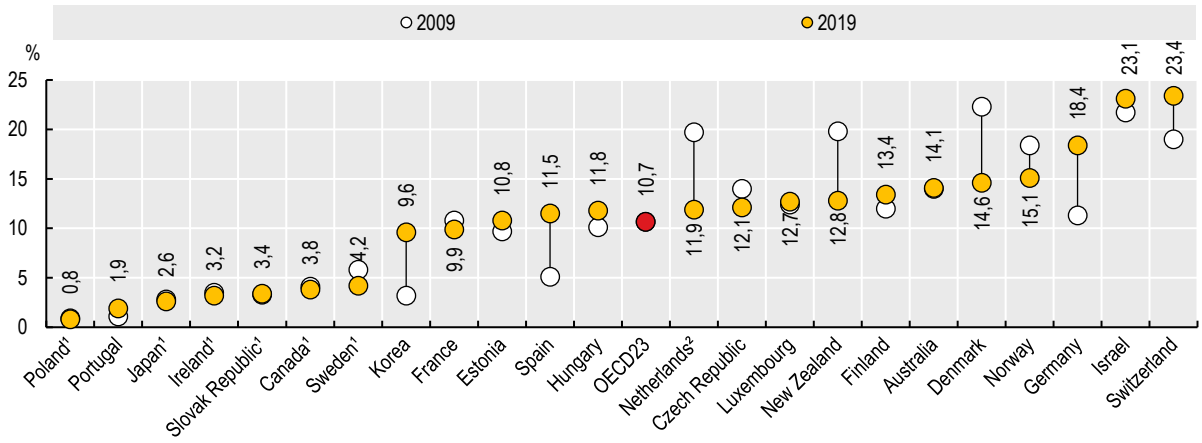
A long-term care system is, therefore, more than publicly owned facilities that provide long-term care. As well as private providers, behavioural change programmes, health insurance and social care, it includes, for example, a carer helping their elderly mother who cannot independently perform basic activities of daily living such as feeding, dressing, and grooming. In many countries, services that are relevant to long-term care are already being delivered through their wider health and social care systems, such as home visits by primary health care teams, carer training and support, the provision of assistive products, and palliative care services. Rather than creating new systems, efforts should be made to transform the existing disease-focussed models of care to include a wider narrative that takes into consideration aspects of functional ability and are centred around a person's needs. To establish a long-term care system, countries will need to identify such existing services and ensure they are provided in a timely, person-centred, integrated, affordable and equitable manner. New types of long-term services should be created and expanded according to national and local contexts and projections. There should be continuous investment in building the capacity of care workers and carers, and quality assurance mechanisms for long-term care services should be implemented to ensure quality and prevent negative outcomes such as abuse of or discrimination against older people. The sustainability of such a system can be ensured via governance, legislation and the financing systems, all of which should be informed by robust data that are disaggregated (for example by region, sex and age group), and strengthened by transparent accountability measures and public participation (European Commission, 2014).

The characteristics of long-term care systems vary markedly among, and even within, countries to accommodate differences in cultural, political, epidemiological, resource and socioeconomic profiles. At one end of the continuum there are countries with no or very little in the way of a long-term system, leaving long-term activities (almost) entirely to families, without any additional support or guidance. Slovakia can learn from other countries in the region and beyond that have successfully integrated health and social care systems. For example, the United Kingdom has implemented an integrated care system that combines health and social care services to support individuals with complex needs. In Norway, a national strategy for coordinated health and social care was developed to provide more integrated support for individuals.

However, despite differences in characteristics, specific standards and principles, underlying long-term care must be universal across systems. Systems with a higher level of development include a wide variety of health and social care services, with the contribution of other sectors such as transportation and education. Formal services may include home-, community- and facility-based care for older people with loss of capacity, but also training of and support for carers (such as respite care). Most importantly, in such developed long-term care systems activities are oriented to the needs of the older person, rather than to the needs of the services, to enable integrated care and support.

1.8 Access to long-term care across selected countries

Across OECD countries an average of 10.7% of people aged 65 and over received long-term care, either at home or in long-term care facilities, in 2019 (Graph 1). More than one in five people aged 65 and over received LTC services in Israel (23.1%) and Switzerland (23.4%), compared with fewer than 5% in Canada (3.8%), the Slovak Republic (3.4%), Ireland (3.2%), Japan (2.6%), Portugal (1.9%) and Poland (0.8%).



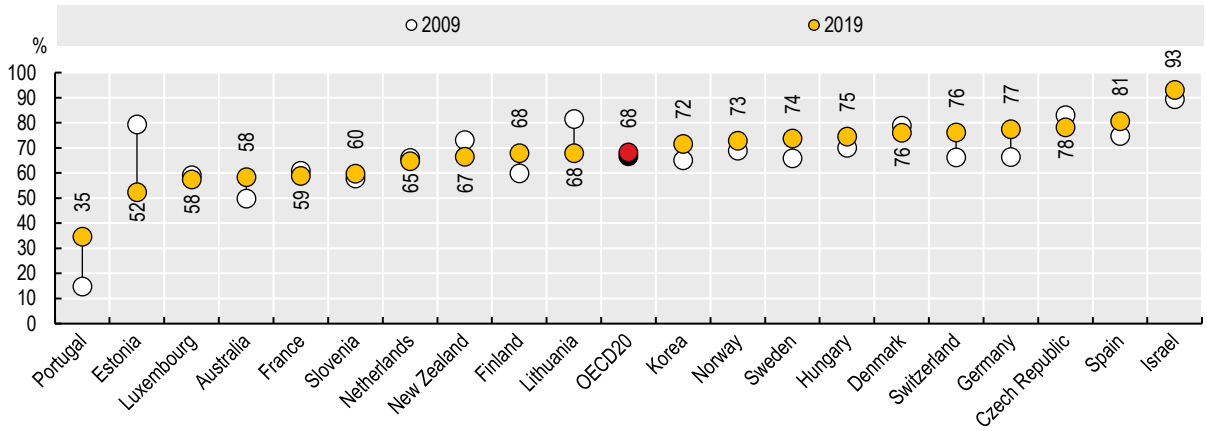
Graph 1 Share of adults aged 65 and over receiving long-term care 2009 and 2019
Source: OECD Health Statistics 2021.

The majority of LTC recipients are older adults (Graph 1). Although LTC services are also delivered to younger disabled groups, people are more likely to develop disabilities and need support from LTC services as they age. In 2019, just 25% of LTC recipients on average across OECD countries were younger than 65, while a further 26% were between 65 and 79. Adults

aged 80 and over represent the majority of LTC recipients in OECD countries. On average in OECD countries, 49% of LTC recipients were aged 80 and above in 2019. In Japan, more than four in five (84%) LTC recipients were 80 and over, while people aged 0-64 represented just 1% of LTC recipients.

While population ageing is a significant driver of the growth in LTC users over time, the cross-country variation in the proportion of older LTC recipients suggests that other drivers – notably publicly funded LTC services – also determine LTC use. For example, Israel has one of the youngest populations among OECD countries, but a greater than average proportion receive LTC. Because data on people receiving care outside public systems are more difficult to collect and may be underreported, figures for countries that rely more heavily on privately funded care may be artificially low. Cultural norms around the degree to which families look after older people may also be an important driver of the use of formal services.

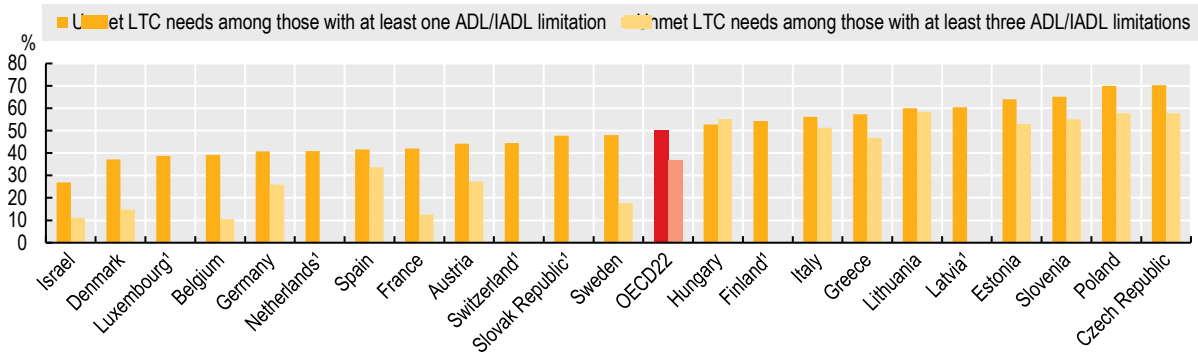
Many people in need of LTC care wish to remain in their homes for as long as possible. In response to these preferences – and the high costs of care facility-based LTC – many OECD countries have developed services to support home-based care for older adults. Nevertheless, changing policy priorities have not always resulted in a significant move away from facility-based LTC. Between 2009 and 2019, the proportion of LTC recipients who received care at home rose only marginally, from 67% to 68% (Graph 2).



Graph 2 Long-term care recipients aged 65 and over receiving care at home, 2009 and 2019
Source: OECD Health Statistics 2021.

Increases were particularly large in Portugal, Australia, Finland, Germany and Switzerland. In Germany, part of the increase was due to policy reforms expanding the definition of LTC,

thereby increasing the number of benefit recipients. In Australia, reforms expanding financing for elderly care and increasing the number of home care packages available has similarly led to increases in the number of LTC recipients. While the proportion of LTC recipients living at home has increased over the past decade in most OECD countries, it has declined significantly in Estonia where there has been an increase in the availability of institutional general care; additionally, the number of added home service users in Estonia has increased at a slower pace compared to number of twenty-four-hour services in the social welfare system. Even where people live with limitations in activities of daily living (ADL) and in instrumental activities of daily living (IADL), they may not always receive sufficient formal LTC support. Among people aged 65 and over across 22 European countries, half of the individuals living at home with at least one ADL or IADL limitation – and nearly two in five (37%) people living with three or more ADL/IADL limitations – reported that they either did not receive sufficient informal LTC help or did not receive any formal LTC support (Graph 3).



Graph 3 Unmet long-term care needs among people aged 65 and over living at home, 2019-2020

Source: OECD Health Statistics 2021.

LTC recipients are defined as people receiving LTC from paid providers, including non-professionals receiving cash payments under a social programme. They also include recipients of cash benefits such as consumer choice programmes, care allowances or other social benefits granted with the primary goal of supporting people with LTC needs. LTC can be delivered in facilities (institutions) or at home. LTC institutions refer to nursing and residential care facilities that provide accommodation and LTC as a package. LTC at home is defined as people with functional restrictions who receive most of their care at home. Home care also applies to the use of institutions on a temporary basis, community care and day-care centres, and specially-designed living arrangements. Data for Poland, Ireland, Canada, the Slovak Republic, Iceland

and Belgium are only available for people receiving LTC in institutions, so the total number of recipients will be underestimated. In Estonia, the decrease in recipients of home care refers to those who have a 'curator' appointed by local government. An increase in other social welfare home service users has not compensated for this decline, partly because not all home services are considered to be LTC health services. In New Zealand, the decline in home care recipients between 2009 and 2019 is attributable in part to a change in methodology, as well as more consistent reassessments of home care needs by District Health Boards.

Data on LTC services are difficult to collect in many countries, and there are some known limitations of the figures. Data for some countries refer only to people receiving publicly funded care, while other countries include people who are paying for their own care. For the indicator on unmet LTC needs, the data relate to the population aged 65 and over, based on the eighth Survey of Health, Ageing and Retirement in Europe (SHARE), referring to 2019 and 2020. It is important to highlight that the COVID-19 pandemic may have affected the field work conducted for the survey in 2020. While there is no internationally accepted definition of unmet LTC needs, SHARE facilitates estimation of the share of older people reporting limitations in daily activities (ADL and IADL) who did not receive formal home care or sufficient informal care.

1.9 The Concept of Long-Term Integrated Care for older adults

Evidence suggests that integrated care is the best approach for implementing the complex spectrum of interventions that are needed if older adults are to experience the best possible outcomes (Garattini et al. 2022; Søren et al. 2022; Goodwin et al. 2021). Integrated care for older adults refers to services that span the care continuum, are integrated within and among the different levels and sites of care within the healthcare and long-term care systems (including within the home) and are integrated according to people's needs throughout life. Integration does not mean that structures must merge; rather, it implies that a wide array of service providers must work together in a coordinated way.

Current models of care for older people have repeatedly been criticised for not being adequately responsive to their diverse needs, priorities and environments (Cesari, 2022). The disease-oriented approach, typical of traditional healthcare, often obscures aspects of health status relevant to the individual and his/her family. Many older persons, especially the most vulnerable ones, often experience inequalities in access to care, consequently remaining with

major unmet health needs. In fact, the inadequacy of the traditional care systems on a background of the clinical complexity frequently generates malpractice, determining misdiagnosis, mistreatment and/or ageist attitudes. Furthermore, usual medical practice is habitually designed to be reactive to diseases and not sufficiently proactive on the longitudinal trajectories of the individual's capacities and characteristics. As the individual's intrinsic capacity gradually deteriorates, the implementation of integrated care and services (e.g., assistive care, palliation, rehabilitation, carers support) to manage the environmental barriers to optimal functional ability becomes crucial to guarantee the person's function and well-being.

In other words, older people with significant loss of intrinsic capacity (i.e., the most vulnerable ones) require not only health care, but also strong social care and support to compensate for loss and sustain a healthy and dignified life. In this context, integrated LTC becomes an essential part of the model for promoting healthy ageing. According to Cesari et al. (2022), health and social services should be reoriented towards person-centred and coordinated models of care because the effective integration of health and social care services is critical in promoting healthy ageing.

To fully understand long-term integrated care, we need a working definition of the term 'integration', but there is a lack of consensus as to its exact meaning. Several different perspectives are possible on the meaning of integration, including managerial, health systems, social science, and patient perspectives (Goodwin, 2016). The British Medical Association (2014) has highlighted that integration is a nebulous term, associated with wide-ranging definitions and processes. Analysts have distinguished between different dimensions of integration thus (Bower et al. 2018):

- Types of integration – functional (key support and functions, e.g., human resources and financial management), organisational (contracting or strategic alliances between different organisations), professional (joint working, alliance and strategic contracting between professionals) and clinical (co-ordination of patient care services).
- Breadth of integration – this includes both vertical (bringing together organisations at different hierarchical levels) and horizontal (bringing together organisations that are on the same working level) integration.
- Degree of integration – full integration or more limited collaboration of services, working practices or organisations.

- Process of integration – this includes structural (alignments of tasks, functions and activities), cultural (values, norms and working practices) and social (the strengthening of social relationships between individuals) integration.

Models of implementing integration are also diverse. Health and social care systems are complex, with multiple providers and different levels of demand on the system, and so integration is likely to be equally variable. A review referred to three different models of integration:

- System level – the focus here is on organisational change, whereby leadership plays a pivotal role in performance.
- Programme or service level – the emphasis here is to try to improve the patient outcomes by providing more co-ordinated care.
- Progressive/sequential models – integration is not a specific goal but is a means to try to improve healthcare performance in general.

The challenges in connection with long-term integrated care were stressed by Rudnicka et al. (2020). One of the challenges may be ensuring the necessary human resources for long-term integrated care in future years. In this context, it is necessary to concentrate on developing a 'health labour market analysis toolkit', strengthening education and training, establishing pilot projects of other social groups and associations taking responsibility for care giving, and building governance capacity. Health workers are often trained to assist with current pressing health concerns, so there is a need to improve knowledge and skills in a holistic approach in geriatric care to deal with chronic problems and multimorbidity. Health professionals should also develop competency in communication, teamwork and overcoming ageist attitudes (Global strategy 2016-2020).

Multidisciplinary teams - including geriatricians, general practitioners, nurses, social workers, pharmacists, dietitians, rehabilitation therapists, psychologists, community workers, and care coordinators - are needed to provide integrated care. To ensure an adequate number of caregivers it is essential to improve the image and status of caregiving by increasing pay and benefits, working conditions, training, and career opportunities. These issues are not properly covered in developed countries and the problem is even more severe in low-income regions. Integrated care also includes care provided by family members, volunteers and other unpaid and often untrained caregivers. There is a great need for services that support caregivers and ensure the quality of care they provide. The support should provide training, information,

education, accreditation and financing as well as offering respite care. There is a negative impact on the employment of family members (mainly women) when they adopt unpaid caregiving roles; in response to this, some governments have passed legislation to provide leave from work or part-time flexible working arrangements for family members so that they can care for older relatives. Several strategies to lessen the financial burden of long-term care on older people and their families are available, such as the employment of family caregivers via their municipalities or by granting tax credits.

1.10 The Growing Demand for LTC Employees in the World and in Europe - challenges for economic and ecologic sustainability

Long-term care (LTC) is an essential service that ensures that ageing populations receive the required care and support. With an increase in the ageing population worldwide, the demand for LTC services has risen significantly. In order to meet the demands of ageing populations, there is a growing need for qualified and skilled LTC employees.

Currently, the number of LTC employees in the world and in Europe is not enough to meet the growing demand and there is a significant shortage. According to statistics, the number of LTC employees in the United States alone is expected to increase by 34% from 2019 to 2029. The roles within the LTC field include nurses, care aides, social workers, therapists, and administrative staff. Despite the importance of these roles, the conditions for LTC employees can be challenging, including long work hours and high levels of burnout.

The global ageing population is projected to double by 2050, with the number of elderly people aged 60 and over set to reach 2.1 billion. This increase in ageing populations will have a significant impact on the demand for LTC services, with an expected 60% increase in job openings related to the LTC field. The need for skilled and diverse LTC employees will be a top priority as a result of this increase in demand. Several strategies can be used to address the growing demand for LTC employees. One strategy is to increase staffing in the LTC field through targeted recruitment and retention policies, including offering attractive benefits and support programmes for employees. Additionally, investing in workforce development through continuing education and training can help reduce the skill gap and increase employee satisfaction. Furthermore, the potential of technology in addressing the growing demands for LTC services should not be overlooked, with innovations such as telehealth and remote monitoring systems among those under consideration.

The LTC industry is evolving, and with it the nature of LTC employment. Trends such as the growth of home-based care, the integration of technology, and the increasing importance of care coordination are forecast to change the type of jobs, roles, and skillsets required in the LTC field. It will be important for policymakers and industry leaders to shape these trends through proactive investments and regulations in order to ensure the provision of quality care for ageing populations. The growing demand for LTC employees in the world and in Europe is a clear reflection of the growth of the ageing population. Implementing policies and strategies to address the increasing demand for LTC employees will be essential in providing quality care and support for older individuals. By expanding the workforce, investing in employee development and adopting the latest technological innovations, the LTC field has the potential to meet the demand for quality healthcare services for the ageing population.

Health promotion and sustainability are interconnected in the context of long-term care for ageing adults. A sustainable long-term care facility could provide health benefits for ageing adults while promoting healthy ageing habits can contribute to the sustainability of the facility itself. For example, engaging ageing adults in gardening activities could promote healthy living while also reducing the need for long-distance food transportation. Health promotion is the process of enabling people to increase control over their health and improve it (WHO, 2017). In the context of ageing adults, it is crucial to focus on health promotion to prevent and manage common health concerns that could arise. Some of these concerns may include cardiovascular diseases, osteoporosis, arthritis, and dementia. Evidence-based knowledge has shown that health promotion brings positive benefits for health and society; however, we should ask, 'How is it possible to achieve sustainability in LTC?' There are several tips that can help ageing adults promote healthy ageing habits, including:

- regular physical activity: it is recommended that ageing adults engage in at least 150 minutes of moderate-intensity aerobic activity per week. This could include activities such as brisk walking, cycling, or swimming.
- a balanced and nutritious diet: ageing adults should focus on consuming a balanced diet that is rich in fruits, vegetables, and protein sources such as lean meats and fish.
- adequate sleep: getting sufficient sleep is essential for ageing adults to maintain their health and well-being. It is recommended that aging adults aim for 7-8 hours of sleep per night.

Sustainable long-term care involves implementing practices that minimise negative impacts on the environment while also providing adequate care for ageing adults. There are several environmental factors that are associated with long-term care for ageing adults, including water usage, energy consumption, and waste management. To achieve sustainability in long-term care it is recommended that care facilities implement best practices, including those appertaining to energy efficiency. Practical measures might incorporate the use of LED lighting, energy-efficient windows, and low-flow water fixtures. Health and social care facilities can also reduce waste by implementing recycling programmes, composting, or transitioning to a paperless system. Additionally, there is scope to conserve water by installing low-flow toilets, sinks, and showers.

Prioritising health promotion and sustainability in long-term care for ageing adults is crucial to ensure their continued health, well-being, and quality of life. By integrating best practices of health promotion and sustainability, care facilities can improve the overall health of ageing adults while simultaneously minimising any environmental impact.

Conclusion

As populations are ageing rapidly, demand is increasing on the long-term care sector to provide care for more, and older, people with complex conditions and heightened needs for expert care. This has put an enormous strain on long-term care systems – a strain that is projected to increase in the coming years as populations continue to age. In more than half of OECD countries, population ageing has been outpacing the growth of the long-term care supply.

The OECD countries have recently promoted policies of deinstitutionalisation and community-based care for the older adults. These policies respond to the common cost pressures associated with population ageing, and the challenge of providing improved care for older adults. They aim to substitute less costly services for institutional ones, to improve patient satisfaction, and decrease expenses. The long-term care workforce has stagnated or declined, even in countries where the LTC supply is much higher than the OECD average (such as Norway and Sweden).

As populations continue to age, demand for long-term care workers is likely to rise. Responding to increasing demand will require policies to improve recruitment and retention and increase productivity. The fact that countries with stronger formal long-term care systems provide fewer people to provide daily care – as shown in the previous chapter - suggests that

there is a trade-off between informal and formal care. Compared to other areas of health care, spending on long-term care has seen the highest growth in recent years. Population ageing leads to more people needing ongoing health and social care. Rising incomes increase expectations of a good quality of life in old age, and yet the supply of informal care is potentially shrinking and gains in productivity are difficult to achieve in such a labour-intensive sector. All these factors create upward cost pressures, and consequently substantial further increases in long-term care spending in OECD countries are projected for the coming years. Declining family size, increased geographical mobility and rising participation rates of women in the labour market mean that there is a risk that fewer people will be willing and able to provide informal care in the future.

Coupled with the effects of an ageing population, this could lead to higher demand for professional long-term care services. Public long-term care systems will need adequate resources to meet increased demand while maintaining access and quality.

2 THE SCANDINAVIAN AND VISEGRAD GROUP COUNTRIES (V4) EXAMPLES OF GOOD PRACTICE

This monograph is a partial fulfilment of a pilot research programme and is published within the project 'Community-Based Social Service Centres as a Tool of Multilevel Partnership for Providing Long-Term Care in Slovakia'. The project is implemented by the Banská Bystrica Self-Governing Region in cooperation with Matej Bel University in Banská Bystrica, Slovakia, and Kristiania University College in Oslo, Norway. For this reason, we will focus on examples of good practice from the Scandinavian and V4 countries. The Visegrad Group (V4) is a grouping of countries in the Central European region which aim to cooperate in several areas of common interest. The Visegrad Group (V4) are similar and comparable to Slovakia in terms of their social and health service systems.

The development of Slovak society, like all developed European countries, is facing and will face significant changes resulting from the process of demographic ageing. Ageing is becoming one of the key factors and challenges of the 21st century, and it will significantly affect the nature and the overall functioning of society. The Czech Republic, Hungary, Poland and Slovakia have always been part of the same civilisation based on the same cultural and intellectual values and common roots of religious traditions, and the group want to preserve and further strengthen these ties. Examples of good practice in care for the older adults in the home environment are based on shared values of perception of the lives of older people in these countries. The V4 aims to contribute to building a European security architecture based on an effective, functionally complementary and mutually reinforcing cooperation and coordination within the existing European and transatlantic institutions. In order to preserve and promote cultural cohesion within the Visegrad Group (V4), the mutual transmission of cultural values, education, science and exchange of information will be intensified.

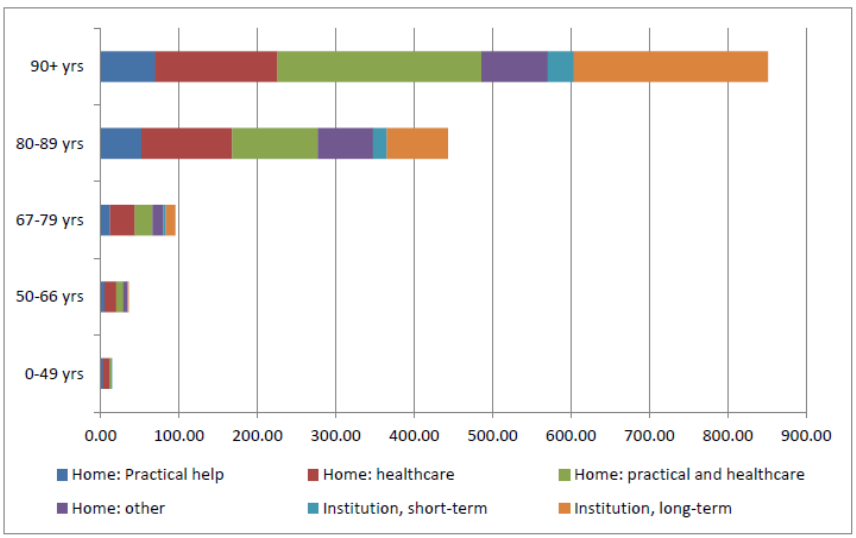
2.1 Norway

In Norway, persons requiring assistance with activities of daily living receive comprehensive support from public health and care services, as well as cash benefits from social insurance. Legislative basis for services provided by municipalities (called 'communities') were revised on 1st January 2012 and set out in the Municipal Health Service Act (HOL). The

new set of regulations replaces the Social Services Act (STL) and the Municipal Health Services (HKL), the aim being to legally merge the two former services as they are often already provided by a single source. Social insurance benefits (Folketrygden) are provided in accordance with the Norwegian National Insurance Act (Folketrygdloven - FTL). In this context, Norway generally focusses on local solutions which are designed by communities without direct input from central government. The aim is primarily to provide outpatient services and various forms of integrated care and assisted living in order to delay admission to an inpatient facility, or to extend the length of stay in an outpatient facility for as long as possible.

Long-term care in Norway is the responsibility of the municipalities and the right to receive care is regulated by the Municipal Health Services Act. The municipalities finance these services from their general tax revenues, grants from the state, and through user payments for certain services. The state influences legislation, standards, regulations, and guidelines and also uses so-called 'soft power' - such as referrals, education, oversight, and targeted grants - to achieve provision of appropriate care. Within this, services may vary from community to community.

Long-term care is usually associated with care for older adults, but long-term care needs can occur and be provided at any age. Care services in Norway focus on the entire population over the age of 18, and although older people are by far the majority in receipt of these social services the number of users aged under 67 is also increasing significantly (Gautun and Grødem, 2015) (Graph 4).



Graph 4 The distribution of long-term care forms by age group. Care recipients per 1000 residents, 2016.
Source: Statistics Norway, 2016.

Norway does not have a defined care sector for older adults, but rather care services for all the population in need of long-term care. Discrimination or unequal treatment based on age is against the law, but there are several differences related to age:

- it is very rare for a person over 67 to be granted a personal assistant based on social contact needs (Gautun and Grødem, 2015);
- unlike older people, people under 67 with extensive needs have a legal right to a user-directed personal assistant;
- nursing homes are in principle reserved for the older adults.

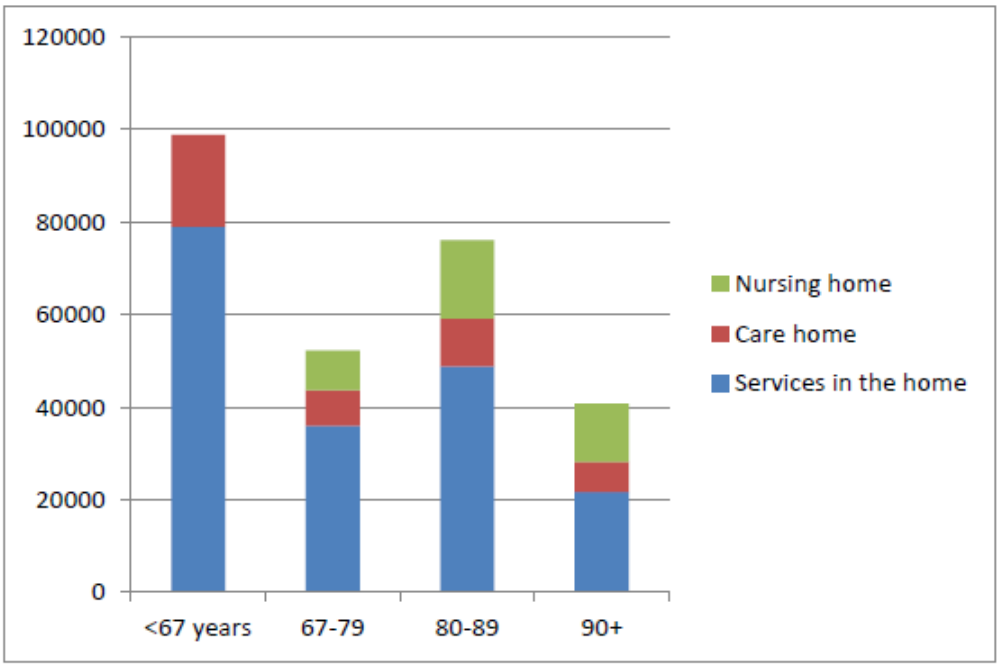
The boundary between state-run specialised health services (hospitals) and municipal health and nursing services has changed over time, especially in 2012 after the introduction of the Coordination Reform (Samhandlingsreformen, 2012). The aim of this reform was to achieve better coordination between primary and secondary health services by strengthening the roles of municipalities in the overall system. For municipalities, the most important aspect of the reform is that they bear full responsibility for patients once they are discharged from hospital. If municipalities fail to offer services to discharged patients, they may be required to co-finance additional nights in hospital. This has motivated local governments to expand their services for somatic patients with significant care needs and encouraged them to communicate more systematically with hospitals.

Users pay for some of the services provided, but not all. User payments are regulated by national guidelines. The general rule is that user payments must not exceed the cost of providing the service and that 'caps' apply to low-income users (HOD, 2011). For long-term stays in nursing homes, municipalities may require up to 75% of the users' annual income up to the basic national insurance amount (currently 93,634 NOK approx. EUR 9 853) and 85% of the annual income above this (very low) level. Allowances are made if the user provides for family members or has a very low income. Payments to users may also be required for practical domestic help (with a ceiling set at the cost of providing the service), whereby nursing care in the home should be free of charge (HOD, 2011). Around 90% of nursing homes are run by municipalities and 97% of costs in home care are directed to services run by municipalities (Sivesind). At the national level, there are between 70 and 80 care homes run by third-party sector organisations and 20 of these are commercially run (Sivesind, 2016). Contracting, particularly with commercial agencies, is still a controversial topic at the political level.

2.1.1 Residential care and home care services

Home care has been the dominant approach in care services since the early 1990s. Helping recipients of support services and long-term care remain in their own home for as long as possible, and enabling individuals to live independent lives, has become the dominant goal for social service provision (NOU, 1992: 1), while reform has become the dominant goal to improve care for people with an intellectual disability (HVPU reform, 1991-1995). Gjærevoll's committee emphasised local care in the home, while the HVPU underlined the need for reform (this reform is the Slovak equivalent of the process of deinstitutionalisation and transformation of the social welfare system, where the responsibility for persons with intellectual disabilities is transferred from the state to the municipality so that these persons can live as independently as possible and be integrated into their local communities.) The ambitious action plans for substance users and persons with mental illness in the late 1990s and early 2000s were based on the same principles (Gautun and Grødem, 2015). Nursing homes (omsorgsboliger) – defined as municipally-owned homes built for people with care needs, often with around-the-clock care - have expanded rapidly since mid-1990s. Daatland and Otnes (2015) estimate that between 1998 and 2005 about 19,000 new care homes were built, in addition to the creation of 5 000 to 6 000 new places in nursing homes (although the expansion in care homes may be overstated, given the lack of clear definitions). In addition, around 5 000 care homes and between 1 000 and 2 000 nursing home places were established immediately prior to the action plan. In the same period, between 5 000 and 6 000 places in so-called 'old people's homes' (aldershjem) were closed. The net increase in residential care beds was thus modest, but there was a transition from ‘institutions for the elderly’ to ‘homes for people of all ages with care needs’. At the same time, nursing homes were increasingly made more homely and ‘cosy’ through renovations, mainly to ensure that more residents could have private rooms (Daatland and Otnes, 2015).

As can be seen in Graph 5, in-home services for users now form the dominant form of LTC across all age groups - even in the 90+ group. It is worth noting that no young people are placed in nursing homes (under 67 years of age). This is deliberate - nursing homes are more or less designed for elderly, especially for those with dementia.



Graph 5 Numbers of people receiving long-term care (service in the home, care homes, nursing homes) by age, 2016.

Source: Statistics Norway, 2016.

2.1.2 Money vs. benefits in kind

Many recipients of long-term care services receive cash benefits from the state called Social Insurance, either as an old-age pension or a disability pension. However, these are not linked to the need for care. There is a set of benefits that are awarded based on care needs, either to the person in need of care or to a private carer, (Grødem, 2016; 2017) and they are known as the support benefit (hjelpestønad), the care allowance (pleiepenger) and the carer's support (omsorgsstønad). Before 2017, this last-named benefit was known as carer's wage (omsorgslønn).

The support benefits and the care allowance are state benefits, mandated by the National Insurance Act and administered by the Norwegian Employment and Welfare (NAV). These two benefits are received by approx. 72 000 people (NAV, administrative statistics). The carer's allowance is mandated by the Social Services Act and is financed and administered by municipalities. Just under 10 000 people receive it (source: Statistics Norway). Support benefits and support carer's allowance can be paid regardless of the age of the carer or the person who needs care. The aim of such benefits is to enable the recipient to establish or maintain a private

arrangement, e.g., informal care through a family member, friend/neighbour or other persons. When claiming the benefit, a medical opinion must be provided indicating the extent of the claimant's disability and a statement of the need for care. The need for assistance must be permanent, meaning it must be ongoing for two to three years (or more) because of the medical condition. The benefit is a lump sum, payable at NOK 14 412 per year (EUR 1 500). It is set to cover approx. 2-2.5 hours of paid care per week and is not taxable. Its use is not monitored and not subject to requirements beyond the documented need for continuing care. However, it may be granted for a limited period and is subject to review. This is done when there is reason to believe that the need for care will change over time. The care allowance (pleiepenger) is paid to carers. It can also be paid in the case of seriously ill children (§§ 9-10 and 9-11) and to persons caring for a relative or other close person during the terminal phase (§9-12) - in the latter case the allowance is limited to 60 days. To claim the benefit, the patient's physician must submit a form indicating the diagnoses and a statement that the illness is (probably) terminal.

The allowance can be used flexibly and combined with part-time work. The care allowance is paid under the same conditions as sick pay (e.g., it only applies to those who are currently employed) and offers full wage replacement from day one. It is taxed as income. People can apply for care support if they do care work in the community, on the condition that the carer does not do it informally. However, local authorities decide the criteria as regards eligibility and priorities. For the municipality to pay the carer support it must accept that private informal care is the most desirable way of providing care for the client. This understanding should be reached through dialogue with the caregiver. Local authorities may require a person with care needs to apply for benefits support (hjelpestønad) and then take the amount received into account when determining the carer's support. The support can be paid regardless of whether and if there is a legal duty of care; it can thus be considered for parents who care for children with special needs, as well as for adults who care for sick parents or spouses. This is not related to loss of income but is available regardless of the recipient's current income from employment and his or her previous jobs.

The level of support is usually calculated using the annual salary of the lowest-paid employees as a starting point. Caregiver support is taxed as income. Its use is not monitored, but it is usually granted for limited periods - generally for a year or less. Most municipalities with limited resources are unwilling to enter into contracts that bind them for more than one fiscal year.

Carers have the right to a relief service (avlastning). The aim of the respite support is to prevent burnout among carers and to allow them to go on occasional leave/holidays and have a normal social life. The measure aimed at meeting the social needs of the cared-for person is 'support person' (støttekontakt). In order to be allocated a support person the applicant has to convince the municipality that he/she has social needs that are not being met. There are no formal eligibility criteria, but persons over the age of 67 are very rarely receive approval for a support person (Gautun and Grødem, 2015). Since 2015, persons under the age of 67 have a legal right to personal assistance.

2.1.3 Formal and informal care and formal job quality

In the most recent Living Standards Survey (population survey, Norwegian version of EU-SILC), 13% said that they regularly provide care and/or supervision to a person outside their own household, while 2% provide such care to a person living in the same household (Table 1). Those who provide care or supervision to a person living outside their own household indicate that they do so for approximately five hours per week.

Table 1 Proportions undertaking informal care work, Norway, 2015

	% in 2015	**Change 2012 – 2015, Percentage points**
Belongs to a household with at least one member with care needs.	6	0
Regularly provides unpaid care or supervision.	15	-1
Regularly providers care or supervision to a person with care needs within the household.	2	-1
Regularly provides care or supervision to a person with care needs outside the household.	13	-1

Source: Statistics Norway, 2016.

Those aged 45-66 years provide the most care (Statistics Norway, 2016b); the most common form of care is the care given to their own parents. Although the proportion of the population regularly providing unpaid care is limited, there is a small proportion that provides comprehensive and continuous care. Most of these are either parents of chronically ill children or older people with partners who need round-the-clock care. Norway estimates that such informal care is provided to 90 000 people per year (Holmøy et al., 2016).

2.1.4 Analysis of the main challenges in long-term care in Norway

All municipalities are required to provide a range of care services. This is the core of the municipality's role, which residents in the municipalities require. Services are therefore available throughout the country, even in rural and remote areas. As described in the previous section, there is a limit to the payments users must make and there are some concessions for low-income users and/or persons suffering from various types of dependencies. These conditions are also valid if the service is provided by a private company under contract with the municipality. Norway's social services system is often touted as a model for other developed countries; however, a persistent issue in the system is the long waiting times for critical services. In the case of nursing homes, a long waiting period is defined as 16 days or more from the date the application for nursing home services is filed with the municipality. Waiting times for other services vary; in 15 days or fewer, 77% of applications for health services are processed, just over 60% of applications for practical help at home are processed, and only 50% of applications for long-term residential care are processed (Statistics Norway, 2017).

Waiting times are generally longer in cities than in small villages. There are no formal rules on when a person should have access to care services. The services are offered when they are needed, and the need is determined by health staff in dialogue with the user and his/her family. Healthcare staff are committed to offering accountable services. The needs of users are not neglected to save the municipality money, but the clients and their families expect services at a responsible level. Users who think that their needs are not being met can appeal to the municipality and, if unsuccessful, to a higher authority than the mayor of the municipality (fylkesmann). At what point is a person too fragile to live in a home permanently, where substantial services are provided? On the one hand, many older people prefer to live independently for as long as possible. On the other hand, many reach a point at which they can no longer live without intensive help.

The Norwegian Directorate of Health recently found that 28% of nursing home users died within the 6th month of admission, with research indicating that the average period between admission and death is two years (Helsedirektoratet, 2017c). This suggests that there are differences between municipalities. It is estimated that about 80% of nursing home residents have dementia and that dementia is the most common reason for nursing home admission (Selbaek et al., 2007, Wergeland et al., 2015). As explained above, cost to users should not be an issue, but nursing homes are expensive for municipalities and therefore are usually used as a last resort. All municipalities are required to provide a range of nursing services. This is the core of what residents in municipalities demand.

2.2 Sweden and the long-term care system for older adults

Sweden has a comprehensive public long-term care system for older people. The Swedish LTC system is decentralised, and municipalities are responsible for institutional care such as nursing homes, residential care facilities and group homes for persons with dementia, and home-help care and services. This decentralised structure gives rise to several important problems. First and foremost, there are no national regulations on eligibility; local authorities decide on the service levels, eligibility criteria and the range of services to be provided for home help and institutional care. Cash benefits (which play a very marginal role in the Swedish LTC system) for family carers are also decided upon locally and are not provided everywhere. In the National Plan on Quality in Health and Social Care of Older People (SOU 2017, p. 21), the investigator suggests that the National Board of Health and Welfare (NBHW) should map out differences between municipalities in their guidelines and practice in granting access to institutional care, and the causes of these differences.

Integrated care is a national policy goal to avoid fragmentation and improve efficiency in care provision for older people by introducing coherent and coordinated LTC services, both within the care systems and between health and social care. Simultaneously, there is pressure to introduce more competition under the umbrella of freedom of choice and diversity. The official goals of (on the one hand) equality and LTC systems of integrated care, and (on the other) freedom of choice, results in a political dilemma involving conflicting goals. At the political level, there is a need to prioritise integrated care (Schön Heap, 2018).

Almost all Swedish welfare state programmes are based upon individual independence, springing from the high value attached to such independence and the idea that family bonds

should be voluntary rather than obligatory; consequently, there is no legislation giving families the responsibility for caregiving. Sweden has a comprehensive public LTC system for older people, the guiding principle of which is the provision of publicly subsidised, widely available services that can be used by everyone in need, regardless of financial and family resources (Sipilä, 1997).

The responsibility for the long-term care of older people is divided between three governmental levels. At the national level, parliament and the government set out policy aims and directives by means of legislation and economic incentives/steering measures. The 21 county councils and regions are responsible for health and medical care. The 290 municipalities are responsible for social care, e.g., institutional care and home help. Home-help services can be complemented by home health care services.

The municipalities vary considerably in population and character and thus the conditions for managing the municipal tasks differ. All citizens are, if needed, eligible for health and social care services. Access to social care is based on a needs-assessment, as opposed to being means-tested. However, there are no national regulations on eligibility. Eligibility criteria, service levels, and the range of services provided (for both home help and institutional care) are decided locally. Cash benefits are also decided locally. Hence, an evaluation of eligibility criteria for LTC services and benefits is difficult to make. Both health and social care services are highly subsidised. Through taxation, county councils and municipalities finance around 90% of the cost of health and social care. Around 5% is covered by national taxes. Users pay only a fraction (4 - 5%) of the cost. Fees for LTC, on which there is a ceiling, include care, rent, and meals. From 2017, the maximum amount charged for care, whether home-based or in an institution, is 2,068 SEK per month (€219). There are two types of municipal cash benefits available for family carers in Sweden. These are, however, not provided everywhere; each municipality may decide whether to provide this programme or not and what the eligibility criteria, level of payment, etc. should be. One such cash benefit is the attendance allowance (hemvårdsbidrag), which is given on top of services provided to the care recipient. This is a net cash payment given to the care recipient, to be used to pay for help from a family member. The level of reimbursement is, at most, about 4,000 SEK per month (450, - €). The other benefit is the carer's allowance (anhöriganställning), which is not actually an allowance; the municipality employs a family member to do the care work.

The carer's allowance is taxed and gives the same salary and similar social security to home-help workers employed directly by the municipality. It is not possible for a person who

is 65+ to be employed. Because data on municipal cash benefits ceased to be part of official statistics in Sweden in 2006, the most recent figures are from that year and the number of persons receiving allowances is assumed to have decreased since then. It is important to stress that cash benefits play a very residual role in the Swedish LTC system, as services in kind are prioritised over cash benefits. In 1992, the community care reform programme shifted the major responsibility for the care of older people from county councils to municipalities. This reform spurred a reduction in the number of hospital beds for several decades afterwards. This reduction is part of a deinstitutionalisation trend in the Swedish LTC system. An 'ageing in place' policy dominates the organisation and performance of LTC in Sweden. This policy has led to a gradual downsizing of institutional resources. Since the 1992 community care reform, the number of hospital beds has been reduced by more than 50% (National Board of Health and Welfare, 2017). In 2014, Sweden had the lowest per capita hospital bed rate in the European Union (EU) - 2.5 beds per 1,000 persons, compared with an EU average of 5.2 beds per 1,000 persons (OECD, 2016a). In the early 2000s, a wave of reductions began in the number of municipal institutional beds (e.g., nursing homes, residential care facilities, group homes for people with dementia). Since then, 30% of municipal places have closed. Thus, over time, more and more people receive help at home rather than in institutions, in accordance with the 'ageing in place' policy. In 2001, 18.3% of those aged 80+ received home help, while 20.0% were living in institutions. In 2017, 22% of those aged 80+ received home help and 12.2% received institutional care (Schön Heap, 2018).

Moreover, there has been a shift in the allocation of home-help care; people with greater needs receive more comprehensive care, while those with less extensive needs are less likely to receive any home help. Another development in Swedish LTC is a strong marketisation trend (e.g., private provision of publicly funded care) including increased competition, along with freedom of choice and diversity. There has been a dramatic increase in privately provided LTC, and the entire increase is the result of the growth of for-profit – in contrast to not-for-profit – provision. In 2009, the Act on System of Choice in the Public Sector (LOV) was introduced, and since January 2010 choice has been obligatory for primary care in all counties and regions. This means that county councils are obliged to introduce freedom of choice for patients, allow the establishment of primary care clinics by authorised private providers, and fund the latter's services from tax income. Thus, private providers do not necessarily need to be established in all counties, but opportunities must exist for such establishments (Ekman & Wilkens, 2015). In effect, private agencies are given the opportunity to start a clinic where they choose, and then

send the bill to the county council. The county councils cannot decide where the clinics are located and therefore cannot, for example, locate them where the need is greatest (Burström, 2015). This reform opened the possibility for county councils and municipalities to, amongst other options, contract out services to private service providers. Despite the private providers and the highly deregulated nature of LTC in Sweden, the system remains publicly funded.

Another feature of the Swedish LTC system, like that in many other countries, is fragmentation. Specialist services are poorly designed to provide care for patients with multiple health problems and social needs. The aforementioned cutbacks in formal eldercare, as well as the altered allocation of home-help services (focussing on those with the greatest care needs), have taken place along with an increase in informal care (refamiliarisation). The proportion of older people who received care from both home-help services and family members to manage their activities of daily living increased substantially during the early 2000s (Ulmanen & Szebehely, 2015). Moreover, the number of hours that relatives spend on caregiving has also increased.

2.3 Denmark and the long-term care system

Denmark has perhaps the most universal LTC system in the world. Danish long-term care aims to increase the quality of life of persons in need of care and to increase their ability to take care of themselves. LTC is organised and delivered by 98 municipalities and, for certain health benefits, by five regions. LTC is financed through general taxation and generally provided free of charge.

The dual goal of Danish long-term care is to increase the quality of life of persons in need of care and to increase their ability to take care of themselves. The Danish system is probably the most universal and comprehensive system in the world. The majority of LTC is provided by way of residence in institutional care, special housing with nurses attached, or home help. Most of the system is organised and financed at the local level, where 98 municipalities adopt and deliver the bulk of LTC services. The regional level is responsible for primary health. There are no LTC policies at the central level, although national politicians agree on general regulation and often strike budget deals that set the economic conditions for local policies. Whereas national politicians define the principal elements in LTC, it is local politicians who define how much should be delivered, by whom, and under what conditions; this leads to 98 municipal

versions of the Danish LTC system (Kvist, 2018). The LTC system consists of five elements (Kvist, 2018):

1. preventative measures
2. rehabilitation
3. home help
4. homes for older adults
5. other measures, including personal assistance and food services.

Municipalities offer older adults a variety of preventative measures, including preventative home visits and activity offers. Depending on their age and life situation, older adults are offered a preventative visit that focusses on their functional, psychological, medical, and social resources and challenges. Everyone above 75 years of age is offered a visit. The offer is also made to people between 65 and 79 years of age who are in a special risk group such as, for example, those who have lost their spouse, are isolated, or have been discharged from hospital. Finally, persons aged above 80 years are offered a visit on an annual basis. As of 2016, municipalities can organise public arrangements as an alternative to individual visits for groups that normally decline home visits. In 2016, 93 424 persons received a preventative home visit, down from 122 794 in 2010 (Danmarks Statistik, 2020).

The scope and kinds of activity offered differ between municipalities; they include visit schemes, workshops, education, talks, and sports for older adults. The offers can be delivered by the municipalities themselves, by associations and organisations, and by citizens. Users should have equal responsibility and influence on the offers, and if they include older adults then the local council responsible for the older adult must be consulted. A food service may also be offered – that is, food prepared outside the home and brought to the older adults or to a local centre.

Rehabilitation is part of the home help service. When a citizen applies for home help the municipality must offer a rehabilitation programme prior to assessing the need for home help. It must also offer rehabilitation to alleviate reduced physical function caused by illness, along with maintenance training aimed at preventing loss of functional capacity or maintaining or improving such capacities. The aim of rehabilitation is to make citizens more autonomous and give them a greater sense of independence in everyday life. The goals of the rehabilitation programme are set jointly by the municipality and the older adults themselves, and it must be holistic and cross-disciplinary. The programme, which can be delivered by private providers, must contain one or more of the following elements: physical training; a medication review;

nutritional intervention; ADL training (training in activities of daily living); physical aids and changes of environment; and measures addressing loneliness. In 2016, 11 279 persons above 65 years undertook rehabilitation (Danmarks Statistik, 2020).

Home help is a central part of LTC and covers personal care, practical help and support, and food services. Personal care consists of help in maintaining personal hygiene, getting dressed, getting out of bed, and eating. Practical help covers cleaning, doing the laundry, and shopping. Home help is given to persons who cannot undertake these activities themselves. The amount of home help is initially decided by a municipal case worker after a home visit and is later also informed by the result of the rehabilitation programme. Although different municipalities have different practices, many municipalities differentiate between five levels of functionality, giving an entitlement to varying amounts and types of home help. Claimants received an average of 5.8 hours of personal care and 0.7 hours of practical help on a weekly basis (Danmarks Statistik, 2020). In total, 538 950 hours of home help weekly were delivered in 2016 (Danmarks Statistik, 2020). In total, 146 214 persons were entitled to home help in 2016 (Danmarks Statistik, 2020).

Older adults are offered a choice between at least two different providers of home help, one of which can be a municipal one. In 2016, 35.7% of home help claimants chose a private provider (Danmarks Statistik, 2020). Besides the free choice of a provider, older adults are also entitled to appoint a person (not a provider) to carry out these and similar tasks. This person must be approved by the municipality which then acts as an employer, sets out the services to be provided, and ensures help is provided in case the person gets ill. The scheme also approves family members but is only relevant for persons under pensionable age.

Persons with special needs have a right to a place in a home for the older adults. Today there are five types of homes for older adults (Kvist, 2018):

1. nursing homes (plejehjemsboliger) are institutions for older adults with live-in staff;
2. sheltered housing (beskyttede boliger) is connected to institutions for older adults, with some having live-in staff and service areas and others operating with emergency call arrangements etc.;
3. housing for older adults (plejeboliger) consists of homes for older adults with associated staff and service areas;
4. general homes for older adults (almene ældreboliger) are designed to be suitable for older adults and persons with disabilities, but they do not have live-in staff or service areas;

5. private care accommodation (friplejeboliger) consists of rented accommodation for persons with extensive needs for service and care, with permanent staff on-site and service areas outside the municipal sector.

The accommodation that older adults reside in will depend on their preferences and care needs, as well as on the local situation with regard to policies on, and vacancies in, nursing homes and general homes for older adults. The needs assessment takes into account physical, mental and social aspects, but not the age of the applicant. If the functional capacity of the older adults is markedly reduced in their existing home, and the latter cannot be made suitable, they may be granted a place in a home for older adults (Kvist, 2018).

After going on a waiting list, older adults must be offered a place in a nursing home (plejehjem) or in older adults housing (plejebolig) within two months. Older adults who have been granted a place have the free choice of applying for a home in another municipality or in a specific institution. Older adults who want to keep living with their spouse or partner must be offered a home suitable for two persons. The number of places in care accommodation for older adults was 79 970 in 2016, slightly down from 82 059 in 2010 (Danmarks Statistik, 2020). The average duration of stay in a home for older adults is 32 months. In 2013 the average age on entering a home for older adults was 83.7 years (Sundheds, Eldreministeriet, 2016). About 50 percent of residents in nursing homes had one or more chronic diseases and 42 per cent in homes for older adult had dementia (Sundheds, Eldreministeriet, 2016).

2.4 The Czech Republic and long-term care system

The Czech Republic, along with other EU countries, is a country with an ageing population. Population ageing is associated with a growing number of people in long-term care and a concomitant decline in the labour force.

The development of long-term care has been carried out in a fragmented fashion in the Czech Republic, with responsibility strictly divided between the healthcare sector and the social care sector (The Ministry of Labour and Social Affairs –MLSA, 2018). Under the public health insurance system, introduced in 1993, providers of healthcare services and social services are mutually distinct entities. In 2006, residential social care providers' entitlement to provide some health care (mainly nursing care) covered by the public insurance scheme was re-established. However, the governance of long-term care, as well as palliative, health and social care, remains

an issue. In 2008, the National Plan of Action on Ageing 2008-2012 declared that the division of responsibilities and funding increased the risk of fragmentation and insufficient coordination of services and gave poor transparency of the system for clients as well as providers, maintained a low flexibility of services, and made it unclear who had the responsibility for achieving results (Ministry of Labour and Social Affairs CR, 2018). Unfortunately, this is still the case; separate legislation regulates each of the sectors, and they each have a different funding scheme and governance. Institutional governance of LTC is a vertically fragmented, plural system, with responsibilities distributed between different institutional tiers: the state, the regions and municipalities. Regions play an essential role in planning and coordinating capacities, and both regions and municipalities serve as major founders of public institutions providing social services.

Formal carers in social services can be registered or unregistered; if they are registered, they are bound by maximum administrative prices, whereas unregistered persons operate within a system without restrictions on pricing, with the cost fully covered by private payments (EC, 2019).

There is no explicit and separate long-term care insurance scheme in the Czech Republic. Multi-source funding is a key funding concept, with clients' fees representing the main funding resource for social services. Other sources consist of subsidies and grants provided by the Ministry of Labour and Social Affairs (MLSA) and regional government. Some services, such as social prevention or rehabilitation, are provided without private co-payments.

In residential care up to 85% of the recipient's income can be used to cover accommodation and food costs. Reimbursement of other social services costs is limited by the recipient's care allowance. Any remaining costs must be covered privately, either by the recipient or their family (EC, 2019).

Social protection measures differ according to the sector of LTC. Health and social services are addressed separately. Eligibility for the care allowance is based on an assessment of the level of dependency on care. The care allowance is provided to people who, due to their long-term unfavourable health condition, are dependent on another person's assistance when dealing with basic living needs (Long-Term Care Report, 2021).

There are also specific allowances guaranteed to people with disabilities (Act No. 329/2011 Coll.). They include mobility allowance and special-aid allowance. The Czech Republic fits the traditional model, where LTC is largely considered a 'family business' and family members and friends provide most non-medical care.

Residential facilities represent the most complex form of social services for older adults. The Social Services Act defines three main types: homes for older people, special-regime homes (for older people with reduced self-sufficiency and ageing diseases), and week-care centres. Besides these, there are so-called boarding houses for older people (they operate on the basis of a rental relationship), residential homes (established by municipalities, not governed by the Social Services Act) and long-term care facilities (medical facilities) (Act No 108/2006 Coll.).

A long-term attendance allowance was introduced in 2018 to address the financial situation of family members who provide care for their dependent relatives. The state pays health insurance premiums through the state budget on behalf of those who are dependent on assistance. The payments operate according to a scale of dependency - at level 1 (mild), level 2 (medium), level 3 (heavy) and level 4 (full) dependency - and the recipients include people caring for children younger than ten years old. There is an insufficiently developed supply of formal home care in the country and the services do not meet the needs of dependent people and informal carers. Residential care suffers from insufficient bed capacity and consequently limited accessibility. Home care and respite care should be strengthened.

The social services system is not prepared for the effects of population ageing. There were no reforms to the system during the period under scrutiny. There are four areas presenting significant challenges: governance, capacity building and investment, quality assurance, and home-based service support, both formal and informal (Long-Term Care Report, 2021).

2.5 Hungary and the long-term care system

The Hungarian LTC system is still on the way to becoming a separate field of social protection and, despite important steps being made in the last few years on integration, it still has a dual structure of healthcare and social care. The two branches have their own legislation, financing mechanisms and services. They maintain parallel institutional networks in both residential care and home care. A project that was launched in 2017, to test the way in which chronic beds and beds in nursing departments of hospitals could be replaced by special care centres (szakápolási központ), is still in its introductory phase.

Despite a rapid extension of home care between 2008 and 2014, the LTC system is still institution centred. The rate of spending on residential care to total spending on LTC is 72% in the public sector, which is one of the highest rates in the EU. Access to public healthcare in

principle is based on mandatory health insurance (Health Insurance Act 83/1997 Coll.) which is held almost universally, with nearly every citizen holding a relevant social insurance card. Eligibility for social care is based on need (Social Act 3/1993 Coll.) and on the administration and provision of social protection. The responsibility for social care provision is divided between the government and local governments and depends on the size of the community. The smallest communities, with less than 3 000 inhabitants, are obliged to provide meals-on-wheels services and home care. Communities larger than 3 000 have to add day-care centres to their care portfolio, and those larger than 30 000 people have to maintain a care home for older people. The responsibility at the community level is to organise provision, but they can apply for funding from the central budget. Institutions serving groups of communities are maintained by the central government. The provision of a system-based home alarm assistance is also the responsibility of the government (Long-Term Care Report, 2021).

As in Slovakia, Hungary's LTC services are administrated separately through the healthcare system and the social care system. The two systems maintain parallel institutional networks, relevant to both institutional care as well as home care. There is no cooperation between the two systems and none of them applies, let alone coordinates, a system of case management. There is no long-term care system; long-term care is a low-priority area of public policy in Hungary, receiving almost no attention and generating almost no debate. Disabled relatives and ageing and dependency are family rather than societal issues. This is reflected in the limited availability of public long-term care services, the lack of related research and the absence of relevant data.

Despite important steps taken recently towards integration, long-term care still retains a dual health and social care structure. Collaboration between them is still weak, despite some minor improvements in recent years, due to the concentration of the health care and social affairs portfolios into one body, the Ministry of Human Resources. The services provided in the health sector are nursing care in the nursing units of hospitals and home nursing care. The three main types of social care services are home care (including 'meals on wheels'), day care, and residential care. The dominant healthcare provider in long-term care is the central government. The main providers of social care are local authorities and churches (home care, day care and residential care) and the central government (residential care). All providers are funded from the central budget based on the type and staffing requirements of the services; however, they are expected to supplement the amount they receive from their own resources

and contributions from beneficiaries (The 2021 Ageing Report, Underlying Assumptions & Projection Methodologies, EC, 2020).

2.6 Poland and the long-term care system

The LTC system in Poland is expected to face increasing pressure in the coming years, due especially to an ageing population. This is expected to lead to higher demand and reduced financial resources deriving from taxes to support the future supply of LTC. There are currently around 6.7 million people aged 65 and over in Poland; the number of older people increased between 2008 and 2019 by 1.6 million people. In Poland, care for older adults at home is provided by state institutions and private institutions. The legal forms of non-public providers are self-employed persons, private companies employing carers with different specialisations (including medical care), foundations, and employment agencies bringing together persons in need of care and persons who provide such care (Long-Term Care Report, 2021).

Eurostat (2020) reports that 25% of the population in Poland is aged over 60 years of age. Social policy with specific objectives and recommendations on long-term care for older adults was developed for the period 2014-2020. One of the first objectives involved preparing a person for the period of old age in terms of knowledge of the physical and mental changes that occur during the ageing process. Other objectives include ensuring the safety of older adults and the prevention of elder abuse, universally accessible designs in regard to outdoor environments and public buildings, as well as creating inclusive workplaces with tailor-made working conditions for older adults. One problem in the delivery of LTC is the shortage of professionals in geriatrics and other professionals who care for older adults (Eurostat, 2020).

The issues concerning LTC can be found in several regulations, which are separate for the healthcare system and social sector. Healthcare sector services are granted to all those insured who are in need of medical treatment and rehabilitation due to a deterioration of their health status. Nursing homecare services are provided by LTC nurses or community nurses based on the decision of a primary-care physician. In chronic care homes (zakłady opiekuńczo-lecznicze) and nursing homes (zakłady pielęgnacyjno-opiekuńcze) care is provided to individuals based on a medical and functional assessment. In hospitals, particularly in geriatric wards, functional abilities are assessed by the Complex Geriatric Assessment (Całościowa Ocena Geriatryczna – COG); however, this practice is not common in primary or nursing care as it is perceived as too complex and time consuming (Long-Term Care Report, 2021).

Residential care services (usługi opiekuńcze w miejscu zamieszkania), including specialised homecare services (specjalistyczne usługi opiekuńcze), are provided to individuals requiring care and assistance at home or assistance with daily personal activities due to age or disability. Services are granted based on an assessment by a social worker, who evaluates the situation of the person in need in a family background interview and, if needed, home visit. The assessment includes an evaluation of the individual's needs and their household situation and income; people with an income below the social assistance threshold may receive services free of charge. An administrative decision to grant services is issued following a family background interview, conducted with a specific questionnaire, which takes into account the medical condition of the prospective recipient based on a medical report. A regulation determines the template used to structure the interview and the way the family background interview is conducted.

The Act on the Provision of Social Services by Centres for Social Services (Ustawa o realizowaniu usług społecznych przez centrum usług społecznych), introduced in July 2019, allows a change of provider, enabling local governments to reorganise its management and provision of services.

Residential care services in social assistance homes (domy pomocy społecznej) are granted based on care needs and are available when the family is incapable of providing full-time assistance. The assessment of needs, as in the previous example of homecare services, is performed by the social worker from the local social assistance centre (ośrodek pomocy społecznej). Family care homes (rodzinne domy pomocy) provide fulltime care to older people or people with disabilities based on the decision of the social assistance centre manager. Decisions are based on the family background interview and a medical certificate confirming that there are no contraindications to placing a person in a family care home. Whilst social assistance homes are typically large, on average providing care to about 100 residents per institution, family care homes are small and provide services to about eight residents per facility (Long-Term Care Report, 2021).

The integration of LTC services faces two types of problems: (i) problems with the integration of institutions that operate on the margins of the health care system with the institutions that operate within the social assistance sector, and (ii) the integration of residential care and home care. Special intervention in both sectors and additional resources are needed to link the two institutional settings of the health care and social assistance systems. Increasing the contracting of medical and nursing services for the social assistance homes is limited due

to the scarce financial resources in the health sector and insufficient personnel in the residential care sector.

As described above, the social and medical functions of LTC are separate in the case of Poland. According to the creators and legislators of the social and health policy systems established after 1990, local governments coordinate the two systems for their clients, although such coordination is not always efficient. The main reasons for these inefficiencies are limited financial resources and managerial constraints. Restrictions in the availability of nursing personnel in both the social assistance and healthcare sectors also pose a significant constraint to integration (Golinowska, 2010).

Conclusion

As Poland's healthcare system continues to undergo transformation, there has been increasing interest in integrated care as a model for delivering coordinated, patient-centred care. Poland's healthcare system, like others around the world, struggles with fragmentation and resource limitations. Healthcare funding and reimbursement systems in the country do not incentivise collaboration or preventive care, and the lack of integration between the care services hinders improved care and outcomes. By creating more coordinated care pathways, integrated care can help address challenges such as long waiting times, unnecessary hospital readmissions, medication interactions, and care plan adherence. One example of a primary care-based integrated care model is the Family Medicine Plus programme, which is being piloted in several Polish cities. The programme provides comprehensive health assessments, creates individualised care plans, and enables interdisciplinary team communication to offer integrated care services to patients. Other hospital-based models include teams comprised of healthcare professionals from multiple disciplines working together to provide a well-rounded care experience. A further area which is developing is the implementation of e-health solutions in integrated care. Many hospitals and healthcare systems partner with technology vendors to implement electronic health records for sharing medical documentation, monitoring patient care, and tracking patient feedback. (Kurpas et. al, 2021). Integrated care has the potential to be an innovative solution to Poland's healthcare challenges. However, successful implementation of integrated care models across the country will require collaboration and coordination among patients, healthcare providers, policymakers, and funding providers.

In Hungary, the need for integrated care has become increasingly important due to the rising burden of chronic diseases such as diabetes, cardiovascular disease and cancer. As a

result, the healthcare system must focus on preventive and patient-centred care to ensure positive health outcomes. Moreover, the fragmentation of healthcare delivery across different providers contributes to poor healthcare outcomes, which increases the overall healthcare expenditure.

To address these challenges, the implementation of integrated care in Hungary is necessary to improve healthcare delivery and make it more efficient. The key elements of integrated care involve collaboration and communication among healthcare providers, patient-centred care and empowerment, the use of technology in healthcare delivery, and standardised documentation and data-sharing.

The Hungarian government has identified the importance of integrated care, and the National Healthcare Services Centre is playing a key role in promoting and implementing integrated care programmes across the country. The Hungarian experience with implementing integrated care has been positive, but it also presents unique challenges in terms of funding and developing a sustainable model. One of Hungary's successful examples of integrated care is the Veszprém County Integrated Care Programme. This programme involves collaboration between the primary-care physicians, specialists, and hospital services, ensuring timely and coordinated care for patients. The programme has shown significant positive results, including improved healthcare outcomes and a reduction in healthcare costs. Key success factors for this programme include leadership, multi-disciplinary teamwork, and patient-centred care. In conclusion, integrated care has the potential to transform healthcare delivery in Hungary. By focussing on collaboration, patient-centred care, and technology, integrated care can enhance healthcare outcomes and reduce healthcare expenditures. There are challenges in implementing integrated care across the country, and it is essential to continue exploring different options to make healthcare delivery more efficient and equitable; however, integrated care could be the answer to improve the quality of healthcare delivery and ensure that patients in Hungary receive the best care possible (Looman et al., 2021).

Integrated care has become a growing priority for many healthcare systems globally, including those in the Czech Republic and Slovakia. These two countries both face various challenges regarding their healthcare systems, which makes integrated care a crucial approach to improving health outcomes for their citizens. Through integrated care, there is an opportunity to better integrate health services and individual care for patients, reduce fragmentation in the healthcare system, and ensure a more efficient use of resources. The Czech Republic's healthcare system has a long-standing history of offering universal coverage, high-quality care,

and innovative research. In recent years, the country has made efforts to improve health outcomes through integrated care; however, there are challenges to its implementation, including fragmentation of the healthcare system, limited financial resources, and reluctance to change. Even so, there are examples of successful integrated care programmes, such as the Pardubice Regional Healthcare System, a model integrated care programme in the region. This programme aims to improve the quality of care for patients, reduce the burden on healthcare providers, and ensure cost-effectiveness.

Looking to the future, the Czech Republic needs to continue its efforts in integrated care and explore ways to overcome the challenges facing its implementation. Recommendations for the optimisation of LTC include increasing the engagement of stakeholders, investing in technology, and fostering a culture of collaboration between healthcare providers.

3 LONG-TERM CARE SYSTEM IN SLOVAKIA

Long-term care includes the broad array of services provided to disabled persons - particularly older adults due to their chronic illness or disability - at home, in nursing homes, and in assisted-living facilities. These services are provided to improve personal functioning and quality of life (The Organisation for Economic Co-Operation and Development 2011; Stallard 2017; Freeman et al. 2017). The integration of social and health care is a complex process that is dependent on a plethora of factors (Struijs et al. 2015; World Health Organisation 2015; Wodchis et al. 2018). Research to date provides some evidence that providing integrative care can lead to positive patient outcomes (Baxter et al. 2018; Liljas et al. 2019; de Bruin et al. 2020; Porteus 2011). Integrated care is a strategy for improving patient care, specifically through better coordination (Shaw et al. 2011; Chen et al. 2020; Craftman et al. 2018; Mauriat et al. 2009). The integrated care model responds to the needs of people suffering from rare diseases, as well as the needs of their families (Czerska and Skweres-Kuchta 2021).

Slovakia is facing significant demographic changes in the next decade, which will fundamentally affect the provision of health and social care. From the perspective of long-term care, there are two main target groups of the population for whom long-term care is intended: older adults (65+) and people with disabilities, (including mental health problems). In this text we are focussing on older adults.

Overall, the Slovak social care system is defined by decentralisation and reliance on a mix of public, private and family (or non-formal) care. It consists of two main parts: the first part includes social services provided by professional staff, and the second covers financial allowances to individuals with disabilities or their close family members who act as their carers. The system of social services in Slovakia is regulated by the Social Services Act No. 448/2008 Coll, which regulates the legal framework in terms of the provision of social services, in addition to its financing, monitoring, and control of their delivery. The supply of social services is decentralised and delegated to the self-governing regions and municipalities.

Slovak social legislation defines the conditions for the provision of formal social care and recognises the social services as professional activities, care activities, other activities, or a combination of these activities. There are public and non-public (private) social service providers. Public providers are established and financed by municipalities or self-governing regions. Non-public providers are established by NGOs or churches, and they are financed partially from state budget and municipal or self-governing region budgets. Some providers of

social services are also supported by ESIF (European Structural and Investment Funds for Social Service Providers). There are no social services fully provided by the public sector. The main difference between providers depends on their financing and access to public funds (World Band, 2020).

The long-term care of older adults in the Slovak Republic is a fragmented system. Social and healthcare services remain two separate systems with minimal coordination and interconnection. Each system is governed by its own legislation and standards. This altogether results in a very complicated system regulated by more than three different legal acts – Act no. 448/2008 on Social Services, Act no. 576/2004 on Health Care, and Act no. 447/2008 on Financial Benefits (to compensate for severe disabilities). Care for older adults is mostly provided within social care facilities (including outreach, outpatient, and residential forms). The system also relies on informal care, which is supported by allowances for caregivers – usually the next of kin of the older adults in need of assistance. The current legislation puts a greater share of social care responsibilities on municipalities, yet they are not well positioned to fulfil this responsibility. There are nearly 3 000 municipalities in Slovakia, most of them inhabited by several hundred people (65,96% of municipalities have fewer than 1 000 inhabitants) (Statistics of the Slovak Republic, 2020). They lack trained personnel, equipment, infrastructure, and financial resources to provide appropriate care for older adults (Ministry of Social Affairs, 2020).

The consequence of this situation is a complicated system of funding of social services and an unequal spatial distribution of people in need of social care. Formal legislation supports a subsidiarity principle, which means that most support and care should be provided in the natural home environment of users. If care and support cannot be provided in the home environment, then the users should go to institutional care. However, under current system, the social care services provided in institutional form are better funded than the community-based services.

Municipalities do not have sufficient resources for providing care at the community level so they resort to recommending that citizens use a regional institutional social care infrastructure, even if they do not need such a level of care and it forces them to leave their communities. Most capacity for care provision is concentrated in the institutional care facilities of self-governing regions and private providers; moreover, most of the social care service providers who deliver community-based services are private providers. The long-term care system in Slovakia suffers from underfunding, which is the reason for the insufficient availability of these services. While LTC is supposed to combine healthcare and social services,

there is no systemic service coordination or integration between the two. Home-based health care is provided mainly by the visits of nurses, home physician visits and assistance provided by mobile hospices. We consider it important to set the appropriate methodological solution of the problem of long-term care with a focus on an integrative care model.

3.1 Description of Slovak demographic changes, welfare state and long-term care system

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

Demographic changes since the mid-20th century have been triggered by the so-called age of ageing (Magnus, 2009). Longer life expectancy and advances in healthcare have led to an increase in the number of older adults (Zainol and Pettit, 2016). From a demographic perspective, declining fertility rates and increasing life expectancy are leading to a gradual increase in the proportion of older adults in many countries. This change increases the burden of the economically productive population to finance sustainable social security programmes, in particular to cover pensions and social care for the older adults.

Long-term care in Slovakia is formally divided between the Ministry of Labour, Social Affairs and Family (MLSAF) (with responsibility for the provision of social services and cash benefits) and the Ministry of Health (geriatric clinics, medical and nursing facilities for the long-term ill, nursing care homes, and nursing care agencies). Long-term care takes three forms: formal care in the form of residential services, formal care provided at home (home care services), and informal care at home (Gerbery & Bednarik, 2018).

Since 2012, Slovakia has begun the process of transforming social services to create and secure conditions for citizens dependent on assistance in their natural social environment, including transferring selected competences to the local and regional level, ensuring the principle of social subsidiarity and supporting the community character of the provision of social services. There is currently an unconnected multi-level system of long-term care services in Slovakia, and individual services in favour of addressing individual needs are not coordinated. Health care and social services are two separate systems, governed by their own legislation and standards. Support services are traditionally fragmented in two areas. The system of social services for older adults – regulated by the Social Services Act no. 448/2008, with the last amendment from 2021 – is also provided within the structures of the health system (Act 576/2004 Coll.), primarily aimed at persons with chronic diseases and the elderly in need of special geriatric care.

The welfare state plays a key role in developed societies and is one of the forms of social organisation which ensures economic equality (Greve, 2014, Van Lancker & Van den Heede, 2021). Demographic ageing is at the centre of the public health policy debate, and management of welfare and long-term care policies lead to a shifting of responsibilities across public sectors (e.g., from health to social care and from national to localised provision) and across sectors (e.g., from state to private or third sector provision) (Rummery, 2021). Long-term care has a major impact on public spending and political leaders are searching for solutions to keep public finances sustainable and allow for population ageing. The healthcare and long-term care systems aim to provide timely access to good quality medical care and contribute to human well-being in the context of an ageing society (Gusmano & Okma, 2018). Care policy, socio-economic and structural issues in developed welfare states lead to discrepancies between supply and demand in the provision of social and healthcare services in many countries. Several European countries have implemented major LTC reforms since the 1990s (Aidukaite et al. 2021; Albesa Jové, 2021; Fischer et al. 2022), and there have been three main trends: a) readjustments to the LTC policy mix – specifically, moves away from residential care towards home and community care; b) efforts to enhance financial sustainability; and, c) improving access and affordability of care, including improving the status of informal carers (Spasova et al. 2018). The Slovak Government approved the first Long-Term Care Strategy in Slovakia in September 2021 as a response to the projected long-term trend of the intensive ageing of the Slovak population (Statistical Office of the Slovak Republic, 2019). This strategy sets out

measures for the introduction of Integrated Social and Health Care (Ministry of Labour, Social Affair and Family, 2021).

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

3.2 Challenges of population ageing in the Slovak Republic

An ageing population is a trend that started in Europe several decades ago and became evident in Slovakia in the early 1990s, reflected in the increasing proportion of older people and the decreasing number of working-age citizens in the total population. According to Eurostat projections (2020), the structure of the European population is expected to change significantly in the coming decades. Slovakia is forecast to have one of the most pronounced ageing populations. While today there are about 20 pensioners for every 100 people of working age, by 2060 there will be three times as many.

On the threshold of the 21st century, all countries of the world are facing significant population changes. As the United Nations (2019) notes, there are primarily four demographic megatrends: population growth, ageing, migration and urbanisation. The significant increase in the population aged 65 and over, particularly in the 80 and over age group, is increasing the number of dependent populations and increasing pressure on the need for health care, while at the same time fuelling a rise in poverty. According to the National Research Council (2001), many countries are currently in the early stages of adapting to changes in the age structure of their populations. According to Eurostat projections, Slovakia will have the second highest proportion of post-working age population in 2060 (after Portugal) and the median age will increase to almost 50 years. As Slovakia is one of the countries with the fastest ageing population in the European Union, systemic measures are necessary to eliminate the growing

burden on the health, social and economic systems and ensure the long-term sustainability of the social security system. In the future it will be necessary to cope with rising public expenditure and to introduce employment measures to prolong working careers and to facilitate labour migration.

By 2080, people aged 65 and over are expected to represent 29.1% of the EU population, up from 20.6% in 2020. At the same time, the share of older adults aged 80+ in the EU population will more than double: from 5.9% in 2020 to 12.7% in 2080. In Slovakia, the share of the population aged 65 and over will increase from 16.6% today to around 30% in 2060 (Eurostat, 2020), while the share of the population aged 80 and over will rise to 12% (currently only 3.4%). Such a large increase in the oldest part of the population involves a significant increase in demand for long-term care provision in whatever form it exists, in addition to the demands on health care.

The effects of ageing cannot be eliminated or mitigated by isolated measures in a short period of time, as the problem requires comprehensive solutions implemented at national level. The aim of this monograph and the following chapters is to highlight the relevant facts, such as the ageing index, and to describe and analyse the current provision of long-term care services. In terms of the legislative framework, competences, financing of local authorities, as well as the large fragmentation of the territory - many municipalities in Slovakia have less than 1,000 inhabitants - the system is not prepared to deal with the changes in demographics which are already taking place.

3.3 Social and health care services for the older adults (60+) in Slovakia

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

Formal care for the older adults usually refers to paid care services provided by a residential institution or individual for a person in need. Informal care refers to unpaid care provided by family, close relatives, friends, and neighbours. In the majority of European countries, most of the care received by those aged over 50 is informal, and about a third of the over-50s provide

help with instrumental tasks and/or personal care to an older dependent person (Broese van Groenou & Boer, 2016). Both forms of caregiving involve a spectrum of tasks, but informal caregivers seldom receive the required training. Formal caregivers are trained in the field, but the depth of their training varies. Non-formal/informal care, also known as unpaid care or family care, constitutes a significant share of the total long-term care (Hoffmann & Rodrigues, 2010; Zigante, 2018). The definition of 'informal care' is broad; in our study, we take informal care to include any care or help provided to older people (family or otherwise), care provided to working age adults, young people and children with disabilities, and people living with mental health problems.

Although industrialised, Slovakia is still intrinsically rural (Statistical Office of the Slovak Republic, 2020). Data from Communities Slovakia show that there are 1 145 municipalities with a population of under 500 inhabitants, comprising 43.3% of all rural municipalities (Gajdos, 2015, p. 242). Small municipalities are often governed by a mayor without educated full time staff. In addition, many municipalities show a lack of trained personnel, equipment, infrastructure, and financial resources to provide appropriate care for older adults (Statistical Office of the Slovak Republic, 2020), leading to challenges in the provision of formal social and health care services. Often the required social and health care is provided by relatives or next of kin (Statistical Office of the Slovak Republic, 2020). Care for older adults is generally provided by family members or other non-formal caregivers and sustains the system, but it comes at a high opportunities cost**.** In Slovakia, informal caregivers have the right to a reimbursement from the municipality: €430.35 monthly for working caregivers and €215.18 for caregivers in retirement (Ministry of Social Affairs of Slovak Republic, 2020). In total, Slovakia provided €230 938,45 (2019) for informal care services by individuals, the majority still active in other paid employment (Ministry of Social Affairs in Slovak Republic, 2020). Their absence from the labour market represents a challenge for themselves and Slovak society, affecting the scope, availability and quality of social and health care services.

The formal care capacity and the availability of social and health care services for older adults is not covering the needs of today and tomorrow. Essential care is being provided informally. The depopulation of regions due to labour mobility has the consequence that the older adults are being taken care of by other older adults, often their retirement-aged adult children. Almost half of informal caregivers are of an economically active age; leaving them out of the labour market is a loss for them and for society. In addition to this, the migration of young people to study and work, together with the isolated nature of rural settlements, increases

the risk of the phenomenon of lonely older adults and becomes a serious argument for strengthening preventive and screening activities. The economic situation of households also affects the provision of long-term care services; according to our results, older adults do not have enough of their own resources to solve the problem of who will care for them.

These trends are influenced by several factors, including long-term family care, the unavailability of public care providers and the price of formal services. According to Katreniakova et al. (2019, p. 36) long-term care in Slovakia was provided at home by one or more family members (together 71.0%), with almost two thirds (57.5 %) of informal carers not receiving assistance care allowance. Another factor might be the care tradition of Slovak households, which is stronger in rural areas than in urban areas. As Slovakia is perceived as predominantly rural, family values and attitudes are significantly influenced by intergenerational responsibility and the feeling of obligation to provide for their parents (or disabled household members). These traditions might affect the extent of informal care (Martinkovičová & Kika, 2016). As research shows (Waniger et al, 2019, Stojak et al, 2019, Ślusarska et al, 2019), family caregivers frequently bear the responsibility of aiding in the instrumental activities of daily living and locating resources, often while raising their own families.

Currently there is a multi-level system of long-term care services in Slovakia that is not interconnected, and no system addressing the individual situation for those in need of assistance. In addition, health and social care services operate as two separate systems. Each of these systems is governed by its own legislation and standards. As there is no unified system of long-term integrated care in the Slovak Republic, those support services are fragmented into three areas (World Bank, 2020):

1. Social services – the system of social services is regulated by the Social Services Act no. 448/2008. In terms of long-term care, it is one of the legislative standards for long-term care. Social services are aimed at preventing, solving or mitigating the unfavourable social situation of a person, their family or community. Currently, social services for older adults are provided mainly in older adult living facilities, specialised facilities and social service centres. Outpatient social services are provided for older adults mainly through home care services.
2. Healthcare system – care for older adults is also provided within the structures of the health system (Act no. 576/2004 Coll.). Here, it is primarily aimed at patients with chronic diseases and older adults in need of geriatric care. In the healthcare

system, this is mainly provided through home nursing agencies, ambulatory care and institutional care (long-term care departments, geriatric, and palliative departments in hospitals), and in specialised healthcare facilities, especially in long-term care facilities, psychiatric hospitals, nursing homes and hospices. All these types of health care are financed by health insurance companies, mainly on a flat-rate basis.

3. Informal care – through this system, care for older adults is mostly provided by their relatives. It takes place mainly in the home environment and is supported by a care allowance (Act no. 447/2008 Coll.).

Although central government (represented by the Ministry of Labour, Public Affairs and Family and by the Ministry of Health) creates legislation at the national level, provision of services to citizens is competitively split between regional and local municipalities. Self-governing regions in Slovakia, e.g., regions with a population ranging from 560 000 up to 820 000, are mainly in charge of residential social services. The responsibility for providing outpatient social services has been shifted to the level of municipalities. The municipality is mainly responsible for: i) preparation of a community plan for social services and creating conditions to support community development; ii) provision of social counselling and selected outpatient and residential social services.

Although the transfer of responsibility was a logical step in bringing services closer to the citizen, the great fragmentation of responsibility among small municipalities does not allow for a comprehensive system of long-term care for the older adults. Moreover, the transfer of responsibility did not result in an obligation for municipalities to provide these services; most municipalities, due to insufficient personnel and skills, provide these services at an insufficient level, or not at all. Citizens must therefore apply for services through their self-governing region, which only provides residential services.

These inadequacies in the system of long-term care are compensated for by informal care. These shortcomings represent a major risk in the long run. The current infrastructure of long-term care services in such a spatially fragmented system is insufficient in all areas for outpatient and residential social services. Municipalities are not required to provide outpatient social services but may do so voluntarily. According to the mayors, however, the municipality lacks financial resources for this type of service.

We conclude that formal health and social services in Slovakia today and in the future will not provide the necessary services for an ageing population. Social and healthcare services are essential for the well-being of individuals and communities, and providing care for the elderly

has become an increasingly important issue in Slovakia as the population of older adults continues to grow. In order to ensure that the elderly are well-cared for, the Slovak government has put in place a number of social and healthcare services, although navigating these services can be difficult for both the elderly and their caregivers. In Slovakia, there are still significant challenges facing both sectors, including underfunding, staffing shortages, and a lack of integration between services. However, there is also potential for improvement, through the development of integrated care systems and the implementation of best practices learned from other countries. By working together and prioritising resources for social and health care Slovakia can create a more effective and efficient system that benefits all its citizens.

3.3.1 The system of social services in Slovakia

The system of social services is regulated by Act No. 448/2008 Coll., as amended by later regulations. From the perspective of long-term care provision, it is a key legislative norm. Social services are defined as professional services and other activities or a combination thereof. Social services are aimed at preventing, addressing or alleviating the adverse social situations of an individual, their family or community. The Social Services Act states that these services are provided for either a fixed or indefinite period. Social services are, according to the form of social service provision, named as follows:

1. **Outpatient Social Services** are provided to an individual who attends alone or is accompanied or transported to the place of the supply of social services.
2. **Field/Home Social Services** are provided to an individual through field/home programmes designed to prevent the social exclusion of that person, family or community in an unfavourable social situation.
3. **Residential Social Services** are services provided in residential social services facilities and include accommodation. Residential social services can be weekly or year-round (World Bank, 2020).

According to Act no. 448/2008 on Social Services we distinguish the following types of social services:

A) **Social crisis intervention services**, which mainly include field social crisis intervention services and the provision of social services in facilities. The aim of this group of social services is primarily to urgently address the unfavourable social situation, perceived as a crisis, of an individual. Facilities include: The Field Social Crisis Intervention Service;

Provision of Social Services in Facilities; Low-Threshold Day Centres; Integration Centres; Community Centres; Overnight Shelters; Shelter; Halfway Houses; Low-Threshold Social Services for Children and Families; and Safe-Home Facilities.

B) **Social services to support families with children.**

C) **Social services for dealing with an unfavourable social situation due to a severe disability, unfavourable health condition or retirement age**, consisting of residential and outpatient services provided in facilities for persons dependent on the assistance of another individual and for people who have reached retirement age. Facilities include: Supported Housing Facilities; Retirement Homes; Nursing Homes; Rehabilitation Centres; Social Services Homes; Specialised Facilities; Day Care Centres; mediation of personal assistance; homecare services; transport services; guide services and reading services; interpretation services; mediation of the interpretation services; and rental equipment.

D) **Social services using telecommunications technology*:*** monitoring and alarm system for those in need of assistance; crisis assistance provided through telecommunications technologies.

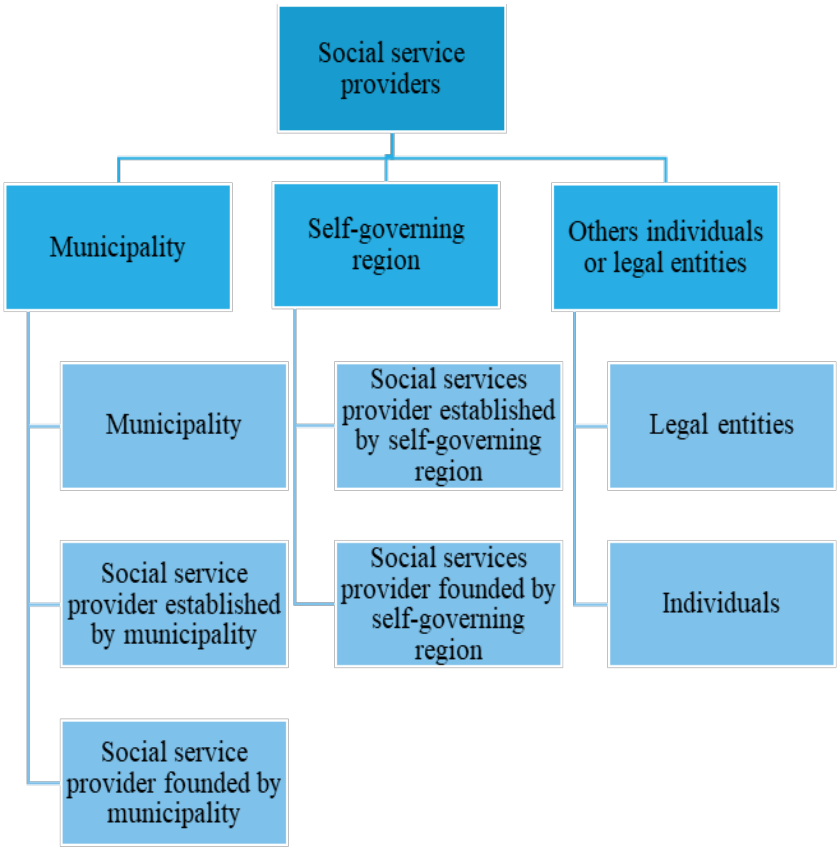
E) **Support services**: Respite Services, assistance in safeguarding custody rights and obligations, Day Centres, support of independent housing, canteen, launderettes, Personal Hygiene Centres (Act no. 448/2008 on Social Services).

The figure below (Figure 5) provides an overview of the various social service providers by means of their establisher/founder. Municipalities and self-governing regions can establish or find social providers, provide social services, are obligated and able to pay for selected social services, are obligated to assess need for selected services, are obligated to plan services in community planning/regional strategy of social services, and can control selected services. Additionally, self-governing regions are responsible for the registration of all social services and keeping registration records of all social providers registered in that region. The Ministry of Labour, Social Affairs and Family Region is obligated to monitor the quality of social services, pay for selected social services, identify national priorities with regards to social services and prepare legislation in the area of social services (World Bank, 2020).

Municipalities and self-governing regions within the scope of their competence ensure the availability of social services for individuals who are dependent on social services and ensure the right to choose social services under the conditions stipulated by this law. If an individual is interested in being provided with social services, he/she must formally request the

municipality or self-governing region to do so. The municipality may provide the social service directly if it is a registered provider, or it will ensure that the service is provided by another registered social service provider. The self-governing region guarantees, within the scope of its competence, the provision of social services in accordance with the right to choose a social service provider by the citizen. If an individual receives a valid decision approved by the municipality on the social service provision, the municipality provides the individual with social services in the scope of individual's degree of dependence confirmed in the pre-determined contract (World Bank, 2020).

Figure 5 The various social service providers by means of their establisher/founder in Slovakia.



Source: World Bank, 2020.

Slovak legislation and practice define several types of social services for different target groups, although not all these types of social services are intended to support older adults. The main objective of this section is to examine the types of social services that are designed to provide support solely for older adults. All stated types of services can be funded and

established by different entities such as municipalities, self-governing regions, private organisations, etc.

Social services can be combined with each other in order to address the social disadvantages of citizens. In terms of content, social services consist of professional activities, service activities and other activities. Professional activities constitute the main content of social services and require professional qualifications to perform. Service activities are mainly provided in residential and outpatient social service facilities and are mainly accommodation, catering, cleaning, laundry, ironing, maintenance of linen and clothes, and the provision of material services related to the provision of outpatient social services in common areas. The last group of social service content activities consists of other activities, including the creation of conditions for the preparation of meals, the dispensing of meals and food, the performance of essential basic personal hygiene, the provision of essential clothing and footwear, the storage of valuables, education, leisure activities, the provision of personal equipment, essential clothing and footwear, transport, the delivery of meals, and the lending of aids.

All these activities can be moved and combined within the framework of individual planning. However, the Social Services Act still creates room for implementation, along with provision for creating the conditions necessary for carrying out other activities that are not regulated in the Act but which increase the quality of the social service. It is this possibility that creates greater scope for creativity within the individual planning, the general aim of which is to improve and maintain the quality of life of the recipient of social services. Some of the social services that fall within the long-term care system are primarily residential social services and home care, and it is necessary for these social services to have an assessment of dependence. This assessment is issued as part of the activities of the Social Services Act.448/2002 Call. If a person wishes to use social services in social service establishments – a supported living facility, a facility for older adults, a nursing facility, a rehabilitation centre, social services home, a specialised facility, a day-care centre or home nursing service - he/she must have an individual assessment that has been drawn up detailing their dependence on a social service (on the basis of a health assessment and social assessment activity). This assessment is prepared by the local government (the higher territorial unit) or by the local authority in which the resident lives (the municipality). One of the most acute shortcomings of the system of assessment is that only the social aspects of dependence on the assistance of another person are assessed, in principle, for self-care and individual tasks falling within the scope of activities of daily living;

there is no assessment of entitlements to health care in the care home (Cangár, Machajdíková, 2017).

3.3.2 The system of health care in Slovakia

The healthcare system in Slovakia falls under the competence of the Ministry of Health of the Slovak Republic and is regulated by Act no. 576/2004 Coll. It is characterised by compulsory public health insurance for all residents. Healthcare services providers are contracted and paid for by the Health Insurance Funds, based on a recurring short-term contract. There are three Health Insurance Funds operating in Slovakia.

Long-term care is partly provided within the structures of the health system, where it is primarily oriented towards older adults in need of geriatric care and patients with chronic diseases. The healthcare system provides LTC primarily through home nursing care agencies, outpatient care (geriatric outpatient clinics), inpatient care (long-term care units, geriatric and palliative wards in hospitals), and specialised health facilities - especially long-term care hospitals, psychiatric hospitals, nursing homes and hospices. All these types of health care are financed by the health insurance companies, mainly on a flat-rate basis. The link between social and health care, which is partly funded by the health system, can be seen in nursing homes and hospices, as well as social services in facilities for older adults, specialised facilities, and social homes services.

Services critical for older adults, such as long-term care, palliative care, and mental health care are facing specific challenges. Long-term care in Slovakia suffers from underfunding, which is the reason for the insufficient availability of these services. While LTC is supposed to combine health care and social services, there is no systemic service coordination or even integration between these two. Home-based health care is provided mainly by visits of nurses, home physician visits and assistance provided by mobile hospices. The visiting service of physicians in the home environment is insufficiently regulated in the legislation, as it is not an obligatory service for general practitioners to perform.

A national reform of the healthcare system is being considered. According to the government legislative agenda for 2020 – 2024 specifically in the areas relating to older adults and community-based care, the Slovak government desires to introduce innovative forms of remuneration which will support a greater efficiency and quality of outpatient clinics and

regional cooperation in integrated centres. The main objectives of the reforms are to create better conditions to keep older adults in their communities by increasing the accessibility of health and social care. The reform aims to propose new legislation on long-term care, which will focus on addressing comprehensive health, social and nursing care, to support the care of the helpless and chronically ill in the home environment through the Home Nursing Care Agencies and mobile palliative care teams, among other goals. All these plans are a good reason to expect new legislation which could help to implement local integrated models of care (World Bank, 2020).

3.4 Formal and informal care for older adults

Europe's population is ageing rapidly. Eurostat predicts (Eurostat, 2019) that the age structure of the European population will change significantly within the next few decades, and Slovakia will face challenges due to an ageing population. Today in Slovakia the old-age dependency ratio is 20 elderly people per 100 active inhabitants, but by 2060 this ratio will change drastically and Slovakia will have one of the oldest populations in the European Union (Vano, 2015; Bartosovic et al. 2017). The ageing population will affect the relationship between the balance of children and older adults - currently, there are more than 102 elderly people per 100 children (Statistical Office of the Slovak Republic, 2020). The need for both short and long-term care will increase over the next few years as the population gets older.

In Slovakia, care can be provided formally or informally. Formal care for older people usually refers to paid care services provided by a residential institution or individual for a person in need. Informal care refers to unpaid care provided by family, close relatives, friends, and neighbours. Both forms of caregiving involve a spectrum of tasks, but informal caregivers seldom receive enough training. Formal caregivers are trained in the field, but the depth of their training varies (Li & Song, 2019). As people age, their intrinsic capacity (e.g., the sum of their physical and mental capacities) tends to decline while their health issues become more chronic and complex. Multimorbidity (e.g., the presence of multiple chronic conditions at the same time) is increasingly prevalent with age. Older people can develop geriatric syndromes such as frailty, urinary incontinence and propensity to falls, which do not fit into discrete disease categories (WHO, 2018).

Informal care forms a cornerstone of all long-term care systems in Europe. Informal caregivers are mostly women aged between 35 and 64 (85%) who are part of the 'sandwich generation' and provide care for multiple people (27%) (Birtha & Holm, 2017, p. 7). It has been gaining increasing recognition in international policy circles as a key issue for future welfare policy. On the one hand, it is seen as crucial to avoid unnecessary, and expensive, hospitalisation or institutionalisation; on the other, many countries have stringent needs assessments before a user receives publicly funded long-term care. In this context, the caring function of families remains the key type of care provision. Informal care is often seen as a cost-effective way of preventing institutionalisation and enabling users to remain at home. However, informal care is not cost-free, either to individuals or to the state (Rodrigues et al., 2013; Tokovska, 2014; Pickard et al., 2017). The needs of carers and the impact of providing informal care on key life outcomes such as employment, health, and wellbeing are further being increasingly recognised in academic literature and in national policies across Europe (Brimblecombe et al., 2018).

Socio-cultural determinants are a strong argument for supporting the development and sustainability of informal care for older adults. Considering Slovakia's rural character, we acknowledge the fact that country life is principally associated with agriculture, keeping animals and the production of home-grown food. It has been estimated that 59% of the Slovak population is involved in subsistence activities, accounting for the largest percentage of the population among the EU member states (Jehlička et al., 2013). In this environment, trust becomes the factor that affects human relations and the reliability of family members. In this context, older adults are an integral part of family life and institutional care is only used as a last resort.

Informal care, also known as unpaid care or family care, constitutes a significant share of total long-term care (Hoffmann & Rodr, 2010). The definition of 'informal care' is broad; in our study, we take informal care to include any care or help provided to older people (family or otherwise), care provided to working age adults, young people and children with disabilities, as well as people living with mental health problems. Different countries have different conceptions of what an informal carer is, and we take care not to exclude any understanding of informal care. There is a lack of standard definition on which to base inclusion criteria for empirical research and hence studies include varying groups, depending on, for example, co-habitation and the amount or type of care provided (Molyneaux, 2011). The available estimates of the number of informal caregivers range from 10% up to 25% of the total population in

Europe. The average varies significantly between countries and groups of countries and depends on how informal care is defined and measured. Informal carers are often women, either providing care to a spouse, parents or parents-in-law, and a large share is provided by people who are older than the standard retirement age (Colombo et al., 2011).

Informal care is likely to become even more important in the future due to changes in the demographic, healthcare advances, long-term care policy and cost-containment pressures leading to the favouring of community care options over institutionalisation where possible (Riedel, 2012). Informal care forms a cornerstone of all long-term care systems in Europe. It has also been gaining increasing recognition in international policy circles as a key issue for future welfare policy.

Formal care systems for older adults aim to ameliorate long-term care burdens by taking over part of the responsibility of informal caregivers (unpaid people providing care to family members). This is assumed to mitigate the caregiving burden among informal caregivers and improve their well-being (Colombo et al, 2011). Other research points to an interaction between informal and formal care (Bonsang, 2009; Van Houtven, Norton, 2004; Jacobs et al., 2015), although when considering individual level factors, such as the level of needs of the care recipient, the substitution effect persists only as long as needs are low and require unskilled care (Bonsang, 2009). This implies some degree of specialisation between formal and informal sources of care according to the individual needs of the care recipient. In addition, recent studies support a bridging hypothesis suggesting that receiving informal support may function as a bridge to formal services, e.g., when informal caregivers help facilitate the ongoing contact between the care recipient and the formal care system (Jacobs at al., 2015). The European Pillar of Social Rights (2017) makes explicit the commitment to people providing care, including their rights to flexible working and access to care services. As literature searches show, several countries offer formal long-term care services for older adults provided by paid professionals. Nordic countries (Norway, Sweden, Denmark, and Finland), the UK, Ireland, Spain, and Australia have developed a tax-based model of formal long-term care services. Germany, Japan, Korea, Luxembourg and the Netherlands provide comprehensive formal long-term care programmes via a social insurance system known as long-term care insurance (Miyawaki et al, 2020).

Formal and informal care can bring rewards and benefits for family and caregivers, and positive psychological effects due to caregiving may mitigate some of the challenges of caregiving as positive effects are associated with lower levels of burden and depression and

better overall mental health. However, there are also invisible costs to family caregiving. Most children feel responsible for and are motivated to care for their parents or in-laws, but they have uncertainty about their own ability and willingness to assume full responsibility for such care.

Thus, informal caregiving and the circumstances of the carers, along with the challenges they experience and their need for support from formal care services as well as other informal networks, is often hidden or even invisible (Losada et al., 2010). An increasing number of older adults with care needs continue to live in their homes because of their personal preference and the authorities' policies on 'ageing in place'. Depending on the societal context, the needs of community-dwelling older adults can be met by care from multiple sources, including publicly provided services, informal caregivers and private services purchased out-of-pocket. However, many countries are reforming their care policies because of the expected increase in public expenditure for long-term care services (Lipszyc et al., 2012), and thus the boundaries between the provision of public, family, and market-based services are being redrawn. We consider it important to note that the World Health Organisation has recently launched an initiative entitled 'Ten Priorities for a Decade of Action on Healthy Ageing'. Its aim is to encourage all countries to develop effective long-term care systems and to reduce caregiver burden (both formal and informal care) (World Health Organisation, 2017).

3.5 Social protection provisions

Social protection provisions are a fundamental aspect of any country's social security system. They provide assistance and support to individuals during different stages of their life, whether in retirement, unemployment or illness. In Slovakia, social protection provisions are an integral part of the country's social security system, helping to provide a safety net for its citizens.

Social protection provisions include social benefits for both caregivers and care recipients (people in need of assistance), as well as the eligibility conditions and regulation of the LTC services' cost-sharing. People who care for long-term dependent relatives can claim attendance service benefit (called 'príspevok na opatrovanie'). The condition is that the person they care for has disabilities − according to an official assessment − and is six years old or over and relies on care. Although the benefit is intended for the relative of a dependent person it can be also paid to another person if they live with the dependent person (e.g., they have a common address of residence). Health and social insurance contributions for nursing allowance recipients are

paid by the state. Attendance service benefit is paid directly to caregivers in the form of a social transfer (paid by the office for Labour, Social Affairs and Family). Its monetary value depends on several factors, including the number of care recipients, whether the caregiver receives statutory pension benefit or not (old-age pension, early old-age pension, invalidity pension), and the use of social service facilities.

The benefit is increased by EUR 100 per month in cases where a person cares for one or more children with severe disabilities or they have no earnings from work and, at the same time, they do not receive any statutory pension benefit. Attendance service benefit is means-tested according to the care recipient's income. This income may come from disability benefits and various other financial compensations that are offered to people with a severe disability. If someone cares for a person with severe disabilities who has an income above a certain threshold (twice the subsistence minimum for an adult), the level of the benefit is reduced. For carers of children with severe disabilities the threshold is higher (three times the subsistence minimum for an adult). If the care is provided by a person of working age, the basic amount of the allowance is €525.65 per month for caring for one person with a disability, and €699.15 per month for caring for two or more disabled persons.

Income-testing is not applied to care recipients receiving various types of pensions. Provision of LTC may be combined with paid work on condition that earnings from work do not exceed twice the subsistence minimum for an adult person. The benefit is also paid to caregivers who increase their qualifications by an external form of study, on condition that they ensure care for care recipients.

Conclusion

The system of long-term care for older adults in Slovakia is fragmented in terms of departments and competences, with fragmented systems of social services, financial benefits to compensation for severe disability and health services. The Ministry of Labour, Social Affairs and Family of the Slovak Republic, in cooperation with the Ministry of Health of the Slovak Republic, is responsible for long-term care. Social services are divided between local and regional authorities. Responsibility is divided between the social and healthcare systems, resulting in the existence of different organisations and funding sources, which creates a barrier to effective coordination. Waiting lists for places in residential care are long and the quality of services is poor, while the cost of private facilities is generally very high. In addition to the challenges of the unavailability of long-term care for older adults, the issue of the shortage and

high age of physicians in outpatient health care in less attractive regions, coupled with the limited capacity of individual municipalities to satisfactorily ensure the fulfilment of their statutory obligations, are also problematic. In 2021, the Government of the Slovak Republic took an important step by approving the Strategy for Long-Term Care in the Slovak Republic.

The intention of the Strategy is to propose substantive solutions which will then need to be translated into changes to legislation to create an effective and functioning system. All parts of the Strategy are designed to improve the quality of life of people in need of long-term social and health care, including by making formal and informal social and health care more attractive and stronger (Majchajdíková, Filipová, 2022).

4 DEMAND OF OLDER ADULTS FOR SOCIAL SERVICES - EMPIRICAL FINDINGS

The following part of the monograph summarises the research findings mapping the health and social needs of older people, and their fulfilment. The research does not map the overall situation in Slovakia; instead, it offers in-depth picture of the situation in three regions for which it is particularly difficult to secure social services for older adults in sufficient quality because of current state of legislation, as described in the previous chapter. The regions have been selected within the Banská Bystrica self-governing region, which is pilot-testing a new model of social care. The selection was based on economic, demographic and social indicators, all of which express the urgency of the need for an intervention into the social and health services provision system. For the implementation of the pilot testing the regions with highest need were selected, and among those villages the selection considered which ones already worked in cooperation with each other. This chapter presents short characteristics of the situation in the selected regions, describes the methodology of the research, and summarises the research results.

4.1 Characteristics of analysed regions

The common characteristics of the three selected regions Novohradské Podzámčie, Veľký Potok and Štiavnicko is the fact that they are comprised of small settlements (most of them below 500 inhabitants) which are relatively far from the centres of the municipalities where the majority of the health and social services are provided. Such municipalities often do not have enough economic and personnel resources to fulfil their obligation in regard to their older adult residents, and therefore such regions are suitable candidates for the project of creating a joint integrated provision of social and health services serving all the associated villages by one common office.

The region "Novohradské Podzámčie" is situated in the south of Banská Bystrica Self-Governing Region (BBSGR). It consists of 14 villages[1]. Nine of these villages have fewer than 500 inhabitants. On average, adults over 62 years of age make up 32% of the residents.

[1] Ábelová, Gregorova Vieska, Halič, Lehôtka, Lentvora, Ľuboreč, Lupoč, Mašková, Podrečany, Polichno, Praha, Stará Halič, Tomášovce and Vidiná

According to the records of BBSGR, four municipalities of the region (Halič, Stará Halič, Tomášovce and Vidiná) have established a home care service for citizens, but currently only two of them actually provide it. The number of served residents is low, in single digits. There are also two smaller residential care centres for older adults and two-day centres. Outpatient services are absent.

The health-care infrastructure is situated in the medical facility in Halič, which provides a dental surgery, a general practitioner for adults, and a general practitioner for children and adolescents. The outreach health service facility is established in the village of Ábelová.

The region Veľký Potok consists of 15 villages[2]. It is in the south-west of BBSGR. Most of the villages are small – ten of them have fewer than 500 inhabitants. Older adults make up approximately one-third of the inhabitants.

Currently, day-care centres are in operation in two villages (Hrušov, Vinica). In the village of Vinica, a non-public provider has established a social service facility with a capacity of 13 places, in which social services are provided to citizens in an outpatient form. In the village of Hrušov, the day-care centre has 16 places for older adults and citizens with disabilities. In the day-care facility, social services are provided to a dependent person only during specific hours. Home care service is offered in 7 out of 15 villages. There are no residential care centres – the demand for this type of services is satisfied by the centres in neighbourhood regions.

There are several established medical surgeries in four villages of the region. Most of them are in the village of Vinica, where there is a general practitioner for adults, a general practitioner for children and adolescents, and gynaecological, orthopaedic, dental and internal medicine surgeries. An outreach health service is not provided in the region at all.

The third selected region is the so-called "Štiavnicko" region. It consists of 17 settlements[3], of which 11 have fewer than 500 inhabitants, as well as the small town of Banská Štiavnica. The region is situated in a mountainous area with poor accessibility.

In 2013, the Older adult Park Prenčov facility was established in the village of Prenčov, consisting of a facility for older adults and a residential care facility. Both provide comprehensive social services, 24-hour professional social and health care, as well as additional therapeutic services. The facility for older adults has a capacity of 30 places and the care service facility has a capacity of 10 places.

[2] Balog nad Ipľom, Čelovce, Dolinka, Ďurkovce, Hrušov, Ipeľské Predmostie, Kamenné Kosihy, Kleňany, Kosihy nad Ipľom, Sečianky, Širákov, Trebušovce, Veľká Čalomija, Veľká Ves nad Ipľom and Vinica

[3] Baďan, Banská Belá, Banská Štiavnica, Banský Studenec, Beluj, Dekýš, Ilija, Kozelník, Močiar, Počúvadlo, Podhorie, Prenčov, Svätý Anton, Štiavnické Bane, Vysoká, Kráľovce-Krnišov and Žibritov

Out of the 17 municipalities, only six municipalities have a registered care service - Banská Štiavnica (four providers), Prenčov, Banská Belá, Svätý Anton, Podhorie, and Močiar., Two of these are non-public providers of home care services. The only health care provider is regional hospital in Banská Štiavnica, which has a limited range of health services. There are no outreach health services in the region.

4.2 Aim and Methodology

The present monograph aims to propose solutions to the challenge of care for older adults in the selected region, based on the theoretical foundations of population ageing and approaches to the care of the elderly. Solutions lie in the development of a methodology to identify the area with the most intensive demand for public social services and in the subsequent construction of a CISHC (Centre of Integrated Social and Health Care). This would link the local and regional level of provision of social services for older adults, while at the same time serving as a platform for the integration of social and healthcare services in the area. The subject of the monograph is, therefore, social and healthcare systems in the context of their service delivery to older adults.

In relation to the main objective of the scientific monograph, we formulated research questions, which we verified in the process of problem processing. They are:

1) What are the possibilities of integration in the field of social and healthcare services?
2) What is the potential of the proposed Centres of Integrated Social and Health Care as a model of meeting the needs of older adults in the field of social and healthcare services?

The goal of the questionnaire survey was to obtain information and data regarding the current state of the quality of life of older adults in connection with the provision of necessary social and healthcare services. The subject of the assessment is mainly the quantity, quality, and efficiency of the provided social and healthcare services.

The data were collected by the contracted firm Actly s.r.o. during the period of June - July 2021 in a face-to-face format through interviewers of their own network. Actly was entrusted with the implementation of the questionnaire survey based on its work contract with the Banská Bystrica Self-Governing Region. The subject of the contract was the collection of data and the implementation of a representative survey among older adults in three selected regions in the BBSGR within the framework of the project ‘Social Service Centres as a Tool for Multi-Level Partnership in the Provision of Long-Term Care at the Community Level in Slovakia’. The

Agency declared compliance with the required sampling parameters, including the size of the sample, which consisted of 600 respondents in the three micro-regions, the representativeness of the sample according to the proportion of the population living in the above-mentioned micro-regions aged 60 years and over (age category 60+), representativeness according to two age categories (60-74 and 75+) and according to the gender of the respondents. The quotas for the sample were based on the most recent data from the Statistical Office of the Slovak Republic on the number of inhabitants in the villages and their age structure. The Agency based the gender composition quota on expert estimation.

The Novohradské Podzámčie microregion is a functional grouping of 14 villages, namely: Ábelová, Gregorova Vieska, Halič, Lehôtka, Lentvora, Ľuboreč, Lupoč, Mašková, Podrečany, Polichno, Praha, Stará Halič, Tomášovce and Vidiná. All the villages are located in the Lučenec district. In this micro-region, 143 respondents were interviewed, of which 60 were men and 83 were women. Three-quarters of the total had completed their secondary education; 101 respondents were in the age category 60-74 years; and 35 respondents declared that they lived alone, while the remainder stated that they lived with their parent(s), with a spouse (partner), with children, or in a multigenerational household. All respondents in the region declared the same economic status - old-age pensioner. The location of the residential household of the respondents in the region was also the same - privately owned apartment/family house. Considering that the age category of the respondent is a significant determinant of the emergence of the need for social services, we have tabulated all the socio-demographic characteristics of the respondents in retired to take account of this factor. An important consideration influencing the possibility of caring for the elderly is the availability of relatives or close acquaintances in their immediate surrounding and, therefore, we observed the distance of the place of residence of any helping relative or close acquaintances, in addition to the number of the children the respondent has. The majority of respondents aged 60 years and over in the micro-district have at least one child living in the same district, and respondents also declared a relatively higher frequency of visits (almost half of the respondents are visited by relatives daily).

The microregion Veľký Potok - Ipeľ is a functional grouping of 15 municipalities: Balog nad Ipľom, Čelovce, Dolinka, Ďurkovce, Hrušov, Ipeľské Predmostie, Kamenné Kosihy, Kleňany, Kosihy nad Ipľom, Sečianky, Širákov, Trebušovce, Veľká Čalomija, Veľká Ves nad Ipľom, and Vinica. All the villages are located in the district of Veľký Krtíš. A total of 154 respondents answered the questionnaire; 61 men and 93 women were aged 60 years and older,

and 68% of the respondents were in the age category 60 - 74 years. Almost 80% of the total respondents had completed secondary education and almost one-third of the respondents declared that they live alone in the household. Respondents mainly stated their economic status as old age pensioners (143 responses), and additional answers included two disabled pensioners, two unemployed, six employed and one entrepreneur. All respondents answered that their place of residence was a privately owned apartment/family home. 133 respondents declared that they had children, and 115 of these stated that these children live in the same district as the they do. A positive finding in the Veľký Potok - Ipel microregion is the fact that up to three-quarters of the respondents' children or relatives visit them once a week or more often (99 respondents stated that they visit them daily or several times a week).

The functional cluster of municipalities joining together to form the CIHSC in the Banská Štiavnica district consists of 17 municipalities, 15 of which are from the Banská Štiavnica district: Baďan, Banská Bela, Banská Štiavnica, Banský Studenec, Beluj, Dekýš, Ilija, Kozelník, Močiar, Počúvadlo, Podhorie, Prenčov, Svätý Anton, Štiavnické Bane, Vysoká and two municipalities from the Krupina district: Kráľovce-Krnišov and Žibritov. In the Banská Štiavnica (Štiavnicko) micro-region there were 303 respondents aged 60 and over, of whom 125 were men and 178 were women, and 71.28% of the respondents were aged 60-74. As in previous regions, the highest proportion of respondents had secondary education (almost 80%). More than 82% of the respondents have children and 72% of them live in the same district as the respondent. The distribution of the respondent pool by economic status confirmed the predominance of the old-age pensioner category with 192 persons; there was also one disabled pensioner, 75 employees, 25 self-employed persons and 10 unemployed persons. 280 persons live in a privately owned apartment/family house, 10 in a commercially rented apartment/family house, 4 in a city/municipal rental apartment and 9 persons elsewhere. 86 respondents (i.e., 28%) declared that they live alone. Analysing the age structure of respondents living alone, we found that in the age group 75 years and over the proportion is as high as 46%. In this age group, almost a quarter of the respondents are visited by relatives only once a month, less often or not at all, or have no relatives.

The high proportion of people living alone appears to be a problem in this micro-region. Elderly people living alone are one of the most vulnerable groups of the population and therefore need to be given increased attention. Of course, loneliness affects all age groups, but it is the elderly who are more susceptible to social isolation, particularly as they are more vulnerable to a range of health and social problems which in turn determine loneliness.

The data collection instrument was a questionnaire (Appendix 1) containing of 18 mostly closed questions, and the identification of the municipality from which the respondent came. Ten questions described the socio-demographic profile of the respondent aged 60 years and over, while the remaining questions were substantive. The backbone of the questionnaire was questions aimed at identifying the needs of the elderly in carrying out daily activities, the choice of those activities that require assistance, the current possibilities of assistance from the family or the neighbourhood, and questions on potential assistance from the municipality.
The data from the questionnaire survey consisted of a total of 94 variables and were processed by IBM SPSS 28, Stata 17 and Microsoft Excel.

4.3 Results

The questionnaire survey was focussed on the level of health and social services provision and the potential demand for these services in the population aged over 60 in the selected regions. Tables 1-3 describe the composition of the sample by age category and gender, by education and by family status.

Table 2 Composition of research sample according to sex (in absolute values)

	Novohradské Podzámčie		Veľký Potok		Štiavnicko	
	60-74	75+	60-74	75+	60-74	75+
Sex:						
Male	48	12	42	19	92	33
Female	53	30	63	30	124	54
Total	101	42	105	49	216	87

Source: own elaboration

Table 3 Composition of research sample according to achieved level of education (percentage of total number of respondents in the individual groups)

	Novohradské Podzámčie		Veľký Potok		Štiavnicko	
	60-74	75+	60-74	75+	60-74	75+
Education:						
Primary	3	48	4	47	8	16
Lower secondary	28	26	26	37	25	45
Upper secondary - professional	39	14	50	10	36	18
Upper secondary - other	24	7	15	6	19	17
Tertiary	7	5	6		13	3

Source: own elaboration

Table 4 Composition of the research sample according to family status (percentage of the total number of respondents in the individual groups)

	Novohradské Podzámčie		Veľký Potok		Štiavnicko	
	60-74	75+	60-74	75+	60-74	75+
Family status:						
single	3		9	6	9	5
married	71	29	71	29	56	37
divorced	3		10	2	17	2
widowed	22	71	9	63	14	55
in consensual union	1		1		4	1

Source: own elaboration

The following parts of the questionnaire map the family situation of older adults in selected regions. Table 4 describes the portion of the respondents living in various family settings. In the age group 60-74, approximately one-fifth of the respondents are living alone. In the age group 75+ the proportion of people living alone increases from 38% to 51%. It is reasonable to assume that this is the group of older adults in which the need for social service arises. A similar situation occurs in the group of older adults living with their spouse only, who is often of a similar age. The size of group varies from 39% to 61% of respondents in the age group 60-74 and from 14% to 28% of respondents for the age group 75+. In summary, more than half of the

older citizens live in family settings without the presence of a younger person (more than 80% in Veľký Potok for both age groups).

Table 5 Family situation of older adults (percentage of the total number of respondents in the individual groups)

	Novohradské Podzámčie		Veľký Potok		Štiavnicko	
	60-74	75+	60-74	75+	60-74	75+
alone	19	38	23	51	24	39
with parents only	1		1		0	
with spouse only	39	14	61	27	47	28
with children only	5	29	4	16	9	15
with the spouse and children	33	14	10	2	12	5
in multigeneration family	3	2	2	2	6	10
other	1	2		2	2	3

Source: own elaboration

The dependence on public services is often determined by the lack of adult children living nearby. The respondents were asked where their children are living and in nearly all the observed groups more than 70% of respondents stated that they have at least one child in the same district (the smaller portion for Štiavnicko could be explained by the fact that the Banská Štiavnica district is one of the smallest in Slovakia, consisting only of 14 municipalities). It means that even if the older adults live with their partner or alone, often there is at least one family member close by who is able and willing to offer informal care to them. The family members can easily provide assistance and manage less severe health conditions, but they are often unable to prevent and attend to more severe health states. Those family members that decide to take up the role of full-time care will often need assistance themselves to ensure an acceptable life quality for both the recipients of their care and for themselves.

Table 6 The residence of the child living the closest (percentage of the total number of respondents in the individual groups)

	Novohradské Podzámčie		Veľký Potok		Štiavnicko	
	60-74	75+	60-74	75+	60-74	75+
The child lives:						
in the same district	86	88	73	78	57	70
in another district, but in the same region	6	2	4	8	13	11
in another region, but in the SR	3	7	4		6	6

Source: own elaboration

In the main part of the questionnaire we presented the respondents with a list of activities (Table 7) and asked them to mark those areas in which they need assistance. In the second step, we asked them to assign a person/institution that helps them when carrying out the activities or record the fact that they do not have help. Subsequently, we invited them to mark any activities in which they would be interested in using the social services of the municipality if they were available.

Table 7 captures the respondents' answers to the question of which activities they need assistance. The most frequently chosen answer for the residents over the age of 60 was transportation by motor vehicle to the physician or for handling official matters (ranging from 12% in Novohradské Podzámčie to 17% in Veľký Potok), being accompanied when visiting a physician or for handling official matters (from 10 to 13%), food shopping (from 9 to 10%), meals delivery (from 6 to 11%) and with household care (7 to 9 %). Overall, in this age group, the portion of the respondents who need help with at least one activity varies from 15% of older adults in the Novohradské Podzámčie to 20% in the Veľký Potok and 27% of the older adults in the Štiavnicko microregion.

The order of the activities is the same in the age group 75+; however, the proportion of people who need assistance increases rapidly. Transportation is necessary for the 45% of the older adults in Štiavnicko and 41% of respondents in Veľký Potok. Food shopping and meals delivery is needed by 41% and 31% of the respondents respectively in Štiavnicko and 29% in Veľký Potok. The portion is much lower in Novohradské Podzámčie, where only 17% of the older adults needs transportation, 14% assistance with food shopping, and 17% meals delivery.

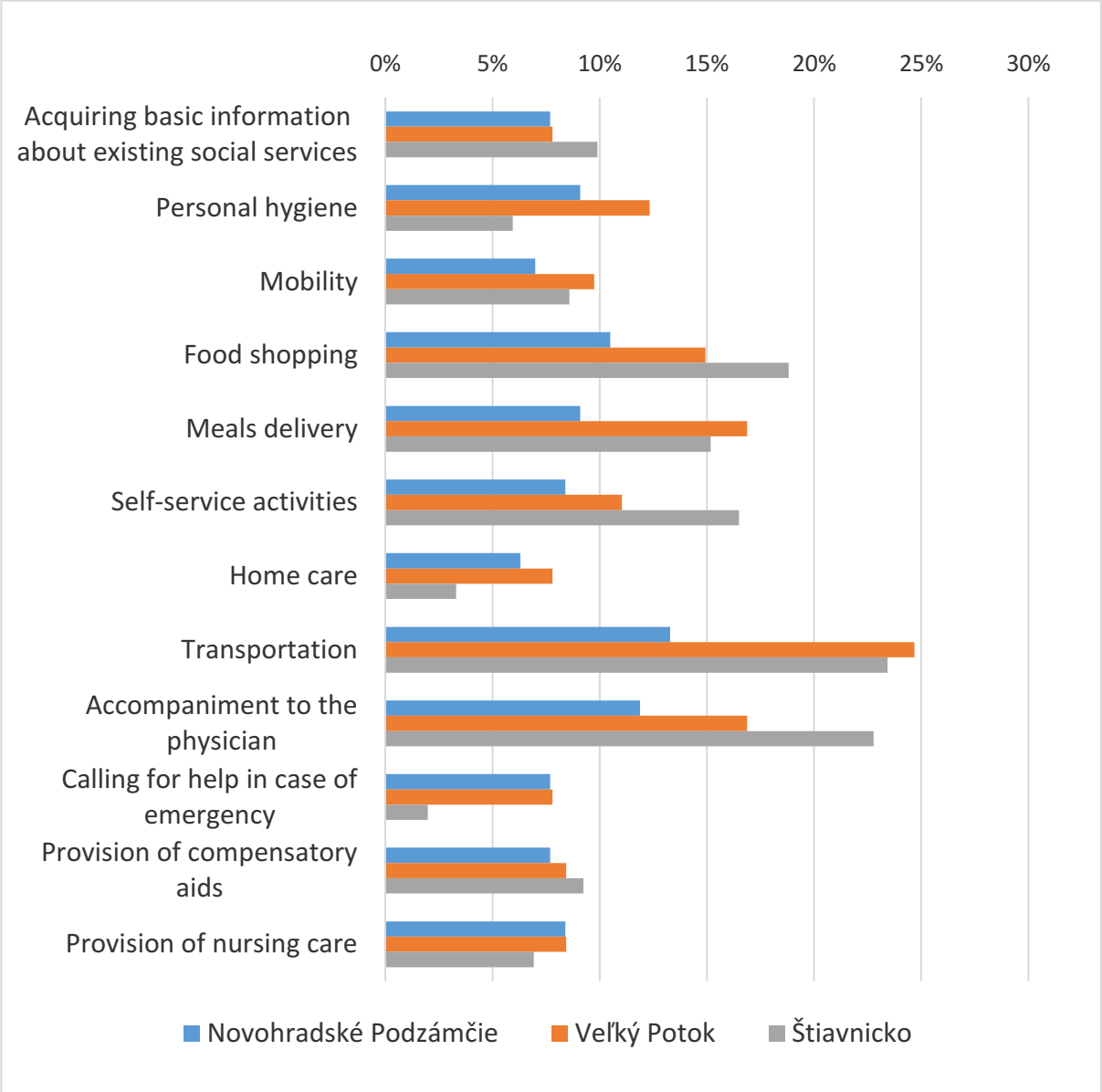
Altogether, 27% of the respondents in this age group need help with at least one activity in Novohradské Podzámčie, 55% in Veľký Potok and 64% in Štiavnicko.

Table 7 Necessity of assistance (percentage of total number of respondents in the individual groups)

	Novohradské Podzámčie		Veľký Potok		Štiavnicko	
	60-74	75+	60-74	75+	60-74	75+
Acquiring basic information about existing social services	6	12	10	4	6	20
Personal hygiene	7	14	10	16	0	20
Mobility	4	14	10	10	2	25
Food shopping	9	14	9	29	10	41
Meal delivery	6	17	11	29	9	31
Self-service activities	3	14	8	8	1	9
Home care	7	12	9	16	8	37
Transportation	12	17	17	41	15	45
Accompaniment to the physician	10	17	11	29	13	47
Calling for help in case of emergency	6	12	9	6	1	3
Provision of compensatory aids	5	14	10	6	2	26
Provision of nursing care	7	12	10	6	4	14
None	85	74	81	45	73	36

Source: own elaboration

The structure of the needs of older adults (both age groups) according to regions is depicted by graph 6.

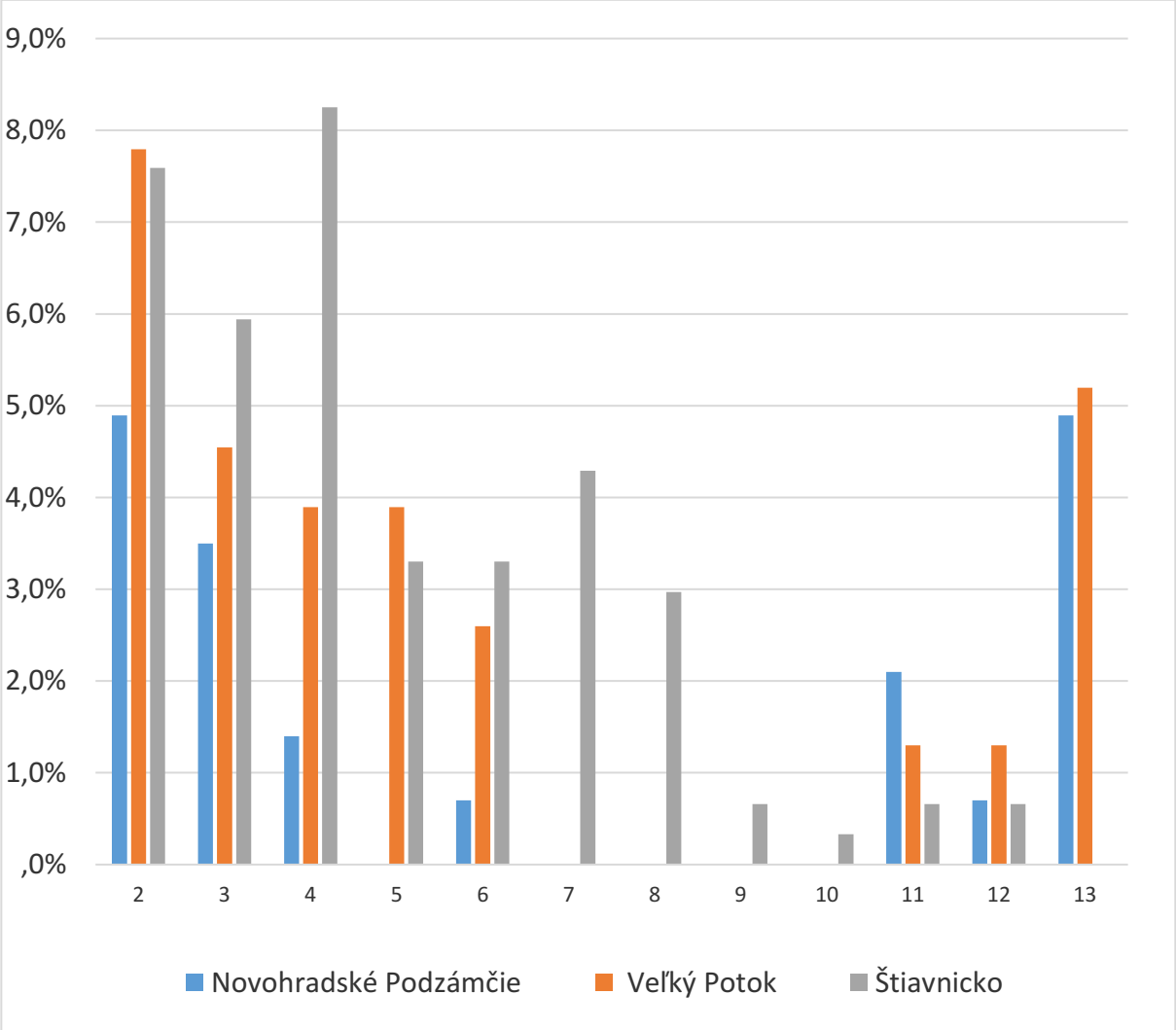


Graph 6 Share of residents aged over 60 who need help in the field of social services (% of the number of respondents)

Source: own elaboration

The individual regions also differ in the number of activities that older adults consider necessary. Graph 6 shows the number of activities that the respondents identified as necessary. The older adults from Novohradské Podzámčie, where social services are the least developed, declare a lower need for assistance when having better health (the respondent only requires assistance in a few tasks). A more complex need for help is mainly declared by residents of the Štiavnicko microregion. However, residents of less developed regions dominate when they face more difficult health conditions and assistance is needed for almost all actions. From the results,

we can conclude that the demand for social services is also caused by awareness of their supply. Older adults may realise the need for help only when they see the implementation of this service in their surroundings.



Graph 7 Share of older adults (as % of the number of respondents) according to the number of activities for which they need the help of others.
Source: own elaboration

In this context, we also asked the respondents about their preferred place for social services to be provided. As shown in Table 8, nearly all the respondents prefer the provision of social services in their home environment. This preference is less pronounced in Štiavnicko, where a relatively good network of social service facilities has already been created. This result also

supports the assumption that a quality supply has the potential to create demand for these services.

Table 8 Preferred place of social service provision (percentage of the total number of respondents in the individual groups)

	Novohradské Podzámčie		Veľký Potok		Štiavnicko	
	60-74	75+	60-74	75+	60-74	75+
Nobody	27	9	10	19	32	25
Family	73	73	60	81	78	82
Home help - public				11	8	21
Home help - private	13		5			12
Other		18	15	4		

Source: own elaboration

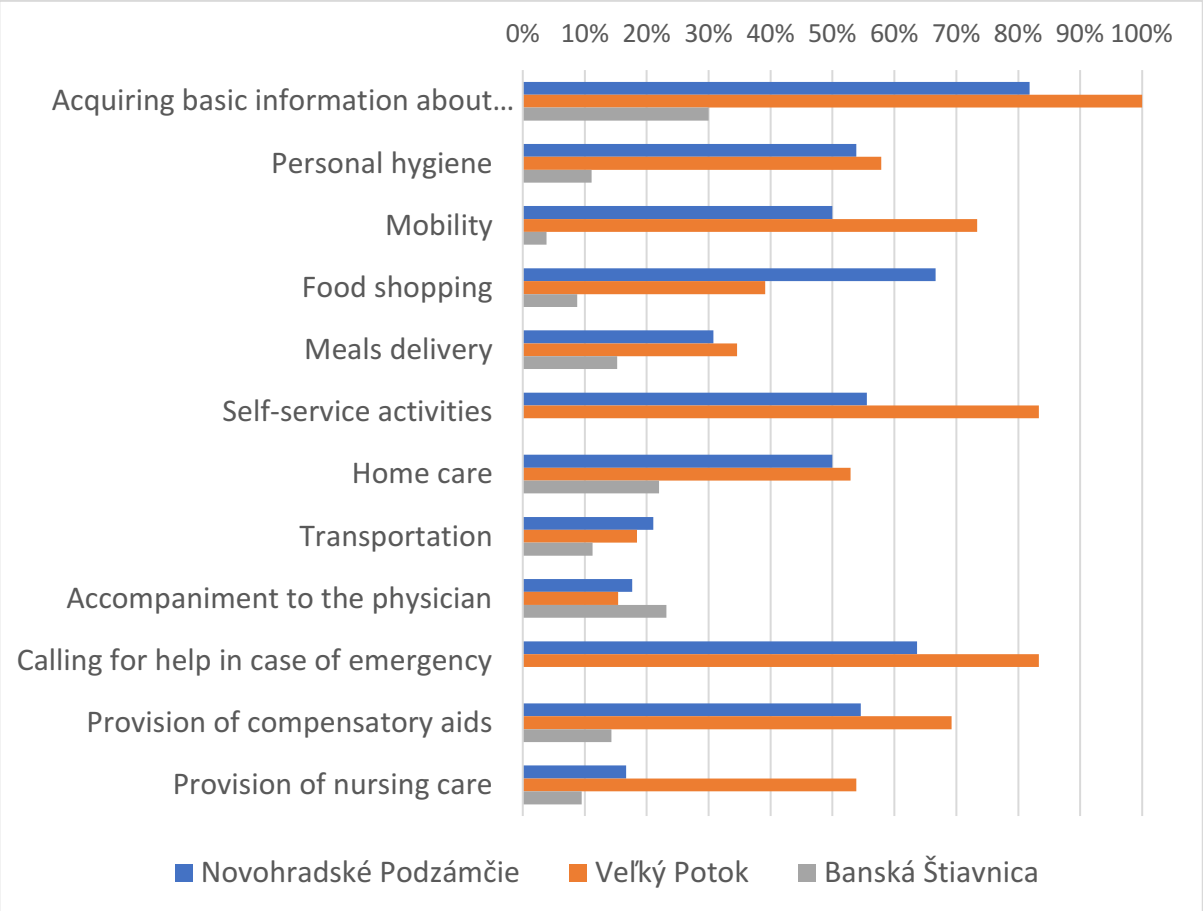
Table 9 shows the structure of the assistance which the older adults are currently receiving. As expected, the dominant position in this regard is held by family. Public services are used predominantly in Štiavnicko region (8% in the age group 60-74 and 21% in the age group 75+). Paradoxically, in Štiavnicko the older adults also reported the worst numbers in terms of the proportion of the older adults who need help and are not assisted by anybody.

Table 9 The areas from which the older adults receive assistance (percentage of the respondents in the individual groups who declared necessity of assistance)

	Novohradské Podzámčie		Veľký Potok		Štiavnicko	
	60-74	75+	60-74	75+	60-74	75+
at home	100	98	100	98	84	74
supported housing		2			6	11
residential care				2	9	14
other					1	1

Source: own elaboration

Graph 8 shows the portion of the respondents (for the individual regions) who declared a need for assistance but do not receive it. The results of the analysis indicate an unfavourable situation in the provision of social services, especially in the regions of Novohradské Podzámčie and Veľký Potok. For most activities, more than half of the respondents who declared that they need help with the given activity do not find assistance. A positive finding is that the activities with which older adults most often need help (transportation and accompanying to the doctor and handling official matters) are among the activities with the highest degree of satisfaction. On the other hand, meals delivery and food shopping are problematic areas in which to secure help - up to a third of the respondents in the region of Novohradské Podzámčie, and up to 67% of respondents who depend on this help do not find help with the purchase of food. In the Veľký Potok region, securing assistance for obtaining information, ensuring personal hygiene, mobility, self-service activities, calling for help and the provision of compensatory aids are particularly problematic.



Graph 8 Share of residents aged over 60 whose demand for social services is unsatisfied (% of those who declared a need for help in the given area).

Source: own elaboration

Table 10 shows the number of respondents who would be willing to use the social services of the municipality for a given activity, if such an offer existed. At least one service would be used by 17% of older adults from the Novohradské Podzámčie region, 30% of respondents from the Veľký Potok region, and up to 44% of older adults from Štiavnicko. Among the respondents, there would be the greatest interest in the provision of transport and being accompanied to the doctor and in handling official matters, food shopping and meal delivery. On the contrary, the fewest respondents showed an interest in activities that interfere most with the personal space of the older adult, such as help with personal hygiene, mobility, calling for help or self-service activities.

Table 10 Share of residents who would use the social services of the municipality.

	Novohradské Podzámčie		Veľký Potok		Štiavnicko	
	60-74	75+	60-74	75+	60-74	75+
Acquiring basic information about existing social services	13				24	38
Personal hygiene		18		4		21
Mobility		27	10		5	18
Food shopping	13	36	30	41	25	52
Meals delivery	20	18	25	37	14	45
Self-service activities		9		4		11
Home care	7	18	20	19	17	34
Transportation	80	45	80	74	41	48
Accompaniment to the physician	47	27	55	37	25	46
Calling for help in case of emergency		9	5			5
Provision of compensatory aids	13	9	5	4	7	30
Provision of nursing care	27	27	20	4	17	18

Source: own elaboration

To evaluate the results of the questionnaire survey we used Spearman's correlation, which measures the strength and direction of the monotonic association between two variables. In the analysis of the results of the questionnaire surveys we consider it important to reflect the demographic structure, because it tends to be a significant factor associated with changes in the

values of the monitored indicators. In the case of our survey, this fact is also evident in the connection to the needs of the provision of social services for older adults (Table 10).

Our first step was to look in general terms at which characteristics are associated with the fact that a older adult needs help with some daily activities. We found significant correlations with almost all socio-demographic characteristics of the respondents. There is a statistically significant moderate direct correlation of the need for help with age, e.g., the need for help is felt more intensely by older adults ($r_s = 0.357$), and a weak direct correlation with gender ($r_s = 0.125$), e.g., a higher need for help is declared by women. A weak indirect dependence was found for the need for help and education ($r_s = -0.142$), e.g., a higher need for help is expressed by people with less education. This could be related to the deteriorating health status of older adults, poorer access to a healthy lifestyle, the ability to think critically and choose evidence-based knowledge, or the economic situation or the availability of health care.

Nominal sociodemographic characteristics of socioeconomic class, marital status, housing type, and household composition also had a weak to moderate effect on the need for help with activities of daily living (all p-values = 0, and Cramer's V values ranging from 0.149 to 0.263). Of all these traits the household composition had the strongest effect, but due to the nature of the traits it is not possible to determine the direction of the relationship. Other sociodemographic traits did not influence the need for assistance in performing activities of daily living.

Table 11 Need for assistance in activities of daily living according to Spearman correlation coefficient

		Need help with at least a few activities
Gender	Correlation Coefficient	0,125**
	Sig. (2-tailed)	0,002
	N	600
How old are you?	Correlation Coefficient	0,357**
	Sig. (2-tailed)	0,000
	N	600
What is your highest level of education?	Correlation Coefficient	-0,142**
	Sig. (2-tailed)	0,000
	N	600
How many living children do you have?	Correlation Coefficient	-0,025
	Sig. (2-tailed)	0,542
	N	600
How often do any of your children or a relative visit you?	Correlation Coefficient	0,004
	Sig. (2-tailed)	0,921
	N	600
Do you have a decision on your level of need for social services?	Correlation Coefficient	,422**
	Sig. (2-tailed)	0,000
	N	600
What is your socio-economic background?	Cramer´s V	0,190**
	Sig. (2-tailed)	0,000
	N	600
What is your marital status?	Cramer´s V	0,200**
	Sig. (2-tailed)	0,000
	N	600
Where do you live?	Cramer´s V	0,149**
	Sig. (2-tailed)	0,000
	N	600
What is the composition of your household? Who do you live with?	Cramer´s V	0,263**
	Sig. (2-tailed)	0,000
	N	600

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Source: own elaboration

Furthermore, we also looked at how sociodemographic characteristics affect the need for assistance in performing particular activities of daily living (Table 12). Gender most significantly influenced the need for assistance in being accompanied to the doctor and handling official matters, along with transportation by motor vehicle (r_s = 0.273 and 0.217, respectively); in both cases a higher need was declared by women. Age had the most significant effect on the need for assistance with personal hygiene and mobility; in both cases the need for assistance increased with age (r_s = 0.247 and 0.243, respectively). Educational attainment was inversely correlated with the need for assistance with self-service activities (r_s = -0.214), e.g., higher assistance was indicated by those with lower educational attainment. The need for help with all activities of daily living showed independence from both the number of living children and the frequency of visits (all p-values were greater than 0.05). The level of dependency significantly influenced the need for help with personal hygiene (r_s = 0.34), grocery shopping (r_s = 0.37), household care (r_s = 0.37), self-care activities (r_s = 0.297), provision of compensatory aids (r_s = 0.367), and nursing care (r_s = 0.393). In all cases the need for help increased as the level of dependency increased.

We find it interesting to note that the number of items older adults need help with is not affected by the number of adult children living in the same residence or the frequency of their visits. The family is of great importance to the older adults and, as a rule, they receive psychological support from the family. It enables them to establish an emotional and social base for the last phase of their life, which is extremely important for the period of ageing and old age. We assume that family and relatives are an important factor in the social environment so that the older adults are not alone.

Table 12 Spearman correlation coefficient for the association between socio-demographic characteristics of the respondents and need for individual services.

		Gender	How old are you?	Age categories	What is your highest level of education?	What is your socio-economic background?	What is your marital status?
Acquiring basic information about existing social services	Correlation Coefficient	,201**	0,004	0,009	-0,040	-0,019	0,127
	Sig. (2-tailed)	0,006	0,959	0,902	0,582	0,800	0,083
	N	188	188	188	188	188	188
Personal hygiene	Correlation Coefficient	,154*	,247**	,249**	-,174*	0,133	0,083
	Sig. (2-tailed)	0,035	0,001	0,001	0,017	0,070	0,259
	N	188	188	188	188	188	188
Mobility	Correlation Coefficient	,187*	,243**	,237**	-0,062	0,135	,170*
	Sig. (2-tailed)	0,010	0,001	0,001	0,396	0,064	0,020
	N	188	188	188	188	188	188
Food shopping	Correlation Coefficient	0,121	,204**	,190**	-0,118	,219**	0,124
	Sig. (2-tailed)	0,097	0,005	0,009	0,107	0,003	0,090
	N	188	188	188	188	188	188
Meals delivery	Correlation Coefficient	0,003	,203**	,185*	-,185*	0,119	0,119
	Sig. (2-tailed)	0,968	0,005	0,011	0,011	0,103	0,104
	N	188	188	188	188	188	188
Self-service activities	Correlation Coefficient	-0,018	,201**	,175*	-0,063	-0,009	,236**

	Sig. (2-tailed)	0,804	0,006	0,017	0,389	0,899	0,001
	N	188	188	188	188	188	188
Home care	Correlation Coefficient	,212**	,165*	,176*	-,214**	0,128	0,041
	Sig. (2-tailed)	0,003	0,023	0,016	0,003	0,079	0,573
	N	188	188	188	188	188	188
Transportation	Correlation Coefficient	,217**	0,070	0,072	-0,036	,222**	0,126
	Sig. (2-tailed)	0,003	0,338	0,323	0,625	0,002	0,086
	N	188	188	188	188	188	188
Accompaniment to the physician	Correlation Coefficient	,273**	,216**	,186*	-0,112	,280**	,189**
	Sig. (2-tailed)	0,000	0,003	0,011	0,125	0,000	0,009
	N	188	188	188	188	188	188
Calling for help in case of emergency	Correlation Coefficient	,198**	-0,009	-0,011	-0,057	0,073	0,081
	Sig. (2-tailed)	0,007	0,903	0,880	0,436	0,320	0,267
	N	188	188	188	188	188	188
Provision of compensatory aids	Correlation Coefficient	0,092	,223**	,212**	-,151*	,179*	0,138
	Sig. (2-tailed)	0,211	0,002	0,003	0,039	0,014	0,059
	N	188	188	188	188	188	188
Provision of nursing care	Correlation Coefficient	0,124	0,062	0,058	-0,134	0,080	0,036
	Sig. (2-tailed)	0,089	0,396	0,430	0,067	0,278	0,622
	N	188	188	188	188	188	188

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Source: own elaboration

Table 12 (continuation)

		Where do you live?	What is the composition of your household? Who do you live with?	How many living children do you have?	How often do any of your children or a relative visit you?	Do you have a decision on your level of need for social services?	What level of dependency do you have in the decision?
Acquiring basic information about existing social services	Correlation Coefficient	0,003	-0,011	0,051	-0,052	0,019	0,160
	Sig. (2-tailed)	0,971	0,879	0,486	0,479	0,796	0,292
	N	188	188	188	188	188	45
Personal hygiene	Correlation Coefficient	-0,076	-0,026	0,027	-0,078	-,227**	,340*
	Sig. (2-tailed)	0,303	0,723	0,709	0,288	0,002	0,022
	N	188	188	188	188	188	45
Mobility	Correlation Coefficient	-0,034	0,107	0,007	-0,029	-,218**	0,152
	Sig. (2-tailed)	0,647	0,143	0,929	0,694	0,003	0,320
	N	188	188	188	188	188	45
Food shopping	Correlation Coefficient	-0,037	0,090	0,101	-0,011	-0,031	,370*
	Sig. (2-tailed)	0,618	0,219	0,166	0,876	0,669	0,012
	N	188	188	188	188	188	45
Meals delivery	Correlation Coefficient	-0,096	-0,010	-0,046	-0,017	-,192**	0,273
	Sig. (2-tailed)	0,190	0,895	0,529	0,821	0,008	0,070
	N	188	188	188	188	188	45

Household care	Correlation Coefficient	0,047	-0,068	-0,057	0,022	-0,129	,370*
	Sig. (2-tailed)	0,523	0,357	0,440	0,765	0,079	0,012
	N	188	188	188	188	188	45
Self-service activities	Correlation Coefficient	-0,069	0,062	0,031	-0,100	-,221**	,297*
	Sig. (2-tailed)	0,344	0,396	0,674	0,174	0,002	0,048
	N	188	188	188	188	188	45
Transportation	Correlation Coefficient	-0,106	0,083	0,037	-0,013	0,017	0,150
	Sig. (2-tailed)	0,146	0,258	0,618	0,859	0,816	0,324
	N	188	188	188	188	188	45
Accompaniment to the physician	Correlation Coefficient	-0,053	0,097	0,020	-0,091	-0,132	0,015
	Sig. (2-tailed)	0,473	0,186	0,786	0,217	0,071	0,920
	N	188	188	188	188	188	45
Calling for help in case of emergency	Correlation Coefficient	-0,121	-0,042	-0,028	-0,025	0,032	0,281
	Sig. (2-tailed)	0,098	0,571	0,699	0,734	0,658	0,062
	N	188	188	188	188	188	45
Provision of compensatory aids	Correlation Coefficient	-0,081	0,048	-0,024	-0,062	-,238**	,367*
	Sig. (2-tailed)	0,267	0,514	0,741	0,398	0,001	0,013
	N	188	188	188	188	188	45
Provision of nursing care	Correlation Coefficient	-0,017	-0,038	-0,066	-0,064	-,203**	,393**
	Sig. (2-tailed)	0,814	0,601	0,369	0,382	0,005	0,008
	N	188	188	188	188	188	45

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Source: own elaboration

Conclusion

The problem of long-term care is not straightforward. The presented research offers an insight into the current state of care in three regions, which could be characterised as underequipped with social and health services. At first sight, it can be assumed that the respondents in the region with the lowest number of services available (Novohradské Podzámčie) would report the highest level of needs, as well as the lowest level of their fulfilment; however, the opposite is true. The unmet demand was most visibly demonstrated in the region where (in comparison to other region) there are some established services available. The survey does not show the reasons for this state, and the results only have a descriptive character. It can be assumed that the demand is to a certain extent formed by the available supply and presence of quality services. On the other hand, the regions with the lowest level of the service provision have a larger number of respondents with high needs, taking into consideration health states. This fact suggests an important preventive role of outreach social services availability. Respondents also express a strong preference towards home care services.

5 THE PILOT STUDY OF THE INTEGRATIVE OLDER ADULT CARE MODEL IN THE SLOVAK REPUBLIC

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

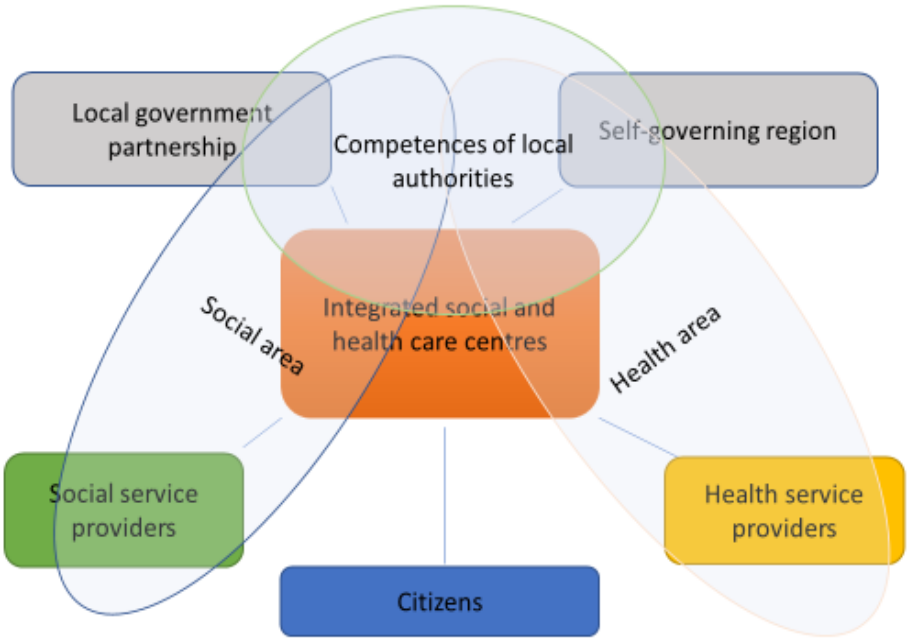
Integrated care has emerged as a viable approach to overcome deficiencies in care management for people with complex health care needs such as chronic diseases, disabling conditions, serious mental illness, and medically fragile children and frail older adults, while at the same time improving efficiency, quality and effectiveness of the health services provided. The focus thus has been on better coordination and integration among health care sectors to manage specific (chronic) diseases. However, it has become evident that in order to provide truly population-centred services that improve population health, the scope of integrated care needs to be expanded to bridge the gaps not only within the health system, but also between the health and social systems. Consequently, initiatives are emerging internationally that have a broader focus than solely integrating health care. These initiatives aim to integrate services across health care, prevention, social care and welfare, and are often labelled as population (health) management (Struijs et al., 2015). For instance, in the Netherlands, several regional partnerships originated in which the participants are care providers, insurers, and stakeholders such as municipalities and representatives of citizens (Drewes et. al., 2015). Similar trends can be observed in other countries, like Germany (e.g., Gesundes Kinzigthal; Hildebrandt et. al., 2015), England (e.g., Torbay) and the USA (e.g., Accountable Community Organization), where initiatives have developed which focus on the management of population's health. The scope of these initiatives reflects a wide array of integrated care concepts, which all need to overcome common barriers and challenges to be successful (Thistlethwaite, 2014).

Since 2020 Slovakia has been implementing an integrative care model for older adults via the project 'Community-Based Social Service Centres as a Tool of Multilevel Partnership for Providing Long-Term Care in Slovakia'.

The aim is to create a functioning model of community-based social service centres for older adults with an innovative approach to long-term care provision. This integrative care model for older adults is one part of reshaping the future of the welfare state. The centres will serve as a platform for integrating the social and health services of various providers both geographically and structurally, potentially achieving a more coordinated and targeted system of flexible and sustainable services covering preventive activities, outpatient and residential social services, and long-term care services.

The aim is to bring social services directly to the older adults in their home environment, whenever their health conditions permit. The proposed activity covers the design of the integrative care model for older adults in three small regions, with the possibility of applying the model to other territories of Slovakia. The results of this model will be analysed and evaluated within the working group with the participation of the Ministry of Labour, Social Affairs and Family of the Slovak Republic as a basis for setting criteria for further legislative processes and long-term care reforms in Slovakia. Horizontal interconnection of adjacent municipalities and systematic support from experts will build up the personnel and knowledge capacities necessary for the high-quality provision of long-term social and healthcare services. Vertical interconnection of different providers at local, regional and national level will create a professional multi-level platform that will ensure better adjustment of services provided directly to the client, with an emphasis on outpatient and ambulatory services. An integrative care model for older adults will improve cooperation and the flow of information between social and health service providers under the administration of local, regional and national organisations, promoting sustainable multi-level partnerships between individual founders and providers of social services and legislators. Measurement of the impact of the integrative care model for older adults, as well as experience with its enactment, will serve as a basis for setting the criteria for further use of EU funds and national implementation.

Figure 6 CISHCS as an integrating element at multiple levels in one territory



Source: Machajdíková, Filipová, 2022.

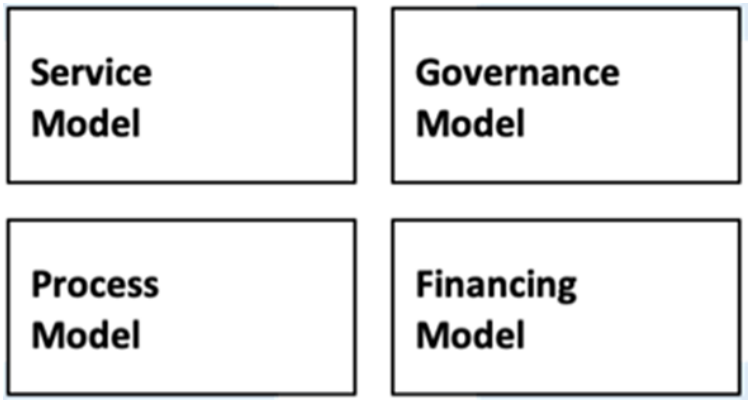
5.1 Integrative Older Adult Care Model Principles and Components

The model is based on the following principles (World Bank, 2020): (1) *Integration of care* - bringing together inputs, delivery, management and organisation of services related to the diagnosis, treatment, care, rehabilitation and health promotion, with the goal of achieving higher efficiency, effectiveness, and a seamless care experience of individuals, including simple communication channels and a coordination of individual services (MacAdam, 2008); coordination of the health and social care service provision, currently provided by the various service providers under several financing schemes and regulated by various principles. (2) *Person-centred approach* - focussing care service provision on individuals, families and communities. It is necessary to understand the person's life, values, priorities and preferences (Šolcová et al., 2020). This approach is more focussed on the needs and expectations of individuals rather than on their problems. (3) *Community-based care* - this allows individuals

with health limitations or disabilities to retain their independence in their own environment and in connection with the local community. Community-based supports and services (CBSS) are designed to help community-dwelling older adults remain safely in their homes and delay or prevent institutionalisation (Wieland & Boland et al. 2010). (4) *Suitability to the current legal framework of the Slovak Republic* - working under the separate systems of the provision of health and social services, with divided parallel schemes of financing.

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

Figure 7 Core Model Components



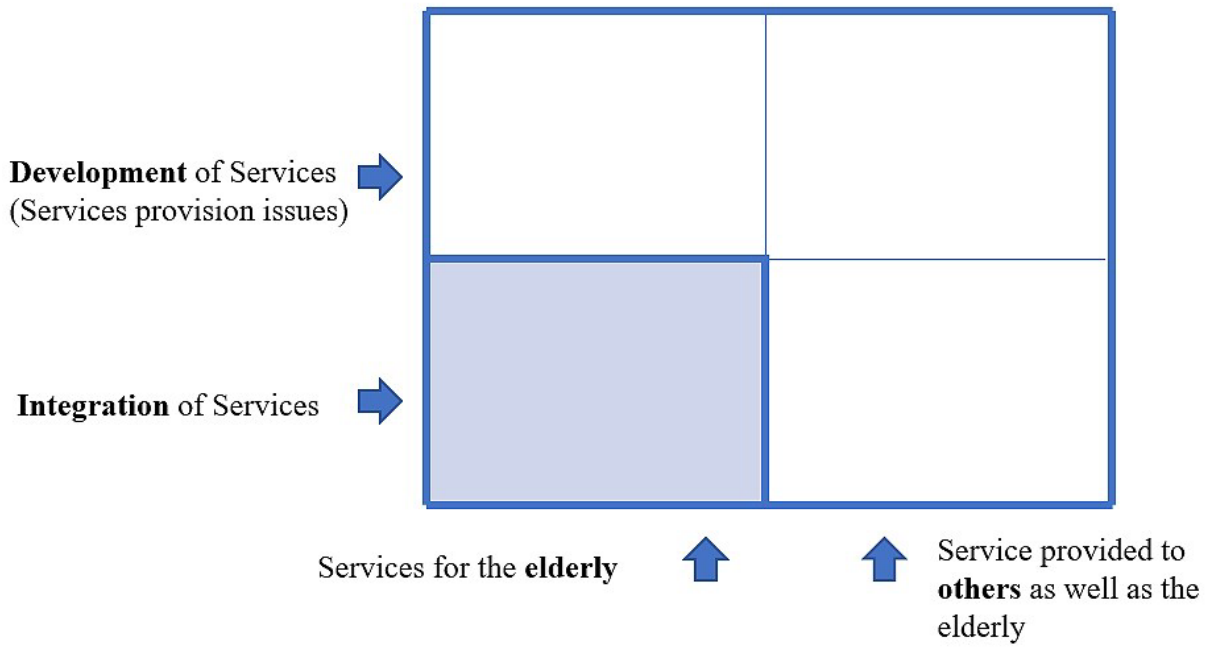
Source: World Bank, 2020.

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

Scope of the Integrative Older Adults Care Model

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

Figure 8 Model Scope



Source: World Bank, 2020.

5.2 Key challenges of the Integrative Older Adult Care Model

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

Key challenges and characteristics from a social care perspective:

(a) social services and care systems are decentralised towards municipalities and regions;

(b) the founders of social services are municipalities, self-governing regions and other private organisations and non-governmental organisations;

(c) the current system offers a wide spectrum of social services, such as outreach, outpatients and residential services;

(d) currently, the self-governing regions and municipalities have a legal responsibility to fund diverse types of services;

(e) divided responsibilities for ensuring social services and lack of their fulfilment result in a complicated system of funding;

(f) existing social services are not focussed on preventive and community support, but rather on institutional care. Thus, community services in Slovakia are in short supply;

(g) the legal framework contains person-centred standards of quality of social services, but monitoring of the services is only in the preparation phase;

(h) municipalities and self-governing regions have an obligation to do community planning;

(i) the existing legal framework allows partnership projects for the provision of social services based on the collaboration of different suppliers - for example, municipalities and private providers - and combining several types of services (World Bank, 2020).

The key challenges identified include:

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

The key challenges and characteristics from the health care perspective:

(a) an organisation focussing on population health, accessibility of the services or the interests of the citizens / patients is missing from the system;
(b) health promotion services and interventions (the responsibility of the Regional Public Health Authority) are dramatically underfinanced;
(c) there is a lack of data on the current and expected health status of the population, including pertinent data related to the districts and municipalities;
(d) no public information is available about any significant epidemiological studies or health needs assessments;
(e) the official statistics are focussed on services provided or patients registered, and based on statistical reporting of service providers;
(f) LTC and other non-core health services (rehabilitation, palliative care, home care nursing, inpatient nursing, and geriatrics) are under-financed, under-developed, low capacity and thus not accessible (World Bank, 2020).

The key challenges identified include:

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

To date there has been no systematic programme of care integration and no localised effort focussed on inhabitants of a specific region or catchment area in Slovakia, except for the investment in the integrated healthcare centres; these, however, failed to achieve the declared goal and have not resulted in a substantial integration of services. The successful cases of care integration refer to individual privately-run facilities or establishments. Aside from the lack of funding, social care and health care fall under different founding competences and are subject to different legislation.

While LTC is provided in both health care and social fields, there is no systemic service coordination or integration between the two. Social care is mainly focussed on prevention and relief in social deprivation, and its function is preventive at most. In many cases, patients are discharged from hospitals in a condition requiring further nursing care. There is no timely assessment of the patient's need for follow-up health or social care and the organisation and provision of follow-up care, especially in the case of infirm patients. Follow-up care for an infirm patient is handled by close relatives, who are often surprised by the situation itself; they

lack professional help in organising follow-up care, and the knowledge to assess real needs and the availability of services (World Bank, 2020).

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

Care integration services could determine the following challenges, which are not currently identified:

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

Other identified challenges and characteristics related to the implementation of the *Integrative Older Adults Care Model in Slovakia.* The national system does not prohibit integration of care; however, without institutional financial support for integration from the national level it is down to regions and municipalities to design and fund processes to support the integration of care. The possibility of integration is confirmed by existing non-public providers combining the provision of health and social services in the form of outpatient care in the case of Centrum Memory, and residential care in the case of Dom Rafael (both located in Bratislava, Slovakia). Locally designed systems should address the shortcomings in service provision based on the needs of the local population. Challenges in care supply require a thorough analysis of population needs and a location-specific approach to address the shortcomings in the existing service provision.

The local care systems for older adults must address both the integration of care and the development of currently insufficient services. Besides integration, better availability of services in rural areas is the main challenge. Local models of care for older adults should prioritise community care, outreach and ambulatory services where possible. The national

system is overly dependent on institutional care; the gap that needs to be filled on the local level is mostly in care models that can help people extend their independence and keep them in their communities.

While individual municipalities do not have sufficient capacity to fulfil responsibilities associated with care provision for older adults, the establishment of local care systems for older adults (integrating care, health, and social services) should be the joint responsibility of a group of municipalities under a partnership arrangement. A good example of quality management and prioritising community-based services can be seen in Slezská Diakonie (the Czech Republic), showing that municipalities need not have sole responsibility for providing services; they can arrange/ensure provision through other entities. It is recommended that there is one separate responsible entity for the integration of services, since current health and social service providers usually do not have the capacity to deliver such services or the legal competency to require cooperation from others.

The simplification and dissemination of the integration of care on a national level will entail national legislation, introducing a separate financing stream for the integration of care and population health management on a national, regional, micro-regional and community level, and furthermore introducing more flexible legislation on patient data exchange between service providers while respecting the protection of personal data. This data exchange would also apply to health and social services planning, development, and integration. The proposed model is expected to establish a new a precedent in care provision for older adults in Slovakia and introduce national reforms. The model relies on the joint effort of municipalities, expressed in the formal partnership provision of additional services that enable and support the integration of all types of care and people-centred community-based approaches. Experience from the pilot model could set up the base for the development of national legislation, and lead to further scaling up of integration in care services for older adults across the first pilot region, and then other parts of Slovakia.

The establishment of Integrated Social and Health Services Centres will strengthen citizens' rights as enshrined in the European Social Charter, Part I: point 13 - Everyone without adequate resources has the right to social and medical assistance; point 14 - Everyone has the right to benefit from social services; point 15 - People with disabilities have the right to independence, social inclusion and participation in society. Mann et al. (2004) pointed out that a variety of barriers and challenges can slow the process of integration, including limited personal, financial

and temporal resources, negative peer opinion, legislative hindrances, and reimbursement shortfalls.

According to Ee et al. (2020), the advantages and challenges of integrative health and social care, collaborative models of care, reviews of research highlights of select integrative approaches, and comment on potential cost advantages, are all currently under discussion. Ignatti & Nakamura (2021) described that, despite advancements in policy development, there remain political and operational challenges to its implementation and expansion; these should be overcome to fully implement complementary and integrative practices in health and social care. Slovakia is also going through this changing process with the aim of improving care, especially for older adults, in the next decade.

Long-term health and social care for older adults in Slovakia does not meet the current needs of the population. Slovakia lags significantly behind in the capacity of community and home care, as well as in the number of informal carers. The inefficiency of long-term care is reflected in a duplicate assessment system, weak prevention of dependency, and confusing management and financing of long-term care. The Integrative Older Adult Care Model is not directly defined in current valid laws. The provision of quality, accessible and comprehensive assistance and support for people with needs, alongside the facilities for long-term care, will increase the inclusion of people with disabilities and older adults in accordance with the Convention on the Rights of Persons with Disabilities. Change and improvement of social and healthcare services requires the coordination of stakeholders from the national to the regional and municipal level. Mutual harmonisation of social care for older adults, both formal and informal, in such a form that is naturally available to citizens, is a priority.

5.3 An integrative care model as a challenge for the future of social and healthcare systems in Slovakia

Long-term care includes a broad array of services provided to disabled persons - particularly older adults because of chronic illness or disability - at home, in nursing homes, and in assisted-living facilities. The services improve personal functioning and quality of life (OECD, 2011; Stallard, 2017; Freeman et al., 2017).

The integration of social and health care is a complex process that is dependent on a plethora of factors (Struijs et al., 2015; WHO, 2015; Wodchis et al., 2018). Research to date

provides some evidence that providing integrative care can lead to positive patient outcomes (Baxters et al., 2018; Liljas et al., 2019; de Bruin et al., 2020; Porteus, 2011).

Integrated care is a strategy for improving patient care through better coordination (Shaw et al. 2011, Chen et al. 2020, Craftman et al. 2018). The integrated care model responds to the needs of people suffering from rare diseases, and responds to the needs of their families (Czerska & Skweres-Kuchta 2021). The World Health Organisation (2016) defines integrated health services delivery as an approach to strengthen people-centred health systems through the promotion of the comprehensive delivery of quality services across the life-course, designed according to the multidimensional needs of the population and the individual and delivered by a coordinated multidisciplinary team of providers working across different settings and levels of care.

The integration of social and healthcare services in Slovakia has been continuously discussed over the past 20 years. The numerous intentions for preparing a legal framework for long-term care were rejected due to the lack of political will and cooperation between stakeholders; however, there have been some small adjustments made in recent years. The integrative care model is widely recognised as an approach which helps address challenges that are rather typical for Slovakia's social and healthcare system: fragmentation, overspecialisation, discontinuity of care, dominance of the institutional model of care provision, focus on treatment of acute conditions rather than focussing on prevention, etc**.** Integration and a shift from acute to preventive care is globally acknowledged as a way to simultaneously improve the experience of people in need of care and make the system more efficient and less costly, helping people to retain self-sufficiency. Slovakia should move towards integration of care to improve the quality of care for older adults and ensure that it matches the needs of the population. It must also overcome the challenges of the fragmentation of the system and avoid huge opportunity costs.

Thus, we will describe the methods of selection of functional groupings to determine appropriate locations and what needs to be considered in implementing care practices - in this case, an integrative care model.

5.4 Long-term Care with Focus on an Integrative Care Model in the Slovak Republic: A Pilot Study

An integrative care model is a challenge; nevertheless, it is the future of social and healthcare systems globally in establishing interdisciplinary cooperation. Planning and policy making should involve professionals in both medical and social care disciplines alongside management and administrators of social and healthcare services, both at national and community levels. All are crucial in integrating health services. These services should be adapted to the culture and requirements of a given community.

This chapter presents and describes the selection methods of functional groupings of municipalities as appropriate locations for implementing care practices for older adults, in this case an integrative social and health services model. The methodology of selection of functional groupings to determine appropriate locations, in the context of the concept of the integrative care model, shows that the approach is justified and can lead to positive outcomes for the patient and their family. Furthermore, it explains the need to consider the perspective of other factors in connection with the community environment.

Since 2020 we have been implementing a pilot project in Slovakia, with a focus on creating a functioning pilot model of community-based social service centres (CSSCs) for older adults. The centres will serve as a platform for integrating the social and healthcare services of various providers, both geographically and structurally. Geographically, the centres will horizontally connect several local municipalities. Through the centres, associated municipalities will provide social and healthcare services for older adults in an area larger than a single municipality (there are many municipalities with fewer than 1000 inhabitants in the Slovak Republic). Centres will concentrate on social care services provided by municipalities. This will create conditions for the provision of social care services that do not currently exist in the region or are insufficient to meet the increasing needs of an ageing population, and for increasing the quality and efficiency of services already provided. Structurally, they will form a platform enabling the vertical interconnection of local, regional, and national levels of social and healthcare services for older adults in Slovakia.

We assume that by interconnecting municipalities and providers it is possible to achieve a more coordinated and targeted system of flexible and sustainable services, covering preventive activities, outpatient, and residential social care services, including long-term care.

The main idea of this pilot project is to bring social care services directly to the recipient in his/her home environment, whenever his/her health. The proposed activity covers the design and pilot testing of a CISHC model in three small regions, with the possibility of applying the model to other territories of Slovakia. The results of the pilot test will be analysed and evaluated within the working group with the participation of the Ministry of Labour, Social Affairs and Family as a basis for setting the criteria for further use of EU funds, legislative processes and long-term care reforms in the Slovak Republic.

The Centre for Integrated Social and Health Care (CISHC) is therefore a tool to support the introduction of integrated long-term care. In order to be a platform for the integration of social and health services in a specific area of a functional cluster of municipalities in the sense of the model outlined above, it must provide (or have provided) activities in three areas (Filipová, Machajdíková, 2023):

1. social services and assistance;
2. health-promoting activities and the provision of health services;
3. activities supporting the integration and coordination of social and health services.

AD 1) In the field of social services the Centre for Integrated Social and Health Care provides or ensures the following activities:

- social counselling (e.g., assessment of the current situation, suggestions for solving unfavourable situations, assistance in arranging for disability compensation through the Office of Social Welfare and Social Assistance, etc.);
- coordination of community social services planning in the territory of the functional cluster of municipalities;
- provision of field social services (care service, transport service);
- provision and mediation of outpatient and residential social services - guiding the client through the process of application for their provision (including the lending of aids, day-care centres, facilities for older adults, specialised facilities, etc.);
- mediation of other forms of social services (monitoring and signalling the need for assistance);
- physically accompanying persons in need of help (to the doctor, to the authorities and to other institutions);

- preventive activities - leisure activities, interest activities, prevention of elder abuse, educational activities, etc.;
- arranging volunteer activities for people in need (building a network of volunteers and organising them).

The need for assistance (care) has emerged in recent years as a societal risk in many countries due to the increasing proportion of the population who are of post-working age, as well as the lengthening of the average life span; it is understood to be necessary because of long-term or permanent loss of independence in carrying out everyday tasks. The need for a social service is defined by the degree of dependence on the assistance of another person (II to VI degree of dependence), which reflects the degree of support needed to carry out activities in different areas (such as self-care tasks: personal hygiene, preparing and serving food, drinking or mobility, etc.). The fundamental role of the CISHC is to support the development of outreach and outpatient social services and to contribute to ensuring accessibility, linking the provision of health and social services and strengthening the responsibility of municipalities for their provision. (Filipová, Machajdíková, 2023).

AD 2) Health-promoting activities and the provision of health services:

- assisting citizens in communicating with health insurance companies when dealing with medical devices;
- arranging medical care (appointment with a doctor, an overview of the network of specialist doctors);
- arranging the acquisition of medical and compensatory aids (wheelchair, stairlift, adjustable bed, oxygen generator, etc.);
- cooperation with health care facilities (hospitals) - support during hospitalisation and return of citizens from hospitalisation to home care, contacting ADOS (Agency for home nursing care) if necessary;
- preventive health promotion activities;
- health education and health promotion services;
- arranging rehabilitation;
- assisting with the selection of prescription medication.

In the area of health services, the CISHC should mainly consist of support for networking and brokering services of healthcare providers in the region. Where warranted, it is also possible for the CISHC to create the conditions for the integration of primary healthcare by building

integrated healthcare centres where there is an opportunity to locate such services in a single building with outpatient clinics (in line with existing plans and calls by the Ministry of Health).
AD 3) Activities supporting the integration and coordination of social and health services:

- networking all service providers, municipalities and counties;
- networking available support for the citizen;
- informing and supporting all concerned parties;
- collecting data relevant for decision making, action and meeting the objectives of the CISHC (Filipová, Machajdíková, 2023).

The main objective of these activities is to ensure a comprehensive approach, a so-called person-centred and holistic approach, in relation to older adults and their next of kin. This model of integrated social and healthcare centres reflects the growing financial and staffing requirements for the provision of social and health services for an increasingly large population of older adults, with the ambition of maintaining, expanding and improving the range of services so that the requirements of older adults are met as closely as possible. These requirements, observed from several surveys, formed the basis from which the Ministry of Social Affairs and Family of the Slovak Republic defined national priorities for care for older adults in which the shift from institutionalised to home-based care, as well as the necessity for integrated social and health care, was highlighted. The integrated model of social care and health care is widely recognised as an approach that helps to address the problems typical of the Slovak social and healthcare system: its fragmentation, over-specialisation, discontinuity of care, dominance of the institutional model of care provision, focus on the treatment of acute conditions instead of prevention, etc. The CISHC model addresses the issue of long-term care for older adults at the community level, linking the process vertically with the activities of the authorities of the local authorities and the relevant ministries. At the same time the CISHS are profiled as organisational units, horizontally linking several municipalities whose older adult citizens can benefit from the services of a centre located in one of the municipalities.

5.5 Possibilities and limitations of a Centre of Integrated Social-Health Care as a form of provision of care services for the elderly

The current system of long-term care services is inadequate, particularly in terms of the competencies that the legislation defines within the various sectors involved, and in terms of the funding and fragmentation of the territories. The establishment of the CISHC will create the conditions for the integration of social and health services for the elderly, with the centres serving as a platform for the multi-level integration of all types of services provided by the various public and non-public social and health services. At the horizontal level, the centres will bring together several municipalities, i.e., there will be a so-called functional grouping of municipalities (FGO), within which the CISHC will ensure the provision of social services for the elderly. At the vertical level, the CISHC will constitute a platform enabling the linking of local and regional levels of the provision of social and health services for the elderly in a selected area of the country.

The issue of ageing and the quality of life of the elderly, which is also related to the quality of long-term social and health care, is increasingly the subject of both popular science articles and purely scientific studies. This is understandable in the light of demographic developments, which have been characterised for several decades by an ageing population, particularly in the economically developed countries. This monograph contributes to the spectrum of publications dealing with this issue from the health, societal or economic point of view, with the aim of presenting one of the possible solutions for the provision and assurance of quality long-term social and health care for older adults.

In terms of demographic development, it can be summarised that population ageing represents and will represent the main challenge for setting priorities for further development of social services in Slovakia. These will be provided in a context of very low fertility, an increasing economic burden on the working population, and a dramatic increase in the number of people aged 65 and over. Most of their life years are expected to be accompanied by limitations in carrying out normal daily activities and dependence on the help of others – next of kin or formal care services. These should be organised and provided in such a way as to enable older people to remain in their natural (especially home) environment for as long as possible. With a rapidly ageing population, the availability and quality of long-term care needs to be improved. Community and home-based health and social care needs to be considerably strengthened, as well as capacity in follow-up care; informal carers must also be supported.

The aim of this scientific monograph is to eliminate the above-mentioned impacts of intensive ageing in Slovakia and improve the availability and quality of long-term care and the interconnection of community and home social and health care. The solutions lie in the development of a methodology for identifying the area with the most intensive demand for public services in the social field; following this, a CISHC should be established so as to link the local and regional levels of provision of social services for the elderly, while at the same time serving as a platform for the integration of social and health services in each area.

In the process of meeting the objective, we have been identifying opportunities and constraints. Critical functions for achieving integration of care require new types of activities that are not currently recognised at a systemic level in the Slovak Republic, and new types of services supporting the integration of health and social care needs to be introduced. This range of new professional activities can be called 'integration services' for citizens and providers of health and social services in the target area. There are several theoretical options for assigning responsibility for integration services to existing or new parties, each with its own advantages and disadvantages. However, there is a risk that providers will not have the necessary qualifications, skills, capacity, and commitment when setting up a CISHC. A key challenge of the governance model is assigning responsibility for integrating care. Although there is no precedent in the Slovak Republic for this to be done at the level of a group of municipalities, there are several bodies at the local level that could take on this responsibility, although there are insufficient qualified persons available at this level. The limited financial and staff capacity of the municipalities would also make its implementation difficult, if not impossible. Furthermore, integration on such a small scale would not be effective and would at best lead to fragmentation.

A CISHC within a cluster of municipalities should allow services to be delivered in a more coordinated and targeted way, with the whole system being more flexible and sustainable. The social services provided should cover not only all forms of social services with long-term care, but also preventive activities. The CISHC will bring these services closer to the client so that they can remain in their natural living environment for as long as their health allows. CISHC also aim to extend the range of services provided to date to include those that were either absent or insufficient to meet the ever-growing needs of an ageing population. CISHC will aim to provide new services that have been lacking in community care for the elderly and improve the quality of services already provided. The centres will thus become not only a provider and facilitator of services, but also a source of information for older adults on how to deal with the

adverse social and health situation they find themselves in. CISHC, with their holistic approach, make it possible to provide several types and forms of social and health services care for the elderly. The provision and delivery of these services requires working with older adults at the community level with an individual approach. Care should start with the provision of preventive services, through the management of acute situations, to monitoring the development of the health status and related changing needs of the elderly person.

Conclusion

The area of long-term care for older adults requires a response from social and healthcare systems which is appropriate to meet the demographic changes which have already started. Based on several theoretical approaches, as well as practical solutions to this issue, we can conclude that deinstitutionalisation and the integration of social and health services are the basic prerequisite for a successful solution to the problem of the mismatch between the growing needs of an increasingly large population of older adults and the possibilities of satisfying them in the form of formal and informal social and health care. As one solution, we have presented the model of Centres of Integrated Social and Health Care, which embodies both the integration of social and health services and the transition from institutional to community-based care. The provision and delivery of these services requires working with older adults at the community level with an individualised approach. Such care should begin with the provision of preventive services, through the management of acute situations, to monitoring the development of the health status and the associated changing needs of the older person.

6 SUMMARY

An ageing population has an impact on the daily lives of individuals and society. Economic growth, fiscal sustainability, health and long-term care, social sustainability and quality of life are all affected. The impact of the pandemic has highlighted problems related to deaths and hospital admissions, as well as disconnections between the health and social services. An ageing population brings new job opportunities and thus new jobs are created. There is an emphasis on social justice and increased prosperity in the economic sphere. The European Pillar of Social Rights lays down several principles in the areas of income and pensions, long-term care, health care, social inclusion, social protection, work-life balance and lifelong learning. The Green Paper is based on the life-cycle principle, which reflects not only personal but also societal consequences. The response to population ageing should be intergenerational solidarity between the young and old. The generations are interdependent, therefore both younger and older people should be involved in policymaking.

The Slovak social care system is generally characterised by its decentralisation and reliance on a combination of public, non-public and family (informal) care. It is comprised of two main parts; the first consists of social services provided by professional staff, and the second consists of financial contributions provided to individuals with disabilities, or close family members who care for them. The reason for this situation is the complicated system of financing social services and the uneven distribution of the population in need of social care. Formal legislation supports the subsidiary principle, which means that most support and care should be provided in the natural home environment of the recipients. Beneficiaries should only move into residential care when care and support cannot be provided in the home environment. Under the current system however, residential social services are better funded than community-based services. Municipalities often do not have sufficient resources to provide care at the community level, so residents are advised to use the regional institutional social care infrastructure, even if they do not need that level of care and it forces them to leave their community. Most of the capacity to provide care is concentrated in the social service facilities of the municipal counties and non-public providers. In addition, most social service providers that provide community-based services are non-public providers.

One of the biggest challenges in the Slovak Republic in relation to social care is the lack of qualified healthcare and professional social workers. Almost every provider of social services in Slovakia Republic confirms a shortage of qualified staff, such as nurses, carers or

social workers. The main reasons causing this situation are the low wages of social services staff in Slovakia and the lure of better financial conditions and opportunities in other countries.

The solution to the complex system of care for older adults in Slovakia is explained in this monograph through the building of Centres of Integrated Social and Health Care (CISHS), which link local, national, and regional levels of provision of social services for older adults in Slovakia in selected regions. Combining municipalities into a functional cluster and integrating social and health services will achieve a more coordinated and targeted system of flexible and sustainable services, covering preventive activities and all forms of social and long-term care services. The goal is to bring social services closer to the client in their home environment, in so far as their state of health allows. The Global Strategy for People-Centred Integrated Health Services 2016-2026 (WHO, 2016 and 2017) defines integrated health service delivery as an approach to strengthening people-centred health systems by promoting the comprehensive delivery of quality services across the lifespan that are designed around the multidimensional needs of the population and the individual and delivered by a coordinated multidisciplinary team of providers working in different settings and at different levels of care.

Since 2020, we have been implementing a pilot project in Slovakia called 'Social Service Centres as a Tool for Multi-Level Partnership in the Provision of Long-Term Care at the Community Level in Slovakia'. The project is implemented by the Banská Bystrica Self-Governing Region in cooperation with Matej Bel University in Banská Bystrica, Slovakia and Kristiania University, Oslo, Norway and is supported by the European Commission. Our common ambition is to create a functioning pilot model of community centres of social services for older adults which will serve as a platform for the integration of social and health services - which are in the competence of various public and non-public providers - at two levels: horizontally, the centres will bring together social services provided by several adjacent municipalities under one roof, thus creating the conditions for improving the quality of the services provided. In the vertical plane, they will form a platform enabling the linking of local, regional and national levels of provision of social and health services for older adults in Slovakia throughout the selected territory. We expect that linking municipalities and providers will enable a more coordinated and targeted system of flexible and sustainable services to be achieved, covering preventive activities and all forms of social and long-term care services. The aim is to bring social services closer to the client in his/her home environment, as far as his/her health condition allows. It is hoped that this scheme will be rolled out to other territories after its functionality has been verified.

This monograph presents the creation of centres of integrated social and health care as a solution to the problems of long-term care for older adults, which support the process of deinstitutionalisation, e.g., the transition from institutional to community care. Services are tailor-made for older adults in a selected region in the municipality/municipalities, focussing on the client's health care using a person-centred approach and the integration of social and health care. Ultimately, it is about bringing services directly to the client in the home environment at the community level. Our intention is to create a functioning pilot model of integrated social and healthcare centres as a tool for increasing the efficiency and quality of long-term care in Slovakia. This monograph originated in partial fulfilment, and with support of the project KEGA 040UMB-4/2021 'Diversification of content and didactic forms for teaching economic subjects in Slovak language and world languages' at the Faculty of Economics, Matej Bel University in Slovakia.

Our vision is a world in which all people can live long, healthy lives, and our focus is on the second half of life. It is linked to the three priorities of the Madrid International Plan of Action on Ageing (WHO, 2020) and reflects the vision of the Sustainable Development Goals to leave no one behind. Actions to ensure healthy ageing can and should be taken at all ages, representing the life-course approach, which includes a healthy start to life, actions at each life stage and fulfilling the needs of people at critical life stages. The actions outlined in this document, if implemented at multiple levels and in multiple sectors, will benefit both current and future generations of older people. The UN Decade of Healthy Ageing: Plan of Action 2021-2030 will adhere to the guiding principles of Agenda 2030 and those in the global strategy and the Global Campaign to Combat Ageism, namely:

1. Interconnected and indivisible - all implementing stakeholders address all the Sustainable Development Goals together instead of a list of goals from which they pick and choose. Inclusive means the involvement of all segments of society, irrespective of their age, gender, ethnicity, ability, location, or any other social category.
2. Multistakeholder partnerships - multistakeholder partnerships are mobilised to share knowledge, expertise, technology and resources.
3. Universal - commits all countries, irrespective of income level and development status, to comprehensive work for sustainable development, adapted to each context and population as necessary.

4. Leaving no one behind - applies to all people, whoever and wherever they are, targeting their specific challenges and vulnerability.
5. Equity - champions equal, just opportunities to enjoy the determinants and enablers of healthy ageing, including social and economic status, age, gender, place of birth or residence, migrant status, and level of ability. This may sometimes require unequal attention to some population groups to ensure the greatest benefit to the least advantaged, most vulnerable, or marginalised members of society.
6. Intergenerational solidarity - enables social cohesion and interactive exchange among generations to support health and well-being for all people.
7. Commitment - sustains work over the 10-year period and beyond.
8. Do no harm - commits countries to protect the well-being of all stakeholders and minimise any foreseeable harm to other age groups. (World Health Organisation; 2019).

The Centres of Integrated Social and Health Care (CISHS) are based on the human rights approach, which addresses the universality, inalienability and indivisibility of the human rights to which everyone is entitled, without distinction of any kind. These rights include: the right to the enjoyment of the highest attainable standards of physical and mental health; the right to an adequate standard of living; the right to an education; the right to freedom from exploitation, violence and abuse; the right to living in the community; and the right to participation in public, political and cultural life. The organisations engaged in the collaboration will adhere to their own guiding principles and values.

BIBLIOGRAPHY

1. Act No. 329/2011 Coll., on the Provision of Benefits to Persons with Disabilities and on Amendments to Related Acts, as amended, Czech Republic. Available online: https://www.mpsv.cz/documents/20142/372793/zakon_329_2011.pdf/5581eb74-2743-d9e1-b2ef-ca9ef4084c12
2. Act No. 447/2008 Coll. on Financial Benefits to Compensation for Severe Disability and on Amendments to Certain Acts. Zbierka Zákonov 165: 3750–889.
3. Act No. 448/2008 on Social Services. Zbierka Zákonov 165: 3844–97.
4. Act No. 576/2004 Coll. on Health care and on services related to healthcare. (2004). Available online: https://www.slov-lex.sk/pravne-predpisy/SK/ZZ/2004/576/
5. Act No. 83/1997 Coll. on Health insurance and on the amendment of other acts relating to supply of pharmaceuticals and social security with the view of the accession to the European Union. Hungary. Available online: https://www.ilo.org/dyn/natlex/natlex4.detail?p_isn=60441&p_lang=en
6. AIDUKATE, J., HORT, S. & AINSAAR, M. 2021. Current trends in social welfare policies toward the older people in the Baltic and Nordic countries: an explorative study. *Journal of Baltic Studies;* DOI: 10.1080/01629778.2021.1998166.
7. ALBESA JOVÉ, E. 2021. Impact of the economic crisis and contractions within the European long-term care systems. *Journal of International and Comparative Social Policy*,37(2), 159-175. DOI: 10.1017/ics.2020.35
8. Allen et al. 2022. Allen, J. O., Solway, E., Kirch, M., Singer, D., Kullgren, J. T., Moïse, V., & Malani, P. N. (2022). Experiences of Everyday Ageism and the Health of Older US Adults. *JAMA network open*, *5*(6), e2217240. https://doi.org/10.1001/jamanetworkopen.2022.17240
9. BARTOSOVIC, I., ZACHAROVA, E., ZRUBAKOVA, K., GAZIKOVA, E., WEST, D. J. a COSTELLO, M., 2017. Demographic Characteristics of Population Ageing in Slovakia. Clinical Social Work and Health Intervention. 20 October 2017. Vol. 8, no. 3, pp. 7–14. DOI 10.22359/cswhi_8_3_01.
10. BAXTER, S., JOHNSON, M., CHAMBERS, D., SUTTON, A., GOYDER, E., BOOTH, A., 2018. The effects of integrated care: a systematic review of UK and international evidence. BMC Health Services Research. December 2018. Vol. 18, no. 1, pp. 350. DOI 10.1186/s12913-018-3161-3.

11. BEARD, J.R, OFFICER, A., DE CARVALHO, A., SADANA, R., POT, A. et.al. 2016. The World report on ageing and health: a policy framework for healthy ageing. *The Lancet*. MAY 2016. Vol. 387, no. 10033, pp. 2145–2154. DOI 10.1016/S0140-6736(15)00516-4.
12. BIRTHA, M., HOLM, K. 2017. Who cares? Study on the challenges and needs of family carers in Europe. Brussels, COFACE report, http://www.coface-eu.org/resources/publications/study-challenges-and-needs-of-family-carers-in-europe/
13. BLEHA, B., ŠPROCHA, B., VAŇO, B. 2018. *Prognóza obyvateľstva Slovenska do roku 2060: Revízia poznatkov a predpokladov v kontexte pokračujúcej transformácie.* Bratislava: INFOSTAT – Inštitút informatiky a štatistiky. 74 s. ISBN 978-80-89398-37-9
14. BONSANG, Eric, 2009. Does informal care from children to their older adults parents substitute for formal care in Europe? *Journal of Health Economics*. January 2009. Vol. 28, no. 1, pp. 143–154. DOI 10.1016/j.jhealeco.2008.09.002.
15. BOWER P, REEVES D, SUTTON M, et al. 2018. Improving care for older people with long-term conditions and social care needs in Salford: the CLASSIC mixed-methods study, including RCT. Southampton (UK): NIHR Journals Library; 2018 Aug. (Health Services and Delivery Research, No. 6.31.) Chapter 1, Long-term conditions and integrated care. Available from: https://www.ncbi.nlm.nih.gov/books/NBK519982/
16. BOWER, P., REEVES, D., SUTTON, M. et al. 2018. Improving care for older people with long-term conditions and social care needs in Salford: the CLASSIC mixed-methods study, including RCT. Health Services and Delivery Research. august 2018. Vol. 6, no. 31, pp. 1–188. DOI 10.3310/hsdr06310.
17. BRIMBLECOMBE, N., FERNANDEZ, JL., KNAPP, M., REHILL, A., WITTENBERG, R., 2018. Review of the international evidence on support for unpaid carers. *Journal of Long-Term Care*. 1 September 2018. Vol. 0, no. 0, pp. 25. DOI 10.31389/jltc.3.
18. BRITISH MEDICAL ASSOCIATION, 2014. What is Social Care, and How Can. Health Services Better Integrate with It? London: BMA; 2014.
19. BROESE VAN GROENOU, Marjolein I. a DE BOER, Alice, 2016. Providing informal care in a changing society. *European Journal of Ageing*. September 2016. Vol. 13, no. 3, pp. 271–279. DOI 10.1007/s10433-016-0370-7.
20. BRUINE DE BRUIN, W., 2021. Age Differences in COVID-19 Risk Perceptions and Mental Health: Evidence From a National U.S. Survey Conducted in March 2020. ISAACOWITZ, Derek (ed.), The Journals of Gerontology: Series B. 18 January 2021.

Vol. 76, no. 2, pp. e24–e29. DOI 10.1093/geronb/gbaa074.

21. BUFFEL, T., 2018. Social research and co-production with older people: Developing age-friendly communities. *Journal of Aging Studies*. MARCH 2018. Vol. 44, pp. 52–60. DOI 10.1016/j.jaging.2018.01.012.
22. BUFFEL, T., PHILLIPSON, C., SCHARF, T., 2012. Ageing in urban environments: Developing 'age-friendly' cities. *Critical Social Policy*. November 2012. Vol. 32, no. 4, pp. 597–617. DOI 10.1177/0261018311430457.
23. BUFFEL, T., 2018a. Co-production with older people. Researching age-friendly communities. *Journal of Aging Studies* 44: 52–60.
24. BURSTRÖM, Bo, 2015. SWEDEN--RECENT CHANGES IN WELFARE STATE ARRANGEMENTS. *International Journal of Health Services: Planning, Administration, Evaluation*. 2015. Vol. 45, no. 1, pp. 87–104. DOI 10.2190/HS.45.1.g.
25. CANGÁR, M. MACHAJDÍKOVÁ, M., 2017. Dlhodobá starostlivosť v Slovenskej republike Potreba systémovej zmen. Publication published in the framework of the Biennial Cooperation Agreement between the Ministry of Health of the Slovak Republic and the WHO Regional Office for Europe for 2016-2017, programme area Disability and Rehabilitation. Available online: https://www.rpsp.eu/wp-content/uploads/2018/04/LTCpolicybrief_final.pdf
26. CARDOSO, T., OLIVEIRA, M.D., BARBOSA-PÓVOA, A. NICKEL, S., 2015. An integrated approach for planning a long-term care network with uncertainty, strategic policy and equity considerations. *European Journal of Operational Research*. November 2015. Vol. 247, no. 1, pp. 321–334. DOI 10.1016/j.ejor.2015.05.074.
27. Centre for Age-Friendly Excellence, 2017. Eight dimensions of age-friendly community, WHO 2017. Available online: http://cfafe.org/vision/
28. CESARI, M., SUMI, Y., HAN, Z.A, PERRACINI, M., JANG, H., BRIGGS, A., AMUTHAVALLI THIYAGARAJAN, J., SADANA, R. BANERJEE, A. 2022. Implementing care for healthy ageing. *BMJ Global Health*. February 2022. Vol. 7, no. 2, pp. e007778. DOI 10.1136/bmjgh-2021-007778.
29. CHALISE, H. N., 2023. Healthy Ageing: A Basic Concept. *Asian Journal of Population Sciences*. 10 January 2023. pp. 124–128. DOI 10.3126/ajps.v2i1.51096.
30. CHEN, Y., CHEN, H., SONG, P., 2020. Promises and pitfalls of integrating home-based health services into Shanghai's elder-care system. *Ageing and Society*. March 2020. Vol. 40, no. 3, pp. 480–500. DOI 10.1017/S0144686X18001095.

31. CHUNG, S., KIM, M., AUH, E. Y., PARK, N. S. 2021. WHO's Global Age-Friendly Cities Guide: Its Implications of a Discussion on Social Exclusion among Older Adults. *International Journal of Environmental Research and Public Health*, *18*(15), 8027. MDPI AG. Retrieved from http://dx.doi.org/10.3390/ijerph18158027
32. CINNAMON, J., SCHUURMAN, N., CROOKS, V. A., 2009. Assessing the suitability of host communities for secondary palliative care hubs: A location analysis model. Health & Place. September 2009. Vol. 15, no. 3, pp. 822–830. DOI 10.1016/j.healthplace.2009.01.003.
33. COLOMBO, F., LLENA-NOZAL, A., MERCIER, J., TJADENS, F., 2011. *Help Wanted? Providing and Paying for Long-Term Care*. online. OECD. OECD Health Policy Studies. ISBN 978-92-64-09758-2.
34. CRAFTMAN, Å., GRUNDBERG, Å., WESTERBOTN, M. 2018. Experiences of home care assistants providing social care to older people: A context in transition. *International Journal of Older People Nursing*. December 2018. Vol. 13, no. 4, pp. e12207. DOI 10.1111/opn.12207.
35. CZERSKA, I., SKWERES-KUCHTA, M., 2021. Integrative Medicine as a New Treatment Model and the Future of Health Care Systems in the World in the Context of Rare Diseases. *EUROPEAN RESEARCH STUDIES JOURNAL*. 1 June 2021. Vol. XXIV, no. Issue 2B, pp. 800–809. DOI 10.35808/ersj/2265.
36. DAATLAND, S. O., HØYLAND, K. OTNES, B., 2015. Scandinavian Contrasts and Norwegian Variations in Special Housing for Older People. *Journal of Housing For the Older adults*. 2. January 2015. Vol. 29, no. 1–2, pp. 180–196. DOI 10.1080/02763893.2015.989778.
37. DANMARKS STATISTIK, 2020. Højere pensionsalder påvirker boligstøtten [Higher pension age influence the housing support], Nyt fra Danmarks Statistik, Copenhagen, Statistics Denmark, 2020. www.dst.dk
38. DEL BARRIO, E., MARSILLAS, S., BUFFEL, T,, SMETCOREN, A., SANCHO, M. 2018. From Active Aging to Active Citizenship: The Role of (Age) Friendliness. *Social Sciences*. 13 august 2018. Vol. 7, no. 8, pp. 134. DOI 10.3390/socsci7080134.
39. DREWES, J., ZHU, W., WUTZ, A. MELCHER, D., 2015. Dense sampling reveals behavioral oscillations in rapid visual categorization. *Scientific Reports*. 6 November 2015. Vol. 5, no. 1, pp. 16290. DOI 10.1038/srep16290.

40. EE, C., LAKE, J., FIRTH, J., HARGRAVES, F., DE MANINCOR, M., MEADE, T., MARX, W. a SARRIS, J., 2020. An integrative collaborative care model for people with mental illness and physical comorbidities. *International Journal of Mental Health Systems*. December 2020. Vol. 14, no. 1, pp. 83. DOI 10.1186/s13033-020-00410-6.
41. EKMAN, B., WILKENS, J., 2015. A literature review of the regional implementation of the central Swedish government's health care reforms on choice and privatization. *Health Economics Review*. December 2015. Vol. 5, no. 1, pp. 39. DOI 10.1186/s13561-015-0076-0.
42. European Commission. (2022). Study on social services with particular focus on personal targeted social services for people in vulnerable situations. Available online: https://ec.europa.eu/social/main.jsp?catId=1169&langId=en
43. European Commission. 2014. Access to high-quality social services. Available online: https://ec.europa.eu/social/main.jsp?catId=1169&langId=en
44. European Commission. 2019. Joint report on health and long-term care systems and fiscal sustainability. Available online: https://ec.europa.eu/info/sites/default/files/economy-finance/ip105_en.pdf
45. Eurostat projections. 2020. Population projections at regional level. Available online: https://ec.europa.eu/eurostat/statisticsexplained/index.phptitle=Population_projections_at_regional_level
46. Eurostat, 2019. EUROPOP2019 population projections. Projected old-age dependency ratio. [online] [cit. 2021-02-11]. Available at (last update 02/2021): https://ec.europa.eu/eurostat/databrowser/view/tps00200/default/table?lang=en
47. FILIPOVÁ M., MACHAJDÍKOVÁ, M. 2023. Centres of integrated social and health care. Methodology of the BBSK. Internal material of the BBSGR.
48. FISCHER, Johanna, FRISINA DOETTER, Lorraine a ROTHGANG, Heinz, 2022. Comparing long-term care systems: A multi-dimensional, actor-centred typology. *Social Policy & Administration*. January 2022. Vol. 56, no. 1, pp. 33–47. DOI 10.1111/spol.12742.
49. FREEMAN, E., KNAPP, M., SOMANI, A., 2017. Long-Term Care Organization and Financing. V: *International Encyclopedia of Public Health*. online. Elsevier. pp. 469–476. [Cit 10 February 2023]. ISBN 978-0-12-803708-9.
50. GAJDOŠ, P. 2015 *Ako sa mení vidiek na Slovensku*. Bratislava: Sociologický ústav SAV, 2015. ISBN 978-80-85544-87-9.

51. GARATTINI, L., BADINELLA MARTINI, M. NOBILI, A., 2022. General practice in the EU: countries you see, customs you find. *The European Journal of Health Economics*. 18 November 2022. pp. s10198- 022- 01549–4. DOI 10.1007/s10198-022-01549-4.
52. GAUTUN, H., GRØDEM, A.S., 2015. Prioritising care services: Do the oldest users lose out? *International Journal of Social Welfare*. January 2015. Vol. 24, no. 1, pp. 73–80. DOI 10.1111/ijsw.12116.
53. GERBERY, D., BEDNARIK, R. 2018. ESPN Thematic Report on Challenges in long-term care Slovakia 2018. Directorate-General for Employment, Social Affairs and Inclusion. Available online: file:///C:/Users/AS/Desktop/SK_ESPN_thematic%20report%20on%20LTC%20(1).pdf
54. Global strategy 2016-2020. Global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life. Sixty-Ninth World Health Assembly; Geneva, 23–29 May; 2016.
55. GOLINOWSKA, S. 2010. The System of Long-Term Care in Poland (November 1, 2010). CASE Network Studies & Analyses No. 416/2010, Available at SSRN: https://ssrn.com/abstract=1710644
56. GOODWIN, N., 2016. Understanding Integrated Care. *International Journal of Integrated Care*. 28 October 2016. Vol. 16, no. 4, pp. 6. DOI 10.5334/ijic.2530.
57. GOODWIN, V.A., ALLAN, L., BETHEL, A., COWLEY, A., CROSS, J.L., DAY, J., DRUMMOND, A., HALL, AJ., HOWARD, M., MORLEY, N., THOMPSON COON, J., LAMB, S.E., 2021. Rehabilitation to enable recovery from COVID-19: a rapid systematic review. *Physiotherapy*. jún 2021. Vol. 111, pp. 4–22. DOI 10.1016/j.physio.2021.01.007.
58. GREVE, B., 2014. *Welfare and the Welfare State*. online. 0. Routledge. ISBN 978-1-315-76102-2.
59. GRØDEM, A.S., 2016. Migration as a Challenge to the Nordic Welfare States. In Veggeland, Noralv (Eds.), *The Current Nordic Welfare State Model*. Nova Science Publishers. p.149–170
60. GRØDEM, A.S., 2017. Family-oriented policies in Scandinavia and the challenge of immigration. Journal of European Social Policy. February 2017. Vol. 27, no. 1, pp. 77–89. DOI 10.1177/0958928716673315.
61. GUSMANO, M.K. a OKMA, K.G. H., 2018. Population Aging and the Sustainability of the Welfare State. Hastings Centre Report. September 2018. Vol. 48, pp. S57–S61. DOI 10.1002/hast.915.

62. GUTTERMAN, A., 2023. World Health Organization and Older Persons. *SSRN Electronic Journal*. online. 2023. [Cit 10 February 2023]. DOI 10.2139/ssrn.4320044.
63. Helsedirektoratet, 2017. ÅRSRAPPORT 2017 Available online: https://www.helsedirektoratet.no/rapporter/helsedirektoratetarsrapporter.pdf
64. HILDEBRANDT, T.M., NUNES NESI, A., ARAÚJO, WL., BRAUN, HP., 2015. Amino Acid Catabolism in Plants. *Molecular Plant*. November 2015. Vol. 8, no. 11, pp. 1563–1579. DOI 10.1016/j.molp.2015.09.005.
65. HOD. 2011. Forskrift om egenandel for kommunale helse- og omsorgstjenester. https://lovdata.no/dokument/SF/forskrift/2011-12-16-1349
66. HOFFMANN, F., RODRIQUES, R. 2010. Informal Carers: Who Takes Care of Them? (Policy brief). Vienna, AU: European Centre for Social Welfare Policy and Research.
67. HOLMØY, E., OTNES, B., HAUGSTVEIT, F.V. 2016. Behovet for arbeidskraft og omsorgsboliger i pleie- og omsorgssektoren mot 2060. Oslo/Kongsvinger: Statistics Norway, report no. 2016/20
68. IGNATTI, C., NAKAMURA, E., 2021. Monitoring the implementation of a Municipal Policy on Complementary and Integrative Practices: the main challenges. Physis: Revista de Saúde Coletiva. 2021. Vol. 31, no. 1, pp. e310107. DOI 10.1590/s0103-73312021310107.
69. JACOB, J., EDBROOKE-CHILDS, J., LAW, D., WOLPERT, M 2015. Jacob et al 2015 CCPP Measuring what matters to patient's appendix. online. 2015. [Cit 10 February 2023]. DOI 10.13140/RG.2.1.2461.7683.
70. JEHLIČKA, P., KOSTELECKÝ, T., Smith J. 2013. Food Self-Provisioning in Czechia: Beyond the Coping Strategy of the Poor: a Responseto Alber and Kohler's 'Informal Food Production in the Enlarged European Union' (2008). Social Indicators Research 111(1):219–234
71. KATRENIAKOVÁ Z., LEVYOVÁ M., NEMCIKOVÁ, M., 2019. Current Status and Needs of Changes in Long-term Care in the Slovak Republic: Informal Carers, Social and Health Services in the Field. Journal Socioterapie 5(1): 33–39.
72. KÖPPEN, J., BALTAXE, E., CZYPIONKA, T, HUIC, M., PITTER, J., RUTHS, S. et.al. 2021. Drivers of successful implementation of integrated care for multi-morbidity: Mechanisms identified in 17 case studies from 8 European countries. *Social Science & Medicine*. máj 2021. Vol. 277, pp. 113728. DOI 10.1016/j.socscimed.2021.113728.

73. KURPAS, D, STEFANICKA-WOJTAS, D, SHPAKOU, A., et al. 2021. The Advantages and Disadvantages of Integrated Care Implementation in Central and Eastern Europe – Perspective from 9 CEE Countries. International Journal of Integrated Care. 8 november 2021. Vol. 21, no. 4, pp. 14. DOI 10.5334/ijic.5632.

74. KVIST, J. 2018. ESPN Thematic Report on Challenges in long-term care: Denmark 2018. European Commission. Available online: https://ec.europa.eu/social/BlobServlet?docId=19844&langId=en

75. LEVINE, Mark a MANNING, Rachel, 2013. Social identity, group processes, and helping in emergencies. European Review of Social Psychology. December 2013. Vol. 24, no. 1, pp. 225–251. DOI 10.1080/10463283.2014.892318.

76. LILJAS, A. E. M., WALTERS, K., JOVICIC, A., ILIFFE, S., MANTHORPE, J., GOODMAN, C. KHARICHA, K. 2019. Engaging 'hard to reach' groups in health promotion: the views of older people and professionals from a qualitative study in England. BMC Public Health. December 2019. Vol. 19, no. 1, pp. 629. DOI 10.1186/s12889-019-6911-1.

77. LILJAS, AE. M., BRATTSTRÖM, F., BURSTRÖM, B., SCHÖN, P., AGERHOLM, J., 2019. Impact of Integrated Care on Patient-Related Outcomes Among Older People – A Systematic Review. *International Journal of Integrated Care*. 24 July 2019. Vol. 19, no. 3, pp. 6. DOI 10.5334/ijic.4632.

78. LIPSZYC, B., SAIL, E., XAVIER, A., 2012. *Long-term care: need, use and expenditure in the EU-27*. Brussels, Brussels, Belgium: European Commission, European Commission, Directorate-General for Economic and Financial Affairs. ISBN 978-92-79-22990-9.

79. LOOMAN, W, STRUCKMANN, LOOMAN, W., STRUCKMANN, V. et. al. 2021. Drivers of successful implementation of integrated care for multi-morbidity: Mechanisms identified in 17 case studies from 8 European countries. *Social Science & Medicine*. 2021. Vol. 277, pp. 113728. DOI 10.1016/j.socscimed.2021.113728.

80. LOSADA, A., MÁRQUEZ-GONZÁLEZ, M., KNIGHT, B.G., YANGUAS, J., SAYEGH, P., ROMERO-MORENO, R., 2010. Psychosocial factors and caregivers' distress: Effects of familism and dysfunctional thoughts. *Aging & Mental Health*. March 2010. Vol. 14, no. 2, pp. 193–202. DOI 10.1080/13607860903167838.

81. MARTINKOVIČOVÁ, M., KIKA, M. 2016. Neplatená práca ako tradičný fenomén slovenských domácností. In: Uramová M, Orviská M. Neplatená práca na Slovensku, s.

99–145. Banská Bystrica: Vydavateľstvo Univerzity Mateja Bela – Belianum. ISBN 978-80-557-1158-4.

82. MAURIAT, C., MATTHIEU de STAMPA, F., 2009. Pistes deréflexion à l'intention des professionnels du domicile. Faisant face au refus d'aide/de soins de la part des personnes âgées àdomicile. Gérontologie et Société 32: 81.
83. MESMER-MAGNUS, J., DECHURCH, L., A., 2009. Information sharing and team performance: A meta-analysis. *Journal of Applied Psychology*. 2009. Vol. 94, no. 2, pp. 535–546. DOI 10.1037/a0013773.
84. MIKOŁAJCZYK, B., 2023. International human rights law and the intangible face of ageism. *Equality, Diversity and Inclusion: An International Journal*. online. 5 January 2023. [Cit 10 February 2023]. DOI 10.1108/EDI-09-2021-0220.
85. MIKTON, Christopher, DE LA FUENTE-NÚÑEZ, Vânia, OFFICER, Alana a KRUG, Etienne, 2021. Ageism: a social determinant of health that has come of age. *The Lancet*. April 2021. Vol. 397, no. 10282, pp. 1333–1334. DOI 10.1016/S0140-6736(21)00524-9.
86. Ministry of Labour, Social Affairs and Family of the Slovak Republic, 2021. National priorities for the development of social services for 2021-30. [cited 2022-11-25]. Available online: https://www.employment.gov.sk/files/slovensky/rodina-socialna-pomoc/socialne-sluzby/nprss-fin.pdf.
87. Ministry of Labour, Social Affairs and Family of the Slovak Republic. 2020. Správa o sociálnej situácii obyvateľstva Slovenskej republiky za rok 2019 [The report on the social situation of inhabitants in the Slovak Republic in 2019]. [online] [cit. 2021-01-22]. Available at: https://www.employment.gov.sk/sk/ministerstvo/vyskum-oblasti-prace-socialnych-veci-institut-socialnej-politiky/spravy-socialnej-situacii-obyvatelstva/rok-2019.html
88. Ministry of Labour, Social Affairs and Family, 2021 Recovery and Resilience Plan. Available online: https://www.employment.gov.sk/sk/uvodna-stranka/plan-obnovy-odolnosti/.
89. MIYAWAKI, A. TSUGAWA, Y., MURAYAMA, H., TAMIYA, N., TABUCHI, T., 2022. Family caregiving and changes in mental health status in Japan during the COVID-19 pandemic. *Archives of Gerontology and Geriatrics*. January 2022. Vol. 98, pp. 104531. DOI 10.1016/j.archger.2021.104531.

90. MOLYNEAUX, V., BUTCHARD, S., SIMPSON, J., MURRAY, C., 2011. Reconsidering the term 'carer': a critique of the universal adoption of the term 'carer'. *Ageing and Society*. April 2011. Vol. 31, no. 3, pp. 422–437. DOI 10.1017/S0144686X10001066.
91. NOU 1992:15. Kommune- og fylkesinndelingen i et Norge i forandring. Available online: https://www.nb.no/items/2fc4b0f139d99c65f13f5f244a17e132?page=1
92. OECD Health Statistics 2021. Health at a Glance 2021. Available online: https://www.oecd.org/health/health-at-a-glance/
93. OWEN, Susan Hesse a DASKIN, Mark S., 1998. Strategic facility location: A review. *European Journal of Operational Research*. december 1998. Vol. 111, no. 3, pp. 423–447. DOI 10.1016/S0377-2217(98)00186-6.
94. PICKARD, L., 2015. A growing care gap? The supply of unpaid care for older people by their adult children in England to 2032. *Ageing and Society*. január 2015. Vol. 35, no. 1, pp. 96–123. DOI 10.1017/S0144686X13000512
95. PORTEUS, D., 2011. The Enabling Environment for Mobile Banking in Africa, Bankablefrontier. Available online: www.bankablefrontier.com/publications.php
96. RÉMILLARD-BOILARD, S., BUFFEL, T., PHILLIPSON, CH., 2020. Developing Age-Friendly Cities and Communities: Eleven Case Studies from around the World. *International Journal of Environmental Research and Public Health*. 27 december 2020. Vol. 18, no. 1, pp. 133. DOI 10.3390/ijerph18010133.
97. REPKOVÁ, K. 2020. Plnenie národných priorít rozvoja sociálnych služieb v rokoch 2015 – 2020. Analýza. Inštitút pre výskum práce a rodiny. Available online: https://ivpr.gov.sk/wpcontent/uploads/2020/07/plnenie_nar_priorit_rozvoja_soc_sluzieb_analyza_repkova_2020.pdf
98. REPKOVÁ, K., BRICHTOVÁ, L. 2015. Odkázanosť na pomoc inej osoby v kontexte sociálnych služieb na Slovensku. In: Fórum sociální politiky 3/2015. Praha, Výzkumný ústav práce a sociálních věcí, 2015, s. 10 – 18. ISSN 1803 -7488
99. RIVADENEIRA, María Fernanda, MENDIETA, María José, VILLAVICENCIO, Jessica, CAICEDO-GALLARDO, José a BUENDÍA, Patricio, 2021. A multidimensional model of healthy ageing: proposal and evaluation of determinants based on a population survey in Ecuador. *BMC Geriatrics*. 1 november 2021. Vol. 21, no. 1, pp. 615. DOI 10.1186/s12877-021-02548-5.

100. RODRIQUES, R, SCHULMANN, K., SCHMIDT, A., KALAVREZOU, N, MATSAGNIS, M. 2013. The Indirect Costs of Long-term Care.Research note. [online] [cit. 2022-11-22]. Available at: https://www.euro.centre.org/publications/detail/415

101. ROSENBLOOM, Michael, KASHYAP, Bhavani, DIAZ-OCHOA, Ana, KARRMANN, Jan, SVITAK, Aleta, FINSTAD, Jennifer, BROMBACH, Ann, SPRANDEL, Ann, HANSON, Leah, DULANEY, Sarah a POSSIN, Katherine, 2023. *Implementation and Review of the Care Ecosystem in an Integrated Healthcare System* online. In Review. [Cit 10 február 2023].

102. ROULEAU, K., ALBEIK, S., SHAH, S. M., YAKUBU, K., SEITA, A., 2022. Integrated People-Centered Health Care: What It Is and How It's Done! V: SIDDIQI, Sameen, MATARIA, Awad, ROULEAU, Katherine D. a IQBAL, Meesha (ed.), *Making Health Systems Work in Low and Middle Income Countries*. online. 1. Cambridge University Press. pp. 368–384. [Cit 10 február 2023]. ISBN 978-1-00-921108-6.

103. RUDNICKA, E., NAPIERAŁA, P., PODFIGURNA, A., MĘCZEKALSKI, B., SMOLARCZYK, R., GRYMOWICZ, M., 2020. The World Health Organization (WHO) approach to healthy ageing. *Maturitas*. september 2020. Vol. 139, pp. 6–11. DOI 10.1016/j.maturitas.2020.05.018.

104. RUMMERY, K., MCANGUS, C., EDWARDS, A., 2021. *What works in improving gender equality: international best practice in childcare and long-term care policy*. Bristol: Policy Press. Shorts: policy et practice. ISBN 978-1-4473-3048-6.

105. SCHON, O., HEAP, J. 2018. ESPN Thematic Report on Challenges in long-term care Sweden. Directorate-General for Employment, Social Affairs and Inclusion. Available online: file:///C:/Users/AS/Desktop/SE_ESPN_thematic%20report%20on%20LTC.pdf

106. SELBEAK, G, HøGAET, LD. 2010. IPLOS and assessment of the need for services among home-dwelling older adults with cognitive impairment (in Norwegian). Sykehuset Innlandet HF, AFS, 2010.

107. SHAW, S., ROSEN, R., RUMBOLD, B., 2011. What Is Integrated Care? London: The Nuffield Trust, p. 23

108. SIDDIQI, S., MAṬARĪYAH, 'A., ROULEAU, K.D. a IQBAL, M. (ed.), 2022. *Making health systems work in low and middle income countries: textbook for public health practitioners*. Cambridge ; New York, NY: Cambridge University Press. ISBN 978-1-00-921109-3.

109. SIVESIND, K., AFSAR, A., BACHMANN, K. E., 2016. Transnational policy transfer over three curriculum reforms in Finland: The constructions of conditional and purposive programs (1994–2016). *European Educational Research Journal*. máj 2016. Vol. 15, no. 3, pp. 345–365. DOI 10.1177/1474904116648175.

110. ŚLUSARSKA, B., BARTOSZEK, A., KOCKA, K., DELUGA, A., CHRZAN-RODAK, A., NOWICKI, G., 2019. Quality of life predictors in informal caregivers of older adults with a functional performance deficit – an example of home care in Poland. *Clinical Interventions in Aging*. 2019. Vol. 14, pp. 889–903. DOI 10.2147/CIA.S191984.

111. ŠOLCOVÁ, J., ALMÁŠI, M., IVANOVÁ, D., SUJOVÁ, A., SIEKELOVÁ, M. (2020). Theory of social work. Banska Bystrica: Belianum.

112. SØREN V., VALENTIN, J.B., VIDEBECH, P., MAINZ, J., JOHNSEN, S. P. 2022. Inequities in Mental Health Care Quality and Clinical Outcomes Among Inpatients with Depression Within a Tax-Financed Universal Health Care System. *Clinical Epidemiology*. Vol. Volume 14, pp. 803–813. DOI 10.2147/CLEP.S322392.

113. SPASOVA, S. et al., 2018. *Challenges in long-term care in Europe.* In: Eurohealth, 24 (4), 7 - 12. World Health Organization. Regional Office for Europe. [cit. 2022-10-30]. Available online: https://apps.who.int/iris/handle/10665/332533

114. STALLARD, E. 2017. Long Term Care for Aging Populations. International Encyclopedia of Public Health 7: 447–58.

115. Statistical Office of the Slovak Republic, 2019. Statistical Yearbook of the Slovak Republic 2019. Available online: file:///C:/Users/AS/AppData/Local/Temp/Temp1_Statisticka_rocenka_SR_2019.zip/Statisticka_rocenka_SR_2019.pdf

116. Statistical Office of the Slovak Republic, 2020. Employment rate by sex. Available online: https://datacube.statistics.sk/#!/view/en/VBD_SK_WIN/eu0010re/v_eu0010re_00_00_00_en

117. Statistics Norway, 2016. Sjukeheimar, heimetenester og andre omsorgstenester. Available online: https://www.ssb.no/helse/statistikker/pleie

118. STOOP, A., LETTE, M., AMBUGO, E., GADSBY, E., GOODWIN, N., MACINNES, J., MINKMAN, M., et.al. 2020. Improving Person-Centredness in Integrated Care for Older People: Experiences from Thirteen Integrated Care Sites in Europe. *International Journal of Integrated Care*. 26 jún 2020. Vol. 20, no. 2, pp. 16. DOI 10.5334/ijic.5427.

119. STRUIJS, J.N., DREWES, H., HEIJINK, R. BAAN, C.A., 2015. How to evaluate population management? Transforming the Care Continuum Alliance population health guide toward a broadly applicable analytical framework. *Health Policy*. apríl 2015. Vol. 119, no. 4, pp. 522–529. DOI 10.1016/j.healthpol.2014.12.003.

120. TAKEDA, C., GUYONNET, S., SUMI, Y., VELLAS, B. a ARAUJO DE CARVALHO, I., 2020. Integrated care for older people and the implementation in the inspires care cohort. *The Journal of Prevention of Alzheimer's Disease*. 2020. pp. 1–5. DOI 10.14283/jpad.2020.8.

121. The 2012 Ageing Report: Economic and budgetary projections for the 27 EU Member States (2010-2060). European Economy 2. May 2012. Brussels. Available online: https://ec.europa.eu/economy_finance/publications/european_economy/2012/pdf/ee-2012-2_en.pdf

122. The 2021 Ageing Report, Underlying Assumptions & Projection Methodologies, EC, 2020. Available online: https://economy-finance.ec.europa.eu/system/files/2021-10/ip148_en.pdf

123. The European Pillar of Social Rights - European Commission. 2017. Building a fairer and more inclusive European Union. Available online: https://commission.europa.eu/strategy-and-policy/priorities-2019-2024/economy-works-people/jobs-growth-and-investment/european-pillar-social-rights_en

124. The Merriam-Webster Dictionary, New Edition, 2022. Copyright, Mass-Market Paperback Mass Market Paperback – October 25, 2022. 960 p. ISBN-10-0877790957

125. The Organisation for Economic Co-Operation and Development. 2011. Public Long-Term Care Financing Arrangements in OECD Countries. Available online: https://outlook.office.com/mail/deeplink?popoutv2=1&version=20211101003.13

126. THISTLETHWAITE, J.E., FORMAN, D., MATTHEWS, L.R., ROGERS, GD., STEKETEE, C. YASSINE, T., 2014. Competencies and Frameworks in Interprofessional Education: A Comparative Analysis. *Academic Medicine*. jún 2014. Vol. 89, no. 6, pp. 869–875. DOI 10.1097/ACM.0000000000000249.

127. TRUKESCHITZ, B., ÖSTERLE, A., SCHNEIDER, U. 2022. Austria's Long-Term Care System: Challenges and Policy Responses. *Journal of Long Term Care*. 24 marec 2022. pp. 88–101. DOI 10.31389/jltc.112.

128. VAN HOUTVEN, C. H., NORTON, E. C., 2004. Informal care and health care use of older adults. *Journal of Health Economics*. november 2004. Vol. 23, no. 6, pp. 1159–1180. DOI 10.1016/j.jhealeco.2004.04.008.

129. VAN LANCKER, W., VAN DEN HEEDE, A., 2021. Economic Equality and the Welfare State. V: LEVRAU, François a CLYCQ, Noel (ed.), *Equality*. online. Cham: Springer International Publishing. pp. 199–230. [Cit 10-2-2023]. ISBN 978-3-030-54309-9.

130. VANO, B., 2015. Editorial. Slovak statistics and demography 2015; 25 (3): p. 1-4.

131. WERGELAND, JN., SELBÆK, G., BERGH, S., SOEDERHAMN, U. KIRKEVOLD, Ø., 2015. Predictors for Nursing Home Admission and Death among Community-Dwelling People 70 Years and Older Who Receive Domiciliary Care. *Dementia and Geriatric Cognitive Disorders Extra*. 4 september 2015. Vol. 5, no. 3, pp. 320–329. DOI 10.1159/000437382.

132. WHO report. 2016. Framework on integrated, people-centred health services: report by the Secretariat. Geneva: World Health Organization; 2016 (A69/39; https://apps.who.int/gb/ebwha/pdf_fles/WHA69/A69_39-en.pdf

133. WHO, 2015. World report on ageing and health. World Health Organization. https://apps.who.int/iris/handle/10665/186463

134. WHO, 2016. Global strategy on integrated people-centred health services 2016-2026. [cit. 2022-11-18]. Available online: https://apps.who.int/iris/handle/10665/258981

135. WHO, 2017. Integrated care for older people: guidelines on community-level interventions to manage declines in intrinsic capacity. Geneva: World Health Organization; 2017 https://apps.who.int/iris/bitstream/handle/10665/258981/9789241550109-eng.pdf.

136. WHO, 2019. Integrated care for older people (ICOPE) implementation framework: guidance for systems and services. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO https://www.who.int/publications/i/item/9789241515993

137. WHO, 2021. "*World Health Organization Global Report on Ageism*", 18 March 2021, Geneve. Available online: https://www.who.int/teams/social-determinants-of-health/demographic-change and-healthy-ageing/combatting-ageism/global-report-on-ageism

138. WHO. 2007. Global age-friendly cities: a guide. World Health Organization. Available online: https://apps.who.int/iris/handle/10665/43755

139. WHO. 2017. Global strategy and action plan on ageing and health. P. 24. [cit. 2022-10-17]. Available online: https://www.who.int/ageing/WHO-GSAP-2017.pdf.

140. WODCHIS, W., BURAU, V., TENBENSEL, T., BRETON, M., GOLDHAR, J., 2018. Implementing integrated Care for Older Adults with Complex Health needs: iCOACH. An international network discussion. *International Journal of Integrated Care*. 23 október 2018. Vol. 18, no. s2, pp. 64. DOI 10.5334/ijic.s2064.

141. WORLD BANK, 2020. *Integrated Older adults Care Model for the South Gemer FunctionalGrouping of Municipalities*. FINAL REPORT PHASE 1. Slovakia Catching-upRegions Initiative. International Bank for Reconstruction and Development / The World Bank, Washington DC'

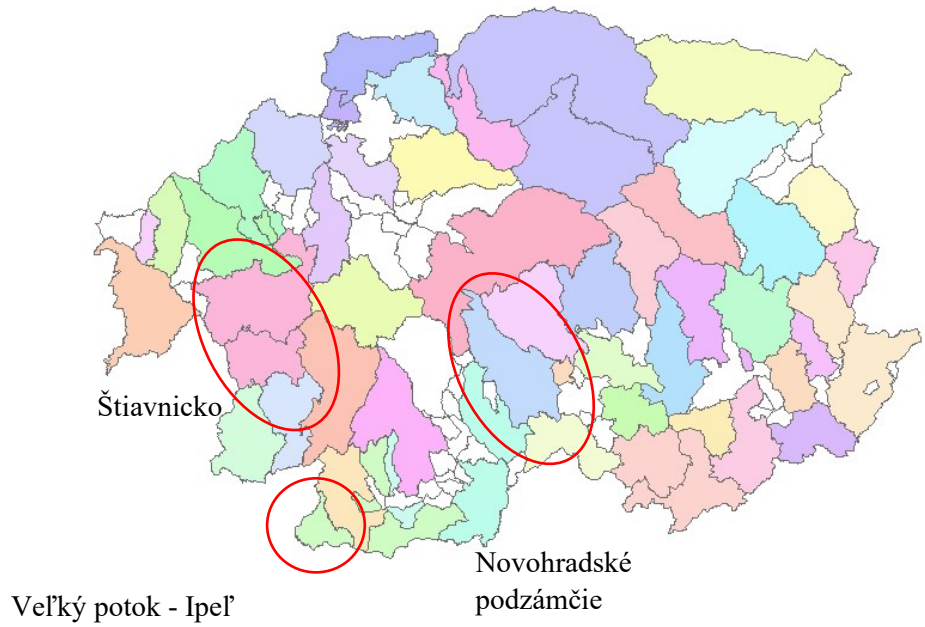
142. YARU ZHOU, L. M., 2022. Intrinsic Capacity in Older Adults: Recent Advances. Aging and disease. 2022, 13(2): pp. 353-359. DOI 10.14336/AD.2021.0818

143. ZIGANTE, V., 2018. Informal Care in Europe. ExploringFormalisation, Availability and Quality. European Commision.London School of Economics and Political Science. [online][cit. 2021-03-09]. Available online: https://ec.europa.eu/social/BlobServlet?docId=19681&langId=en

APENDIX

Banská Bystrica Self-governing region on the map of the Slovak Republic

The selected regions on the map of Banská Bystrica Self-governing region



Authors: PhDr. Andrea Seberíni, Ph.D.
Doc. PhDr. Miroslava Tokovská, PhD.
Ing. Anna Vallušová, PhD.

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Andrea Seberíni is an Assistant Professor at the Department of Economics, Faculty of Economics, Matej Bel University in Banská Bystrica. In her scientific research and publishing activities she focuses on the field of psychology, psychological aspects of organization, management and market, as well as the field of social services and social innovation. In practice, she has worked as a social-health worker in a medical institution, a lecturer in the field of social services and currently acts as a guarantor of social services in a charity institution in Banská Bystrica. She participates in domestic and international projects at the Faculty of Economics of the University of Medical Sciences in cooperation with the Banská Bystrica Self-Governing Region and Kristiania University College in Oslo, Norway.

Miroslava Tokovska is an Associate Professor at the School of Health Sciences at Kristiania University College in Oslo, Norway. She teaches both Applied Public Health Sciences and Basic Medicine to graduate students and Lifestyle Change and Public Health to undergraduate students. Her research is focused on qualitative methods, especially in the elderly population, public health, health promotion, migrants and mental health, non-pharmacological treatment of dementia, health literacy, social support and relatives. Miroslava collaborates with Matej Bel University within research activities focusing on social work, smart active ageing and health promotion for persons with dementia.

Anna Vallušová is an Assistant Professor at the Faculty of Economics of Matej Bel University. In her research, she focuses on changes in the labour market resulting from digitalization processes, with an emphasis on the specifics of Central and Eastern Europe. Currently, she is responsible for a research project focused on digital inequality and its implications for the HR management. She is the author of publications dealing with inequality issues, the specificities of HR management in the Central European region and corporate social responsibility. She is also working on a project for the Banská Bystrica Self-Governing Region aimed at redesigning social services for the elderly.

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