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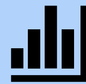
SLOVAKIA: OPTIONS FOR MEETING HEALTH & SOCIAL CARE NEEDS[i]

MACROECONOMIC CONTEXT

Strong growth, and past reforms in health and social spending, have helped lower the fiscal deficit to below 1 percent of GDP in 2018. At the same time, following consecutive years of favorable performance, the export-oriented Slovak economy is facing deceleration, mostly driven due to softening macroeconomic conditions in the Eurozone and global trade tensions. Still, IMF projections see the government running a balanced budget over the medium term.



DEMOGRAPHIC TRENDS

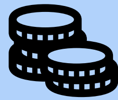
Notwithstanding continuous improvement over the last decade, there is still a gap in headline health indicators between the Slovak Republic and the rest of the EU. Public health in the country is gradually improving but sizeable socio-economic health disparities exist. Life expectancy (80.7 years for women and 73.8 years for men in 2018) is still below the EU average (83.8 for women and 78.4 for men). However, over the last five years, the gap with the EU average life expectancy at birth has narrowed by almost five months. There is also a gap in healthy life years (55.1 years for women and 54.8 years for men in 2015 vs. EU average of 63.3 and 62.6 respectively), which have been showing a decreasing trend after 2007, only to start picking up again over the recent years.

Differences based on socio-economic status are significant. The life expectancy gap between citizens with tertiary education and those with less than lower secondary education was 10.4 years in 2016. Reflecting similar patterns, more than threequarters (78 percent) of Slovak people in the highest income group report being in good health, compared with less than two-thirds (61 percent) of those in the lowest income quintile.

More than a third of the overall burden of disease in Slovakia in 2017 was attributable to lifestyle-related risk factors. Based on IHME estimates, more than 35% of the overall burden of disease in the Slovak Republic in 2015, as measured by DALYs, can be attributed to lifestyle-related risk factors. (IHME 2017) These include smoking and alcohol consumption, as well as dietary risks and low physical activity contributing to high body mass index and other health risks. The lack of effective coordination between care sectors, as well as a significant decrease in prevention spending in the past years, negatively affected the impact of existing health promotion programs.

Dependency rates of the elderly expected to increase in Slovakia. The number of people in dependency is forecasted to increase from 510 thousand in 2015 to 770 thousand in 2070, a 52 percent change, higher than the increase in the EU (25 percent). Additionally, the proportion of the population being dependent in terms of severe limitations in daily activities is projected to increase from 9.3 to 15.6%, giving a 68% increase, compared to the more modest EU trend of 21%.

FUNDING, SERVICE PROVISION AND GOVERNANCE OF ELDERLY HEALTH AND SOCIAL SERVICES



PUBLIC EXPENDITURES ON HEALTH AND SOCIAL CARE

Slovak spending on health and long-term care is below the EU average. Total expenditure on health as a percentage of GDP (6.7 percent in 2018) is below the EU average (9.9 percent). Expenditure increased from 5.4 percent in 2003 but is below its peak in 2009 (8.5 percent of GDP). This is due to fiscal consolidation associated with reforms to curb health spending in the years after the financial crisis. Total public spending on Long-Term care (combining health and social expenditures) amounted to 0.9 percent of GDP in 2016, below the EU average of 1.6 percent of GDP.

Demographic forecasts project an increase in expenditure on both health and long-term care over the long run. The EC's "AWG reference scenario forecast" (EC 2018), encapsulating health-status and demographic cost drivers, envisages public expenditure on health care to increase by 1.2 percentage points of GDP by 2050, compared to an average increase of 0.9 percentage points for the EU. In the same scenario, public expenditure on long-term care is expected to increase from 0.9 to 1.5 percentage points of GDP until 2050. Aggregating the overall costs of ageing (including pensions), the EC's fiscal sustainability forecasts (EC 2018) project an increase of ageing related costs of 2.4 percentage points of GDP until 2060, potentially jeopardizing fiscal sustainability.

About three-quarters of overall health spending stems from the public sector. In 2015, 68 percent of total health expenditure funding came from mandatory health contributions plus 6.7 percent from other government sources. The remaining part is private expenditure on health including private health insurance and out-of-pocket payments. A large part of private expenditure (18.4 percent) is out-of-pocket, mainly as payment for private health services as public health services have only limited cost-sharing modalities. Private health insurance expenditure accounts for only 1.8 percent of health expenditure.

Most of the funding for long-term care provision in Slovakia stems from local government's budgets and the Ministry of Social Affairs, whereas only limited funding is provided through the health insurance. The majority of formal LTC in Slovakia is provided through the social budget of municipalities and self-governing regions. These entities finance home-based care, daycare facilities, and institutional care facilities (for which they receive some earmarked budget contributions from the Ministry of Social Affairs). Some services are co-financed by EU social funds. The Ministry of Social Affairs directly finances a means-tested caregiver allowance (cash benefit) for the informal carers of dependent elderly. The smallest funding stream stems from the mandatory health insurance which mainly provides geriatric care in specialized hospital departments. The overall low level of funding implies that a considerable part of current LTC needs are not covered by public means and either require high co-payments or high levels of informal care.

SERVICE DELIVERY AND GOVERNANCE

The Slovak health care system is financed by the compulsory payments to the health insurance funds that cover all residents. Public health insurance is mandatory, and payments are executed through three health insurance companies, one of which is state-owned and two of which have the form of private joint stock companies. The market is dominated by the state-owned company whose market share amounts to 63 percent in 2016. The government pays the contributions for some population groups (pensioners, students, etc.) whereas the remainder of the population pay contributions through a social insurance-type system. Coverage extends to the majority of the population with only a negligible share (about 4 percent in 2015) not being covered by the public health insurance system.

The provision of health care, managed by the Ministry of Health, is decentralized and based on a public-private mix. The Slovak Ministry of Health plays a central role in the governance of the system. It sets policy priorities, manages the overall system, defines the benefit package and maximum waiting list, and mandates the insurance companies to contract providers. Public and private health care providers sign contracts with the health insurance companies (mentioned above) in order to be eligible for reimbursement. Insurance companies are free to contract with providers and negotiate quality, prices and volumes individually. Most primary care providers operate either as public providers or have contracts with health insurance companies. About 40 percent of total inpatient facilities, including university hospitals and few highly specialized institutions, are directly owned by the government. In recent years the ownership and management of most public institutions has been decentralized from the central to the regional level. Only a limited number of doctors with a specialization in geriatrics operate in Slovakia.

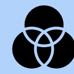
Long-Term care is mainly provided informally at home, with a small amount of formal care provided primarily through public long-term care institutions and publicly funded home care. The majority of services (around 60 percent) is delivered through informal home care, generally by the beneficiary's family, which receives a small cash benefit. Institutional care and home-care services provided by professional carers account for around 30 percent and 10 percent of the total are mix, respectively. Despite the limited resources devoted to the sector, the proportion of the over-65s benefiting from long-term care is similar to the average for OECD countries, reflecting the high importance of informal care.

Administration of long-term care is shared between the Ministry for Social Affairs, the Ministry for Health, and regional and local governments. Long-Term care in the area of health is provided in the form of geriatric care in outpatient departments, specialized hospital departments, day care centers, home nursing agencies, and hospices. The Ministry of Labor, Social Affairs and Family provides cash benefits for informal care (including paying for their health and pension insurance contributions). It also regulates and monitors institutional care facilities operated by municipalities. Provision of in-kind care delivered at patients' homes is devolved to and mostly financed by municipalities and regional authorities. Access to in-kind services and cash benefits

is means-tested and conditional on the applicant meeting certain dependency criteria. Furthermore, almost all services in both the health and social sectors require co-payments by patients.

Government reforms in the area of health care focus mainly on increasing the gatekeeping role of GPs. The Ministry of Health has taken actions to proportionally change the redistribution of patients visits from 80 percent managed by specialists and only 20 percent fully managed by GPs to around 60/40 percent over the next few years. In line with that goal, the government intends to move towards more integrated health care provision to reduce expensive hospital and specialist treatments.

Policy reforms in long-term care over the past years were targeted almost exclusively on the formal sector of LTC, with reform impetus on integration of care accelerating only recently. The Ministries of Health and Labor are currently developing a long-term strategy to improve coordination between the sectors. Furthermore, the National Programme for Active Ageing 2014- 2020, approved by a government resolution in 2013, gives the possibility to introduce LTC insurance by 2020. However, LTC insurance introduction currently seems unlikely with the Ministry of Health being opposed to it. While reforms to transition towards home-based care are moving only slowly, the government's strategy of deinstitutionalization of social services and strengthening of care foresees a systemic transition from institutional to community-based care. Furthermore, the newly established government has listed deinstitutionalization as one of its reform priorities in the social sector.



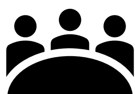
GAP ANALYSIS

Although reforms in previous years have reined in increases in health spending, medium-term demographic trends will lead to significant spending pressures. A declining and low fiscal deficit, single-digit gross financing needs, and a stable access to financing led to sustainable public finances. However, considerable fiscal resources are needed to accommodate social and infrastructure investment and higher pension spending in the future. Moreover, the constitutional law passed in March 2019 that reversed earlier pension reforms by capping the retirement age at 64 for men, with early retirement options for women with children, will also raise long-term pension expenditure. Thus, the government will need to make available significant resources over the medium-term combined with an increase in the efficiency of spending, to accommodate expenditure pressures.

Fiscal sustainability in the health sector is very dependent on the trends in the labor market. Since the Slovak health system is largely funded out of payroll contributions, the funding is directly dependent on high labor market participation and rising earnings. This dependency on labor market performance requires contingency planning to safeguard the health sector when the labor market weakens. In the long run, low birth rates and increases in life expectancy will lead to an increase in the ratio of people aged over 65 relative to the working-age population from currently one of the lowest in the EU to one of the highest by 2060. This necessitates increases in labor market participation rates,

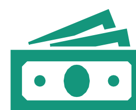
especially for women, to balance out increasing dependency ratios.

The majority of long-term care is provided informally (EC 2019) but, apart from small cash benefits, the government does not address the needs and challenges of those providing care. Polices reforms in the past did not address informal care provision. Evidence shows (World Bank 2018) that informal care provision, especially when coupled with other care or labor market responsibilities, can be a significant burden on caregivers and lead to caregivers dropping out of the labor market or requiring health services, thus increasing the cost of the system. Furthermore, informal care provision has an important gender dimension as the majority of caregivers are women. Given that increasing female labor force participation is one of the levers for the government to increase the sustainability of the health and pension systems, assisting informal care givers should be a policy priority.



For the moment, there is a very limited coordination between health and social long-term care, but lack of coordination is perceptible also between state administration and regional/local administration. There is an acute demand for measures integrating health and social care into one institution. The multiple channels for aid, managed by different bodies, make the system opaque and difficult for users to navigate (Vagac et al., 2014). The bureaucracy involved in evaluating an elderly person's needs is drawn out and cumbersome, and the different kinds of aid are not well coordinated. Furthermore, the distribution of service delivery responsibilities across multiple entities leads to a fragmented provision of care provision.

Shortages of both nurses and long-care workers pose significant problems to these sectors. Health workforce shortages are a challenge that disproportionately affects citizens in rural and disadvantaged areas. The number of nurses per capita is lower than the EU average (5.7 compared to 8.4 per 1000 population in 2016) and has decreased sharply in the past years due to the increasing number of nurses leaving to work abroad. Recent estimates by the Ministry of Health show that hospitals face a shortage of over a thousand nurses, and that only 44 percent of domestic nursing graduates take up nursing jobs (Ministry of Health, 2018). Although less exacerbated, there is also a shortage of GPs (42 per 100,000 inhabitants compared to the Eu average of 78.3). Moreover, formal jobs in the long-term care sector are poorly paid, despite difficult working conditions, and, as in nursing, a high proportion (an estimated 65 percent) of carers trained in the Slovak Republic work abroad, mostly in Germany and Austria, where there is high demand for these workers (Nadazdyova et al., 2013; Vagac et al., 2014).



Although the Slovak Republic spends a significant proportion of its LTC envelope on home care, more could be done to move away from costly institutional long-term care provision. The expenditure for institutional services makes up 48.6 percent of public expenditure on LTC in-kind benefits (which favorably compares to 66 percent in the EU), whereas 51.4 percent is being spent for LTC in-kind services provided at home (compared to 33 percent in the EU). Still, the generally small fiscal envelope means there is still a lack of in-home care capacity, resulting in long waiting lists for access to homecare services.

There is a large untapped potential for private sector participation in long-term care. There is currently only a very limited role for the private sector (for-profit and non-for-profit) in the long-term care sector. Long-Term care is provided either through the public sector (health and social) or informally with a limited government role in the regulation of private sector delivered care. Given the large unmet care needs and the extensive reliance on informal care, there is a strong likelihood of an informal (gray) market of long-term care operating without proper regulation. Establishing a legal framework for private sector provision, as well as enabling the development of a competitive market would be a low-cost option for increasing the efficiency and diversity of service provision.

PRIORITIES FOR REFORM AND POLICY OPTIONS

The policy recommendations stemming from the European Semester as well as the government's strategy documents clearly delineate reform priorities in the areas of health and social care for the elderly. The EC Country Report on Slovakia (EC 2019) outlines the most urgent reform priorities for the Slovak government. Policy objective 4 in Annex D (A more social Europe) states the importance to "enhance equal and timely access to quality, sustainable and affordable social and healthcare services" (ibid.). Specifically, the document recommends to "improve accessibility of long-term care services for the elderly and promote active and healthy ageing" and "support the transition from institutional care to community- or family-based services". Government strategy also outlines the need for policy area in the areas of health and social care: (i) The Ministry's of Health strategic framework for health 2014-2030 (SFH) mentions the necessity for "long-term professional integrated healthcare and social care provided in a community". (ii) The Ministry's of Finance "National Reform Programme of the Slovak Republic 2019" mentions health care and labor markets as two top reform priorities for the government, thus elevating the priority of long-term care reform as an area that pertains to both sectors. Furthermore, the newly stablished government has lsited reforms in LTC provision as one of its priority policy areas.

Slovakia's rapid demographic changes, coupled with an unsustainable reliance on informal familial care, necessitate reforms to the sector. As outlined above, Slovakia faces an ageing population and the associated fiscal pressures on pensions, health care, and long-term care. A higher dependency ratio will lead to an ever-smaller workforce having to shoulder the tax burden of financing these systems. Furthermore, heavy reliance on informal care is an unsustainable solution in the long run as the ceiling on female labor force participation is already a binding constraint for the Slovak economy. Thus, reforms to increase the sustainability and effectiveness of health and long-term care for the elderly is an urgent policy priority. The SFH notes the need for "significant increase in efficiency of use of existing financial resources in health sector".

I. Reforms will be needed to establish a financing mechanism for Slovakia's long-term care system that moves away from financing inputs (i.e. beds in institutional facilities) to financing services for elderly with needs, to meet the rising demand expected in the coming years. First and foremost, this will require moving towards principles of "money follows people" which implies allocating financing to personal budgets, rather than to the facilities or providers alone.

This may also require increasing the resources of regional and local administrations to boost the quantity and quality of care provision. Financing schemes range from universal tax-financed provision of services to strictly means-tested targeted subsidies. An alternative solution could be the introduction of a mandatory dependency insurance, similar to schemes adopted in some other countries, including Germany and Japan. Also in Estonia, the World Bank developed different financing scenarios and outlined the different service packages available under different fiscal envelopes (P158968).

II. Home-based and community-based services should be strengthened through reforms to support informal carers so as to increase efficiency and quality of services and mitigate the negative effects on familial care's health and labor market participation. Supporting family carers could take the form of flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, align cash benefits paid to care recipients with incentives for employment of carers. In Estonia, the World Bank has implemented a RAS to develop policy options for the government with the aim of introducing reforms to support informal caregivers (P158968).

III. Integrated care model that adequately coordinates the health and social sectors promises significant efficiency gains and should be gradually introduced. This could consist of the creation of one-stop shops at the regional level with adequately trained personnel centralizing access to information, simplifying the application process for the various services available and helping to coordinate the different long-term care providers, creating a single integrated information system to track beneficiaries which allows for referrals within the system, and providing a catalogue of services available at the local level[1]. This is in line with SFH which notes the need for "implementation of an integrated model of healthcare provision based on provision of nursing care services at home". Furthermore, the Institute of Health Policies within the Ministry of Health focuses on the development of integrated care. In Chile, the World Bank has implemented a RAS to integrate care systems (P159331). The program not only unified and streamlined existing disparate support mechanisms (cash transfers, in-kind benefits) but also created a one-stop shop and a unified menu of services in each municipality.

IV. Upgrading the stewardship capacity of the government for both the public and private components of the long-term care market can unlock significant efficiency gains. This would entail developing, piloting, and implementing standards (accreditation and certification, service delivery standards, staffing standards, governance and management standards, M&E standards) for residential, community-based, and home-based aged care services will piloted to improve the quality of service provision and management. Such standards could also encourage home care and contain regulations controlling admissions to institutional care to avoid unnecessary institutionalization. The SFH specifically mentions the need to increase the use of public-private partnerships in the health/LTC sector. In China's Anhui province, the World

[1]Although the Ministry of Labor provides a central register with the list of social services available throughout the country it is hard to access and navigate for care-dependent elderly.

Bank is implementing a project to develop aged-care standards and finance the upscaling of both home-based and institutional care services (P154716.).

V. Creating a policy framework to manage the availability of a long-term care workforce in the face of persistent outmigration of skilled professionals is critical. Substantial wage differentials continue to incentivize qualified care workers towards outmigration. This issue will become increasingly salient over the next decade as the demand for LTC workers increase. Creating a comprehensive policy framework that encompasses measures related to migration, language, labor market policies (including regulation and supervision of recruitment practices of job agencies), "remittance-friendly" measures in the financial and banking sector of both sending and receiving countries could help mitigate the brain-drain. In Australia and the Pacific Islands, the World Bank has advised governments to set up a system for managing circular migration of care workers and remittances (P155609).

[i]This note is produced by Elena Glinskaya, Ian Forde, and Florentin Kerschbaumer as an output of an "EU: Aging and Value-for-Money in Delivery of Health and Social Care services" (P172480).