SLOVAKIA CATCHING-UP REGIONS

INTEGRATED ELDERLY CARE MODEL FOR THE SOUTH GEMER FUNCTIONAL GROUPING OF MUNICIPALITIES

European Commission
BANSKOBYSTRICKÝ SAMOSPRÁVNY KRAJ
MINISTRY OF INVESTMENTS, REGIONAL DEVELOPMENT AND INFORMATIZATION OF THE SLOVAK REPUBLIC
WORLD BANK GROUP

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ACRONYMS AND ABBREVIATIONS

ADOS	Health Nursing Care Agency (Agentúra domácej ošetrovateľskej služby)
BBSK	Banska Bytrica Self-governing Region
BoP	Board of Partnership
CuRI	Catching-up Regions Initiative
DHO	Dependence on the Help of Others
DOS	Health Nursing Home (domáca opatrovateľská služba)
ERDF	European Regional Development Fund
ESIF	European Structural and Investment Funds
FG	Functional Grouping—refers to the group of municipalities considered for the pilot on elderly care and to the one finally selected. The selected pilot FG is referred to as South Gemer FG.
HCSA	Health Care Surveillance Authority
HCSP	Health Care Service Provider
HIF	Health Insurance Fund
ICC	Integrated Care Center
IHCC/CIZS	Integrated Health Care Center (Centrum integrovanej zdravotnej starostlivosti)
ICT	Information Communication Technology
IPG	Integration Process Guidelines
IROP	Integrated Regional Operational Program
LAG	Local Action Group
LTC	Long-term care
MoH	Ministry of Health
NCZI	National Center for Health Information
NGO	Nongovernmental Organization
NPO	Nonprofit Organization
OECD	Organisation for Economic Co-operation and Development
PHA	Public Health Authority
RPHA	Regional Public Health Authority
ŠDTP	Standard Diagnostic and Therapeutic Guidelines
SGR	Self-governing Region
SIDC	State Institute of Drug Control
VšZP	General Health Insurance Company (Všeobecná zdravotná poisťovňa)
WHO	World Health Organization
ZSS	Social Service Facility (Zariadenie sociálnych služieb)

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EXECUTIVE SUMMARY

Elderly care is an area of growing importance for the Slovak Republic. The world population is aging, and the Slovak Republic's population is aging particularly rapidly. The share of people above 65 in the Slovak Republic is expected to double, and the portion of the population over 80 to quadruple by 2060.[1] This presents a substantial challenge for the social and health care systems. As the share of the population relying on these services will keep increasing, the demand and the importance of this sector will grow, while the resources available to this sector may become constrained by the shrinking share of the working-age population. Thus, it is critical to start improving the provision of elderly care to achieve better wellness for the population, as well as financial sustainability.

The national system for health and social care does not offer a framework of integrated elderly care provision. However, there are examples of care integration at the local level. The national system can be predominantly defined by fragmentation. National legislation offers no framework for the integration of health and social care, and financing of these two related services is provided and regulated separately. While the integration of these services is not enabled by the national legislation, it is broadly considered the gold standard for elderly care provision. Another issue comes from the fact that in the Slovak Republic a lot of responsibility for social services, which includes most of the services for the seniors, rests with the municipal governments. Yet, because most municipalities in the Slovak Republic have a population under 1,000[2], they lack the financial and human resource capacity to fulfill these obligations. However, the opportunity to achieve person-centered integrated elderly care exists at the local level in the Slovak Republic. While support for care integration is lacking at the national level, a number of providers have shown that it is possible to overcome the system's fragmentation and ensure better care for the elderly.

The Catching-up Regions Initiative (CuRI) of the World Bank (WB) and the European Commission (EC) is proposing a model for integrated elderly provision in a pilot area of in the Banská Bystrica Region. This report presents a model of integrated elderly care that was developed as a joint effort of the WB and the BBSK in October 2019–October 2020. The ambition of the model and its pilot is, first of all, to improve the experience of the elderly in the pilot area. However, it also aims to lay the foundations for improving elderly care nationwide, either through producing lessons that will inform national-level reform, or through the replication and scaling up of the model in other areas across the country. The South Gemer functional grouping of municipalities (South Gemer FG) was selected as a pilot through a rigorous screening and consultation process. The proposed model is entirely in line with the existing legislation of the Slovak Republic. The changes to the national system and legislation that could simplify integration of care are provided in this report as preliminary proposals.

The proposed model will seek to improve the experience of the elderly, while also offering a financially and institutionally sustainable way of providing elderly care. The main goal of the model is to improve the quality and access to elderly care. For this reason, it is based on the principles of integrated person-centered care offered at the communal level. The model is also mindful of organizational and financial considerations that are critical to ensure the long-term sustainability of care provision. The model suggests that if a group of municipalities pool their resources and capacities to organize a joint elderly care provision system, all the additional costs of the proposed model can be covered through local government contributions, with the potential support of the regional authorities, as well as support from European Union (EU) funds during the establishment phase. This approach also indicates that the scale and ambition of the model can be adjusted to match the resources available without losing its essential components.

The proposal presented in this report covers four components of the new elderly care model: service provision, governance, operation process, and financing. All the components focus on the specific circumstances and needs of the South Gemer FG. The Service Model points out services that are missing in the area and recommends options for improving provision. The Governance Model proposes the institutional structure for implementing the model, while the Process Model focuses on the activities and functions that need to be fulfilled in order to bring the new model to life. Finally, the Financing Model discusses how the operation and investment costs of the model can be covered.

The central proposal of the model is to establish the Integrated Elderly Care Agency in South Gemer FG (hereafter referred to as 'the Agency'). The Agency will be governed by a partnership of the municipalities that will elect its executive board and will focus on providing a number of additional services to the existing care providers and population, and on evaluating and supporting the improvement of the existing services—for example, through mainstreaming a person-centered approach and case management practices, developing new services, and maintaining a communication platform for stakeholders and the population. The proposed entity will not replace any of the existing care providers, rather, it will act as an addition to the current system, aiming to provide the missing integration of services. The agency's range of activity, scale, staffing, and financing needs will depend on the specific goals and action plans that are agreed upon by the municipalities when they establish the Agency. The report presents the lists of activities recommended for the Agency. While some of the activities can be deemed essential to achieving a minimal viable level of integration, others that would achieve a level of care that meets all the criteria of integration, would be desirable but are less critical.

The integration of elderly care and the development of a new care provision system will be a gradual process and will require adjustments. Time and substantial capacity from the Integrated Elderly Care Agency will be needed to fulfill the full scope of actions desired to achieve the full integration of care and a full transition to person-centered care. It is expected that in the pilot area of South Gemer FG, this transition will take one to three years. It is critical that a balance is maintained during this transition period between the commitment to improve the quality of care and to ensure the sustainability of the new system, while the relevant lessons for scaling up of the model are learned.

While it is expected that the model will be financially self-sufficient in the future, it is recommended that EU financing is mobilized to support the operation of the Agency in the establishment phase, as well as the necessary infrastructure improvements. The proposed model of elderly care presents an important innovation, that may unlock opportunities for highly impactful reform in a policy area of critical importance for the EU. This is why it is recommended that EU funds support the pilot. The report includes a specific proposal and estimates relating to the operating costs of the Agency and the health and social care infrastructure. The largest investment proposed for the model is the development of an Integrated Care Center (ICC) in Tornal'a—a project that is expected to both address the service deficiencies in the area, and act as a hub of care integration, thereby promoting and building recognition for the new, integrated way of providing elderly care in South Gemer FG.

CHAPTER 1

INTRODUCTION

The world's population is aging. The number of people over 60 years old is growing faster than in any of the younger age groups, and Europe is leading the demographic change. Based on Eurostat predictions[3], the age structure of the European population is about to change significantly within the next few decades. According to these forecasts, the Slovak Republic will be one of the countries that will see the most substantial change in the population age. While there were 23.5 people of senior age for every 100 people of working age in the Slovak Republic in 2019 (population 65 and over compared to population of 15 to 64 years), it is estimated that by 2060, the number will almost triple.[4] This will make the Slovak Republic one of the oldest states in the EU. The ratio of 65+ population in the Slovak Republic will increase from the current 16%[5] to approximately 30%. The ratio of 80+ population will rise to 12% by 2060 (now it is only 3%)[6]. Such a significant increase of the share of the elderly population assumes not only bigger health care demands but also a significant increase in long-term care demands.

The system of elderly and long-term[7] care provision in the Slovak Republic is fragmented. Care for the elderly is mostly provided within social services facilities (including outreach, outpatient, and mainly residential). The system also relies on informal care, which is supported by allowances for care givers who are mostly relatives of the elderly in need of help. In 2002–2004, a decentralization of the social services system took place. Its goal was to strengthen the autonomy and responsibility of the municipalities and self-governing regions, to secure the availability of social services that match the needs of the population. After almost 14 years of attempts to build a system that achieves greater effectiveness and economic efficiency in the social services, as well as increased availability of care, these goals have still not been met. The current legislation puts a greater share of social care responsibilities on municipalities. Yet they are not well positioned to fulfill this responsibility. There are nearly 3,000 municipalities in the Slovak Republic, most of which are inhabited by several hundred people (65.05% of municipalities have less than 1,000 inhabitants[8]). The municipalities lack the trained personnel, equipment, infrastructure, and financial resources to provide appropriate senior care for their populations.

As regional governments step in to support the municipalities in providing care, the care provision moves further away from the communities. Because the municipalities are unable to provide sufficient social and health care services for the elderly, the regions try to step in with their providers to address the service gaps. However, such help is usually limited to a residential care model (for example, retirement homes). As a result, despite the long-term effort and the declaration of support for community-based services as a national priority, residential institutional care still predominates in the Slovak Republic.

The national legislative framework creates barriers for social and health care integration. Unfortunately, the efforts to create a legislative framework for long-term health and social care have not yet been successful. The negative consequences of this legislative vacuum are plentiful. For example, according to current legislation, nursing care is the only type of service (out of the four types of recognized health services) that is not fully covered by the health insurance. This has made this service, that is so important for the elderly, less affordable for the population and less attractive for providers. Another issue is that the current legislation allows the financing of social services from the health insurance funds (HIFs) only under very restrictive conditions. As a result, access to this funding is difficult and expensive for providers. Additionally, even after they have fulfilled all the conditions, the funding is rarely sufficient to provide high-quality care. For example, for a retirement home to obtain HIF funding, it needs to follow tough regulatory conditions on technical equipment, the number of professional staff with formal qualifications, and so on; yet the funding they will receive will hardly be sufficient (HIFs contribute just € 3.30/ per day/per patient). Therefore, this option is not widely used. More generally, the flaws in the legislative and financing system are to blame for the fact that there is a lack of extended-stay facilities where people can recover until they regain full self-sufficiency after an illness. The same can be said about the shortage of outreach home care services, which can support people in transitioning back to their home environment.

Elderly care provided by the family members or other nonformal caregivers, sustains the system, but comes at a high opportunity cost. Slovak legislation gives nonformal caregivers the right to social care allowance (€ 430.35 monthly for a caregiver of productive age, € 215.18 for a caregiver of retirement age). The care allowance was provided to 57,048 people taking care of their family members with severe disabilities (including seniors) in 2019. The total amount of payments totaled at € 230.9 million[9]. Almost half of the nonformal caregivers (receivers of care allowance) are still of a productive age, and their absence from the labor market is a loss to themselves and to society.

The health services most relevant to the elderly are often insufficient, particularly in remote locations. Long-term care (LTC) in the Slovak Republic suffers from underfunding, which is the reason for the insufficient availability of these services. LTC is further undermined by the difficulty of integrating it with social care, which is critical for these types of service. Home-based health care is provided mainly through nurse and home physician visits, but they are not an obligatory service for general practitioners (GPs) to perform, which often results in limited access to the most basic health care for the elderly.

To improve the quality of elderly care and ensure that it matches the needs of the population, while also overcoming the challenges of systemic fragmentation and avoiding huge opportunity costs, the Slovak Republic should move toward the integration of care. The integration of care is widely recognized as an approach which would help address the typical challenges of the Slovak Republic's health and social system: fragmentation, overspecialization, discontinuity of care, the dominance of the institutional model of care provision, focus on the treatment of acute conditions rather than prevention, and so on. It 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, by shifting from acute to preventive care and helping people to retain self-sufficiency. The World Health Organization (WHO) defines integrated care in the following manner: *"Integrated health services delivery is defined as an approach to strengthen people-centered 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. It should be effectively managed to ensure optimal outcomes and the appropriate use of resources based on the best available evidence, with feedback loops to continuously improve performance and to tackle upstream causes of ill health and to promote well-being through intersectoral and multisectoral actions."*[10]

While the national legislation needed to initiate the top-down development of integrated care has still not been passed, the current system does allow for the integration of care at the local level. Even though the individual municipalities do not have the capacity to tackle challenges of care provision, municipalities can and should unite to jointly manage senior care. On the one hand, this approach will allow for the provision of care that meets the needs of population and is woven into the fabric of the local communities. On the other hand, by combining the resources of municipalities, it will provide them with the greater capacity needed to ensure high-quality care provision and enable them to reach a scale (from the population standpoint) that makes care provision economically and logistically more efficient.

The Banská Bystrica Self-governing Region (BBSK) faces the many challenges described above, but, at the same time, it has an opportunity to lead the Slovak Republic in improving the quality of elderly care. The BBSK is among the fastest aging regions in the Slovak Republic. In 2019, the aging index (number of persons older than 65 per 100 people aged 14 or under) in the Slovak Republic was 104.80, but in the Banská Bystrica Region it reached 119.[11] This population structure is the result of the rapid outmigration of the young population (in childrearing age) in search of greater professional opportunities. The demand for health and social services is particularly hard to meet in the most rural, remote parts of the region, which suffer from the highest levels of outmigration. These are usually also the areas where municipalities lack capacity. There are 516 municipalities in the BBSK (including 24 towns); 405 of the municipalities[12] have less than 1,000 inhabitants[13], and the average population density is only 68 people per square kilometer (km^2)[14]. Such small administrative units struggle to fulfil their service delivery responsibilities. For all of these reasons, the development of the new integrated elderly care model for remote areas was selected as a priority for the collaboration between the European Commission (EC), the Ministry of Investments, Regional Development, and Informatization of the Slovak Republic, the World Bank (WB), and local stakeholders, in the framework of the Catching-up Regions Initiative (CuRI).

This report presents a proposal for the development of an integrated elderly care model in the southern Gemer area of the BBSK. The model of integrated elderly care provision was developed as a joint effort of the World Bank and the BBSK in October 2019–October 2020. The southern Gemer area was selected as a pilot through a rigorous screening and consultation process. The proposed model is entirely in line with the existing legislation of the Slovak Republic. This report provides the framework of the model, a description of its main parameters, and the action plan for its implementation. It is estimated that the model's implementation can be achieved in the target area within two to three years, conditional on the establishment of a productive partnership between the municipalities, as well as the necessary organizational and financial support in the initial stages from the BBSK, national authorities, and the European Commission.

This report reflects the results of the first phase of the Catching-up Regions Initiative to create an integrated elderly care model for the Banská Bystrica Region of the Slovak Republic. While the first year of joint work has targeted the model's development, the second phase of this project will aim to support the implementation of the elderly care model and its potential scale-up in other areas.

CHAPTER 2

KEY PRINCIPLES OF, AND LESSONS FOR, DEVELOPING AN INTEGRATED ELDERLY CARE MODEL IN THE SLOVAK REPUBLIC

The development of an integrated care model for a given area requires a primary understanding of the key parameters of the national social and health care systems. The ambition of this exercise is to propose an elderly care model that would be implementable at the local level, with limited support from the other levels of government (regional, and national levels). However, a basic assumption of this exercise is that the national, legal, and organizational framework for senior care will remain constant. The currently discussed reforms may simplify the implementation of models, including the integrated care model presented in this report. But given the past record of failed reforms in the sector, to make the proposal the most realistic possible, no changes to the national system were taken into account. Thus, it is critical to account for the key characteristics of the existing national framework.

This section presents the summary of a more detailed review of the Slovak social and health care systems, as well as international best practices. The longer version of the overview is available as a background paper to this report.[15] At the end of the section, key characteristics of the systems, as well as the central lessons learned from international best practices are summarized, and the crucial principles for the development of the new model of care provision are formulated.

SECTION 2.1

THE SOCIAL CARE SYSTEM IN THE SLOVAK REPUBLIC

Overall, the Slovak social care system is defined by decentralization, and reliance on a mix of public, private, and family (or nonformal) care. The social care system in the Slovak Republic consists of two main parts. The first includes social services provided by professional staff. The second covers financial allowance to individuals with disabilities, or their close family members who take care of them. The system of social services in the Slovak Republic is regulated by the Social Services Act No. 448/2008 Coll. This act regulates legal relations in the provision of social services, likewise their financing, monitoring, and the control of their provision. The provision of social legislation defines the conditions for the provision of formal social care and recognizes the social services as professional activities, care activities, and other activities, or a set of them. There are public and nonpublic (private) social service providers. Public providers are established and financed by the municipalities or self-governing regions[16]. Nonpublic providers are established by NGOs or churches, and they are financed partially from the state budget, and from municipal or self-governing region budgets. Some providers of social services are also supported by European Structural and Investment Funds (ESIF) (for seniors, there is relevant support for home care services). The main difference between providers depends on their financing and access to public funds.

In the Slovak Republic, there are many types and forms of social services. The types of social services are defined based on the target group to which support is offered. They are divided into five main categories:

- Social crisis intervention services include the field social crisis intervention service and provision of social services in facilities (for example, low-threshold daily centers, integration centers, community centers, overnight shelters, shelters, halfway houses, low-threshold social services for children and family, safe-house facilities).
- Social services to support families with children include assistance in the personal care of children, assistance in the personal care of a child in a temporary childcare facility, services to promote reconciliation of family and working life, services to promote the reconciliation of family life and working life in the institutional care for children under three years of age, and early intervention service.
- Social services for dealing with an unfavorable social situation due to severe disability, unfavorable health condition, or retirement age include (for example, supported housing facility, retirement home, nursing home, rehabilitation center, social services home, specialized facility, day care center[17], mediation of personal assistance, and others).

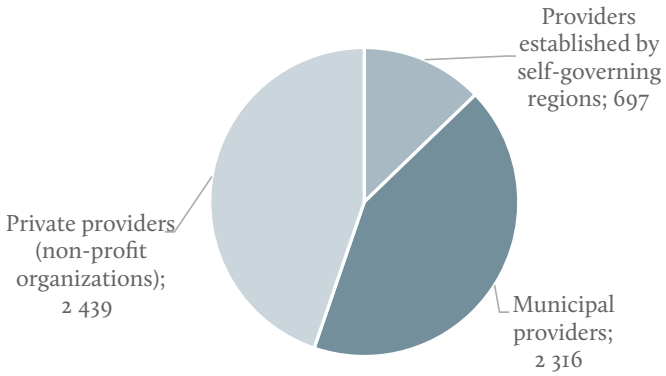
- Social services using telecommunications technology include monitoring and emergency response devices, and the crisis assistance provided through telecommunications technologies.
- Support services include respite services, assistance in safeguarding custody rights and obligations, daily centers, support for independent housing, canteen, launderette, and personal hygiene centers.

The forms of social service provision available in the Slovak Republic include:

- Outpatient forms – provided to an individual who is coming alone, or is accompanied, or is transported to the place of supply of the social services
- Outreach forms – provided to an individual through field/home programs designed to prevent the social exclusion of that person, family, or community in an unfavorable social situation
- Residential forms – provided in residential social services facilities and include accommodation
- Remote Information Communication Technology (ICT), an technology enabled, remote form of social service provision

Key statistics of social care show the dominance of residential care, and the importance of regions and municipalities as organizers of care provision. According to the *Report on the Social Situation of the Population of the Slovak Republic for 2019*, there were 5,452 social service providers registered in the Slovak Republic (*Figure 1)* offers a breakdown of providers by ownership type. Of all providers, 62.12% offer social services conditional on an assessment of dependence on the help of others (hereafter, 'DHO services/facilities'). There are almost 55,994 users of these services (one percent of the total population of the Slovak Republic). There were 45,702 users who received care in specialized facilities (retirement homes, social services homes, specialized facilities, day care centers, supported housing, rehabilitation centers, nursing homes), and 16,124 who benefited from home care service. The residential form of care provision is still prevalent—64.17% of users are in residential care, 10.5% use outpatient forms of the services, and 25.33% are clients of outreach forms of social services.[18] More details about the types and forms of social services are provided in the first chapter of the background note to this report.

FIGURE 1. Social Care Providers by Ownership



Source: The Report on the Social Situation of Inhabitants in the Slovak Republic in 2019 (2020). Ministry of Labor, Social Affairs and Family of the Slovak Republic.

The dominance of residential care has multiple negative impacts on the availability and efficiency of care. The provision of social services and elderly care in the Slovak Republic is primarily provided through residential social services that are more focused on care for people in acute situations and difficult circumstances than on preventive and community support. This results in ineffective care offering. On one hand, it pushes people towards a more expensive type of care, while underinvesting in prevention. On the other hand, it directs users to institutions usually far away from the community where they live, and thus makes for a less enjoyable experience, particularly for the elderly.

Social services are decentralized, and the system of financing is extremely complicated. The Ministry of Labor, Social Affairs and Family of the Slovak Republic provides national budget funding for selected services according to the Social Service Act. However, for certain services, users should cover at least part of the cost themselves (using their pension, own saving, or the help of family members). The highest user co-financing is required for retirement homes, specialized facilities, homes of social services, and nursing homes. For some of the social services, there is no guarantee of state financing (this specifically refers to community-based services for crisis intervention or support services). As a result, these services suffer from poor availability. European funds support is provided for home care services; however, the current utilization of this funding does not solve the issue. In November 2020, the Supreme Audit Office of the Slovak Republic published a report on home care service which points out that European sources were used only for the caregivers' salaries, thus the Slovak Republic still misses the opportunity to leverage the funding to start the systemic reform of care.[19] Fundamentally, the system of financing social care by the state conflicts with the philosophy of elderly care development proposed by the current legislation. While priority should be given to community and ambulatory services, the current funding gives greater support to residential/institutional care. Under the current system, the burden of financially supporting community and home care often falls on municipalities, yet this is often unfeasible for the smallest of them.

One of the biggest issues in the Slovak Republic regarding social care provision is the shortage of trained professionals. Almost every social provider in the Slovak Republic reports the shortage of professional care workers, such as nurses, caregivers, and social workers, or the pre-retirement age of employees. The main reasons causing this situation are the low salaries of the local social services employees, and better financial conditions and opportunities in other countries such as Austria, Switzerland, and the Netherlands.

Overall, the social care system in the Slovak Republic is complicated and fragmented. The reason for this situation is a complicated system of funding for social services, and an unequal spatial distribution of people in need of social care. Formal legislation supports a subsidiarity principle, which means that the 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 the current system, the institutional form of social services are better funded than the community-based services. Municipalities do not have sufficient resources to provide care at the community level, so they resort to recommending citizens to use a regional institutional social care infrastructure, even if they do not need such a level of care, and even if it forces them to leave their communities. Most of the capacity for care provision is concentrated in the institutional care facilities of the self-governing regions and private providers. Moreover, most of the social service providers who deliver community-based services are private providers, while public provision of such services is limited.

SECTION 2.2

THE HEALTH CARE SYSTEM IN THE SLOVAK REPUBLIC

The health characteristics of the Slovak population have been improving, but challenges still remain. Life expectancy at birth was 77.4 years in 2018, four years more than in 2000, but still nearly four years below the EU average (81 years)[20]. Slovak women live about seven years longer than men. The gap in socioeconomic status is even greater: the most educated men live 14 years longer than the least educated. The life expectancy of men and women at age 65 has increased substantially since 2000, but many years of life after that age are spent with chronic diseases and disabilities. Preventable and treatable causes of mortality in the Slovak Republic are among the highest in the EU. Avoidable hospital admissions are also far above the EU average. The general increase in life expectancy is partly linked to gains in longevity among older people. In 2017, Slovaks aged 65 could expect to live an additional 17.4 years, 2.4 years more than in 2000.

Health care spending in the Slovak Republic is far behind the rest of the EU. In 2019, the Slovak Republic spent $ 2,353.6[21] per person on health (adjusted for differences in purchasing power), which is over 40% below the EU average. Despite a substantial increase, in absolute terms, over the past decade, health expenditure as a share of GDP has remained stable, accounting for 6.9% of GDP in 2019[22]—a much lower share than the EU average of 9.8%. In 2018, the Slovak Republic had a physician density close to the EU average (3.5 physicians per 1,000 population versus 3.6)[23], but the number of nurses was below the EU average. The country is one of the few reporting a reduction in the number of nurses between 2000 and 2018[24].

The Slovak health care system is characterized by compulsory public health insurance for all residents. It provides them (almost) full and universal health risk coverage. Health care service providers (HCSP) are contracted and paid by the health insurance funds (HIFs), based on a recurring short-term contract. There are three HIFs operating in the Slovak Republic. The largest one is publicly owned and covers approximately 67% of the population; the other two are privately owned. All types of HIFs and health care service providers ownership are treated equally. Inpatient acute care services are dominated by publicly owned universities or teaching hospitals, many of which hold large long-term debts and suffer regular losses. Other small or midsize hospitals usually balance at the edge of profitability. Specialized institutes maintained by the state (cardiology and oncology) are profitable, due to the good reimbursement level from the HIFs, and cheap investment capital provided by the government. Still, overall, there is a high fragmentation of the service providers, and real integration of care is lacking at the national level.

The model of financing services is one of the factors making the provision of health services in more remote areas complicated. The industry, as a whole, is experiencing a shortage of qualified professionals due to an array of reasons: aging physicians, poor working conditions (including low income, heavy workloads leading to burnout, and so on). Some services are disappearing from the periphery and less attractive regions, which can reflect the way services are funded. General practitioners (GPs) are paid in proportion to the patients they serve, and, to a lesser extent, by output-based payment for performance. Ambulatory specialist service providers are reimbursed by procedure, with a monthly limit. Hospitals are paid for hospitalization cases based on a confirmed diagnosis, although the system is changing toward diagnosis-related groups (DRGs)—the German version (a pricing system setting prices for medical procedures and hospital services depending on the type of medical condition, paid by the HIF based on public health insurance.)[25] While it is not clear whether or when DRG will be implemented in full, and how it will impact the system, current situations are not conducive to maintaining services in some of the areas that need them the most.

All health care services, including those that are most relevant for the elderly, are defined in the basic benefit package and covered by mandatory public health insurance. The eligibility criteria for the service provision are purely medical indications (there is a medical problem identified by the physician, where diagnostics or therapy is necessary). The coverage of the basic benefit

package is very broadly defined and covers almost all diseases. However, the financial limits provided by the HIF, as well as the limited capacity of the providers, may restrict the availability of the services. Moreover, there are no specific benefit packages for the elderly.

The system of reimbursing the cost of services is extremely complicated. For example, nonmedical services related to ethe provision of health care (for example, meals, bed days, accompanied person's stay, transport services, spa treatment, and so on) are covered by the public health insurance only if the related health care services are also covered (in full or in part), and usually in similar proportion. Overall, the scope of health care services paid by the public health insurance is legally determined, but very confusing for the patients.

Services critical for the elderly: long-term care, palliative care, and mental health care are facing specific challenges. The long-term care (LTC) in the Slovak Republic 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 nurse visits, physician home 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 GPs to perform.

The national reform of the health care system is being considered. According to the government legislative agenda for 2020–2024, specifically in the areas related to elderly and community-based care, the Slovak government desires to introduce the innovative forms of remuneration which will support a greater efficiency and quality of outpatient clinics and regional cooperation in integrated centers. The main objectives of the reforms are to create better conditions keeping seniors integrated 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.

SECTION 2.3

INTEGRATION OF CARE IN THE SLOVAK REPUBLIC

The integration of social and health services in the Slovak Republic 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 are some small adjustments that have been made in recent years.

Current legislation provides opportunities for the integration of care. The Social Service Act recognizes nursing care in facilities as a professional activity. Nursing care should be provided or ensured in four types of social services (retirement homes, social service homes, nursing homes, and specialized facilities). Nursing, under precisely defined conditions, might be partially reimbursed by public health insurance as well. At the moment, only 64 nursing care providers out of 1,435 have signed contracts with health insurance companies. Social service providers could also be registered as health providers after fulfilling all conditions, which are rather stringent, as discussed above. This is the basis for an integration of health and social care within facilities such as retirement homes and elderly day care centers.

In the process of integration, it is also important to have a framework for cooperation and coordination between relevant stakeholders. Legislation provides an option for the legal arrangement of such a framework. A partnership is a special institution that is established by the Social Services Act. A partnership is a group of individuals and other legal entities established to implement projects or programs to prevent or mitigate people's unfavorable social situations or to solve these situations and to support community work projects and programs. Members of the partnership may include municipalities, self-governing regions, labor offices, community representatives, but also other legal entities and individuals. The partnership is established based on a written agreement/contract, which defines the partnership members, the start date of the partnership, the duration of the partnership, the purpose of the partnership along with the obligations of the partners, and the way of financing the project or program.

SECTION 2.4

INTERNATIONAL AND NATIONAL EXAMPLES OF BEST PRACTICE

To develop a successful integrated model of care in the Slovak Republic, it is necessary to examine the integrated care systems that exist abroad as well as the international and national examples of best practice in providing elderly care. This section presents a series of examples of the elderly care provision system, and highlights some of the key features that could be replicated. More in-depth discussion of these examples is provided in the background paper.

The internationally recognized model of integrated care, Gesundes Kinzigtal, operates a regional integrated care system in Germany. This integrated care system is one of the few integrated care models in Germany. Its main philosophy is to create and maintain a healthy population on a regional scale. Gesundes Kinzigtal currently works with more than 260 institutions and organizations, including physician practices, hospitals, nursing homes, local municipalities, and local small and medium enterprises. Company providers are encouraged to recognize patients who are at risk for certain diseases to enroll them in suitable health programs. The intervention of Gesundes Kinzigtal includes about 20 preventive health programs for specific conditions. The primary goal is to improve patients' overall health and the quality of their lives. There are 10,000 patients actively enrolled in specific care programs. The integrated care applied in Gesundes Kinzigtal appears to be a promising approach to achieve the twofold goal of a significant population health gain and substantive comparative savings in relation to more traditional forms of care. Similar integrated care projects are being developed in several parts of Germany. These initiatives might develop into a role model for large parts of the German health service system.

A different example of best practice in providing elderly care on the municipal level is offered by De Weister Residential Care Center in Aalbeke, Belgium. This model is based on providing services in the home residential social care facilities, grounded on small-scale normalized living. For instance, the De Weister Residential Care Center consists of 46 residential units spread over three residential houses in Aalbeke, Belgium. Two of these houses are intended for seniors with dementia; a third house offers a home for seniors who require physical care. The De Weister residential care center creates a safe and calm atmosphere with attention to the 'ordinary' things in life. It was designed with a sense of living in small living groups, attempting to re-create the feeling of life at home. Since December 2012, this center has operated according to the principles of small-scale normalized living. Moreover, Aalbeke has been recognized as a dementia-friendly municipality.

Models of elderly care from the Czech Republic offer examples of prioritizing residential, semi-residential, and community-based service provision to institutional care. The Czech Christian nonprofit organization, Slezská Diakonie, provides high-quality services and focuses on implementing best practices through international cooperation, and ensuring that high-quality management services are centered on community-based support, through personal assistance and

respite care. Moreover, the main goal is to educate caregivers to provide suitable care for both the physical and psychological aspects of people in need. This support is based on multidisciplinary and suitable care in the home environment.

Slovak Republic offers some best practice examples as well. Dom Rafael in Bratislava gives options of long-term and short-term nursing stays with health services hospice care for elderly people. Dom Rafael is one of the few service providers in the Slovak Republic with registered health and social services under one umbrella. It has qualified medical and social staff. Dom Rafael is financed from public health insurance, public funds from regional government, funds from the Ministry of Labor, Social Affairs and Family, and also from the users' payments. MEMORY Center , another example of good practice, provides specialized outpatient services for elderly people in the Slovak Republic and has integrated health and social services since 2002. The integration of outpatient health and social services leads to the comprehensive support of people with dementia and Alzheimer disease, and their families. It has multisource funding from the regional governments, Ministry of Labor, Social Affairs and Family, and public health insurance for health services. These experiences, while not easy to replicate, demonstrate the possibility of care integration in the Slovak Republic.

Overall, the above-mentioned practical examples highlight that locally designed and managed integrated care is a strategy for continuous improvement of care. The key lessons from the presented best practices highlight the potential of locally organized and managed (at a municipal or regional level) elderly care systems. The experiences also show the critical importance of building a deep commitment and appreciation for the essential aspects of integrated care: creating an enabling environment, building common values, developing competencies for integrated care, aligning financing, human resources, facilities and equipment and other conditions, to ensure the best possible experience for the care recipients. Finally, they demonstrate that integrated elderly care provision is possible and achievable in the Slovak Republic. These findings reinforce the key principles of the model proposed in this report.

SECTION 2.5

MAIN PRINCIPLES FOR THE DEVELOPMENT OF THE INTEGRATED CARE SYSTEM

Based on the current review of health and social care systems in the Slovak Republic, the following key characteristics of the existing system need to be considered when developing the integrated senior care model.

Key characteristics of the social care system:

- The social services and care systems are decentralized toward municipalities and regions.
- The founders of social service providers are municipalities, self-governing regions, other private organizations, and nongovernmental organizations (NGOs).
- The current system offers a good spectrum of social service types and forms—outreach, outpatient, and residential services.
- According to the current legal system, the self-governing regions and municipalities are obliged to fund diverse types of services due to their legal responsibility.
- Divided responsibilities for insuring social services results in a complicated system of funding social services.
- Existing social services are not focused on preventive and community support, but on institutional care. Thus, community services in the Slovak Republic are in short supply.
- The legal framework contains person-centered standards of quality for the social services, but their monitoring system is only is only being developed.
- Municipalities and self-governing regions have an obligation to do community planning.

- The existing legal framework provides the possibility of partnership projects for the provision of social services based on the collaboration of different actors—for example, several municipalities and private providers, as well as combining several types of services.
- The key challenges include:
  - The lack of funding in the social care and services system
  - The shortage of trained professionals in social services in the Slovak Republic, specifically in less developed regions
  - The low wages of personnel in social services including allowances for nonformal care
  - The lack of integration between social and health services in the Slovak Republic

Key characteristics of the health care system:

- The payment mechanisms for health services are highly fragmented. Thus, it is very difficult for providers to manage the integration of health services and to introduce a person-centered approach, and there is very little incentive to do so. Moreover, the providers' ownership and control are highly fragmented as well. Health and social systems are not harmonized on the legislative level nor there is an integration on the level of service provision.
- A blend of publicly and privately owned providers with different governance principles is in place.
- Entities who are closest to the people locally or regionally (municipalities and self-governing regions) have almost no say in the health service provision or health sector policy at all.
- Health insurance companies do not have an obligation to offer the services to the clients if there is insufficient provider capacity in the region.
- Health promotion services and interventions (the responsibility of the Regional Public Health Authority [RPHA]) are dramatically underfinanced.
- There is a complete lack of data about the current and expected health status of the population. However, the main lack of publicly available data is found at to the level lower than self-governing regional level (districts, municipalities).
- There is no publicly available information about any significant epidemiological studies or health need assessments conducted in the country.
- The official statistics are focused on services provided or patients registered, and they are based on the statistical reporting of service providers.
- The HIFs are neither obliged, nor allowed to, provide the local and regional data to the municipalities or self-governing regions, although HIF data is the most valuable source of information about the consumption of health care services.
- LTC and other noncore health services (rehabilitation, palliative care, home care nursing, inpatient nursing, and geriatrics) are underfinanced, underdeveloped, and have low capacity, and are thus, not accessible.

From the integration of care perspective:

- There has been no systematic program of care integration and no localized effort focused on inhabitants of a specific region or catchment area in the Slovak Republic, except for investments in the integrated health care centers (supported by EU funding), which however, have failed to achieve the declared goal, and have not resulted in any substantial integration of services. Multiple reasons for the limited success of the initiative can be listed, including:
  - Lack of requirements for the integration of care in the conditions of calls
  - Replacement of the concept of integration with a less complex concept of concentration
  - Social care provision listed as nonobligatory in the condition of calls
  - Very harsh conditions and penalties for health care service providers, putting providers at high risk if they participate
  - Viable grant sizes of € 700,000 or € 900,000 which in many cases was insufficient
  - Restrictive eligibility criteria of the calls that limited the participation of regional governments and larger urban municipalities

- The successful cases of care integration refer to individual privately run facilities or establishments, which exist largely in spite of the overall policy context, rather than because of it.
- Aside from the lack of funding, social care and health care fall under different key competencies and are subject to different legislation. While LTC is provided in both health care and social fields, there is no systemic service coordination or even integration between the two.
- In many cases, patients are discharged from hospitals when they are in a condition with an acute need for further nursing care or outpatient health care. Especially in the case of infirm patients, there is neither a timely assessment of the patient's need of follow-up health or social care, nor is there any organization for the provision of follow-up care. 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 organizing follow-up care, and they do not know how to assess real needs and what services may be available.

To overcome the systemic separation of health and social systems, as well as the highly fragmented payment mechanisms, there is a need for new types of activities, additional to health and social service provision—care integration services. Care integration services should serve as a key enabler to achieve integrated care.

It is critical that the following care integration services, which are not present in the current system, are introduced:

- Mapping the needs of populations.
- Planning and development of social, health and integration services at regional level.
- Training the existing and new health and social workers in integrated care (physicians, nurses, caregivers, coordinators of care, case managers, public health specialists, health promotion specialists, and other nonmedical health specialists, and others).
- Ensuring more detailed health and social data collection and exchange on the regional level.
- Facilitating the cooperation of the stakeholders such as, health and social service providers, physicians, nurses, caregivers, municipalities, public health authorities, NGOs, HIFs, and so on.

Main principles for the development of an integrated care system

Based on the summaries above, the following main principles can be formulated for development of the integration of care at the local level:

- The national system does not prohibit the integration of care. However, while there is no institutional financial support for integration from the national level, it is up to regions and municipalities to design and fund processes that are required to support the integration of care. The possibility of integration is confirmed by the existing nonpublic providers that have successfully combined the provision of health and social services—outpatient services in the case of MEMORY Center and the residential services in the case of Dom Rafael. More details are provided in the background paper to this report.
- A locally designed system can, and should, address the shortcomings in service provision based on the needs of the local population. What is required is a thorough analysis of population needs and a location-specific approach to addressing the shortcomings in the existing service provision, through the utilization of all funding streams allowed by the national legislation.
- The local systems of elderly care must address both the integration of care, and the development of services that are insufficient. Besides the integration of care, service development for better availability in the rural areas is the main challenge. The details, in practice, depend a lot on the context and the particular stakeholders involved at any given moment of time, and thus lie outside the scope of this report.

- The local model of elderly care should prioritize 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 mostly concerns care models that can help people extend their independent lives and remain in their communities. A good example can be demonstrated by a provider from Žilina who provides outreach service that coordinates formal and informal support for people to live independently. This example is described in the background report.
- While individual municipalities do not have sufficient capacity to fulfill the responsibilities associated with elderly care provision, the establishment of local elderly care systems (including integration of care, health, and social service development) should be the joint responsibility of a group of municipalities that come together under a partnership arrangement. A good example of quality management and prioritizing community-based services can be seen in the case of Slezská Diakonie (Czech Republic), showing that municipalities do not have to provide services by themselves; instead, they can arrange/ensure provision through another entity.
- It is recommended that there be one responsible entity for the integration of services. Health and social service providers usually do not have the capacity to deliver such services. Moreover, they do not have the legal competency to require cooperation from others.

For the simplification and mainstreaming of the integration of care on the national level, the following changes in the national framework would be desirable[26]:

- Recognizing the need for integration activities/services in national legislation and in the financing of health and social services.
- Introducing a separate financing stream for the integration of care, and population health management on the national, regional, microregional, and community levels.
- Introducing more flexible legislation on patient data exchange between service providers.
- Strengthening the role of the municipalities in the legislation regarding health and social services planning, development, and integration[27].

CHAPTER 3

MODEL OF INTEGRATED ELDERLY CARE

This section of the report presents the model of integrated care. It starts with a description of the overall framework that was utilized to develop the model, then describes how the pilot area for model development was selected. Finally, it provides a detailed description of each of the four components of the model identified in the framework.

SECTION 3.1

MODEL FRAMEWORK

This section defines the goals, principles, and the structure of the elderly care model. The Model of Integrated Care for the Elderly was designed with the general aim to:

- Develop a model, and later support implementation and operation of the integrated elderly care system in selected municipalities;
- Address the needs of the local elderly population;
- Provide a higher quality and level of coverage which, at the same time, is sustainable and follows the principles of deinstitutionalization.

The model aims to address challenges relevant to the service development and integration of elderly care within the Slovak system which were identified previously. The model reflects the lessons learned from the review of the current status of the health and social system in the Slovak Republic, inspired by the experience made in integrating care in other countries, the real capabilities of the Slovak health and social system players, the capacity of the municipalities and other specifics of the local situation.

The model is designed based on the following key principles:

- **Integration of care**—The coordination of the health and social care service provision, usually provided by the various service providers under several financing schemes and regulated by various principles, with the main goal to achieve higher efficiency, effectiveness, and more seamless care experience for the individual, including a simplified communication channel and the coordination of individual services.

- **Person-centered approach**—The care service provision is to be centered on individuals, families, and communities. It means that the provided services will respond to the individuals' needs and preferences in humane and holistic ways. This approach is more focused on the needs and expectations of individuals than on their problems.

- **Community-based care**—Care should be provided in a manner, that allows individuals with health limitations or disabilities to retain their independence in their own environment, and stay connected with the local community.

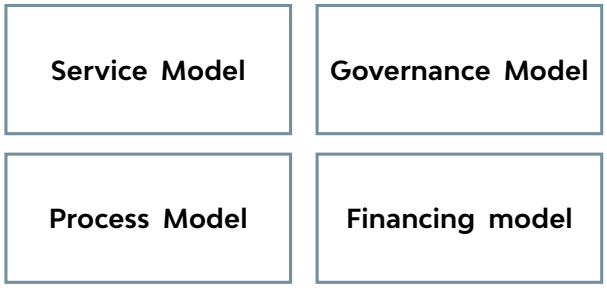
- **Suitability of the current legal framework of the Slovak Republic**—The model is designed to operate under the current system, and the financing of services is divided into several parallel schemes of financing.

The proposed model is expected to establish a new precedent in elderly care provision in the Slovak Republic, and to inform the mainstreaming of integrated elderly care in the Slovak Republic. The model relies mainly 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, as well as the people-centered community-based approach. Experience from the pilot implementation of the model could set up the basis for the development of national legislation and the further scaling up of elderly care integration across the Banská Bystrica Region, as well as in other parts of the Slovak Republic.

Model components

The proposed model of integrated elderly care consists of four core model components: the Service Model, Governance Model, Process Model and Financing Model (*Figure 2*)**.** The core model components are harmonized and each of them is also supported by additional extensions.

FIGURE 2. Core Model Components



Source: Elaborated by the authors.

The **Service Model** component provides analysis of the existing social and health services and proposes improvements to spatial distribution, availability, and the integration of health and social services in the target area**.** For the modeling of services in the selected municipalities in the southern Gemer area, a tool for analyzing and modeling the service availability and needs was proposed and developed, and available data was collected, processed, and evaluated.

The **Governance Model** defines the institutional structure for integrated care provision and management. It proposes an optimal distribution of roles and responsibilities among the key actors and clarifies their interrelations. Options for optimal legal arrangements for the proposed institutional structure were also analyzed.

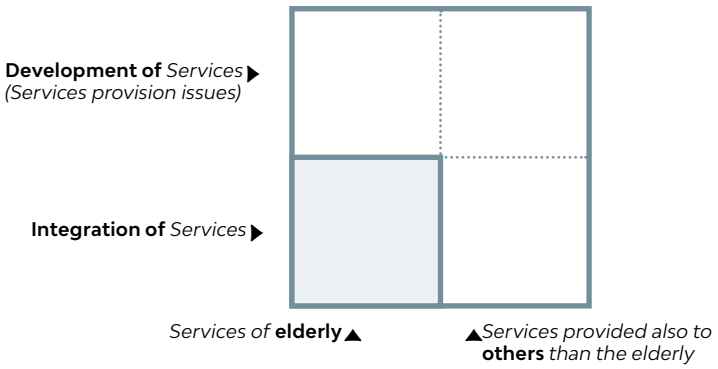
The **Integration Process Model** lays the practical foundations of the integration of care and identifies the main functions and processes that need to be introduced and managed locally by the entity responsible for the integration of services. This section of the model proposes a range of activities of the entity responsible for the integration of services and suggests the introduction of the Integration Process Guidelines (IPG)—a key tool for the service providers to become a part of the integrated process of care.

The **Financing Model** describes the current as well as the proposed future model of financing of the social and health services and their integration, delivering a rough estimate of the costs and contributions needed.

The scope of the model

To achieve integrated care for the elderly, it is necessary to also solve the service provision issues beyond the integration of care (for example, to address the problem of health care services that are not available within a reasonable distance or travel time for many residents). Because most health care services are not specific to the elderly, the focus should also be on services which are provided to the general public, and not limited to the elderly (for example, specialist doctors). Therefore, the scope of the model might be broader than just integrating care for the elderly. *Figure 3* provides a visual representation of the activity areas that are critical for building a fully functional and efficient integrated elderly care system. It clearly shows that while integration of services for the elderly is the main innovation of the proposed model and is its core component, questions related to the development of services (including for the general public), and broader mechanisms of care integration, need to also be recognized as important components of a functional integrated elderly care model.

FIGURE 3. Model Scope



Source: Elaborated by the authors.

SECTION 3.2

INTEGRATED ELDERLY CARE MODEL PROPOSAL

SELECTION OF THE FUNCTIONAL GROUPING OF MUNICPALITIES

The selection of the municipalities was driven both by consideration of their representativeness, and the existence of favorable conditions for the success of the model. On the one hand, the goal was to pick an area that faces the typical challenges of elderly care provision in the peripheral and sparsely populated parts of the Banská Bystrica Region and the Slovak Republic as a whole. The thinking behind this approach was that the success of such a model would pave the road for its replication in other similar areas, and would also be useful in stimulating national integrated care reforms, as the lessons learned in the BBSK would be applicable nationwide. On the other hand, the selected area and group of municipalities were also screened for the presence of conditions that would ensure a high likelihood of the implementation of the model. Of course, the initiative would not be successful without effective implementation of the model, additionally, favorable starting conditions would reduce the costs associated with the establishment of the model.

In accordance with the two goals listed above two groups of criteria were used.

The first group of criteria:

- Acute need for elderly care based on population structure;
- Insufficient provision of care, relative to other parts of the region;
- Representative characteristics of remote areas of the BBSK (and the rest of the Slovak Republic)—dispersed population and small municipalities with a limited capacity.

The second group of criteria:

- Active willingness and enthusiasm of all (or the great majority) of the local leaders about the project;
- Previous experience in cross-municipal coordination within the subregion.

Following these criteria, a four-stage process for identifying the target group of municipalities was followed:

Stage 1: A set of indexes describing the situation in each of the districts and municipalities of the Banská Bystrica Region was developed.

- The Economic Performance Index included measures such as the level of urbanization, unemployment rate, vacancies per each unemployed individual, average salary, percentage of workforce with a university degree or without basic education.

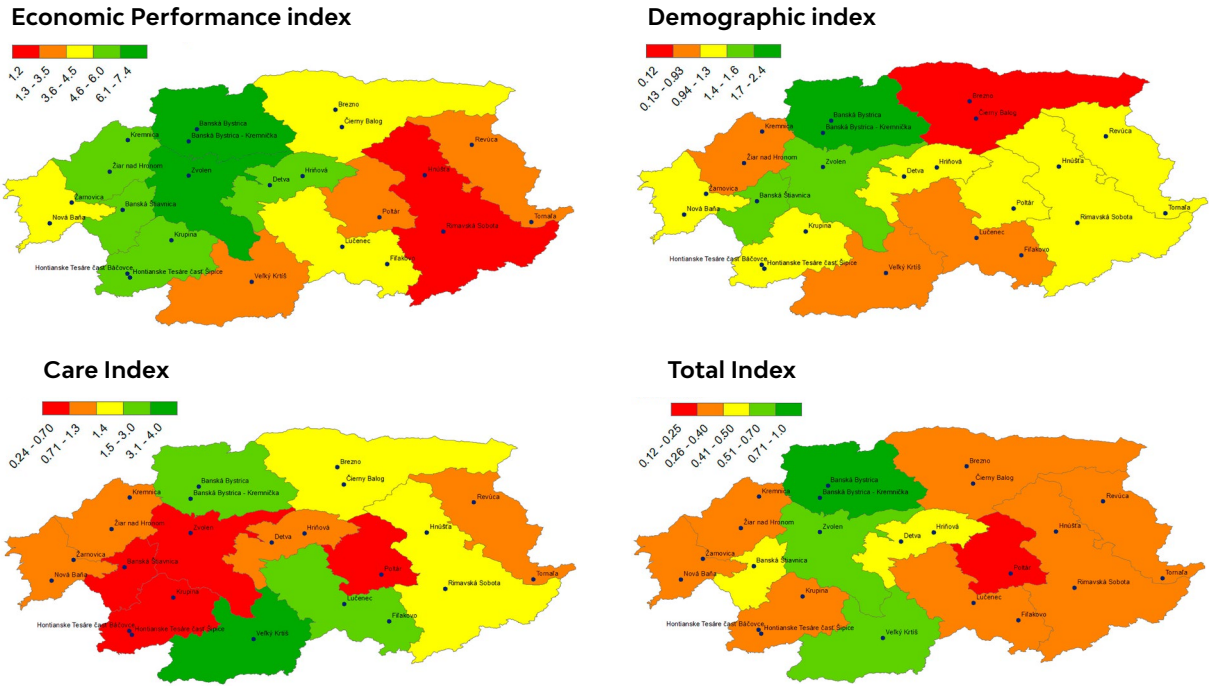
- The Demographic Index included the measure of net migration, the old age dependency index, and the total number of people an retirement age.

- The Care Index was designed to reflect the availability of services in the area, and included the total capacity of retirement homes, total capacity of day care centers, the number of nursing homes, and the number of transportation establishments.

- The values of each component of the indexes were normalized and weighted based on the assessment of the relative importance of the indicators by experts. Then, a total index was created as a sum of the three. *Figure 4* presents the results of this analysis.

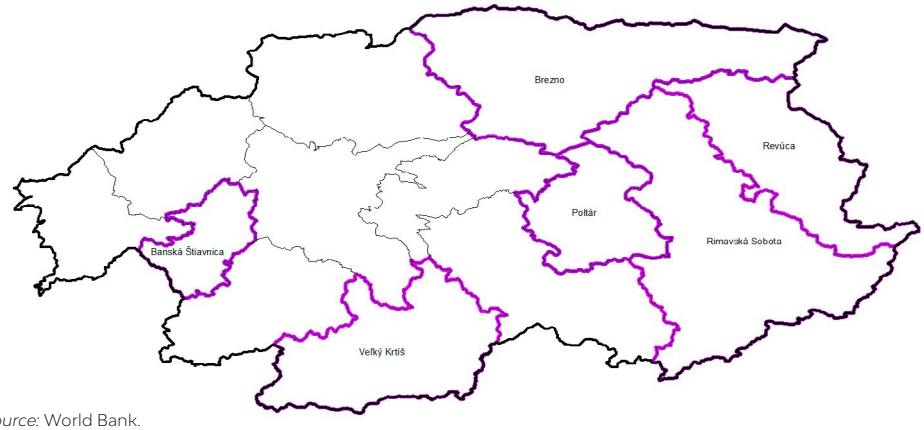
- As a result of these calculations and discussions with the BBSK officials, the Revúca, Rimavská Sobota, Velký Krtíš, Brezno, Poltár, and Banská Štiavnica districts were identified as areas with basic suitability for the development of the pilot model *(see Figure 5)*.

FIGURE 4. Characteristics of the Districts of the Banská Bystrica Region



Source: World Bank calculations based on data of the Slovak Republic Statistical Agency.

FIGURE 5. Districts Selected as Suitable for Pilot Model Development



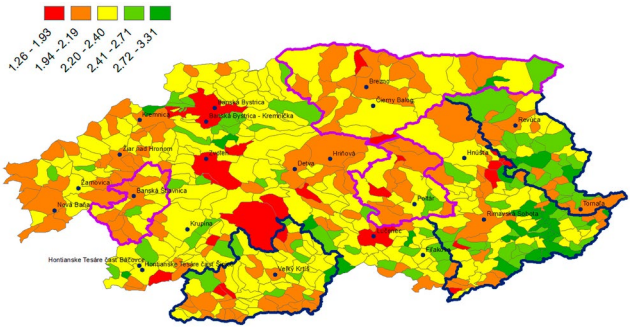
Source: World Bank.

Stage 2: In stage two, the economic development and demographic indexes were calculated at the municipal level. The Care Index could not be calculated at the municipal level, because there are not sufficient care providers located in each municipality (density factor). Thus, the location of providers was overlaid in the results of the quantitative analysis of economic and demographic dynamism on the map, with the idea that the most underserved areas should be prioritized for final selection (*Figure 6*).

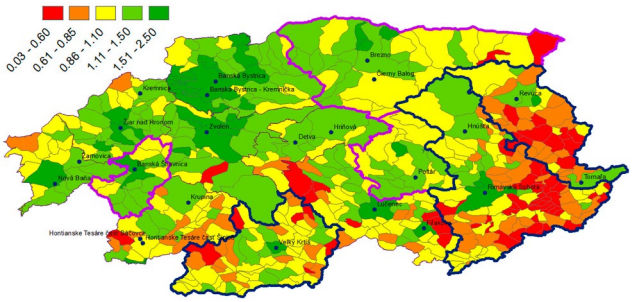
After the data collection exercise was completed, the preliminary groups of municipalities were selected through consultations with the BBSK Region and local experts. The groupings of municipalities were formed and identified in the parts of the region where there was a high need for elderly care (based on demographic indicators), and poor economic performance coincided with a relative lack of services. However, specific groupings were defined using the local understanding of the historical regions and the historical ties in certain areas. As a result, five preliminary groupings of municipalities were selected (*see Figure 7*).

FIGURE 6. Characteristics of the Municipalities in the Banská Bystrica Region

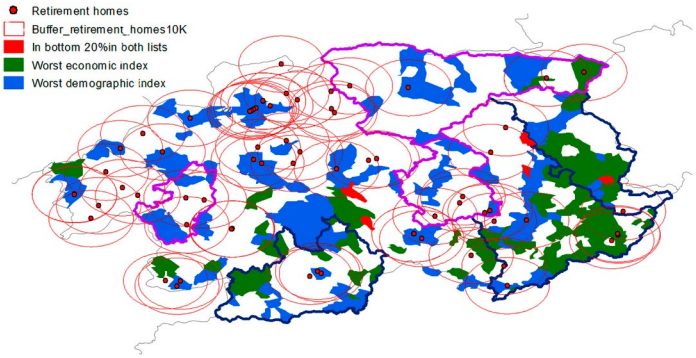
Municipality Demographic Index



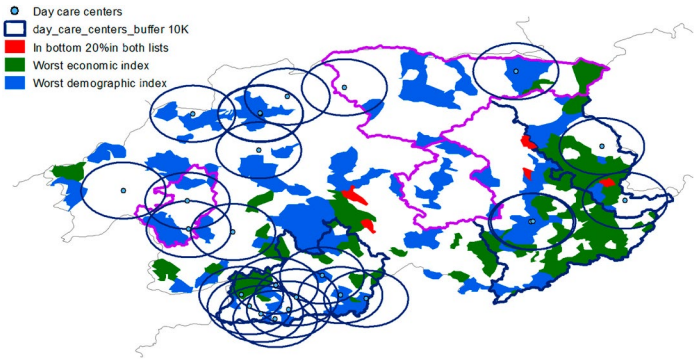
Municipality Economic Performance Index



Worst Performers in the Two Indexes and Location of Retirement Homes

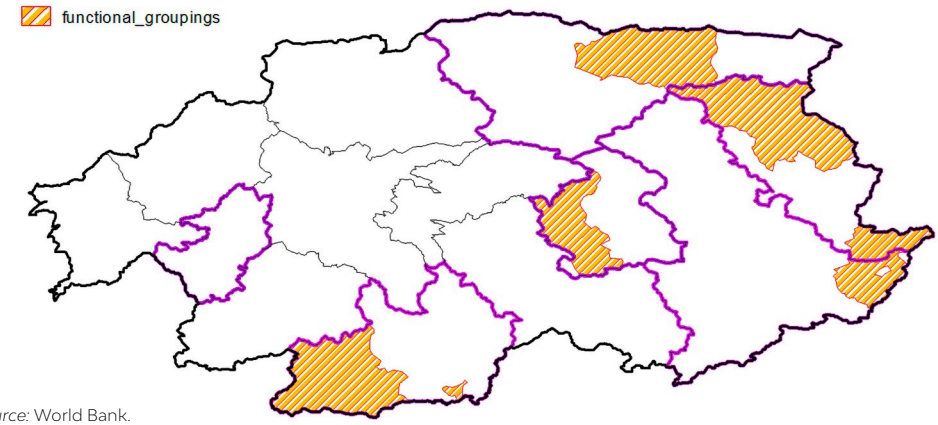


Worst Performers in the Two Indexes and Location of Day Care Centers



Source: World Bank calculations based on data of the Slovak Republic Statistical Agency.

FIGURE 7. Longlist of Groups of Municipalities for Pilot Integrated Care Model Development



Source: World Bank.

Stage 3: In this stage, a survey of the mayors in each of the groups of municipalities was conducted. This survey aimed to evaluate whether the municipalities rate elderly care as an important part of their agenda, whether they had the additional capacity to engage with an ambitious project, and whether they had any experience of collaboration. The goal of the survey was not necessarily to identify the strongest performers in the listed categories, but rather to find a group of municipalities that combined the presence of substantial challenges with the basic characteristics that would make the group suitable for the implementation of the pilot. The survey was conducted online and included 20 questions. The survey combined open-ended questions and multiple-choice questions with questions designed to establish the priorities of the municipalities by asking respondents to rank different issues on a scale from "not important at all" to "extremely important, top priority". The survey included four sections covering each of the criteria for the selection of municipalities: capacity, commitment, need, and collaboration.

Based on the results of the survey *(Table 1)***, two groups were identified as the most fitting**: the Revúca north group of municipalities, and the South Gemer group of municipalities. They were shortlisted for the final stage of the selection of the pilot functional grouping.

TABLE 1. Results of the Survey of Longlisted Municipalities, After Evaluation of Each of the Five Groups

	Capacity	Commitment	Need	Collaboration
FG Brezno	Strong	Strong	High	Strong
FG Poltár	Weak	Strong	Low	Strong
FG Revúca north	Strong	Medium	High	Medium
FG South Gemer (including municipalities from Rimavska Subota & Revuca)	Medium	Weak	Medium	Medium
FG Velký Krtíš	Medium	Weak	High	Weak

Source: Survey conducted by the BBSK and the World Bank.

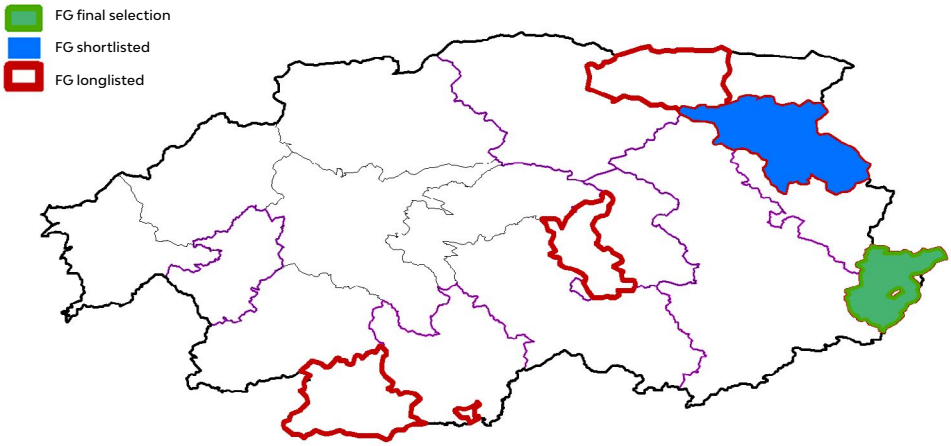
Stage 4: This stage included roundtable consultations with the mayors and NGOs[28] in each of the two shortlisted functional groupings. The roundtables were conducted in December 2019–January 2020. 12 mayors from Rimavská Sobota District, 14 mayors from Revúca District, and 13 members from the local NGOs participated in round table discussions. The roundtables focused on validating the results of the survey and understanding whether the basic conditions for building an elderly care model are present in the area. *(see Figure 8)* Contrary to the earlier observation, the South Gemer group of municipalities demonstrated a greater level of commitment (starting from the fact that all but one of the mayors joined the roundtable). During the roundtable it was also confirmed that the municipalities in this area were more open to collaboration on equal terms (not just waiting for the lead of the larger towns in the area). Finally, this area has more social and health services already present. And while on the one hand, they were clearly insufficient to serve the elderly population, they presented a decent basis for the development of the new model, rather than having to build it from scratch. Based on these considerations, the South Gemer group of municipalities was selected as the pilot functional grouping of municipalities (FG) for implementation integrated elderly care model.

The selected FG includes the following municipalities: Tornaľa, Gemer, Stránska, Abovce, Hubovo, Chanava, Kráľ, Lenka, Neporadza, Riečka, Rumince, Štrkovec, Včelince. Further in this report these group of municipalities will be referred to as South Gemer FG. (*Figure 8*)

FIGURE 8. Roundtable Consultations with the Shortlisted Groups of Municipalities

Source: pictures taken by the authors.

FIGURE 9. Map of Both Longlisted and Shortlisted Selected Groups of Municipalities



Source: World Bank calculations based on data of the Slovak Republic Statistical Agency.

The rest of this section presents the key characteristics of the proposed model, including each of the four components as specified in the framework. The design of the model considers the characteristics and needs of the municipalities in the selected pilot area.

SERVICE MODEL

The Service Model is the foundation of the elderly care model. The Service Model component focuses on the need for services, spatial distribution, availability, and integration of the health and social services in the target area. The service model contains an analysis of data on the availability of services, including such parameters as the number and location of providers, their capacity, human resources, infrastructure, service output, common trends in service provision, and the issues (problems) detected. The results of this analysis were used to develop a services master planning package, which proposes a basic methodology and tools for analyzing and modeling service availability and sufficiency. The data collated in the Master Plan of Services was ultimately used to inform the service improvement proposals presented below (see Annex 1).

Several parameters should be considered when evaluating services. Accessibility, quality, and efficiency are usually the main measures of planning, providing, and evaluating health and social services or systems. While quality and efficiency are also critical, under the current conditions, the accessibility of health and social services in the selected area is the main concern from the perspective of the population. It is necessary to differentiate among the various concepts of accessibility: (1) physical (distance/travel time), (2) capacity (time to access the service, after initial contact with the provider), and (3) social (financial and/or mental ability to afford and/or arrange the services). Accessibility should be the basic condition for all new services and products in compliance with the EU Accessibility Act[29]. To achieve the optimal accessibility of services from the perspective of clients/patients, there is a need for the continuous mapping, master planning, and development of the services. This means that the analysis conducted in preparation of this model, should not be recognized as the final output, rather, as the start of the ongoing work, that would be regularly updated (that is, on an annual basis) by the entity responsible for the integration of services and for the overall operation of the model in the area.

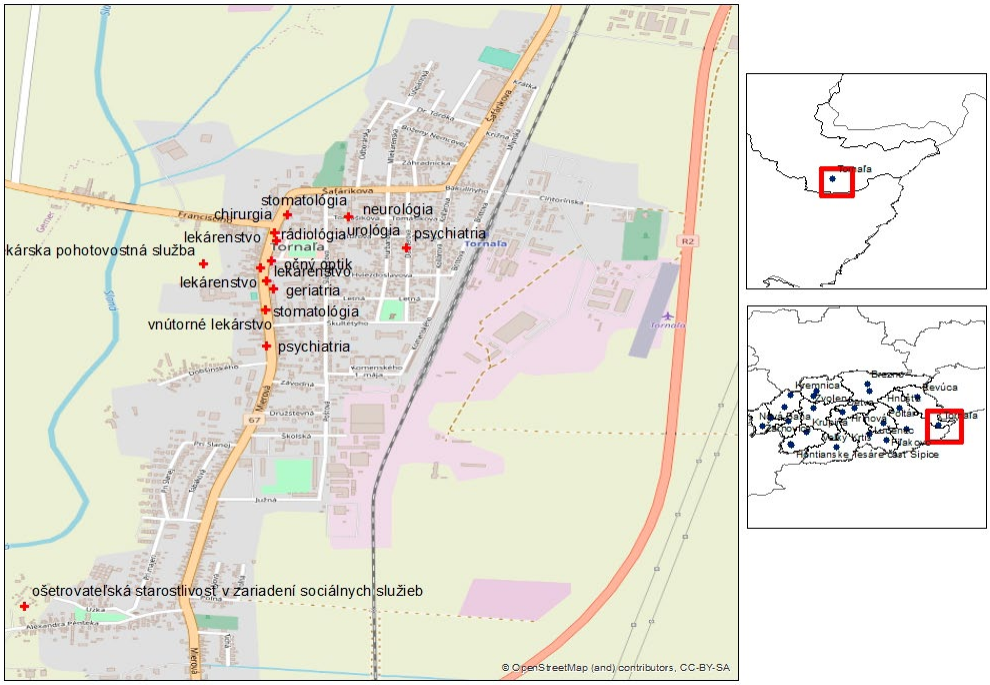
Availability of Services

Analysis of the current spatial distribution of health and social services, as well as the general availability of services in the area, shows the existing gaps in access to health and social services.

Health services

While some services are available in South Gemer FG, the main concern is their accessibility for the elderly. All outpatient health care services provided in South Gemer FG are in the municipality of Tornaľa (*see Figure 10)*. The closest inpatient facilities are located in Rimavská Sobota, Revúca, and Rožňava. The analysis of the data of HIF Dôvera (covering 35% of the Slovak Republic's population) for the years 2017–2019 shows the pattern in service usage by the elderly population (see *Table 2*). The result of the analysis clearly shows that for the population of the target municipalities, the services of providers located in Tornaľa only make up 45% of the services received, meaning that the rest of health services are received outside the area. The second highest share of health services are provided to the population of the South Gemer FG in Rimavská Sobota, which is located more than 50 kilometers away. It means that a largea number of services are underprovided locally and are only available at a minimum of a half day trip away for the elderly, which is highly inconvenient. This is particularly slow and inconvenient, because if the elderly from the South Gemer municipalities are travelling by public transport, they have to first travel on a bus to Tornaľa, and then change to the bus to Rimavská Sobota. To make the matter even more difficult, they need to be at the doctor's office usually at six o'clock in the morning in order to get a place on the waiting list, usually without any guarantee to be treated on that day.

FIGURE 10. Map of the Distribution of Health Care Service Facilities in South Gemer FG



Source: Map based on data provided by the BBSK.

TABLE 2. Municipalities of Health Care Service Provision for the Elderly Population in South Gemer FG

Municipality	Percentage of inhabitants	Percentage of exams/visits
TORNAĽA	41.93%	56.04%
RIMAVSKÁ SOBOTA	28.38%	22.43%
LENÁRTOVCE	2.50%	5.97%
STROPKOV (LAB EXAMS)	7.35%	3.60%
ROŽŇAVA	5.08%	3.13%
BANSKÁ BYSTRICA	3.37%	1.87%
KOŠICE	3.23%	1.75%
LUČENEC	1.38%	0.90%
JESENSKÉ	0.28%	0.44%
REVÚCA	0.64%	0.41%

Source: Based on the data of health insurance fund Dôvera.

Proper access to health care services for the senior inhabitants in South Gemer FG is an important precondition of service integration. However, it is not a straightforward process and it will require strategic planning, the attraction of providers, provision of favorable conditions to attract specialists, and potentially, several years of committed work in this area. *Table 3* provides a summary of the current situation with health service provision in the South Gemer FG, with recommendations for service improvement. For a more detailed overview of the health services available in South Gemer FG, and in the districts of Rimavská Sobota and Revúca, see Annex 1: Service Model.

TABLE 3. Improvement Proposals Through Health Service Development

Population Needs	Current Situation	Proposed Improvements
• Defined by standards of network minimum (expressed as number of physicians or nurses for a settlement of a particular size, established in the law[30]) • Defined by standards for civic amenities • Based on information collected during the community planning process	• Several services in the group of municipalities are missing or underprovided. • Services are provided in the city of Tornaľa (natural center of) or Rimavská Sobota—a long trip away on public transport for many of the elderly. • Services in Tornaľa are declining as the physicians are retiring. • Succession in the service provision is rare.	The following outpatient services need to be added in Tornaľa: urology, dermato-venereology, gastroenterology, cardiology, clinical oncology, clinical psychology, nephrology, orthopedics, ultrasound examinations, and nursing care. This list of services recommended to be added was selected based on information collected during the community planning process (through discussions with health service providers) from the full list of services missing from Tornaľa.

Source: Based on the data of health insurance fund Dôvera.

Social services

Social services, while available in the area, have clear gaps in provision, like the health care services. All the social services present in the South Gemer FG are types that support people with severe disabilities, unfavorable health conditions, or of retirement age. Although there is a large group of nonformal family caregivers, no support services are provided for them. Most of the services provided are residential services, while outreach services are absent. The largest capacity is offered by the social care facility operated by the BBSK government in Tornaľa (175 places that include three types of care). Other residential services are provided by nonprofit organizations. Only four municipalities in South Gemer FG have registered providers of social services. See more details in *Table 4* and *Figure 11*.

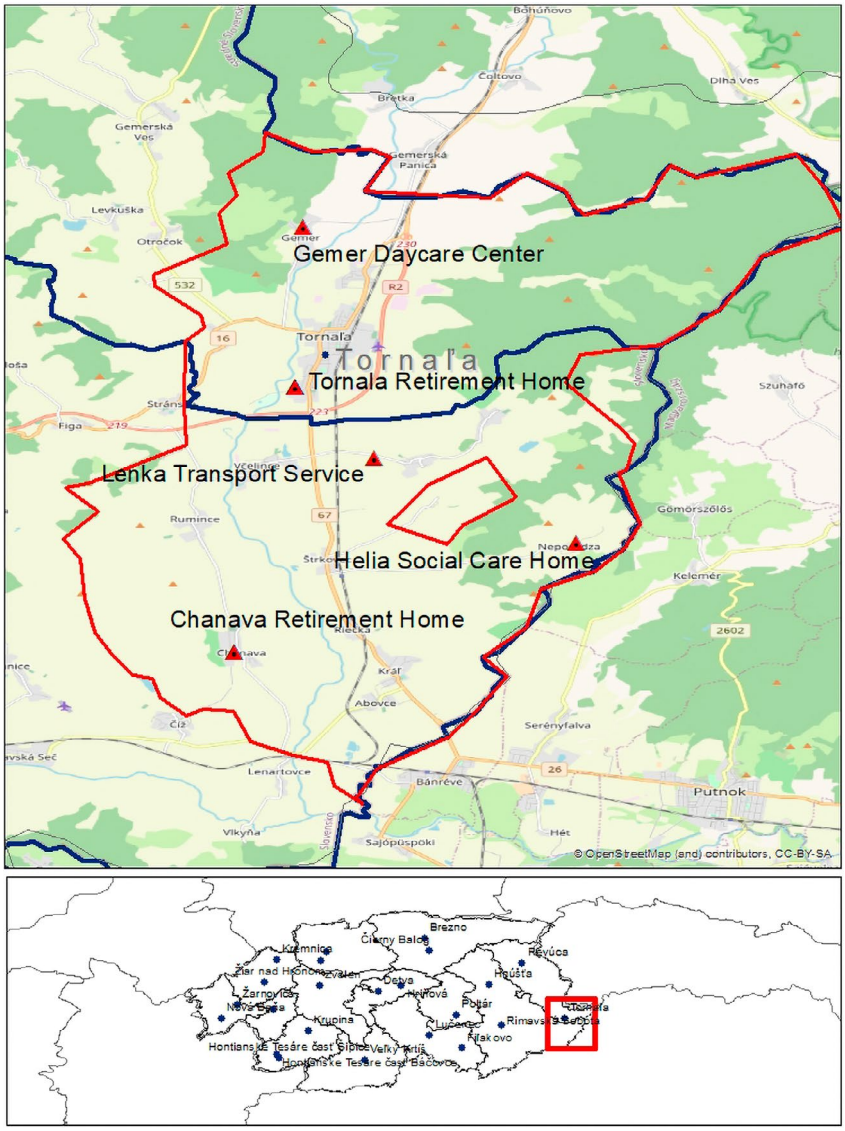
It is important to mention that the recipients of the care allowance for nonformal caregivers are supported by the Labor, Social Affairs and Family offices. Even though it is not a social service, it plays a significant role in elderly care. In 2019, there were 165 people cared for by 161 family members in South Gemer FG. Out of these, 107 were seniors, of whom 48 were over 80 years old. Also, there were 57 seniors who were taking care of their family members.

TABLE 4. Summary of Social Services in South Gemer FG

	Type of social service	Form of social service	Capacity
Services dedicated to seniors	retirement home	residential	3 providers/capacity 145
Services used by seniors and other groups	home care service	outreach	2 providers/3 carers and 4 seniors
	day care center	outpatient	1 provider/capacity 15
	transportation service	outreach	1 provider
	social service home	residential	2 providers/capacity 120 (40 clients in 2019 were seniors)
Services for other target groups	supported housing facility	residential	1 provider/capacity 16/people with disabilities

Source: World Bank.

FIGURE 11. Map of Social Care Service Facilities in the South Gemer FG



Source: based on ArcGIS geodata and data social services data provided by BBSK.

To determine the need for social services, a comparison of the sociodemographic characteristics of South Gemer FG with the service provision standards was completed. The most useful example is the Czech model of standards for social services that was developed to determine what types of social services are missing in the analyzed areas.[31] The Czech experts from the Research Institute for Labor and Social Affairs propose that the minimum size of the municipality in which it is possible to run basic social services is about five thousand inhabitants. Municipalities the size of about 10,000 residents are important as centers of provision of certain types of social service for broader areas. In the catchment area of about 25,000 inhabitants, all social and population groups are generally large enough that the social needs of all target groups can be met professionally at the acceptable cost. South Gemer FG has nearly 13,000 inhabitants and this catchment area has the potential to cover a wide range of different types of services for seniors. The comparison with the standards shows a lack of some types of services (for example, canteens and nursing homes) or insufficient capacity, mainly of home care service. The details in *Table 5* show the social services provided in South Gemer FG compared with the standards.

TABLE 5. Social Services Provided in South Gemer FG in Comparison with the Standards

Capacity of social services for seniors	Expectations based on comparison with peers (Czech Republic standards)	Current situation	Comparison
Retirement home	209	145	-64
Social housing for seniors + Support to live independently	19	0	-19
Nursing home	37	0	-37
Home care service	154	4	-150
nonformal carers (allowance)		*107*	*-43**
Specialized facility	66	0	-66
Day care center	necessary	15	can be expanded
Daily center	necessary	0	missing
Canteen	desirable	0	missing

** if we also take into account nonformal caregivers and home care service, services for 43 seniors are still missing.*

Source: Based on data from the BBSK Register of Social Service Providers and own research.

Based on the above comparison, the following social services should be strengthened or introduced in the South Gemer FG:

- Home care service/outreach
- Day care center/outpatient
- Nursing home, retirement home, or specialized facility/residential
- Support for nonformal caregivers (specialized social advisory, respite care, peer groups, training, and so on)

There might be alternatives to expanding residential care in the area. Although there is no social housing for seniors, we propose to substitute this service with a different type of social care. Similar results can be achieved either by providing support for independent living or with a specialized social advisor. Both these options represent established types of social services that can be provided in the outreach forms. There were 93% of the residents of the South Gemer FG who were living in their own housing, and only five people who were homeless, according to the 2011 census. Thus, we do not expect a high demand for social housing. The proposed services could also be helpful for other target groups, especially nonformal family caregivers.

The standards employed are only a comparative tool useful for preliminary analysis. This comparison should be followed by community planning and discussions with the relevant stakeholders (municipalities, SGRs, service providers, and seniors). The results of such a process could bring several scenarios for further service development that would consider the needs and capacity of every stakeholder. *Table 6* offers a summary of the current social service provision situation in the South Gemer FG and offers recommendations for service improvements.

TABLE 6. Improvement Proposals Through Social Service Development

Population Needs	Current Situation	Proposed Improvements
Methods for determining a need of social services is based on a sociodemographic analysis of South Gemer FG, standards, and the local situation. • Standards for minimal amenities for municipalities, based on the number of inhabitants • Proposal of recommended standards of service facilities, based on analysis of needs per 1,000 or 10,000 inhabitants • Community planning of social services according to Social Service Act 448/2008	• Residential social services are at 69.4% of needed capacity • Outreach social services (home care services) are at only 2.6% of needed capacity • No support services for nonformal caregivers • There are also outpatient social services and their capacity is underestimated (according to current community plans)	Significant increase of outreach social services—home care services, monitoring services, transport services, and social canteen services. Support of nonformal family caregivers via diverse types of services —specialized social advisory, respite service, day care center, or daily center. In case of an increase in residential care: • Nursing home for short-term stays is an important community-based service, also used by people with disability and for respite service • Specialized facility for people with dementia, Alzheimer's patients (in BBSK region nearest is 90 km/1:30 hour by car, in KSK Region is 35 km/31 minutes by car)

Source: World Bank.

Both for social and health care services there are multiple options that can be considered to address shortages in service availability. Traditionally, the Slovak system gravitates toward the residential form of service provision, or at least the ambulatory form, which requires well-equipped physical facilities. While that is critical for a lot of services, other forms of service provision should also be considered:

- Home visits of specialists—This option would require additional costs to incentivize the service providers as they have no need or incentives to visit the patients in the current system.

- Specialists working in all or selected municipalities at different times rotating between them—This option is neither efficient for the providers, nor sustainable for the system, as it requires extensive infrastructure improvements.

- Attracting missing specialists to work in Tornaľa part-time or full-time—This is a feasible solution but there is a need to establish or attract new service providers, or to collaborate with providers from other areas, through establishing regular office hours in Tornaľa. Investment in space and equipment would be necessary, as well as providing additional compensation to the provider. Additional attention needs to be given to transport services, to ensure that locations in Tornaľa are accessible to all the residents of the whole FG area.

- Telemedical and Telecare Services[32]—The situation with the introduction of telecare is slightly different in health and social care. There is currently a missing legal and financing framework for telemedical services in the country. However, a pilot in South Gemer FG testing a small-scale solution would be feasible. After successful testing, it can be implemented in routine operations. Telecare in social services (that is, monitoring service) can be implemented almost immediately as a registered social service or as a "commercial" service. However, telecare in social services also lacks a financial framework, so any introduction of it in South Gamer would need to be done in a pilot mode.

- Transporting patients to Rimavská Sobota or Revúca—This option would cause extra costs for the municipalities/social system and is a logistical challenge. However, it may be considered for selected services, which are not feasible to provide locally.

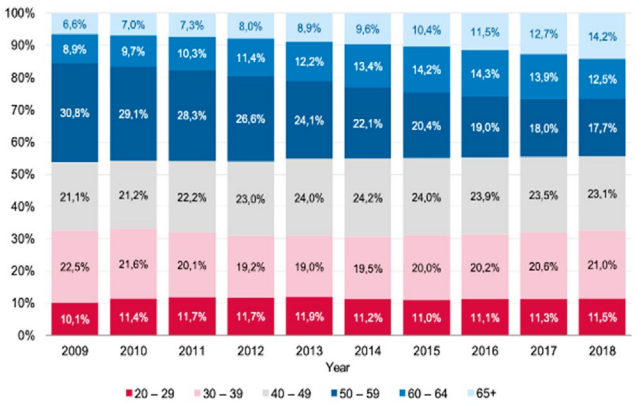
Other issues of service provision

In addition to the availability of services, our analysis has identified other issues related to service provision in the area. These issues are not unique to the area, but their recognition is a critical input into the development of the model.

Lack of qualified staff

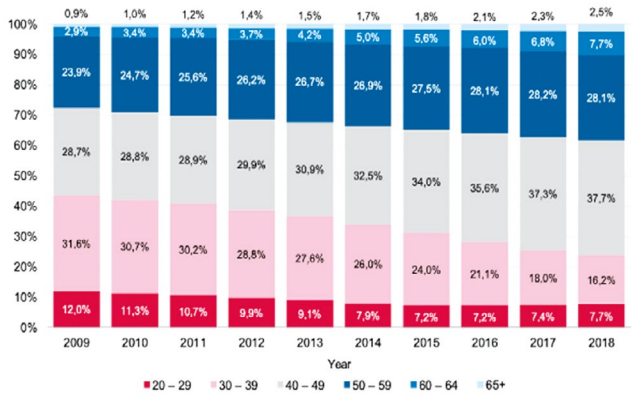
There is a shortage of qualified health care personnel in the municipalities of South Gemer FG. There are no statistics available on the human resources of health care services in South Gemer FG, but according to the local physicians consulted, each health care facility has one physician working with one nurse, all the physicians with one exception are over 50, most of them are (almost) of senior age (65+). Several physicians are already over 70. This is a challenge typical for the Slovak Republic (*see Figure 12 and Figure 13*). However, it is critical that the municipalities take proactive measures to address the situation before it becomes critical. The first step is to collect and analyze the age data of all the providers and build a midterm plan for recruiting different health care specialists into the area.

FIGURE 12. Age Structure of Physicians in the Slovak Republic



Source: NCZI 2018.

FIGURE 13. Age Structure of Nurses in the Slovak Republic



Source: NCZI 2018.

There are several overall problems in Slovak social service provision. The salaries of employees of the social services are low in comparison with the national average wage[33]. The interest for working in social services is also generally low because it is challenging work with an elevated level of responsibility. Predominantly female staff in this sector need to do a lot of physically difficult tasks. Other problems also include the aging of primary care staff and the insufficient educational level of primary care staff (caregivers), because only 220 hours of training and a basic education are required. This results in low motivation, frequent rotation, and consequently, a shortage of professional and committed staff. Another problem is the high number of clients per social worker, which results in employees having excessive workloads, which results in further demotivation.

Most of these problems exist in the South Gemer FG. The BBSK operates the largest residential facility in South Gemer FG. There are 88 employees and 56 of them work in direct contact with 175 clients. Even though they meet minimal legal requirements for staff, the staff is still overburdened. There are several reasons to anticipate an improvement with this problem in South Gemer FG. There was a nationwide increase of salaries in the social services sector, so for people in Tornaľa (where relatively few employment options are available) this salary is becoming more appealing. The secondary vocational school in Tornaľa has an education program for educational and care workers. There are 97 students (and an additional 22 students in a Hungarian language program) in a four-year program for the school year 2020/2021. According to the published BBSK forecast for newly admitted pupils, in 2021/2022 there will be an increase from 32 to new 51 students[34]. This is in line with meeting the region's needs, based on the needs' assessment completed as a part of the community planning, and should help with meeting the needs of the area as well.[35] The gradual wage increase could help retain graduates in the region, as it makes local jobs relatively more competitive with the employment opportunities abroad.

Infrastructure quality (in health and social services)

The main health care facility in the area requires attention. The building of the former polyclinic located at 1 Sládkovičova Street, which hosts a significant proportion of health care providers in Tornaľa, needs serious renovation. Other buildings have been renovated or at least partially renovated. Lack of appropriate, sufficient, and modernized space for the service provision in the building of the former polyclinic (or other building) is one of the factors for the declining number of health service providers in Tornaľa, as well as a contributing factor to their physical dispersion, and the lack of a location where a range of services can be concentrated.

Social service infrastructure issues are widespread in the South Gemer FG. The building of the main retirement facility owned by the self-governing region (the largest provider of residential care in the South Gemer FG) was renovated 10 years ago. However, there are some sections, as well as the exterior of the building, that need to be improved to increase accessibility for the patients (for example, elevator, barrier free access, and others). The building for outpatient social services owned by the municipality is in good condition; it was renovated five years ago. Transportation service providers do not have vehicles for people with disabilities. Additional social services would also need new infrastructure. The municipalities own some buildings that could be upgraded and repurposed as day care centers (according to the BBSK and the municipalities, they are in decent enough condition to be considered), or as a base for the outreach services that were mentioned in section 3.2. If there is a need for a greater capacity for any type of residential care, the construction of a new building would be necessary. This could give the opportunity to build a facility that would meet modern elderly care design principles and standards.

Lack of integration of care

The integration of care can be defined on various levels. Integration of care can be understood as an integration of the processes of service provision by health and social service providers (on various levels), or additionally also as a physical integration of service providers in a specialized facility—the Integrated Care Center (ICC).

Process integration can be applied at the level of:

- Information and data sharing
- Coordination of care
- Case-based multidisciplinary cooperation of health and social professionals
- Interoperability of providers—requires the application of process management methods (process mapping, modeling, use of rules, guidelines, workflows, and so on) by the health and social service providers as a precondition

The health and social services for the inhabitants of South Gemer FG are not integrated, just like in the rest of the Slovak Republic. Even though there is a high fragmentation of service providers, there are no real integration initiatives implemented in the country. The lack of a legal as well as a financial framework is a systemic problem of the Slovak health and social services systems. The only time concept of integration introduced in the country so far has been in the Integrated Health Care Centers (IHCC/CIZS) program supported through the Specific objective 2.1.2. of the Integrated Regional Operating Program (IROP) which is a European Regional Development Fund (ERDF) co-financed program. The intentions were that investments in the renovation and equipment of facilities of the integrated care centers for health and social services would incentivize the introduction of the integration of care. However, following the modification of IROP, no integration was required. Tornaľa was eligible to apply for the aforementioned program, but the municipality failed to submit a viable project due to the complicated conditions of the call, which were hard to meet (specifically there were complications with securing the commitment of service providers), combined with a high level of financial uncertainty and extremely short deadlines.

The integration of care can be achieved by various models. This depends on the systems of social and health care work: governance, legislative rules, and financing. This report will propose one possible approach to integrating care in the Slovak Republic, particularly in the municipalities of the South Gemer FG. During the analysis and planning of the spatial distribution of the health and social services in this chapter, we used methodology further described in Annex 4. There are several policy options for the integration of care and the improvement of the gaps in service availability in the South Gemer FG. The following text introduces comments in terms of the implementation of the possibilities within the most typical options that reflect the situation in the Slovak Republic.

GOVERNANCE MODEL

The Governance Model defines the institutional setup needed to achieve integrated care in the South Gemer FG and to ensure the long-term sustainability of the proposed solution. The Governance Model determines and describes the roles of all the key actors and the scope of their activities.

Goals of the Governance Model

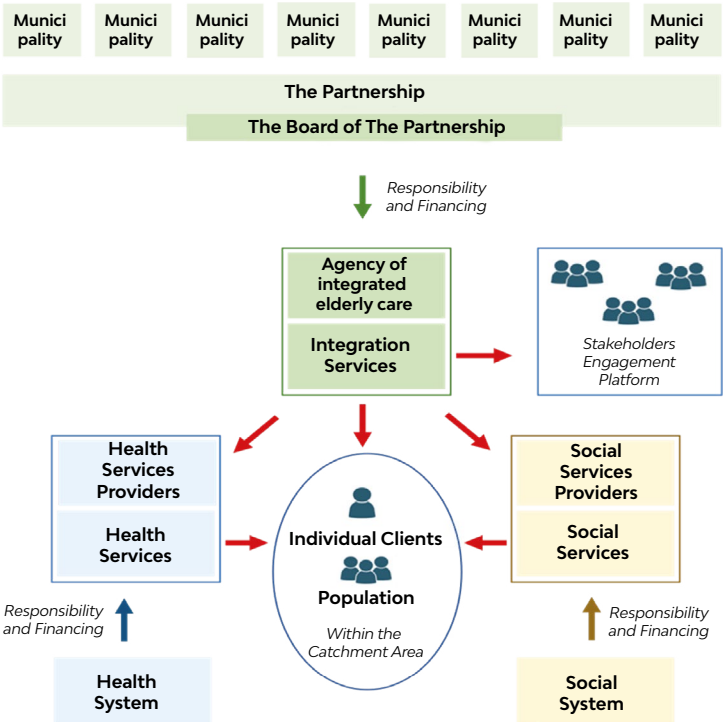
The main goals of the Governance Model are:

- To engage all the South Gemer FG municipalities, and to create conditions for them to actively participate, cooperate, and take responsibility and control of the development and integration of social and health services in the area, including its financing;
- To achieve a sufficient scale (size of the region covered) for efficient integration of service provision;
- To keep the decision-making and service provision close to the citizen;
- To align the new integration service provision with the existing health and social service provision, avoiding the overlapping and gaps in mission and activities;
- To ensure the professional execution of integration and service development services and to build sufficient capacity;
- If necessary, to enable joint social and health service provision by the municipalities (in case there is no social or health service provider available in the South Gemer FG and setting up a new provider would be considered as an option).

Description of the Governance Model

The Governance Model defines the entities responsible for the management of care and their roles in the local system. The proposed Governance Model clearly assigns the roles among the new entities responsible for the new activities (the agency, partnership, and stakeholders' engagement platform), and the entities keeping their original roles (health and social service providers). Overall, this governance structure relies on the municipalities taking on a new level of responsibility and leadership in service provision. This has been discussed with the local leaders in the past, and thus it is considered possible. The clear definition of the responsibilities of all parties is an important precondition for a smooth functioning of the system. The next section covers the responsibilities of each of the main stakeholders. (*Figure 14* illustrates the relationship between all the actors of the proposed Governance Model.)

FIGURE 14. Governance Model



Source: World Bank.

The Partnership of Municipalities for Integrated Care is a legally binding relationship between all, or at least most, municipalities in South Gemer FG. The purpose of the partnership is to express the will, as well as the commitment, to a defined level of cooperation between the partnering municipalities represented by their self-governing bodies. The partnership can be implemented in various legal forms (partnership agreement, joint office, nonprofit organization, company, and others). Whatever legal form will be implemented, there should be equal rights for all the members of the partnership defined in the agreement. The members should meet a minimum of once a year at the general assembly to approve the annual report and plans for the upcoming year. There should be a governing body of the partnership (that is, a board) created for more flexible decision-making between the annual meetings of all the member municipalities. This body should have three to five members elected from the representatives of all the municipalities, optimally for a one-year term. The partnership should have a statute defining the decision-making rules (that is, majority voting), as well as the obligations and relations between the general assembly of the partnership, the governing body of the partnership, and the management of the executive body described later. The partnership and the executive body can be part of the same legal entity. For example, the partnership can function as a board of the NGO, which is the legal form of organizing the Agency. This form would minimize the complexity of the legal structure. However, the choice of the specific arrangement should be left to the municipalities.

Executive body/Integrated Elderly Care Agency

In the current system several critical functions are missing. Compared to the experiences from other countries, these are the key functions (high-level processes) of integrated models which are missing in the Slovak Republic:

- Integration management and support
- Service development (health and social services)
- Population health planning
- Individual health planning[36]
- Coordination of care
- Case management
- Health needs assessment[37]

The critical functions for achieving the integration of care require new type of activities that are not currently recognized at the systematic level in the Slovak Republic. To make the functions operational, there is a need for the introduction of a new type of service supporting the integration of health and social care. This range of new professional activities can be called 'integration services' for the citizens and health and social service providers within the target area. Integration services are defined as the additional supporting services needed to ensure the integration of health and social services in the defined catchment area. The introduction of integration services is a way to overcome the current fragmentation of the social and health services. The integration services will focus mainly on the person-centered coordination of care, case management, and proper integrated health/social planning on both the individual and population levels. There are several theoretical options for assigning the responsibility for the integration services to existing or new actors. Each, however, has its pros and cons.

The key challenge of the Governance Model is assigning responsibility for the integration of care. While there is no precedent of this being done at the level of a group of municipalities in the Slovak Republic, there are several actors that are present locally that could take on the responsibility.

Social or Healthcare service provider(s)

- **Cons:** This option would require the introduction of legislation and a financing framework at the national level (top-down approach). However, there will be the additional risks associated with insufficient qualifications, capabilities, and capacity on the part of the providers in order to incorporate these additional functions. Additionally, it might be perceived as distracting from their main responsibilities.
- **Pros:** It provides a systemic solution that would cover the whole country. However, it is not a suitable solution for the proposed model.

Health Insurance Funds

- **Cons:** This option would require the introduction of legislation and a financing framework at the national level (top-down approach). The HIFs do not cover social care, so taking on integration would represent a substantial expansion of the areas of responsibility for them. This expansion of responsibilities will raise questions about a conflict of interest at the for-profit type of Health Insurance Fund (HIF). Even more generally, it is not clear how the HIFs can be incentivized to add integration services to their responsibilities. If it is done through a legislative mandate, will health insurance remain an attractive market niche for the private sector? Additionally, the HIFs do not operate locally, so while they should be a part of the discussion about the integration of care financing, they cannot take on the job of providing integration services.
- **Pros:** The HIFs have all necessary data to optimize the distribution of services and to incentivize the providers of health services (currently optimizing profitability). Therefore, it is necessary that this model advocates the importance of engaging in negotiations with the HIFs.

Government / a new government entity

- **Cons:** A new government entity would be an innovative approach requiring substantial structural and administrative reform, which usually takes a lot of time. It will create a top-down approach by design and will be too far removed from the citizen—meaning that it will be less suitable for the adjustment of services to the local needs and circumstances. The role of the region and municipalities in service provision and service delivery design would be unclear.
- **Pros:** It would cover the whole country and could introduce a unified approach with certain benefits of scale.

Self-governing region (BBSK and others)

- **Cons:** This option runs the risk of adding, on the one hand, a function that distracts from the multitude of responsibilities of the regional government; and, on the other hand, being too far down the list of priorities to get sufficient attention of the regional leadership. This option will still be too far removed from the citizen and would not allow for the full engagement of the municipal leadership. This option would also require the reform of regional responsibilities on the national level in order to expand regional authority. Currently, the political will to finance health care measures at the regional level is limited due to the restricted scope of responsibilities in this field that are held by the self-governing regions.
- **Pros:** It would provide a centralized approach across the region, would allow some benefits of scale in combination with some adjustments to the local contexts.

Municipalities (individual)

- **Cons:** The limited financial and human resource capacity of municipalities would make it impossible to implement. Additionally, integration at such a small scale would not be efficient and would, at best, result in fragmentation.
- **Pros:** It provides a hyper-local solution that is close to the beneficiaries.

The existing joint office (focused on education, construction permiting, and local roads maintance)

- **Cons:** This option will need to use a structure that the municipalities established for another purpose. There is a risk of an extremely limited eligibility of the legal form of the joint office to receive EU funding. The joint office does not include social and health agenda, only education (elementary schools) and construction agendas, including local roads maintenance.
- **Pros:** This option utilizes the preexisting structure, thereby leveraging the existing record of accomplishment in municipal collaboration. It is also a solution that is close to the beneficiaries.

New entity—the Integrated Elderly Care Agency

- **Cons:** This option incurs the extra administration costs of running a separate entity (minor). There is only a limited capacity of qualified personal available locally. There is a risk of limited eligibility for EU funding in the case of a nonsuitable legal form.
- **Pros:** The entity will be a specialist in care management and integration, and it will have a clear scope and mission. If necessary (preferably not), it can act as the social or health service provider. With this solution, the responsibility, financing, and control of the entity stays with the municipalities in South Gemer FG, and therefore also close to the beneficiaries.

Based on the evaluation of the options for assigning the missing set of functions, we suggest establishing a new entity, which we will be referred to as the Integrated Elderly Care Agency (or 'the Agency'). In various countries, the functions described above are distributed among various system actors (depending on national legislation), combining them, for example, also with the responsibility for health or social services (National Health Service [NHS] trusts in the UK, health districts in Germany, and others). In respect to the situation in the Slovak Republic, we therefore suggest the delegation of those functions to a dedicated entity (the Agency) under the governance of the partnership of municipalities (*see Figure 14*). Among others, these are some of the reasons why this is the best option:

- The Agency will be an organization with a clear focus and a commitment to improving elderly care (which will be harder to achieve under the existing joint office arrangements), and this will be important for attracting and accumulating the necessary expertise.

- At the same time, the Agency will be a natural extension of municipal authority, as the municipalities will form its board, define its strategy and priorities, and hire its key staff.

- The list of specific functions and responsibilities of the Agency can be defined by the municipalities, which will make it much more adjustable to the local circumstances and the willingness of the municipalities to contribute resources. This will make the model more sustainable in South Gemer FG, and more replicable in other areas.

The main reasons to prefer the model where integration services are provided by the Integrated Elderly Care Agency versus the option with the health and social service providers include the following:

- The main professional focus, qualification, and incentives in the social and health service providers and the workforce are targeted toward maximizing the quality of medical/social service itself. Therefore, the integration of care would only play a minor and unimportant role compared to their main objectives.

- Integration services are not recognized and not awarded in the payment mechanisms of the social and health systems in the Slovak Republic today. Introducing it would require a major reform.

- The result of a model of integration, based mainly on the involvement of the social and health service providers in delivering the integration aspects of the model, would depend on the individual attitudes of the providers and their employees, rather than being established at the level of the whole local system of care provision.

The Agency is a professional executive entity providing integration services—the additional supporting services needed to ensure the person-centered integration of the health and social services. The full scope of the integration services provided by the Agency is described later in the Process Model section of this document. The Agency should be managed by professional staff, and the executive management (director) should report to the partnership board. There are diverse options concerning the legal form(s) of the Agency, considering various aspects (that is, the ability to receive EU grants). Out of several identified legal forms, the authors of this report recommend setting up the Agency as a nonprofit organization (NPO) (see Annex 2 for a more detailed discussion). By establishing a legal entity of municipalities which are entering a formal partnership, they take on collective responsibility for the management of the new organization and they act as an oversight partnership board as well. The final decision about the legal form of the Agency needs to be made by the municipal leadership and should be based on further legal analysis.

Stakeholders engagement platform

The stakeholders engagement platform operated by the Agency should ensure and support continuous consultation dialogue between the stakeholders (service providers, health and social workers, citizens, NGOs, and others), the community, and the partnership/Agency. The platform will be an integral part of the community planning process. The subject of the dialogue should be health and social service issues in the South Gemer FG, plans and activities of the Agency, and so on. The consultations can take the form of meetings, discussions, presentations, information campaigns, education events, and others. Involving the community stakeholders is crucial for public support and the long-term sustainability of the proposed model. The model should be defined and developed by the real needs of the people and other actors involved in service provision (that is, health care service providers, medical doctors, and nurses), involving experts' work to support this purpose, in contrast with an approach driven by the experts' specific agendas. The vital link with the stakeholder groups will help keep the focus on solving the practical problems identified in service provision (such as, dysfunctional services or processes, low quality of services, lack of services, obstacles in getting services, and so on), as well as the onboarding of the people and other stakeholders for active participation. The Agency can act as an intermediary that collects feedback from the beneficiaries and transmits it to the service providers, and then works with them to address the complaints. The beneficiary's comments can also lead to changes in the Agency's priorities. For example, if it identifies shortages, the Agency can recruit new providers to the area; it can also lobby the regional government and negotiate with the HIFs to increase funding for specific services and functions. While the Agency's executive powers will be limited, it will be well positioned to have a holistic view and understanding of the system.

Health and social service providers

Under the proposed model's design, the health and social service providers retain their current functions and roles. The integration of their services will be achieved through the provision of integration services as described in the Process Model. This is based on the analysis presented in Annex 2: Governance Model, Analysis of Options.

INTEGRATION PROCESS MODEL

The integration Process Model covers the operational aspects of the integration of care for the elderly. It predominantly focuses on the functions and responsibilities of the Integrated Elderly Care Agency, identifies steps that need to be taken to build the capacity needed to fulfill these functions and, finally, defines the Integration Process Guidelines—a key instrument for the integration of care.

Importance of defining the operating principles for the new model

The Integrated Elderly Care Agency[38] is a new type of organization, performing new types of activities and providing new types of complex services involving many entities and citizens. Therefore, it is important to invest in an initial effort to develop and plan its operational and organizational principles.

There are three main groups of Agency activities:

- Services provided to the citizens (such as, the coordination of care, individual health planning, and others)
- Services provided to the health and social service providers and the municipalities (such as, the coordination of care, service development, strengthening the person-centered approach, and so on)
- Supporting enabling services and activities (such as, data collection, project development, services to other stakeholders, and so on)

Functional areas of responsibility of the Integrated Elderly Care Agency and its proposed activities in the South Gemer FG

The Agency serves as a professional executive entity providing the supporting services needed to ensure the person-centered integration of health and social services that will achieve integrated care. The functions which should be generally covered by the Agency shall include the following:

- Population needs assessment: epidemiology of the region, health needs assessment, and population health planning;
- Integration services development: further development and implementation of the catalogue of services, services distribution masterplan for the region, and development of Integration Process Guidelines;
- Business and capacity planning for the health, social, and integration services: investment planning (infrastructure and technologies, capital expenditure), business planning (revenues, grants, operational expenditure), capacity planning based on community planning;
- Project management of transition and development projects: project development, planning and implementation;
- Operations of services provided directly to citizens, service providers, and stakeholders: health planning for individuals, health programs for populations, coordination of care provided by the health and social service providers, building capacity to support the person-centered approach and individual planning, education and training of service providers, services to the stakeholders, and cooperation with the stakeholders;
- Data program covering populations, services, and other relevant fields: data collection and analysis program;
- Integrated system e-platform for citizens, municipalities, and service providers: electronic platform for electronic citizen records, health planning, information exchange for service providers, integrated services management platform, data collection platform, and citizen/members information platform.

Based on these high-level functions, a set of activities proposed to be managed and executed by the Integrated Elderly Care Agency of the South Gemer FG was identified. The list includes:

- Health and social needs assessment of the elderly: epidemiology, morbidity, comorbidities, social needs, health needs, and unmet health needs
- Systemic problem detection: identification of problems preventing the proper access or quality of care from the perspective of the elderly population, service providers, municipalities, and other stakeholders; staying involved in community planning in the South Gemer FG
- Informing the elderly in the South Gemer FG about the integration services for citizens provided by the Agency
- Informing the relevant service providers about the integration services provided for service providers and citizens by the Agency
- Stakeholders' engagement platform activities: organizing meetings, engaging the health service providers, physicians, nurses, social service providers, caregivers, nonformal caregivers, municipalities, the BBSK, NGOs, and others
- Developing and implementing the IPG (including the training of service providers) with the aim to implement a person-centered approach
- Services development planning (including services master plan update)
- Human resources (HR) capacity development plan for the health and social work force
- Investment plan for the health and social infrastructure
- Service innovation (that is, introducing new methods of work in health, social, and integration services)
- Financial flows data collection, analysis and planning in health and social services
- Cooperation and negotiations with the HIF in planning for the financing of the health care services (that is, developing, together with local health and social service providers, new ways, including financial incentives, to achieve better experience and outcomes for the clients of the HIFs). The Agency should aim to demonstrate to the HIFs that the integration of care is in their interest, as it allows them to save on expensive acute care through investing in preventative practices. This may, over time, change the position of the HIFs on supporting the integration services.
- Individual, person-centered service provision:
  - Coordination of care
  - Basic social advisory
  - Cooperation with social service providers on individual plans for their clients
  - Individual health planning
- Health promotion programs for the elderly population (planning and performance of activities for the elderly with the aim to strengthen their health and prevent health issues, prepared and executed in cooperation with the regional public health authority [RPHA] in Rimavská Sobota)
- Fundraising program: EU-funded project preparation and implementation in:
  - Health and social data collection and analysis
  - Infrastructure investment (CIZS)
  - Human resources development
  - ICT (software and hardware equipment)
  - Health promotion
  - Innovation
  - Research and development (R&D)
- Agency's own activity planning, staffing, training, and financial management

This ambitious proposal will require a substantial reorganization of care provision. Therefore, we expect that the integration of care by the Integrated Elderly Care Agency in the South Gemer FG will not happen overnight and will require several stages. The full integration of care with the wide range of activities suggested by the list above, can, at best, be achieved in the South Gemer FG after two to three years of the Agency's operation (assuming that the agency continues to be supported and expands its capacity). In the meantime, the integration activities should be gradually introduced by the Agency. It is important that when the Agency is established, its top priorities (from the proposed list) are identified for the initial period of its operation, and their implementation plan is agreed upon by all the municipalities. The achieved level of integration and service development will depend on the capacity available within the Agency. Due to the natural limitation of the number of staff, and the extent and level of their qualifications, those activities where highly specialized expertise is required should be outsourced. More information about the potential priorities and activities of the Agency is presented in the action plan section of this report.

The Agency can achieve substantial results without taking on 100% of the responsibilities listed above. The model and the Agency's responsibilities can be modified in consultation with the relevant experts, so that it develops reduced, but still substantial, improvements to elderly care. This needs to be kept in consideration at the establishment phase of the Agency. It is critical that the ambition of the model and the agency is matched with the resources and the capacity available to it.

For each of the key functions proposed to be managed and executed by the Agency in the South Gemer FG, there should be more detailed processes and workflows drawn up by the Agency. Preparation, implementation, and optimization of the processes and workflows will inevitably last over several years. The Agency can also provide health and social services (for example monitoring, home care service, and any needs assessment required for social services) in the case where it will be evaluated as feasible. The activities proposed above should be planned in detail by the Agency's professional staff. The staffing and financing of the Agency is described further in section 3.2.

The description of the Integration Process Guidelines for service providers and municipalities

The Integration Process Guidelines are a key tool for the health and social service providers and municipalities to become a part of the integrated process of care. The purpose of the IPG is to give guidance and thus ensure the appropriate immediate reaction of each actor to the needs of a particular person who is identified at the time of service provision. The actions will include, for example, sharing the information about the needs of the person, sent in a standardized format to the coordinator of care at the Agency, and in some cases, also the provider of social/health services necessary for the client/patient. For the Agency, receiving this information will serve as a trigger for further action. It is necessary to support the entire process with ICT tools such as the integration process management information system. The further development, implementation, and evaluation of the guidelines utilization is also a responsibility of the Agency. The guidelines shall be harmonized, maintained, and updated by the Agency. An example of an Integration Process Guidelines are included in this document as Annex 3.

FINANCING MODEL

The Financing Model covers the investment and operational costs of the proposed model, and the possible sources of financing. This includes the integration services as well as the financing of the costs of proposed improvements in social and health services (described in section 3.2. Service Model). This section addresses the current model of financing and proposes changes in the financial architecture that will be required to operate the proposed model. It includes a rough estimate of the costs and contributions required that would need to be clarified and further detailed as model implementation is initiated.

The Financing Model differentiates between three main perspectives:

- Financing of Integration Services—as this is an area new to the Slovak system of care, the focus is on identifying a new systemic way of financing for the new types of integration support services proposed to be introduced.

- Financing of Health Services—as there is no available information about current financial flows on health services in the South Gemer FG, the focus is on proposing how to ensure a better allocation of services financed from public health insurance funds, in terms of availability, reflecting the needs of the elderly population in the South Gemer FG, as well as the need for the integration of health and social services under a given system of financing. The current status and recommendations for changes are provided for all geographic levels.

- Financing of Social Services—as there is more detailed information on the current financial flows to the social services available, the focus is on proposing how to increase the volume of financial resources according to the existing legislation, in a way that reflects the needs of the elderly population in South Gemer FG, all under a given system of financing.

Financing the new integration services

Financing for the integration of care in the Slovak Republic is currently nonexistent. A combination of national and local action is needed to change this situation. On the **national** level, we propose introducing legislative changes to ensure the systemic financing of integration services. On the **national level, for the EU-funded** interventions we propose to provide support for the integrated care model implementation in the form of grants for microregions/partnerships of municipalities to cover the establishment costs, such as personnel cost, expert services, data collection and analysis, and ICT. On the **regional level**, we do not consider a need for additional contributions, provided there will be sufficient financial resources available in South Gemer FG. However, the region can act as a guarantor of the funding responsibilities of the municipalities. The regions will also remain a part of the system of financing for the integrated services, as they remain responsible for a substantial amount of health and social care. On the individual **municipal level**, there is a need to introduce contributions from the municipal budgets that accumulate to support integration of care **at the South Gemer FG level**. Financing (payment for services) **on the level of the individual person** should be considered, but only in the future, and after analysis and discussion with the stakeholders in South Gemer FG. Introduction of payments by beneficiaries during the testing phase of the model's implementation would be counterproductive, given that the new service model would be an unknown entity for most, and given the exceptionally low purchasing power of people in South Gemer FG. For all factors mentioned above, introducing personal contributions will not generate substantial income.

The municipalities should share the costs of the Integrated Elderly Care Agency. In the long term, the Agency and its operations should be predominantly financed by the municipalities of South Gemer FG. However, during the establishment phase, the operation costs should be supported by external financial sources to develop trust in the functionality and usefulness of the system (that is, for up to three years). Overall, the financial and legislative framework for the support of integrated care should be developed by the national government. Currently, however, the implementation of this model should be an opportunity to collect and share the information about the costs and implementation of the integration of care, using a 'bottom-up' approach. The activities and the model of funding for the Agency should be discussed and agreed on by the municipalities before the creation of a legal entity. Options regarding the legal form of the Agency are discussed in Annex 2.

The scope, the capacity needed, and thus the costs of operation of the Integrated Elderly Care Agency, are subject to agreement between the municipalities. The number of staff members and the organizational structure of the agency will depend on the decision of the municipalities and the board of partnership on the final range of activities of the Agency. The minimal level of activities (management and coordination of care) of the Agency should be financed mutually by the municipalities via the partnership. The establishment phase of the Agency as well as the full proposed activities are beyond the financial capacity of the South Gemer FG municipalities. An external financial intervention for the pilot phase (Support from BBSK government, national government or EU) would be necessary. The size of the new additional costs of the integration services will be defined by the scope of the Integrated Elderly Care Agency as approved by the municipalities through the partnership. The minimum feasible capacity of the Agency should include two full-time employees providing the coordination of care, sharing appropriate office space and equipment. The rough estimate of the minimum costs is €50,000 per year. Related aspects are discussed in the subsection on the Integration Process Model in section 3.2, as well as in the section 4.1 on the action plan.

Financing of health services

While there are no major changes expected to the financing of health services, the focus could be on maximizing access to resources at the local level. In current conditions, and under the new model of elderly care provision in South Gemer FG, the Agency can play the role of representing service providers to negotiate coverage and reimbursements with the HIFs. The **national system** financing of health care services is not expected to be changed in a major way in the near future.[39] Therefore, it makes more sense to focus on negotiations and the cooperation of the Agency with the HIFs to ensure there is sufficient contracting and funding of health care services available to the elderly in South Gemer FG, as well as to help introduce changes in the payment methods of the HIFs which support the integration of care. Some Slovak HIFs already have minor experience with health service integration[40]. HIFs are open to discuss the integration of financing issues, provided there is additional value generated for their clients. Currently there is no systematic way of financing integration services, as the HIFs are relatively autonomous in making decisions about purchasing health care services. Contrary to the social services, the data on the total cost of health services in each area (including South Gemer FG) are not disclosed by the HIFs. This fact makes it impossible at this stage to model the costs for health care service providers under the new system. The existing financing of **health promotion and protection** is through the budget of the public health authority (ÚVZ) (the regional public health authority [RÚVZ]). We propose that the Agency should negotiate with the RÚVZ in Rimavská Sobota to secure funding for services within South GemerFG. Additionally, the Agency can enter cooperation with private partners, which is a minor (in terms of the funding that can be secured) but proven way of fundraising for health promotion activities.

Given the current situation the following adjustments are proposed at each of the potential funding sources:

- **EU funds** allocation for health care is defined **at the national level**. The existing Integrated Health Care Centers (IHCC/CIZS) program, supported through the Specific objective 2.1.2. of IROP, supports the modernization of healthcare infrastructure for the purpose of primary health care integration. We propose to continue this support, but with major modifications in the concept and conditions, focusing on real integration outcomes and the strong participation of the South Gemer FG partnership of municipalities. Further, we propose to specifically support those health care services which are insufficient in South Gemer FG. To move the decision-making on the interventions to support the health care services development to the regional level (SGR or selected municipalities) would be of benefit. However, a reasonable level of advance community planning should be required as a precondition to the interventions.
- On **the regional level,** there is a system of financing of health care, and we do not anticipate the need for changes to the established system. However, the region might need to be ready to support the Agency in the establishment phase (this will depend on the availability of EC support).
- On the **municipal level,** there is no, or very limited, financing of health care (mainly for the renovation of health care facilities). We propose shifting the focus to pooling the available resources at **the South Gemer FG level** to support the Integrated Elderly Care Agency and to address other issues in the whole catchment area. Funding would be needed for the development of health and social services which fall within the responsibilities of the Agency.
- In terms of **individual contributions from beneficiaries,** the health insurance payments and the co-payments for the services, drugs, and medical aid equipment are currently the subject of regulation on the national level, so decisions about introducing new co-payments cannot be made locally.

Financing of social services

Social care financing is a recognized problem in the Slovak Republic. The basic framework for financing for most of the social services relevant to is prescribed by the law. There is a lot of evidence that this system is not sufficient, especially in the case of smaller municipalities. The new government has announced several reforms in its manifesto, but so far, they have not presented the full content of the reform, or even its key principles.

However, while the announced reforms are needed and highly anticipated, we are not aware of the exact timing and details of the proposals; therefore, they are not built into the current proposal. The social service provision in the proposed model takes into account the existing system and the sources of financing it includes at the national, regional, and municipal levels. Additional financing is necessary due to the insufficient provision of services. In addition to client payments, the regional budget (facility, founded by the region), the contribution from the Ministry of Labor, Social Affairs and Family (nonpublic and municipal providers), and the municipal budget, directly cover a part of the cost of elderly social care.

- The largest share of financing for social services in 2019 came from the BBSK (regional level) budget, as it is the founder and provider of the existing residential services facilities. The region also co-finances the operation of some of the private providers (social service homes).

- Municipalities, according to the current legislation, should co-finance social services for seniors from their receipts of the share of personal income taxes. This funding should cover the cost of the provision of home care services and be a contribution to covering the operating costs of the nonpublic and municipal providers of social services. However, this is not an obligation, and the municipalities are only recommended to use five percent of their income tax receipts for social services for citizens 62+. For 13 South Gemer FG municipalities, the five percent of total income tax receipts was equal to € 269,524 in 2019, which substantially exceeds the costs of the currently existing municipal providers. The total expenditure of the four municipal providers on social services in 2019, was less than € 75,000 (and they were also covered by an EU grant and client payments, in addition to the municipalities' contributions).

- The recommended amount of municipal funding for social care should be redirected to support the Integrated Elderly Care Agency, which should identify the best mode of delivering the missing services. Services, a lot of which are missing in the South Gemer FG, are the responsibility of the municipalities. Due to the small numbers of inhabitants in individual municipalities, and the correspondingly small tax incomes, there is no way for small municipalities to provide social services. For example, the municipality of Lenka has 200 inhabitants. Its total monthly tax receipts forming their share of income taxes is € 3,520 per month, of which € 176 is designated for services for the elderly. Based on that income, the municipality cannot even employ a social worker or a caregiver on a part-time basis. Because of this lack of local resources in the South Gemer FG, the services for seniors that should be co-financed by the municipalities, are missing or are provided by the BBSK (retirement home). We propose that municipalities use the bulk of the five percent of their income tax receipts (that are commended to be spent on social care) toward funding the Integrated Elderly Care Agency. The agency can work to identify the most efficient way of providing and financing the missing services. The Agency also has the option of acting as a provider itself, hiring the specialists required, and dedicating funding from its own budget to cover the costs.

The data on the total cost of social services in the South Gemer FG is only partially available. The model assumes that the addition of missing social services and the necessary infrastructure will be required in the area to achieve satisfactory level of service provision. Due to the large shortage of necessary services, especially outpatient and outreach services, compared to the standard, the increase in operating costs for social services could amount to at least two-and-a-half times the current costs. In 2020, according to the analysis, the cost of the provided social services for seniors by all the providers in the South Gemer FG was € 1.719 million. This includes the cost of the retirement home, the senior clients of the social service home, day care center, home care service, and transport service. The estimated cost of the services is hard to calculate precisely because they depend on the agreement of the partnership of the municipalities and the community plan for social services. If they would like to establish all the missing services and capacity according to standards, and reach the cost benchmark of the services cost in the Banská Bystrica Region, the total cost could be up to € 4,459,549.92. The details in *Table 7* show the estimated annual operating costs of all social services to meet the standards in terms of type and capacity.

TABLE 7. Estimated Annual Operating Costs of all Social Services

Type of social service for elderly in the South Gemer FG (proposed)	Form	Number of units to reach standard	Average cost per year
Retirement home	residential	99	€ 1,059,197.04
Retirement home	residential	46	€ 492,152.16
Day care center	outpatient	15	€ 67,613.40
Home care service 1+2	outreach	4	€ 65,200.00
Transport service	outreach	20	€ 35,600.00
Specialized facility NEW	residential	40	€ 636,000.00
Specialized social advisory/ support to live independently NEW*	outpatient/outreach	2	€ 18,000.00
Nursing home NEW	residential	12	€ 126,288.00
Retirement home NEW	residential	12	€ 128,387.52
Day care center NEW**	outpatient	15	€ 67,613.40
Home care service NEW	outreach	105	€ 1,711,500.00
Rental equipment NEW	outreach		-
Monitoring and alarm for the need of assistance NEW	outreach	30	€ 13,298.40
Daily Center NEW	outpatient	2	€ 18,000.00
Canteen NEW	outpatient	5	€ 20,700.00
Respite service NEW	included in capacity of Retirement home/ Nursing home, Home care service and Daily center		
			€ 4,459,549.92

** More detailed information is available in Annex 6: Financing model—Social Services.*

Source: authors estimates based on data provided by different social care providers in BBSK.

Fulfilling the expected standards is financially unrealistic in the short term. Therefore, we propose to introduce social services gradually in stages. The partnership of municipalities, in the process of community planning and cooperation with the BBSK, must choose the combination of services to start with. However, we strongly recommend supporting the development of outreach care services, transport services, and services that will help relieve domestic nonformal caregivers (for instance, outpatient services). These types of services are less costly to provide and do not require substantial infrastructure investments. With regard to residential services, it will be important that the BBSK reaches an agreement with the partnership regarding the incorporation of the services in the retirement home (which currently covers the region) into the broader elderly care model and the coordination of services offered with the Integrated Elderly Care Agency. (The services provided in the retirement home, and funded by the region, technically fall under the responsibilities of the municipalities.)

Given the service deficiencies in the area, we assume that the financing of services by the region will need to be maintained for the foreseeable future. At the same time, we expect a higher rate of co-financing from the municipalities—at least at the level of the recommended five percent of shared taxes channeled through the Agency. This will allow the Agency to start operating, identify service provision gaps, and plan to fill them. Finally, at the beginning, financial support from EU funds will be needed for the completion of the infrastructure and the launch of some new services. ESIF allocations currently support home care service, deinstitutionalization activities (training, infrastructure investments), and community-based services (infrastructure investments). We propose to continue the support of community-based services, and expand support to long-term care (training, soft skills, as well as infrastructure investments, including social housing for seniors), and social innovations in elderly care/support and active aging.

SECTION 3.3

A PERSON-CENTERED LOOK AT THE MODEL

APPROACH

Person-centered care is an internationally accepted approach to organizing care provision. The person-centered approach was developed by the psychologist Dr. Carl Rogers (1902–1987). This approach has grown beyond the field of psychotherapy and can be applied in education, health care, social work, management, and even politics. The people-centered approach in social or health services consciously adopts the perspectives of the individuals, families, and communities, and puts them at the center of the care and service provision models. The provided services should respond to their needs and preferences in humane and holistic ways. People-centered care requires that people have the relevant information and support that they need to make decisions and participate in their own care—empowerment of the individual. This approach is organized around the needs and expectations of people rather than their 'problems'.

The person-centered approach could be provided through integrated and coordinated care based on an individual plan. The key condition for effective and successful individual planning is cooperation. Collaboration on individual planning means:

- Defining what a person needs support for, and what they can do on their own
- Who can provide this support, and which tasks can the person handle him/herself
- When support should be provided
- How support should be provided

The law on social services also defines the quality assessment of social service provision. Quality standards of social care are based on the human rights approach and UN Convention on Rights of People with Disabilities (CRPD). There is a strong focus on human rights, and a person-centered approach. One of the expected indicators of the person-centered approach are individual plans for the clients. This is also the baseline for case management and coordination in this model.

A 'key worker' in social services is a person who comprehensively coordinates the planning process together with the person, and oversees that the complex needs of the client are met. This employee plays a crucial role in planning and providing the service. He or she negotiates with the person, with whom they plan and organize joint meetings, helps to formulate individual personal goals and needs, helps to involve other participants (building a network) in the planning process, and monitors the fulfillment of the individual plans. The key worker becomes the client's guide and advocate on his life journey.

The person-centered approach is one of the key principles of the proposed model of integrated elderly care. This means that the coordination of care and integration services should permit the person/family, in a particular 'case', to identify and follow the best way to meet their needs within the existing system, based on an individual plan. This section discusses how the experience of an individual with a specific set of challenges can be transformed through the introduction of the proposed model.

CASE STUDY

The following case study underlines the basic principles of integrated care in a person-centered approach that aims to provide services which can respond effectively to the specific needs of a particular senior. The limitations of today's social and health system can be most often seen in a situation where the health conditions of a senior suddenly deteriorates, and it is necessary to combine health and social care. This case study illustrates two scenarios for one situation of a particular senior. The study demonstrates the opportunity for positive changes for the elderly through the implementation of the presented model of integrated social and health care for the elderly.

Description of the situation

Anna is a 79-year-old widow who lives alone in a village near Tornaľa. Her two children and their families do not live in the same area, as they moved far away to bigger cities for work. One lives and works in Banská Bystrica, the Slovak Republic (134 km away from Tornaľa), and another one in Budapest, Hungary (187 km away from Tornaľa). Both try to visit Anna at least once a month. Anna has heart disease and regularly visits a doctor in Rimavská Sobota which is approximately 27 km away from Tornaľa. She needs prescribed medication regularly, but she is not aware of how to use the electronic prescription, so she needs to visit the doctor more often. She is able to take care of herself. She can cook and clean the house. However, she does not feel comfortable doing work in the garden and waits for her children's help. They also help her with large store purchases.

Unfortunately, Anna has a stroke and needs to be hospitalized immediately in the neurology department of the hospital in Rimavská Sobota. Luckily, after two weeks in hospital, she feels better and can leave home. However, she is still not fully mobile and has to use a walking aid. The stroke also impacted her speech, and she has difficulty talking properly. In this condition, Anna is not able to take care of herself.

Case scenario in the current system

Since Anna cannot be home alone and her children are not able to take care of her immediately, they arrange for her to stay in a different hospital unit—geriatrics. Because of the unit's patient capacity, Anna needs to be transported to a different geriatrics unit that is available in a different city. Thus, she is taken to the hospital in Revúca. She stays there for another two weeks. During working days, she is visited by a rehabilitation nurse. The speech therapist does not work at this hospital. When Anna leaves the hospital, she is provided with a walking aid until she gets her own through the health insurance company.

After she is released, her family members search for practical options of care for Anna. They search on the internet, they contact friends, ask doctors, and so on. They learn that the best way to receive the relevant information is to contact the municipality or self-governing regional office. If they want to take care of her themselves, they need to contact the Labor office.

The municipality informs Anna's family that the municipality itself is not able to provide a home care service and recommends placing Anna in a residential care facility in Tornaľa. The family decides to opt for the residential care service, which requires going through a needs assessment and other administrative procedures. Moreover, the facility in Tornaľa does not have capacity to place more clients and puts Anna on the waiting list after 24 other waiting clients.

In this situation, Anna stays home, and her children need to take unpaid days off from work to take care of her. They realize that Anna needs professional medical assistance, and they request preferential placement in a specialized facility within the self-governing office. For this type of service, a needs assessment is required again and is repeated.

After a few weeks, Anna leaves to the specialized facility, which is approximately 150 km from Tornaľa. Anna leaves her house, village, and community and starts to live in a specialized facility in a bedroom with another senior, probably for the rest of her life.

Main problems of the current situation

The current system is fragmented and many services in the South Gemer FG municipalities are insufficient. In cases like Anna's, the main weaknesses of the system are evident. Due to the absence of preventive contacts and any monitoring of the situation of seniors living alone, there is a late provision of adequate help and support. If there is an absence of follow-up care services, hospitalization in acute hospital beds is extended. In emergency situations, relevant information is not provided to family members proactively. There is a lack of both service coordination and a unified need assessment system. Therefore, the client will most often receive only the care provided by one provider. The South Gemer FG lacks several social services, especially outreach home care, and nursing care and facilities that offer an option of short-term stays with rehabilitation (nursing home).

Case scenario in the future system aligned with the presented model of integrated social and health care for the elderly

Since Anna is a cardiac patient, the Agency for integrated services has her medical information in its database. For prevention purposes, she was provided with a monitoring bracelet and can contact the emergency service at any time. In addition, she is regularly visited by the Agency (coordinator) who monitors her health and social needs as well. When Anna suffers a stroke, her monitoring bracelet alerts the Agency and emergency services, so she can receive immediate help. During her hospitalization in Rimavská Sobota, the Agency starts planning 'the next steps' with Anna's family and her doctor. The Agency has all the information about its clients, and each client has already prepared an individual care plan for such cases, based on the principle of advance planning. At the end of her hospitalization in neurology, Anna needs intensive rehabilitation and support from the speech therapist. In Tornaľa, the capacities needed for her treatment are created in a nursing home, which provides short-term stays for people in a comparable situation, or to relieve the informal family caregivers. For the provision of this service, a needs assessment is required and is provided by the Agency, which is delegated to perform this function as an organization established by local governments.

During her four-week stay at the nursing home, the Agency prepares a care plan for her home environment—food delivery and care service. The visit of a cardiology nurse (or a doctor) will be arranged to check the patient's condition and adjust the treatment. The Agency also arranges a consultation with a speech therapist and home caregivers for further support in therapy. After returning to her own house, Anna is provided with a comprehensive care plan for the week, as well as during the weekend, if needed. Anna is able to stay in her own home. Besides the professional services, she also has support from her neighbors, occasional volunteers, and family members.

Main benefits of the proposed model

The proposed model provides seniors with the certainty that there is someone they can turn to in a complicated situation. They are in contact with the Agency and all their acute needs or health deterioration are monitored. In case any problem arises, all information is available in one place. Moreover, the Agency's staff can also help with arranging the many administrative procedures that follow. Fully operational integration services can prevent unnecessarily prolonged hospitalization. The most important benefit of the proposed model is providing seniors with care in their home environment, if possible, due to the proper coordination of services and the availability of the appropriate services.

CHAPTER 4

BUILDING THE MODEL

This section of the report focuses on the steps that need to be taken to establish the model of elderly care described above. First, the action plan for establishing the Integrated Elderly Care Agency is discussed. Then the proposal to establish the Integrated Care Center (ICC) is discussed in detail. After which the question of mobilizing financing for the establishment of the model is covered. Finally, additional recommendations related to improving care provision in FG, to necessary national reforms and to potential replication of the model are provided.

SECTION 4.1

THE ACTION PLAN FOR THE INTEGRATED ELDERLY CARE AGENCY

Achieving the integration of care will be a gradual process over several years, starting with a lower level of integration (that is, coordination of care) and eventually leading to a fully developed model. The pace of development will depend on the resources available and the level of cooperation achieved with the other parts of the social and health systems. Overall, the municipalities would need to decide what level of integration and model development they want to pursue, based on the available resources. Hand in hand with the integration of services, service provision issues must be addressed, including those services which are provided also to people other than the elderly.

This section offers a list of the key activities for each initial period of the development and implementation of the new model for care integration. Not all the activities listed are mandatory for achieving an improved quality of care, even though all are required to build a fully functional integrated model.

The initial period of model implementation will include the following stages (a more detailed description of activities is presented in *Table 8*):

- Preparation period (for preparing the start of the Agency)
- Establishment and pilot period (for the full establishment and pilot execution of all major functions of the Agency and key interventions in the infrastructure)
- Routine operation

Preparatory period

The preparation period starts with the decision process for the establishment of the partnership and the Integrated Elderly Care Agency, and continues till the Agency starts to perform its activities. The period is likely to last up to six months. This phase of the model's implementation is characterized by planning, consensus building, and key decision-making at the South Gemer FG level, leading to the creation of governance structures. After this phase, the partnership and the Agency will be able to start to execute the establishment and pilot activities.

- First, the municipalities and other stakeholders should be informed about the proposed model and several rounds of discussions should take place to ensure the mutual understanding and acceptance of the model among all the stakeholders. The scope of the preliminary activity of the Agency for the establishment and pilot period should be discussed as well.
- Decisions about the establishment of the Agency should be held at the level of the municipalities, resulting in a preliminary agreement in the form of a memorandum of understanding between the municipalities, or some similar form.

- For the establishment of the Agency, a legal entity should be created and a board of partnership (BoP) should be established. Subsequently, the selection of a director and staff for the Agency should be organized by the BoP.

- Office space for the Agency should be rented and equipped with all the necessary equipment.

- The internal organizational rules, procedures, and workflows of the Agency should be defined.

- The Agency's own activities for the establishment and pilot period should be planned by the Agency's staff. Personnel capacity and budget (including payroll, office rent, office equipment, ICT costs, and the cost of external services—such as legal advice, accounting, tax advisory, security, and other specialized professional services) should be planned according to the activities.

- The Agency's plan for the establishment and pilot period should be approved by the BoP.

- If possible, the staff of the Agency should participate in the ongoing community planning process.

Establishment and pilot period

The second period of Agency operation should be used to test and adjust all the necessary aspects of its operation. This phase begins when the agency starts to execute the activities planned and approved during the preparation phase, and lasts until the planned activities are successfully fulfilled. This phase is expected to last up to 24 months (about two years). During this period, the internal capacity and capabilities should be established and every aspect of the proposed model should be tested, and if necessary, adjusted before the phase of routine operation starts. Increased external expert consultation and financial support for the Agency will be required during this period.

The planned activities of the Agency should be executed during the establishment and pilot phase in a trial mode. The lessons should be recorded, and adjustments for the future should be defined and introduced. The following functions (or a subset of them, if the defined scope of the agency is smaller according to the agreement of the partnership) should be tested:

- Health and social needs assessment for the elderly should cover the following elements: epidemiology, morbidity, comorbidities, social needs, health needs, unmet health needs, and typologies should be measured and analyzed.

- Systemic problem detection should provide the identification of problems preventing proper access to, or reducing quality of, care, from the perspectives of the elderly population, service providers, municipalities, and other stakeholders.

- It is crucial to inform the elderly in the South Gemer FG about the integrated services for citizens. The Agency should ensure that the population understands the available elderly care options.

- It is necessary to inform the relevant health and social service providers about the integration services provided to the service providers and citizens by the Agency.

- Stakeholders' engagement should include the program of activities prepared on a regular basis, mainly in the form of meetings involving service providers, physicians, nurses, health service providers, caregivers, informal caregivers, municipalities, the BBSK, NGOs, and others.

- Integration Process Guidelines should be developed, updated, and implemented (including the training of service providers).

- **Services development planning** should be performed within the following stream of activities: (i) financial flows data collection, analysis and planning in health and social services should be performed, (ii) services master plan should be developed and updated, (iii) HR capacity development plan for the health and social work force should be made, (iv) an investment plan for the health and social infrastructure should be prepared, and (v) a service innovation plan (that is, introducing new methods of work in health, social, and integration services) should be prepared. These planning outputs should be used as a valuable input to other activities, mainly fundraising and the management of development projects.

- **Cooperation and negotiations with the HIFs** in the planning and financing of the health care services should be done on regular basis. Cooperation can be realized, for example, in the pilot testing of new incentives for the integration of care, analysis of the HIFs' data and the patients' experience, identifying potential for improvement.

- **Individual person-centered service provision** should be the core activity performed by the Agency's internal staff. Within this stream of activities, the coordination of care, individual health planning, and basic social advisory should be provided to the citizens on a daily basis.

- **Health promotion program** for the elderly population should include proper planning and performing of activities for the elderly, with the aim to strengthen their health and prevent health issues. This should be prepared and executed in cooperation with RÚVZ in Rimavská Sobota.

- **EU-funded project identification**, preparation, and implementation should be performed in collaboration with municipalities and BBSK, scientifically as the program for the new programming period is being finalized.
  It is commended that further EU financing is mobilized for health and social data collection and analysis, infrastructure investment (such as ICC/CIZS), human resources development, ICT (software and equipment), health promotion, innovation, R&D, and so on.

- **Contribution to national government policy**—the Agency should aim to stay in dialog with BBSK and relevant national government agencies to transfer experience accumulated during the model implementation phase in order to create a legislative and financing framework for the integration of care in the Slovak Republic.

Throughout the pilot period the Agency should be supported, and its results should be evaluated. The activities of the Agency during the establishment and pilot period should be sufficiently supported by outsourced professional services, such as data collection services (design, collection, evaluation), opinion research services, communication services, facilitation services, project management services, and various expert advice (for example, in epidemiology, population health, health planning, health insurance, medical specialties, architecture, and so on). The Agency's activity plan should be evaluated by the board of partnership (BoP) on a yearly basis. After the end of the establishment and pilot period, this phase should be evaluated, and changes to the model of integrated care for the elderly and its routine operation, should be proposed.

***Table 8* below offers a more detailed list of activities that should be considered for the Agency in the preparation and establishment periods.** The actual action plan for the agency needs to be developed using this proposal, but it should also take into account the specific ambitions and goals set for the agency by the partnership of municipalities.

TABLE 8. Action Plan for the Establishment of the Integrated Elderly Care Agency

	Activity	Duration	Responsible party	Description
Preparation period (up to 6 months)				
First Priority	Model acceptance	0–1 m	WB+BBSK+ municipalities	Municipalities and other stakeholders informed about the proposed model, after several rounds of discussions, common understanding and acceptance of the model among all stakeholders achieved
	Agency scope	0–1 m (parallel)	WB+BBSK+ Municipalities	Scope of preliminary activity of the Agency for the establishment and pilot period (E&P) discussed
	Decision on the Agency	0–1 m (parallel)	Municipalities	Decision about the establishment of the Agency at the level of municipalities made, resulting in a preliminary agreement in the form of a memorandum of understanding of municipalities, or similar
	Legal entity creation	2–3 m	Municipalities with external support	Legal entity created for the establishment of the Agency, and board of partnership (BoP) established
	Staff selection	2–3 m	BoP	Director and staff of the Agency selected by the BoP
	Office renting and equipment	3–4 m	Agency	Office space for the Agency rented and equipped with all the necessary equipment
	Operational process development	2–4 m	Agency	Internal organization's rules, procedures, and workflows of the Agency are defined
	Agency Establishment and Pilot (E&P) period planning	2–4 m	Agency	Agency's own activities for the E&P period planned by the Agency's staff. Personnel capacity and budget (including payroll, office rent, office equipment, ICT costs, costs of external services such as legal advice, accounting, tax advisory, security, and other specialized professional services) planned according to the activities
	Agency E&P period plan approval	4–6 m	BoP	Agency's plan for the E & P period approved by the BoP.
Second priority	Contributing to community planning	4–6 m	Agency	The staff of the Agency participate in the ongoing community planning process.
Establishment and Pilot period (up to 2 years)				
First priority	Integration Process Guidelines development and implementation	First 1–6 months of the phase	Agency	Integration Process Guidelines should be developed, updated, and implemented (including training of service providers)
	Information dissemination	2 years	Agency	Informing the elderly in South Gemer FG about the integration services for citizens. The Agency should ensure that the population understands the available elderly care options. Informing the relevant health and social service providers about the integration services provided to the service providers and citizens by the Agency
	Individual service provision	2 years	Agency	Individual, person-centered service provision should be the core activity performed by the Agency's internal staff. Within this stream of activities, coordination of care, individual health planning and basic social advisory should be provided to the citizens daily.
	Project identification, preparation, and implementation	2 years	Agency	EU-funded project identification, preparation, and implementation should be prepared in the areas of health and social data collection & analysis, infrastructure investment (such as ICC/CIZS), human resources development, ICT (software and equipment), health promotion, innovation, R&D, and so on.

	Activity	Duration	Responsible party	Description
First priority	Systemic problem detection	2 years	Agency	Systemic problem detection should provide identification of problems preventing proper access or quality of care from the perspective of the elderly population, service providers, municipalities, and other stakeholders.
	Cooperation and negotiations with the HIFs	In the second year of the phase	Agency	Cooperation and negotiations with the HIFs in planning and financing of the health care services should be prepared on a regular basis. Cooperation can be realized, for example, in the pilot testing of new incentives for the integration of care, analysis of the HIFs' data and the patients' experience, identifying potential for improvement.
Second priority	Stakeholders' engagement	2 years	Agency	Stakeholders' engagement should include the platform of activities prepared on a regular basis, mainly in the form of meetings involving service providers, physicians, nurses, health service providers, caregivers, informal caregivers, municipalities, the BBSK, NGOs, and others.
	Health promotion program	2 years	Agency with BBSK and relevant national authorities	Health promotion program for the elderly population, including proper planning and performing of activities for the elderly with the aim to strengthen their health and prevent health issues. This should be prepared and executed in cooperation with RÚVZ in Rimavská Sobota.
	Services development planning	2 years	Agency	Services development planning should be performed within the following stream of activities: (i) financial flows data collection, analysis & planning in health and social services should be performed, (ii) services master plan should be developed and updated, (iii) HR capacity development plan for the health and social work force should be made, (iv) investment plan for the health and social infrastructure should be prepared and (v) service innovation plan (i.e. introducing new methods of work in health, social, and integration services) should be prepared. These planning outputs should be used as a valuable input to other activities, mainly fundraising and management of development projects.
	Health and social needs assessment	In the second year of the phase	Agency	Health and social needs assessment for elderly should cover the following elements: epidemiology, morbidity, comorbidities, social needs, health needs, unmet health needs, typologies should be measured and analyzed.
Third priority	National policymaking contribution	2 years	Agency	National policymaking contribution should include activities to help transfer experience accumulated during the model implementation phase, in order to create the legislative and financing framework for the integration of care in the Slovak Republic.
	The Agency's activity planning	The last 2–3 months of every year	Agency	The Agency's activity plan should be evaluated by the BoP on a yearly basis.
	Evaluation and changes to the model	The last 3 months of the phase	Agency	After the end of the E & P period, this phase should be evaluated and changes to the model of integrated care for the elderly should be proposed for its routine operation.

Source: Authors.

The action plan presented needs to be adjusted and elaborated in more detail at the time of the establishment of the Integrated Elderly Care Agency, in order to closely reflect the scope and priorities of the Agency that will be agreed upon by the municipalities.

- First-priority activities should be initiated right at the beginning of the phase.
- Second-priority activities should be initiated as soon as the Agency has the capacity, and after the completion of some of the first-priority activities.
- Third-priority activities should be initiated as soon the Agency has spare capacity, after the initiation of the first priority activities and the advancement of their implementation.

SECTION 4.2

THE INTEGRATED CARE CENTER (ICC)

While the Integrated Care Center is not essential for the establishment of the proposed model, it is seen as an important building block. It will simultaneously help with addressing service gaps, update the infrastructure and equipment for existing services, and provide facilities for services that are missing, simplify care coordination and integration (by putting the Agency, health, and social care providers under one roof), and it will also signal a fundamental change in the care offering, especially elderly care, to the population of the South Gemer FG.

The Integrated Care Center is a facility that works as a center for health and social services and is a tangible representation of the new model of elderly care. The ICC should become the new 'one-stop shop' for the care of the elderly (and not exclusively elderly), a center for integration care services, and the head office of the Integrated Elderly Care Agency. It is also expected to play a symbolic role of signaling the shift to a new model of care provision. The ICC should be established in Tornal'a, which is the most accessible location for the whole South Gemer FG. The model of ICCs is an internationally accepted mode of service provision. It is also a model that it supported by the EC and is included in the Specific objective 2.1.2. of IROP. Within this program, Tornaľa would be eligible to apply for funding to support the ICC's establishment. One option for ICC development is the renovation of the old polyclinic building that already hosts several important health services. However, the facility would need to be improved. Another option would be to use a land lot owned by the municipality of Tornaľa, which will allow the development of a modern civic amenity building that also has enough space for social services and other community functions. This decision should be based on a feasibility evaluation.

An optimal mix of services within the ICC would include (but would not be limited to):

- Primary care (GPs, gynecologists, dentists, geriatricians, pediatricians, and others)
- Selected specialists' ambulatory care (several types such as surgery, internal medicine, urology, and so on)[42]
- Diagnostics (X–ray, ultrasound, small laboratory)
- Social services (basic social advisory, home care services)
- Health promotion services
- Nursing agency

The ICC should be established by the partnership of the municipalities (or the city of Tornaľa as a member of the partnership—depending on legal constraints). The facility can be owned by, or leased long term to, the partnership/municipality of Tornaľa. The services in the ICC can be those which are provided in the selected facility already, or some can be relocated from other sites, or can be provided by providers that will be new for the South Gemer FG. The ICC should serve as a 'hub of integration' to all inhabitants of the catchment area, as well as all health and social service providers in the South Gemer FG. The ICC should also serve as a base for the Integrated Elderly Care Agency, if possible. Combination with other types of community services would be a benefit: for example, coffee shop, canteen, and so on. The final parameters of the ICC are the subject of a detailed planning process that should be led by the Agency and the partnership.

The ICC should be owned by a public entity, ideally by the partnership of municipalities. The providers of health services in the ICC will be private. The providers of social services in the ICC can be private or public. The offices will be leased to the service providers. The ownership of equipment will be the subject of individual arrangements with providers. The Integrated Elderly Care Agency should aim to manage the facility and have its offices in it. If it is done this way, part of the rent income from the facility should contribute to the budget of the Agency. However, if operating the facility is considered too big a burden for the Agency, other options should be considered.

Investment in the establishment of the ICC is beyond the financial capacity of the South Gemer FG municipalities. An external financial intervention (by the BBSK, national government, or through EU funding) is necessary. In the case of financing the capital expenditures (building and equipment) by the program of Specific objective 2.1.2. of IROP, modifications of the parameters and conditions of the call within the Specific objective 2.1.2. of IROP would be necessary for the project to be eligible within the parameters described that enable the full integration of care.

Maintenance and operation costs of the ICC can be covered by the income from the leasing space. However, the financial plan should count on the break-even point to be reached in several years, due to the time period needed for the relocation of some services to the ICC.
The integration services (for example, coordination of care) provided within the ICC will be provided by the Agency and the costs will be planned as a part of the operating costs of the Agency.

The BBSK is currently considering the development of a social care center supported by another EU initiative. The two ideas can be combined, but coordination is critical to ensure that they do not duplicate each other. Consulted experts confirm that these two concepts can be combined in one facility, even if with reduced facilities for each. This option is preferred to duplication, or to choosing a social care center over the ICC, as this would fail to address the whole scope of the service provision gaps in the area.

SECTION 4.3

THE FINANCIAL PROPOSALS

To enable or support the planned service development and integration of care, additional investments and additional operating costs shall be financed in the South Gemer FG. We have identified proposals for infrastructure investment and the support needed to cover the operating costs to establish key parts of the proposed integrated elderly care model. Because the costs of investments and additional operating costs are far beyond the financial capacity of the South Gemer FG municipalities, mobilization of EU funding would be critically important. The summary of proposals for attracting EU financing are provided in *Table 9*. Following the table, further details on projects that can use the existing or planned calls to fund infrastructure improvements are proposed.

TABLE 9. Financing Proposal Summary/Investment and Additional Operating Costs

Support area	Main objective	Amount	Applicant
The Integrated Elderly Care Agency	Direct costs of the Agency in the first 3 years after establishment	2 FTEs*/year (ca. € 50,000)	BBSK (EC project) / partnership
	Technical assistance for the Agency	Provided under CuRI phase 2	Partnership / Agency
	Training and capacity building (staff)	€ 30,000	Partnership / Agency
	Base for the Agency part of the ICC part of social service infrastructure		
Health care infrastructure	Building the Integrated Health Care Center (renovation), optional base for the Agency	€ 1.5–3 million	Partnership / Agency
	Health care nursing agency (ADOS) — outreach nursing care—car, equipment	€ 100,000	Partnership / Agency
Social services infrastructure	Retirement home—Štrkovec Municipality	€ 985,000	Štrkovec Municipality
	Day care center—Kráľ Municipality	€ 350,000	Kráľ Municipality
	Transportation service—accessible car—Lenka Municipality	€ 35,000	Lenka Municipality
	Transformation of the retirement home and other social service providers in Tornaľa, including improving accessibility (can be considered as location of the Agency)	€ 335,000 + € 30,000 for Option B	BBSK
	Center of social services (Home care service, monitoring service, social advisory, daily center) in Tornaľa, optional base for the Agency	€ 1.5–3 million	Tornaľa Municipality
Human resources	Temporary financing of the pilot provision of the missing or insufficient capacity services, especially outreach services—home care service, monitoring service, social advisory	€ 150,000/year /12 FTEs	Partnership / Agency

** Note: Full-time equivalent (FTE) measures the total number of full-time employees, based on hours worked rather than the exact number of employees.*

Source: Authors.

Detailed description of the proposal:

Health Care Infrastructure

Project proposal: Building the Integrated Care Center (ICC) in Tornaľa

- Objective: securing the building/renovation/facility serving in the future as an integrated center for health and social services and an optional base for the Agency.
- Estimated investment volume: € 1.5–3 million.
- City of Tornaľa would be eligible for standard ICC call.

Project proposal: Outreach nursing care

- Objective: investment needed to secure vehicles and other essential equipment.
- Investment volume: € 100,000.

Social Services Infrastructure

The integrated care model should benefit from the fact that the EC recommends the prioritization of community-based service investments and the transitioning away from institutional care. The attraction of EU funding would be critical for smaller municipalities, for whom investing in social care infrastructure is beyond their scope. The goals and the specific technical aspects of these projects should reflect the conclusions and recommendations of the structured community planning process in South Gemer FG arrived at by the BBSK experts. During the ongoing consultations with the local stakeholders, several potential investments have already been identified. All of them are initiated by mayors and confirmed by the World Bank and BBSK experts as investments that respond to local needs. More investment projects will be modified as a result of community planning.

Project proposal: Building the senior retirement home in Štrkovec Municipality

- Objective: renovation of the building, securing the equipment for the facility— capacity 12 clients.
- Investment volume: € 1–1.5 million.

Project proposal: Day care center for seniors and a transportation service in Kráľ Municipality

- Objective: renovation of the premises—capacity 15, securing the material equipment, vehicle.
- Investment volume: € 300,000–400,000.

Project proposal: Transportation service in the Lenka Municipality

- Objectives: purchasing a vehicle equipped to be accessible for people with disabilities.
- Investment volume: € 35,000.

Project proposal: Transformation of the BBSK provider in Tornaľa, BBSK

- Objective: reconstruction of the building and upgrade of the equipment to expand the scope of services offered, renovation, optional base for the Agency.
- The type and quantity of services offered in the transformed municipality should be agreed by BBSK, Tornala municipality and the Agency, and should be informed by results of community planning.
- Investment volume: € 335,000 + € 30,000 for Option B.

Project proposal: Center of integrated services, Tornaľa Municipality

This proposal is based on the goals of the currently initiated BBSK social care project supported by the EU. This should be seen as an alternative to the ICC idea presented above as there is no need for two facilities of similar functionality in the area. However, if the decision is made in favor of the social care center, it is critical to ensure that it is integrated into the model, and thus it is proposed that the Agency be based in it.

- Objective: renovation of the premises, material equipment, ICT, and vehicle.
- The proposal originates from the new BBSK project supported by the EC "Community-based social service centers as a tool of multilevel partnership for providing long-term care in the Slovak Republic". The aim of the project is to create community-based social service centers for seniors. The centers will serve as a platform for integrating the social and health services (the Agency) and providing services itself.
- Optional or temporary base for the Agency, until the ICC investment is realized, if at all.
- Investment volume: € 1.5 – 3 million (Note: optional long-term lease for the building).
- Ideally, this 'center of integrated service' will be a part of the ICC, using the premises of the ICC, as well as providing integration and social services, being incorporated into the Agency.

SECTION 4.4

ADDITIONAL RECOMMENDATIONS

Problems and solutions at the South Gemer FG level:

Lack of providers close to the inhabitants in the South Gemer FG

The proposed solution is to support the establishment of the health and social services that are lacking in Tornaľa and other recommended sites. First the information on what is preventing the providers from offering their services in the South Gemer FG should be gathered, then methods of incentivizing the providers should be developed. The integrated care proposal discussed below is one of the key aspects of motivating providers to move to the area.

Telemedicine service development should also be considered for services that are not available locally. This might be complicated by the lack of a national legal framework for such services. However, pilot models might be attempted.

Lack of health and social professionals in the South Gemer FG

The proposed solution is to systematically address the attractiveness of the South Gemer FG to professionals in health and social services and to create conditions required to compete for the workforce by making the working and living conditions better, and by providing specific help or services to the professionals, if needed.

The lack of health and social professionals is a global challenge, independent of the level of economic development. A major solution that has been applied in other countries is to attract professionals from the less developed countries by providing higher salaries than in their countries of origin, as well as supporting them in advancing their language skills, helping with work and residential permits, providing accommodation, and so on. Similar solutions have already been applied in the Slovak Republic (by the BBSK). The ways and means very much depend on the local situation. Besides this type of solution, systemic education, and incentives for the local inhabitants should be offered, although the possibilities for are limited because of factors that are out of the control of the South Gemer FG (that is, the level of financing for the services, the level of regional economic development, movement of population, and others).

Lack of data about the health services in the South Gemer FG

The proposed solution is to establish the data program of the Agency, including cooperation with the HIFs, initiation of changes to the legislation permitting easier sharing of the clients' data (together with the BBSK), and collecting own data about the South Gemer FG.

National reform recommendations

Although the model implementation is independent of any national reforms and legislative changes, integration of care in South Gemer FG and in the Slovak Republic overall would be much easier and much more likely to succeed in a systemic environment that supports the integration of care and the regional development of services. Therefore, the following legislative changes should be considered by the national authorities.

- For the simplification and mainstreaming of the integration of care on a national level, the following changes will be needed:[43]
  - Recognizing the need for integration activities/services in the national legislation and in the financing of health and social services;
  - Introducing a separate financing stream for the integration of care and population health management on the national, regional, microregional, and community levels;
  - Introducing more flexible legislation on patient data exchange between the service providers;
  - Strengthening the role of the municipalities in the legislation regarding health and social services planning, development, and integration.

- Considering the competencies of the municipalities in social services (Act 448/2008 and Act 369/1990)
  - Position of small municipalities;
  - Reasonable funding for competencies;
  - Support cooperation and share responsibilities between the municipalities;
  - Support community planning of social services—tool for providing evidence-based social policy, cooperation with stakeholders, and data collection.

- Introducing a unified assessment system for health and social care (social services and a system of compensation for severe disability)—(new law or wide amendments of Acts 447/2008 and 448/2008).

- Introducing a long-term care legal framework (integration of health and social care) (new legal framework).

- Reforming the financing of social services (Act 448/2008)
  - Ensuring the development of outreach and community-based services;
  - Increasing the social status of social service employees;
  - Relieving nonformal caregivers and families.

- Ensuring equality in the financing of public and nonprofit providers of services (Act 448/2008).

- Digitalization of public administration (Act 448/2008, Acts 153/2013 and 95/2019):
  - Digitalization of the informational system for social services;
  - Connecting the social and health systems.

- Ensuring adequate quality and inspection, respecting human rights, and a person-centered approach in social care.

- Introducing legislative changes in both health as well as social legislation: (i) to ensure a legal framework for, and the systemic financing of, the integration services and regional service development, as well as (ii) to strengthen the role of the municipalities in the newly defined regions of optimal size in service development and the integration of care.

- Redefining the minimum network concept in health legislation to ensure better standards for spatial services distribution.

- Introducing changes in the legislation to achieve easier sharing of the clients' data (health and social) by health insurance funds and service providers.

Notes on the replicability of the model

The model proposed in this report relies on the bottom-up approach, and in its basic form, can be implemented without major legislative changes, and as such, it is fully replicable in other regions. Its implementation should start with the proper selection of a microregion (functional grouping of municipalities) based on geographic, administrative, historical, accessibility, service usage, and other criteria). The population size should, in most cases, be between 20,000–40,000 inhabitants, and it should usually form a cluster of a natural (urbanized) center (town), and a group of smaller rural peripheral municipalities, within reasonable limits of the size of the area (travel time of inhabitants and home care service providers). The selection of the microregion should be done participatively, it should be properly explained and discussed, and consensus needs to be arrived at among the potential member municipalities on the choice of Governance Model.

Replication in larger geographical areas can be considered. Replication of the suggested model in a larger geographical area could bring additional benefits—as, in addition to the functionalities of the local agencies, additional services can be provided more efficiently at a scale of several functional groupings. However, it depends on a good definition of the microregions, as well as the optimal assignment of functions to be executed on the regional and microregional levels. The same applies to national-level replicability, including the need for legislative and financing reforms (as mentioned in the national reform recommendations above).

Options for a large-scale version of the model should be considered in the future. Various modalities for the broad scaling up of the model can be discussed, including the utilization of the framework provided by the existing association of municipalities. However, further analysis of this question lies outside of the scope of this report.

CHAPTER 5

CONCLUSIONS

The model of integrated care for the elderly in the South Gemer group of municipalities was designed with the aim to develop a model for—and later support the implementation and operation of—an integrated elderly care system in selected municipalities that addresses the needs of the local elderly population, provides higher quality services, and increases the level of coverage, which, at the same time, ensures sustainability and follows the principle of deinstitutionalization.

The model was inspired by the experience of other countries but is based on the reality of the Slovak health and social systems, the capacity of South Gemer FG, and the local situation. To achieve integrated care for the elderly, the model emphasizes the need to systematically solve the health and social service provision issues beyond the integration of care.

The model relies on the joint effort of the municipalities expressed in a formal partnership, the integration of care, and a people-centered approach. The model consists of four core model components: The Service Model, Governance Model, Process Model, and Financing Model.

The implementation of the proposed model will make it possible to overcome the systemic separation of health and social systems, as well as the highly fragmented payment mechanisms, by providing new types of activities additional to health and social service provision. New integration services, which are not present in the current system, will be introduced at the South Gemer FG level, and serve as a key enabler to achieve the integration of care.

The model introduces a new type of actor, the Integrated Elderly Care Agency, to ensure the professional implementation and execution of all the proposed functions, and the further development of the service model.

The results of the pilot implementation of the model can significantly help the policymakers on the national level in: (i) recognizing the need for integration activities/services in the national legislation, and in the financing of the health and social services, (ii) introducing a separate financing stream for regional integration and population health management on the national, regional, microregional, and community levels, (iii) introducing more flexible legislation on patient data exchange between service providers, and (iv) strengthening the role of the municipalities in the legislation.

Certain aspects of the model need to be finalized by the partitioning municipalities: the specific scope of agency activities, as well as the staff and financing corresponding to it, the agency priorities, and the timeline for scaling up, and so on. The model presents the framework within which the integration of care at the local level may be pursued.

Replication of this model beyond the target area is possible and preferable, even though the best mechanism for large-scale replication in the Slovak Republic remains outside the scope of this report and will be the subject of further analysis.

ANNEXES

ANNEX 1

SERVICE MODEL—DATA AND TOOLS

TABLE 10. Services Availability for the Inhabitants of the South Gemer FG Region

Name of the outpatient health care service	Municipality of the closest service facility	No. of providers in Tornaľa	No. of providers within the districts of Rimavská Sobota and Revúca
Orthodontics	Tornaľa	1	3
Surgery	Tornaľa	1	9
Dermatovenerology	Rimavská Sobota		6
Diabetology, metabolic and nutritional disorders	Tornaľa	1	7
Endocrinology	Rimavská Sobota		2
Physiatry, balneology and medical rehabilitation (physician)	Tornaľa	1	6
Physiatry, balneology and medical rehabilitation (physiatry therapist)	Tornaľa	1	7
Gastroenterology	Rimavská Sobota		3
Geriatrics	Tornaľa	1	5
Gynecology and obstetrics	Tornaľa	1	28
Cardiology	Rimavská Sobota		7
Clinical speech therapy	Tornaľa	1	4
Clinical oncology	Rimavská Sobota		2
Clinical psychology	Rimavská Sobota		6
Pharmacy	Tornaľa	4	38
Nephrology	Rimavská Sobota		2
Neurology	Tornaľa	1	5
Ophthalmic optician	Tornaľa	1	5
Ophthalmology	Tornaľa	1	8
Orthopedics	Rimavská Sobota		4
Community nursing care			
Nursing care in social services facilities	Tornaľa	1	1
Otorhinolaryngology	Tornaľa	1	6
Pediatric ophthalmology	Tornaľa	1	3
Psychiatry 0052	Tornaľa	1	9
Psychiatry 0056	Tornaľa	1	3
Radiology	Tornaľa	1	10
Rheumatology	Rimavská Sobota		1
Dentistry	Tornaľa	3	29
Urology	Rimavská Sobota	1	4
Internal medicine	Tornaľa	2	21
General practitioner	Tornaľa	6	57
Dental technology	Tornaľa	1	11
Dentistry	Tornaľa	1	20
Dental emergency service	Tornaľa	5	49
Health promotion services	Rimavská Sobota		

Source: Social services and health department of the BBSK Office, 2020.

ANNEX 2

GOVERNANCE MODEL— OPTIONS FOR CREATING THE LEGAL STRUCTURES FOR THE PARTNERSHIP AND AGENCY

The baseline for the partnership of the municipalities in integrated care is a signed agreement of cooperation and common commitment to the same goal. If a framework is created on the local level for the integration of services, and their provision and coordination, a specific entity should be formed to fulfill that task–the Integrated Elderly Care Agency.

The main characteristics of this entity are:

- Having the integration of care as its core focus
- The possibility of having all three governance levels within one entity: partnership, board, and the professional management structure for the agency's service provision
- Flexible decision-making
- The possibility of hiring employees with expertise (social care, health care, project management, and others)
- Access to different sources of funding (eligibility of the legal form)
- Flexibility in establishing partnerships with the relevant stakeholders
- Neutrality and equality of all the municipalities
- Easy process for the expansion of the catchment area
- Possibility of service provision

There are several options for the legal entities of the Agency of integrated services, under consideration for :

- Office of the self-governing region
- One municipality (with the mandate from others in the South Gemer FG)
- Joint office of several municipalities
- Association of municipalities
- Local action group
- Nonprofit organization (NPO) founded by the municipalities

Office of the self-governing region

Act No 302/2001 on self-governing regions (zákon o samospráve vyšších územných celkov)
In the context of the division of self-government, the self-governing unit stands above the municipalities and cities. It is an independent territorial self-government, as well as an administrative unit. Despite its higher self-governing form, it is not a superior municipality or city. It has its statutory competencies in self-government, as well as in the local state administration, while the state provides the material and financial coverage for the fulfillment of the legally delegated tasks of the local state administration.

Pros	Cons
Attempt of current leadership to implement integrational services	'Too far removed' from citizens—BBSK has 647,874 (2019) inhabitants and an area of 9,454 km^2
Human resources and expert know-how	Low commitment of municipalities to cooperate
	Social services for seniors are primarily in the competencies of municipalities
	Budget—approved by the regional parliament—there would be low understanding of how to use the regional budget to supplement the municipalities' competencies and only for South Gemer FG.
	Conflict of interest—BBSK is the provider of the largest institution in South Gemer FG

One municipality (with the mandate from others in South Gemer FG)

A municipality is a legal entity which independently manages its own property and its own income. The municipality finances its needs primarily from its own revenues as well as from state subsidies. The basic role of the municipality in the performance of self-government is to take care of the all-round development of its territory and the needs of its inhabitants. The performance of specified tasks of local state administration may be transferred to the municipality by law. The costs of such a delegated performance of state administration shall be paid by the state.

Pros	Cons
Easy management and governance structure	Based on the personal relation between the majors and their willingness to cooperate
	Unclear financial responsibilities
	Possibility of preference for one municipality over another in South Gemer FG

Joint municipal office

Act n. 369/1990 on municipal establishment (obecnom zriadení)
Municipalities may cooperate on the basis of a contract signed for the purpose of performing a specific task or activity, or on the basis of a contract for the establishment of an association of municipalities. The cooperation of municipalities is governed by the principles of legality, mutual benefit, and compliance with the needs of the inhabitants of the municipalities. Municipalities have the same position in mutual cooperation.

Pros	Cons
Same position for all municipalities	Joint office already exists, but other municipalities are involved
Experience with a joint office for performing other competencies	Unclear financial responsibilities of each municipality

The BBSK's experts initiated a **questionnaire for the existing joint offices** (There is a register of joint offices kept by the Ministry of Interior (*https://www.minv.sk/?prehlad_SOU*). According to the results of this questionnaire, most of the respondents consider that the efficiency of a joint office relies on the number of agendas of the office, or on the number of municipalities. Forty-eight percent of the respondents answered that the optimal number of inhabitants for which the joint office will provide services depends on how many municipalities come to mutual agreement.

The respondents consider home care services and basic advisory to be the most necessary social services that the municipalities should provide using the joint office. The social services that are optional for municipalities to provide are: home care services provided on weekends and at night, transport service, respite service, day center for the elderly, and shelter. Respondents consider the rental of compensatory aids and the emergency hotline to be social services that the joint office would not have to provide.

More than half (56%) of the respondents consider the municipalities/joint offices able to independently perform an assessment of needs within the social services, but with an adequate budget for experts. Forty percent think they are not able to do so.

Twenty-eight of the respondents would welcome the new type of joint office for integrated social and health services. Thirty-two percent of the respondents think that the today's tasks are sufficient.

Association of municipalities

Act n. 369/1990 on municipal establishment (o obecnom zriadení)
An association of municipalities is a legal entity established by the municipalities in an agreement. The subject of the association of municipalities is mainly the area of social affairs, environmental care (especially collection, removal, and treatment of municipal waste, and drainage and wastewater treatment), local transport, education, culture, and local tourism. Its activities help the association of municipalities to create the conditions to fulfill the tasks of municipalities, as well as the tasks of a higher territorial unit.

There are two associations of municipalities in the South Gemer FG

Association of Municipalities - Včelince a Rumince—activities are oriented toward the support of the integration of people in need, outreach social work, and so on *https://ives.minv.sk/rez/registre/pages/detailzzob.aspx?id=152336&full*

Association of Municipalities Microregion near Slaná (Hubovo, Chanava, Kráľ, Rumince, Štrkovec, Riečka, Tornaľa, Abovce, Gemer, Lenka, Neporadza a Včelince)— activities cover a wide range of areas, that include social care and health care *https://www.mrprislanej.eu/; https://ives.minv.sk/rez/registre/pages/detailzzob.aspx?id=152222&full*

Pros	Cons
Same position for all the municipalities involved, based on an agreement	Two different associations already exist within ; no need to have all of them
Experience with this form of cooperation	A different aim for the association has already been set up. Even in the case of Mikroregión pri Slanej, it is very similar.
	Recognized as a public (municipal) entity—cannot be recipient of grants for NGOs

Local action group

Setting up a local partnership, known as a 'local action group' (LAG), is an original and important feature of the LEADER[44] and community-based local development approach.[45] The LAG has the task of identifying and implementing a local development strategy, making decisions about the allocation of its financial resources, and managing them.

A LAG should associate public and private partners. It should be well-balanced and representative of the existing local interest groups, and drawn from the different socioeconomic sectors in the area.

LAGs usually:

- Aggregate and combine the available human and financial resources from the public sector, the private sector, and the civic and voluntary sectors
- Associate local players around collective projects and multisectoral actions, in order to achieve synergies, joint ownership, and the critical mass needed to improve the area's economic competitiveness
- Strengthen the dialogue and cooperation between the different rural actors, who often have little experience in working together, by reducing potential conflict and facilitating negotiated solutions through consultation and discussion
- Facilitate, through the interaction between different partners, the processes of adaptation and change in the agricultural sector (for example, quality products and food chains), the integration of environmental concerns, the diversification of the rural economy, and the quality of life *https://vspjuznygemer.sk/*

Pros	Cons
Same position for all municipalities involved, based on an agreement	Already exists, no need to include all of them; members are also for-profit companies and NGOs from other than the social or health sector
Experience with this form of cooperation	Already set up with a wider scope of interest and activities
	LAGs are funded by specific EU funds

Nonprofit organization founded by the municipalities

Act n. 213/1997 on nonprofit organizations providing services of general interest (o neziskových organizáciách poskytujúcich všeobecne prospešné služby)
According to the law, the nonprofit organization is a legal entity, which provides services of general interest under predetermined conditions for all users. Its profit may not be used for the benefit of founders, members of bodies, or its employees. Profit must be used in full to provide services of general interest. The activity of a nonprofit organization must be the provision of services of general interest in accordance with the act (for example, provision of health care, provision of social assistance and humanitarian care, and so on).

Pros	Cons
Same position for all involved municipalities, based on partnership and as founders	Does not exist
Different possibilities for funding (in some cases easier than municipalities)	
More flexible form of managing than municipality/based on yearly budget	

ANNEX 3

INTEGRATION PROCESS GUIDELINES

Conceptual Examples

TABLE 11. Integration Process Guidelines (IPG) for Service Providers

Structure of the Integration Process		Examples
WHO?	(for which service provider is the procedure intended)	• Doctor • Nurse • Home carer • Mayor • Social worker • Other
WHEN? / WHERE? / CIRCUMSTANCES	(when, where, or under what circumstances does the case typically occur)	• Visiting a doctor • Preventive inspection • Doctor home visit • Nurse home visit
TRIGGER EVENT	**(**case identification with parameters)	• Meeting the set of specified parameters or their combination • Injury • Decompensation
ACTIONS	(what needs to be executed)	• Find out ... • Contact ... • Inform ... • Take an action... • Record....

Source: Authors, 2020.

Integration Process Guideline 1

WHO?
Service provider: social service (residential form)—manager

WHEN? / WHERE? / CIRCUMSTANCES
Whenever there is a sudden deterioration in health

TRIGGER EVENT
Acute deterioration of a senior's health—loss of consciousness

ACTIONS

- Ensure the vital functions of the senior
- Contact the emergency ambulance
- Identify staff who will stay with the senior
- Provide an accompanying person who knows the senior (in case of a deterioration in the communication of the senior)
- Contact relatives of the patient and inform them about the patient's circumstances
- Contact a senior general practitioner
- Prepare the documentation needed for medical admission, including:
  - Information in the care and health record
  - Information on the health care provided/nursing and care plan
  - List of prescribed medications
  - Dietary restrictions
  - Important information from the senior's 'individual plan', and from the senior's pre-expressed wishes plan
- Prepare the senior's personal belongings needed during hospitalization
- Monitor the health status of the senior until the emergency services arrive

Integration Process Guideline 2

WHO?

Self-government: mayor, employees of the municipality, postman, informed neighbors, and pastor

WHEN? / WHERE? / CIRCUMSTANCES

In order to prevent a deterioration in health, it is necessary to regularly contact the risk groups. The risk groups are: widowed seniors (one to two years), senior caregivers, living alone seniors without the possibility of socialization, seniors who have recently stopped working (retired, have been fired), stopped driving or doing a favorite activity for health reasons, low-income seniors, seniors with recently deteriorating health, and seniors who are more than 80 years old.

TRIGGER EVENT

- Senior who:
  - Belongs to the risk group
  - Is disoriented in time
  - Does not recognize the contact person

ACTIONS

- Contact the senior who is at risk in order to identify his/her interests, abilities, needs, and engender a feeling of trust/relationship
- Contact the Agency with the basic information and any risk suspicions:
  - Personal data (name, address, age)
  - Family situation (with whom he/she lives in the household, whether there are children in the village, and so on)
  - Social situation
  - Information that has led to the suspicion that the senior is at risk
- Repeat the visit to senior within seven days
- Offer the senior the mediation of a visit by an agency's employee at his/her home environment, and offer service and support through the Agency
- Offer the additional support available from the region or municipality

Integration Process Guideline 3

WHO?
Service provider: general practitioner for adults, specialist

WHEN? / WHERE? / CIRCUMSTANCES
- When the patient visits a doctor in an outpatient clinic
- When the doctor visits a patient at home

TRIGGER EVENT
- Senior
- Patient after acute hospitalization has problems:
  - Vascular
  - Cardiac
  - Fractures of the spine or lower limbs
- Patient with an acute change in mental or motor abilities/decompensation

ACTIONS
After the health care is provided

Find out...

- Information about the patient´s situation
  - Personal situation
  - Family situation
  - Social situation (indication)
  - Mental capacity
  - Other circumstances
- Contact information
  - Patient
  - Closest relatives of the patient
  - Other people close to the patient (neighbors, friends)

Contact...

A person from the patient's immediate relatives or close relatives who will provide the patient with basic assistance at the place of residence and will be available to be contacted repeatedly if necessary

Inform...

- The Agency through the structured report covering:
- Description of the problem
- Urgency/severity of the condition
- Redundancy report (if it is current)
- Relationship with the service provider
- Social service

Record....

To the information system of the integration services

- Proposal for further action
- Necessary services
  - Nursing
  - Long-term care (LTC)
  - Subsequent rehabilitation
- Need for medical aids
  - Wheelchair
  - Personal hygiene aids
  - Anti-decubitus mattress

Request...

The Agency for the beginning of a social assessment investigation in the case of a necessity for social services and/or compensation for a severe disability.

ANNEX 4

ABBREVIATED SERVICE MASTER PLANNING METHODOLOGY

INTRODUCTION

The Service Model for the target region is expressed in a Master Plan of Services accompanied by a set of documents and data tables in a master planning package, providing the basic methodological guidance and tools for analyzing and modeling service availability and sufficiency.

Master planning is the process of creating a Master Plan of Services. Master planning focuses on the analysis of data on the availability of services, including such parameters as: number and location of providers, their capacity, human resources, infrastructure, service output, common trends in service provision, issues (problems) detected, and so on.

The master planning process can be generally defined by the following sequence of process steps:

- I. Defining of territory and demography
- II. Collecting data on the current state of services
- III. Processing of data inputs from data sources to the services database (DbS)
- IV. Producing outputs from the processed data
- V. Designing of model options/scenarios (outpatient care)

Defining of territory and demography

For the needs of planning and modeling, four territorial levels are considered:

- U1 South Gemer FG (13 municipalities)
- U2 Selected districts relevant to the territory of FG (RARS)
  - RS - Rimavská Sobota
  - RA - Revúca
- U3 BBSK (Banská Bystrica Region)
- U4 SR (Slovak Republic)

The basic demographic data to be considered are collected in the D1.xlsx demography table—containing data about the population of the U1 and U2 territorial levels, differentiated by municipality, age (65+), and gender.

Collecting data on the current state of services

The processing of the data about the current situation is based on the following data sources:

Data sources on Health and Social Services

- Z1 eVUC Database/Providers register
- Z2 ÚDZS Providers database
- Z3 Data of the HIFs
  - Z3.1 Publicly accessible data of the HIFs (current list of contractual relations— "Data set ID 534—list of current contractual relations")
  - Z3.2 Publicly inaccessible data of the HIFs—extracted and provided by the HIFs
- Z4 Data from the register of social services
- Z5 Data on distances/travel time
- Z6 Own data collection for the purpose of:
  - Z6.1 Data validation
  - Z6.2 Data extensions

Notes:
Data from source Z1 will be re-provided; it is not yet possible to automatically link them to the data from source Z2.

Data from source Z3.2 were only partially provided by the health insurance funds.

Limited standardized access to health care data is one of the main difficulties of master planning on the regional level. In the future, unpublished data provided by the Ministry of Health (MoH) might add more insight on the current state of services.

Official Standards

- N1 Government regulation on the public minimum network
  - N1.1 Valid version
  - N1.2 Upcoming version as of November 2019 (added availability of the locality—travel time). A new version of public minimum network is the subject of preparation and might be significantly modified in the future.
- N2 Civic amenities standards

Processing of data inputs from the data sources to the DbS

Data from sources Z1, Z2, Z3.1, and Z4 are transformed and consolidated into the services database (DbS), which is then expanded with data on distances/travel time (Z5).

Subsequently, the data are validated and supplemented by own collection (Z6). Within the project, physical validation was performed by the local coordinator.

Tables of the Catalogue of Services

The data structures table: defines the structure of 4 key tables: catalogue of service types (KTS), database of service providers (DbPS), database of services (DbS), and database of municipalities (DbM).

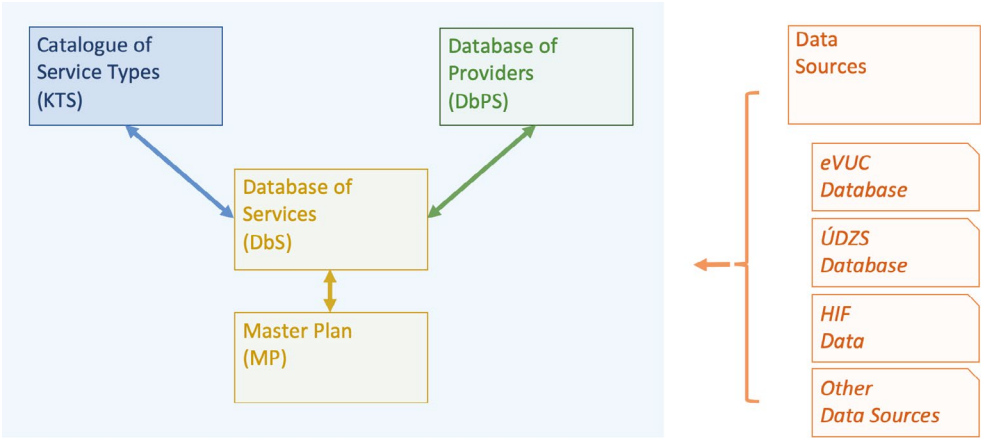
The catalogue of service types (KTS) table: contains all the types of services that exist in the Slovak Republic and can, theoretically, be received by the inhabitants of the region. This table shall be continuously extended.

The database of services (DbS) table**:** contains the acquired and processed data. These data need to be continuously supplemented, cleared, and confirmed. The table is a key data source for the modeling of the master plan scenarios.

The database of service providers (DbPS) table: contains data on service providers. The table shall be continuously updated and extended.

The database of municipalities (DbM) table: contains acquired and processed basic data on the municipalities.

FIGURE 15. Diagram of Catalogue of Service Components



Source: World Bank, 2020

Producing outputs from processed data

Based on the transformed, supplemented, and consolidated data in the DbS, the following outputs were possible to prepare:

V1 Availability of service points (medical facilities) for residents at the level of the U1 (south Gemer FG) and U2 (RARS) area, according to the types of services, based on the travel distance.

Based on the transformed, supplemented, and consolidated database data from the Z2 data source, the following outputs will be prepared:

- V3.1 Comparison of the number of outpatient service providers in the individual levels of the territory (U1–U4), their numbers and percentage
- V3.2 Types of outpatient services whose providers have a place of provision at the level of the U2 area (RARS), their numbers and percentage
- V3.3 Types of outpatient services whose providers do not have a place of provision at the level of the U2 area (RARS), their numbers and percentage
- V3.4 Types of outpatient services whose providers have a place of provision at the level of the U1 (South Gemer FG) area, their numbers and percentage
- V3.5 List of the municipalities at the level of the U2 area (RARS) which are a place of provision of outpatient services
- V3.6 Comparison of the structure of hospital services in RS and RA (U2)

The outputs are compared with the standards and the specific situation in the area. Based on this comparison, services under-present in the territory (present in suboptimal travel distance) and/or services of insufficient capacity are identified. A comparison with the norms in N1.1, which are expressed by the number of medical places, could not be performed based on the available data, due to the absence of data on the number of medical places in the facility.

Outputs based on Z3.2 publicly inaccessible ZP data, were produced only partially, based on the data provided from the HIFs.

Designing of model options/scenarios (outpatient care)

The design of the Service Model options/scenarios should be implemented using the **master plan planning form,** based on individual service types.

The first scenario is represented by the current status of services.

Other valid scenarios should be recorded in the catalogue of services after approval.

ANNEX 5

ABBREVIATED METHODOLOGY FOR TARGET AREA SELECTION

As presented in section IV.2.1, the selection of the functional grouping of municipalities followed a robust four-stage process. This annex further elaborates on the methodology behind it.

Stage 1

Stage one included the analysis of three indexes. All indexes were meant to inform the selection of the subregion, and their values were only used to inform the discussion about the suitability of different territories.

The **Economic Performance Index** was calculated using the following formula:

$$I_{Econ} = \mathrm{D} + \mathrm{U\%} + \mathrm{Un}_{\%} + \mathrm{Un}_{\#} + Un_{LR\%} + W_{AVG} + LowEd_{\%} + HighEd_{\%}$$

Where:

- D —population density of the district (people per km²)
- U% —percentage of population living in cities and towns in the district
- $\mathrm{Un}_{\%}$ —unemployment rate
- $\mathrm{Un}_{\#}$ —number of unemployed
- $\mathrm{Un}_{\mathrm{LR\%}}$ — percentage of long-term unemployed
- $\mathrm{W}_{\mathrm{AVG}}$ —average wage
- $\mathrm{LowEd}_{\%}$ —share of working-age population with no high school diploma
- $\mathrm{HighEd}_{\%}$ —share of working-age population with university degrees or higher

The **Demographic Index** was calculated using the following formula:

$$I_{Dem} = \mathrm{NG} + \mathrm{NM} - Econ\ Dep_{OLD}$$

Where:

- NG —natural population growth in absolute terms
- NM —net migration in absolute terms
- $\mathrm{EconDep}_{\mathrm{OLD}}$ – economic dependency index for old age

The **Care Index** was calculated using the following formula:

$$I_{Care} = \mathrm{RH}_{CAP} + \mathrm{DCC}_{CAP} - NS + TS$$

Where:

- $\mathrm{RH}_{\mathrm{CAP}}$ —capacity of retirement homes
- $\mathrm{DCC}_{\mathrm{CAP}}$ —capacity of day care centers
- NS —number of nursing service providers
- TS —number of transportation service providers (for the elderly)

All indicators were normalized before inclusion into the index, so that the maximum value in the sample was considered to be equal to 1, and the lowest was equal to 0, and the rest were adjusted proportionately. (In cases where the indicator is negatively associated with the outcome, the index is measuring factors like unemployment and economic performance—the maximum value was considered a 0, and the minimum was considered a 1).

In the economic performance and demographic indexes, all indicators were taken with equal weights, while in the care index, the capacity of elderly homes and day care centers was taken with a value of 2, while the number of nursing services was given a weight of ¾, and the number of transport services was given a weight of ¼.

The **Total Index** is a sum of the normalized values of the three individual indexes (maximum value taken as 1; minimum as 0).

The latest available date was used for the index; most indicators were from 2018.

Stage 2

To select municipalities within districts, two indexes were calculated using municipal-level data. The methodology was simplified substantially from the district level because fewer indicators were available.

The **Economic Potential Index** was calculated using the following formula:

$$I_{Econ} = \mathrm{D} + LowEd_{\%} + HighEd_{\%}$$

Where:
I_{Econ} —economic index
$LowEd_{\%}$ —share of working-age population with no high school diploma
$HighEd_{\%}$ —share of working-age population with university degrees or higher

The **Demographic Index** was calculated using the following formula:

$$I_{Dem} = \mathrm{NG} + \mathrm{NM} - AGE_{MEAN}$$

Where:
NG —natural population growth in absolute terms
NM —net migration in absolute terms
AGE_{MEAN} —mean age of the population of the municipality

To aid spatial analysis of these results, the maps of the worst and best performers were produced and overlaid with the location of the service providers. This helped to perform the visual analysis and identify the areas that would be most suitable for the pilot. The location of the service providers were mapped using an automated georeferencing algorithm that used the addresses of the providers. Based on the results of this analysis, as well as discussions with the BBSK, representative preliminary groupings of municipalities were shortlisted.

Stage 3

At this stage, a survey of the mayors was conducted, the results of which are presented in section IV.2.1. The questionnaire and the results processing techniques can be provided upon request.

Stage 4.

The focus group discussions followed a semi-structured discussion methodology, after which a consensus decision on the selection of the grouping was made in a discussion between the World Bank and BBSK experts, who considered the criteria. These criteria are presented in section IV.2.1.

ANNEX 6

FINANCING MODEL— SOCIAL SERVICES

TABLE 12. Avaliability of social services in South Gemer FG

Capacity of social services for seniors	According to standards	Currently	Comparison
Retirement home	209	145	-64
Social housing for seniors + support to live independently	19	0	-19
Nursing home	37	0	-37
Home care service	154	4	-150
nonformal carers (allowance)		107	-43*
Specialized facility	66	0	-66
Day care center	should be	15	according to Community Plans
Daily center	should be	0	missing
Canteen	can be	0	missing

** If nonformal care givers and the home care service are also taken into account, services for 43 seniors are still missing.*
Source: Elaborated by the authors based on data provided by BBSK, 2020.

TABLE 13. Total operational costs of social care facilities in the South Gemer FG (current and proposed)

TYPE OF SOCIAL SERVICE for Elderly in the South Gemer FG — CURRENT	Form	Unit	BBSK average per unit*	Existing provider	Number of units	Cost per year/ existing provider	BBSK average
Retirement home	residential	client/ month	€ 945.75	707,26	99	€ 840,224.88	€ 1,123,551.00
Retirement home	residential	client/ month		720,896	46	€ 397,934.59	€ 522,054.00
Social service home (only seniors)	residential	client/ month	€ 993.67	901,41	20	€ 216,338.40	€ 238,480.80
Social service home (only seniors)	residential	client/ month		882,51	18	€ 190,622.16	€ 214,632.72
Day care center	outpatient	client/ month	€ 375.63	259,61	15	€ 46,729.80	€ 67,613.40
Home care service 1	outreach	hour	€ 8.15		1	€ 6,840.00	€ 16,300.00
Home care service 1	outreach	hour	€ 8.15		3	€ 21,180.00	€ 48,900.00
Transport service	outreach	kilometer	€ 1.78	0	0	0	0
						€ 1,719,869.83	€ 2,231,531.92

* The BBSK average is included to show the fact that current services are underfinanced in comparison with similar providers in the region. The cost for the community-based form of service provision was selected (up to 40 people) to highlight the need for community-based services.

TYPE OF SOCIAL SERVICE for Elderly in the SOUTH GEMER FG — PROPOSED	Form	Unit	Average cost per unit	Number of units to reach standard	Average cost per year
Retirement home	residential	client/month	€ 891.58	99	€ 1,059,197.04
Retirement home	residential	client/month	€ 891.58	46	€ 492,152.16
Day care center	outpatient	client/month	€ 375.63	15	€ 67,613.40
Home care service	outreach	hour	€ 8.15	4	€ 65,200.00
Transport service	outreach	kilometer	€ 1.78	20,000	€ 35,600.00
Specialized facility NEW	residential	client/month	€ 1,325.00	40	€ 636,000.00
Specialized social advisory/support to live independently NEW	outpatient/ outreach	hour	€ 9.00	2,000	€ 18,000.00
Nursing home NEW	residential	client/month	€ 877.00	12	€ 126,288.00
Retirement home NEW	residential	client/month	€ 891.58 12	12	€ 128,387.52
Day care center NEW*	outpatient	client/month	€ 375.63	15	€ 67,613.40
Home care service NEW	outreach	hour	€ 8.15	105	€ 1,711,500.00
Rental equipment NEW	outreach	client			-
Monitoring and alarm for the need of assistance NEW	outreach	client	€ 36.94	30	€ 13,298.40
Daily Center NEW	outpatient	hour	€ 9.00	2,000	€ 18,000.00
Canteen NEW	outpatient	meal	€ 4.14	5,000	€ 20,700.00
Respite service NEW	Included in capacity of retirement home/nursing home, home care service and daily center				
*this mode proposes that missing capacity of home care services can be adressed through increase in Day Care Center and Monitoring Services form of service provision					**€ 4,459,549.92**

Source: Authors calculations based on the data provided by BBSK, and collected from individual service providers, 2020.

TABLE 14. Funds according to sources for social services dedicated and important for service (all type of forms)

	Obligatory				Conditional/possible		
TYPE OF SOCIAL SERVICE	Obligatory contribution from national budget / ministry	Obligatory contribution from self-governing region	Obligatory contribution from municipality	Payment from citizen	Payment from health insurance	EU funds -OPEX (OP HR)	EU funds - CAPEX (IROP)
Retirement home	yes	-	yes	yes	yes	-	yes
Nursing home	yes	-	yes	yes	yes	-	yes
Specialized facility	yes	yes	-	yes	yes	-	yes
Day care center	yes	-	yes	yes	no	-	yes
Home care service	no	-	yes	yes	no	yes	yes
Transport service	no	-	yes	yes	no	-	yes
Rental equipment	no	-	-	yes	no	-	yes
Monitoring and alarm for the need of assistance	no	-	-	yes	no	-	yes
Respite service	no	-	yes	yes	no	-	yes
Daily center	no	-	-	yes	no	-	yes
Canteen	no	-	-	yes	no	-	yes
Social advisory— specialized	no	yes	-	no	no	-	yes

Source: Authors, 2020.

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6) Healthcare spending review II Final report, October 2019

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9) Inštitút urbanizmu a územného plánovania URBION (2010) Štandardy minimálnej vybavenosti obcí. https://www.mindop.sk/ministerstvo-1/vystavba-5/uzemne-planovanie/dokumenty-1 (Ministry of Transport, Construction, and Regional Development)

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NOTES

1. Eurostat data https://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do
2. http://datacube.statistics.sk
3. https://ec.europa.eu/eurostat/data/database?node_code=proj
4. https://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do
5. https://ec.europa.eu/eurostat/databrowser/view/DEMO_PJANIND__custom_227210/default/table?lang=en
6. http://www.prog.sav.sk/sites/default/files/2018-03/Vano_PP3_clanok_doplneny_c_4.pdf
7. Following the definition of the OECD, long-term care is a set of services which are required by persons dependent on assistance for common day-to-day activities (activities of daily living [ADL]). This applies to any self-service activities which an individual is supposed to do every day, such as personal hygiene, getting dressed, eating, and so on. Such personal assistance is often provided in combination with basic health care services, such as wound treatment, administration of medications, prevention, rehabilitation, and palliative care. Apart from the home environment, long-term care is also frequently provided under residential conditions—that is, in facilities of long-term care nursing.
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16. The difference between these two legal forms is discussed further in the background paper.
17. Day care center - type of social service. To be accepted into day care center clients need to undergo dependance assesmet.(at least Grade II of dependance is usually the minimal requirement). This shouldn't be confused with dayly care center – a different type of social service proviced in sthe Slovak Republic, which is more of a facility for social activities of the elderly, and doen't require dependance assesment.
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25. https://www.udzs-sk.sk/centrum-pre-klasifikacny-system-drg/sk-drg-system-aktuality/
26. These proposals will be developed further in the second phase of implementation of this component of the CuRI project.
27. Section V.3.2 includes a list of policy and legislative changes at the national level that are recommended for the simplification and mainstreaming of the integration of care.

28. The participating NGOs included:MAS/n.o./ Jednota dôchodcov, MAS Verejno-súkromné partnerstvo Južný Gemer, MAS Cerovina MAS Malohont, MAS Partnerstvo Muránska planina - Čierny Hron,MAS VSP Stredný Gemer,Jednota dôchodcov Slovenska - Revúca - Jednota dôchodcov Slovenska - Rimavská Sobota,Občianske združenie BAGAR YMCA Revúca, Evanjelická diakonia ECAV na Slovensku, Diecézna charita Rožňava, Opora G + N .
29. https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=COM%3A2015%3A0615%3AFIN
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32. By telemedical services, we mean a distant provision of health care services via digital communication devices and applications. By telecare services, we mean a distant provision of social services via digital communication devices and applications.
33. According to the Report on Social Situation (2019), the tariff wage for a caregiver was only € 516 (brutto, with bonuses: € 866). Meanwhile, the average monthly wage in the national economy in 2019 was € 1,092. https://www.mfsr.sk/files/en/finance/institute-financial-policy/strategic-documents/national-reform-program/npr_2020_final_en.pdfp. 31
34. This school is also covered by the Catching-up Regions—VET component, with an emphasis on social inclusion. Datasource: https://www.cvtisr.sk/buxus/docs//JC/PREHLAD/SS/sos_k6.xls
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36. This is a role of the RPHA, which is not exclusively reserved, and in practice, not properly executed. The proposal here is for the agency to take up reasonable responsibility for health planning in the catchment area, in cooperation with RPHA, if possible).
37. While this might stretch the capacity of the Agency, we propose that a health needs assesment is attempted as one of the projects of the Agency. It should be designed to be appropriate in its scope and ambition to the limited capacity of the Agency. It can be designed in the second phase of the CuRI engagement.
38. The proposed agency would be the first of its kind in the Slovak Republic. The governance structure proposed here would have been very risky to test by the municipalities without external support. Therefore, implementing it with EC support under the CuRI program is a unique opportunity to test a local care provision model that may be applied throughout the country.
39. On the national level, there is an existing public health insurance system of payments for health care services (HCS) paid by the HIC to the HCS providers. The financing of LTC is missing, but the government announced that it is preparing new legislation on LTC.
40. Based on the prior experiences of the authors of the model.
41. Including, for example, the service of case management provided by qualified nurses.
42. Specific needs need to be confirmed by the Agency through futher consultations.
43. These proposals will be developed further in the second phase of the implementation of this component of the CuRI project.
44. LEADER – an accronom from French - Liaison entre actions de développement de l'économie rurale – meaning Links between actions for the development of the rural economy. It is a European Union initiative to support rural development projects initiated at the local level in order to revitalise rural areas and create jobs.
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