MINISTERSTVO
PRÁCE, SOCIÁLNYCH
VECÍ A RODINY
SLOVENSKEJ REPUBLIKY

Report on national implementation measures for the implementation of the Council Recommendation on access to affordable high-quality long-term care

1. Background and baseline

The need to combine the provision of social services and health care, especially in the scope of nursing care and physiotherapy, is currently one of the most topical topics in Slovakia in providing assistance and support to several groups of the population, especially the elderly, persons with disabilities and persons with chronic diseases, persons reliant on the long-term help of another person in coping with everyday activities. One of the answers to the need for a coordinated approach in providing support to these persons is the system of long-term social and health care (LTHC), which has been absent for a long time in the Slovak Republic. Long-term support for deprived persons was implemented partly within the sectoral remit of the health sector, as well as within the sectoral remit of the labour, social affairs and family sector, without the desired systemic and integrated approach, with the associated pooling of public funds into the necessary interventions for the benefit of the individual.

The Government of the Slovak Republic, based on the recommendations of the European Commission and the Declaration on Solutions for Socio-Health Care in the Government Programme Statement for 2020-2024, **approved the Long-Term Care Strategy in the Slovak Republic ('the Strategy') by Resolution No 546 of 29 September 2021, publicly available information is available at:** Long - term care strategy in the SR - MoLSAF SR (gov.sk).

The aim of the Strategy is to propose substantive solutions, which will then need to be translated into interdepartmental cooperation and legislative changes in order to create an effective and functioning system. **The strategy is drawn up in accordance with the Recovery and Resilience Plan of the Slovak Republic**, to which it is also directly linked. All parts of the Strategy are designed to improve the quality of life of people in need of long-term socio-health care, including by making formal and informal social and health care more attractive and stronger.

Its aim is to introduce a systemic solution for the provision of LTHC for residents who will be eligible recipients of such coordinated and integrated care as a priority in the home and, if this is not possible or sufficient, in the institutional environment. LTHC should preferably be provided in the field and outpatient form rather than in the residential form. This solution will be conditional on pooling public and private resources into the necessary interventions for the benefit of the individual.

The main reasons for the need to address the situation of people in need of long-term care are the increasing representation of these citizens in the population (due to demographic developments and increasing life expectancy with associated consequences, as well as the unfavourable development of the health status of the population) and the related increasing demands for financing the necessary assistance and support from both public and private sources, which require ensuring the effectiveness, efficiency and targeting of the social and healthcare services provided. It is therefore essential to proceed without delay with the implementation of workable solutions to the basic shortcomings of the current social and health care system for people in need of assistance.

1.1. Diagnosis of gaps and remaining challenges

The intention of the LTHC solution was also declared in the Government-approved Strategic Framework for Health Care for 2014-2030, where one of the priorities of the reform of institutional health care is also "rethinking the number and structure of acute beds and strengthening the beds of nursing units, rehabilitation, nursing and beds for the long-term sick." At the same time, this proposal also takes into account the objectives and measures set out in the Strategy for the deinstitutionalisation of the system of social services and alternative care approved by the Government of the Slovak Republic in 2011, but also the measures of the National Strategy for the deinstitutionalisation of the system of social services and alternative care (hereinafter referred to as the National DI Strategy). These documents recommend, as a specific solution, the reprofiling of those social service institutions (SSF) that provide specifically social and specifically health care for residents for whom other types of services are not suitable or effective.

The DI's national strategy also draws attention to the need to integrate health and social care, either in a low-capacity facility (hospice, nursing home – NH, SSF) or in integrated outpatient and home care, respecting the basic principle of providing community-based care before institutional care, which is also a priority of the LTHC strategy.

Social assistance system

Within the LTHC, the Slovak social assistance system is divided into two main variants.

Informal care, provided mainly at home , is supported in the form of a cash allowance for care and a cash allowance for personal assistance (Act No 447/2008 on cash allowances to compensate for severe disability and amending certain acts, as amended).

The Offices of Labour, Social Affairs and Family ('OoLSAF SR') and the Central Office of Labour, Social Affairs and Family are the competent administrative authority for proceedings concerning the promotion of the social inclusion of individual with severe disabilities in society and medical and social assessment activities. The administrative bodies of the 1st and 2nd level decide on the proposed forms of compensation for the social consequences of severe disability and supervise the fulfilment of the legal conditions for their provision. They decide on contributions and ensure that the legal conditions for their payment are met. However, they do not realistically supervise the extent of informal care for people in need of help from another person. There is also a lack of necessary support for informal carers.

An accessible and high-quality socio-health system is therefore one of the key elements in reconciling work and family life, which is also described as a strategic priority in the National Strategy for Equality between Women and Men and Equal Opportunities 2021-2027. The LTHC strategy thus forms part of a wider state policy aimed at providing better and more accessible assistance to families caring for their dependent members, most of which are women.

Formal care in the system of social services is provided mainly through social services provided in institutions (outpatient form or residential form weekly or year-round) or through the use of home care services.

The main objective of social services is the prevention, resolution and mitigation of the adverse living situation of a person, family or community, the preservation, restoration or development of the ability of a natural person to lead an independent life and the promotion of their inclusion in society. Social services are provided by public and non-public providers. Among the various types of CSS, social service homes, facilities for the elderly, nursing homes, child protection and social guardianship facilities and specialised facilities are particularly important in terms of the range of clients requiring CSS, as only within these social assistance facilities is Act No 576/2004 Coll. in §10 and allows the provision of nursing care.

In 2019, 16,000 people received home care services, a slight increase from the previous year, mainly thanks to the National Project Supporting the Development and Accessibility of Field Care Services. European Union funding for this service is not a systemic solution and this leads to recurrent problems in the continuous provision of these services. Slovakia has committed itself in various strategic documents (National Priorities for the Development of Social Services 2021-2030) as well as in the Government Programme Statement 2020-2024 to create conditions for the provision of social services on a community basis, so that a person can stay in their natural environment for as long as possible, in particular by providing field and outpatient services. Section 13(6) of the Social Services Act emphasises the priority of providing field and outpatient forms of social services over residential social services. Despite these commitments and legislative support, this principle is not being implemented.

For the sake of completeness, it is also necessary to mention the context of the social and legal protection of children and social guardianship (SPCHSG) and at least the framework situation in this area. The main reason why it is clearly necessary to mention the area of SPCHSG is that the quality and efficiency of this system is, among other things, directly dependent on the quality and efficiency of both the social services and health care system. Apparently, the topic of child protection in the social field operates relatively independently and the reason for the implementation of the SPCHSG measures is not and must not be 'only' a health condition/disability, but one part of the children for whom it is necessary to implement the SPCHSG measures for various reasons are children with disabilities and one part of the parents of children for whom the SPCHSG measures are implemented are severely disabled persons or persons in treatment.

A serious problem is **the persistent absence of facilities providing professional assistance to children with mental disorders in** combination with behavioural disorders and not infrequently with associated mental disabilities. Despite the fact that these children require professional – psychiatric care (of course combined with professional assistance under the responsibility of the LSAAF), SPCHSG facility is usually the only option to address the child's situation. SPCHSG facilities are not only unable to provide outpatient or inpatient pedopsychiatric care to the extent necessary, but also provide long-term childcare, which requires not only education and care, but also continuous professional pedopsychiatric care.
The specific objectives and tasks in this part of the exercise are contained in the 'Blueprint for ensuring the implementation of measures in social and legal protection and social guardianship facilities for the years 2021-2025 Deinstitutionalisation Plan'.

Health system

Currently, LTHC provided within the structures of the health and social system is oriented mainly towards chronically ill patients. It is provided in an outpatient form through home nursing agencies (hereinafter referred to as HNCA); specialised outpatient care (mobile hospices, geriatric clinics); in the form of inpatient health care (departments for the long-term sick, geriatric and palliative departments in hospitals) and in specialised health care facilities (psychiatric hospitals), and in particular in long-term care homes, nursing homes (NH), hospice homes, and social assistance facilities (in care homes for the elderly, nursing homes, specialised facilities, social services homes and facilities for the social and legal protection of children and social guardianship).

The assessment of reliance on the assistance of another person in self-service activities in the health sector is not ongoing, for the use of inpatient health care services, including nursing care, and HNCA is sufficient indication from the attending physician (general, specialist with competence or even the attending physician during previous hospitalization). On the positive side, this system in practice significantly shortens the period between the actual indication or need for the service and the admission of the patient to the services of HNCA, NH, hospice, etc. (compared to SSF, where the

process is much longer – in the order of months). A limiting factor for early admission is inadequate management of care after discharge from the hospital (disorientation of the patient and his family in the system), but also occupied capacity of the provider, which can result in serious health and social complications.

The main drawback is the underestimation of nursing care in the social sector and the underestimation of social care in the health sector.

Due to the level of health complications of NH clients, we cannot expect that social services will be provided at the same intensity as in SSF. However, there is definitely a need for a social worker to assist clients and their families with long-term care planning. It is therefore necessary to set an appropriate amount of personal budget for clients in follow-up care.

The use of HNCA services has been growing in recent years, in terms of the number of patients, visits, services and payments of the total insurance company. It should also be noted that the cost of transporting HNCA (the so-called mileage) is not covered by health insurance. These costs must be covered by HNCA from their own resources.

HNCA capacities are not sufficient. The problem is the lack of support for comprehensive nursing monitoring and patient management. The HNCA reimbursement system does not cover a series of necessary preventive actions defined in the standard procedure of the Ministry of Health of the Slovak Republic. In the long term, care in more remote locations is less accessible compared to patients living in cities.

Palliative care and hospice

According to the available data, dying in hospitals has an increasing trend, compared to dying in home care, where, on the contrary, it has a decreasing trend. In the group of geriatric and oncological patients, that is, patients with multimorbidity and/or with incurable progressive disease, dying in an institution, in an unnatural environment, is a phenomenon behind which the poorer quality of life in the disease is hidden. A greater proportion of those who die in the natural environment or hospice will be an indicator of the increasing quality of care for those targeted by the reform. The implementation of the reform stemming from the RRP will increase the number of deaths in the natural home environment and in the hospice.

In Slovakia we have 225 beds in 13 stone hospices, but only in 4 of them is available specialized palliative care (SPC) carried out by a paliatologist. There is no SPC available in 59 palliative compartment beds.

Mobile hospices as part of specialized outpatient care (SOC) with the possibility of visiting doctors and nurses are available only in five regions of Slovakia. In NHIC, there are data on 22 mobile hospice service providers, of which only 12 actually provide a visitor (field) service to a doctor and nurse.

A model example of providing comprehensive palliative care is the teaching center at the National Institute of Oncology (NIO) Klenová, where an ambulance of palliative medicine and mobile hospice are present at the Oncology Department F of the Clinical Oncology Clinic focused on palliative medicine. The department team implements a consiliary service for the entire NDU. The team includes a social worker, a nutritionist and psychologists. Patients are referred to palliative care in palliative multidisciplinary seminars. Ambulance of palliative medicine in NIO is the only ambulance of PM in Slovakia.

In Slovakia, we have 294 beds for palliative care, while the SPC is provided on a third of these beds. The need for acute beds is about 20 beds per one million inhabitants, so the inhabitants of Slovakia should have at their disposal about 110 acute palliative units. The only acute palliative department is established within the Clinical Oncology Department of NIO Bratislava and has 19 beds

at its disposal. The need for mobile palliative teams is approximately 1 mobile palliative team per district. Slovakia has 79 districts, we have 8 mobile palliative teams, in seven PM specialists.

Assessment activity

It is clear from the above that the LTHC system is highly fragmented, which is addressed in several legislative acts and, within two departments, essentially on different bases and financing mechanisms (different involvement of public funds, including sources of public health insurance and the participation of the recipient of the social service or the patient in the costs of the care provided).

A key consequence of this fragmentation of the assessment work carried out for different purposes is a non-uniform and non-standardised system for assessing reliance on the assistance of another natural person for self-service. The inconsistency of the processes for assessing reliance on care leads to the fact that the necessary support and care is not provided in a targeted manner and is not based on the real individual needs of persons reliant on the help of another person, and also has negative consequences for the financing of various forms of support and care (e.g. frequent placement of clients in facilities not based on their needs, but based on a vacancy with the provider and the financial possibilities of the municipality, financial possibilities of municipalities that affect the provision of a contribution to the operation of facilities, underfunded care service by the municipality reliant on funding from European funds).

The description of the current social and health care systems for people in need of assistance reveals the following main challenges and problems in the field of long-term care:

1. **Absence of a functional link between social and health care and vertical fragmentation of competences.**
2. **Inconsistent and unsystematic assessment of disability and long-term care needs.**
3. **Lack of long-term, follow-up and palliative care services, in particular community-based services.**
4. **Inefficient way of financing.**
5. **A dysfunctional system of supervision of social care, including care at home.**
6. **Absence of preparedness of NH, SSF for patient/client isolation needs.**
7. **Non-additional level of application and implementation of telemedicine and telenursing.**
8. **Absence of regulation of the institution of prior wish, including in the field of long-term care.**
9. **Absence of travel and patient management after the end of hospitalization in acute beds, the need to provide long-term care, based on a comprehensive health-social assessment and the needs of persons in need of health-social care.**

1) Absence of a functional link between social and health care and vertical fragmentation of competences

Competences in the field of long-term care are mainly divided between the social and health sectors, whose cooperation is insufficient for the needs of integration in the long term. Until recently, health and social care departments in the field of long-term care have not cooperated sufficiently.

<u>As a result:</u>

•There was a lack of a common vision, strategy and capacity planning that took into account current infrastructure, the needs of the population, future demographic developments and respect for human rights.

•**The transition of a person with long-term care needs between health and social services has not been coordinated.** This contributes to the deterioration of the patient's health and, especially in the elderly, to unnecessary rehospitalization. Similarly, the transition to these systems of young adults with disabilities and long-term care needs who, as children, have been placed in the CCHAF following a court decision, has not been coordinated.

•**Health care in social services facilities is not adequately provided in legislative, personnel or financial terms. Nor is there adequate provision of legislative, personal or financial assistance in health care facilities.**

•In Slovakia, there are 940 residential institutions of social services with a total capacity of 42.5 thousand places, which according to the law should provide nursing care Only 7.4 % of these institutions have a contract for the payment of comprehensive nursing care with a health insurance company. The reasons for not concluding contracts are low payments by insurance companies, as well as the administrative burden associated with contracting.

•The payment of a health insurance company for nursing care provided to a client in a social services facility in accordance with the standard determined by the Ministry of Health (€3.30 per day) is lower than the payment of a health insurance company for care in health care facilities with similar or the same type of clients and care (e.g. the payment of a bed in institutional nursing care is on average €26 per day).

•Of the 514 million euros spent annually on financing the provision of social services, 2.8 million euros are paid for the provision of nursing care provided by public health insurance, which represents 0.5% of the total cost. Healthcare workers account for 13% of staff in social services facilities. Even though nurses do not necessarily provide health/nursing care throughout working hours, the difference between the amount of care provided and reimbursement is striking.

•The inflexible assessment process and the lack of coordination with social service providers extend the waiting time for social services even in urgent cases.

Social services• facilities for many clients replace long-term psychiatric care. 27% of clients (15.5 thousand) in social services facilities are set up for antipsychotic treatment. Compared to institutional care facilities, they often lack adequate professional psychiatric care, nursing care and material and technical equipment. The same situation with the absence of specialist psychiatric care is also in centers for children and families.

•**There is a lack of facilities where patients diagnosed with a vigilant coma would also be hospitalised,** which are partially compensated by long stays in the Departments of Anesthesiology and Intensive Medicine (DAIM); long-term artificial pulmonary ventilation ('long-term APV') in geriatric compartments, where applicable. More such specialised facilities need to be set up.

•**The vertical fragmentation of competences also prevents the integration of both systems.** These are divided between ministries, municipalities, HTU, Offices of Labour, Social Affairs and Family and other public administration bodies. The combination of providing different types of care is considered a sign of its quality and not an inefficient use of funds. Appropriate and effective combination of different types of social services is also possible under Act No 448/2008 on social services. At the same time, it is already possible for one provider to provide both social and health care at the same time.

2) Inconsistent and unsystematic assessment of disability and long-term care needs

•**The assessment system is fragmented and inefficient.** In order to benefit from the personal assistance allowance and the care allowance, a natural person must first be assessed as a severely disabled natural person before the degree of reliance on the assistance of another person or the extent of personal assistance is assessed. However, recognition as a person with severe disabilities is not necessary for the provision of social services, only reliance on the assistance of another person is considered. **Therefore, the same person is often repeatedly assessed by different entities for different purposes under different laws with different criteria.**

• **The assessment is inconsistent and unfair due to the fragmentation of the system and its low level of control.** Evaluation activities for various types of social services and allowances are carried out by various authorities – municipalities, HTU and the Offices of Labour, Social Affairs and Family (OoLSAF SR). According to the findings of the 2017 inspection of the Prosecutor General's Office, up to 69 % (227 out of 329) of the opinions reviewed showed elements of illegality. The most common problems are the transfer of assessed persons within the assessment activity between different levels of self-government (depending on the type of service on which the person is assessed) and the disparity of

the outcomes of the assessment activity, where one person has different degrees of reliance in several decisions.

•**The criteria for assessing reliance on severe disability are narrow and disadvantage people with mental disorders.** Conversely, severe disability is often recognized by people whose disease is well managed by modern treatments.

•**When assessing reliance on social services, a conflict of interest arises.** Unclear rules and insufficient control of the assessment allow municipalities that carry out the assessment activity and are at the same time the settlor of a large part of the facilities to attribute to applicants higher levels of dependence than they actually have. The contribution of the Ministry of Labour, Social Affairs and Family of the Slovak Republic to clients in higher levels of dependence is higher.

The assessment involves an inadequate bureaucratic burden for both medical assessors and assessed persons and their relatives. One of the main reasons is the lack of digitalisation of the process. OoLSAF SR medical assessors do not use the e-health system and the applicant is forced to prove his/her state of health with numerous documents.

• **The work of the medical assessor is unattractive due to low financial valuation and bureaucratic burden.** The emoluments of the medical officer shall be less than half the emoluments of a medical specialist employed in an institute of health care. Despite the low financial rating, smaller municipalities are unable to pay medical assessors, which is why they often refer their citizens asking for an assessment to HTU.

3) Lack of long-term, follow-up and palliative care services, especially community-based services

• **The network of health and social care services does not take into account the needs and preferences of the population. There is a significant lack of community-based and home-based care capacities in long-term care in Slovakia,** despite the fact that 89% of the Slovak population would prefer home-based care, either with family support, professional service or in combination with outpatient care.

•**The social services offer is dominated by residential services of an institutional nature,** with 28.6% of people reliant on long-term care living in residential social services facilities in Slovakia, compared with 19.7% in neighbouring Czechia.

•**In residential care, large-scale facilities predominate over smaller community-based facilities.** 73% of clients in residential social care are in a facility with a capacity of more than 40 seats.

•**The deinstitutionalisation of long-term care in Slovakia is slow due to both procedural and financial barriers.** Legislative changes in 2014 limited the emergence of large-scale facilities, but did not adequately develop community services. Since 2016, the capacity of daily stationaries has even been shrinking due to a change in financing and operating conditions.

•**The burden on families caring for dependent relatives (including minor children) is disproportionate due to the lack of outpatient and field social services.** Only 611 caregivers used outpatient social services for their relative in addition to care.

•**The current system does not provide support for families caring for dependent loved ones.** Although the legislation guarantees the beneficiaries of the care allowance (caregivers) the provision of a respite care service for 30 days per year, out of 57 048 caregivers, only 259 used it in 2019. Due to insufficient capacities, less than 1% of informal carers use the respite service.

•**The supply of social services does not sufficiently cover the needs of people with lower levels of dependency.** At the same time, accessible and timely integrated care can slow or halt the increase in dependency rates throughout life.

•**Most social services, as well as care allowances, are subject to the two highest levels of dependency.** This is also the reason why Slovakia has a significantly higher proportion of dependent people at the highest level of dependency (53% of dependent people) than e.g. Czechia (14%) or Germany (7%). At the same time, it is necessary to draw attention to conflicts of interest when the municipality assesses, finances and at the same time provides social services.

•**The current healthcare system cannot identify and address the risk of long-term care dependency in a timely manner.** There is a lack of legislative definition and capacity for follow-up care aimed at recuperating the patient after hospitalisation and maximising his/her rehabilitation potential. Insufficient capacity for recuperation of the patient contributes to unnecessary rehospitalization in acute beds.

•**The legally defined minimum network of home and inpatient healthcare providers is not flexibly adapted and does not reflect the needs of the population. Moreover, in many regions it is only partially fulfilled.** In institutional care, the minimum network is not contracted in several regions in the case of nursing and recuperation beds.

There is a shortage of home care• providers. Compared to the Czech Republic, it is adopted by a 30% smaller share of the population. The minimum network of providers is determined by the number of 809 nurses (FTE) on the territory of the Slovak Republic and has not changed since 2008. At present, even this minimum network is filled to only 78-93%, depending on the health insurance company.

•**The system does not legislate for the provision of intensive nursing care in the home.** This is particularly the case for patients who require artificial pulmonary ventilation for a long time and are currently hospitalised in an institutional care facility or receive care at home without clear legal regulation and sufficient provision of nursing care.

•**There is a lack of specialized centres for early neurorehabilitation, which is a systemized specialized health care that concentrates in one place highly professional medical and nursing care, but above all intensive physiotherapy in order to achieve the best clinical outcome of the patient with the maximum possible inclusion in the activities of daily life as the nature and extent of the disease allows.**

•**There is a lack of field intensive home nursing services (IHNC), e.g. for patients who are reliant on APV or are in a vigilant coma.**

•**There is a lack of inpatient health care capacities for patients requiring long-term support of vital functions in the form of IHNC.**

•**A network of palliative services for patients with chronic incurable disease is not sufficient. In addition, there are significant regional differences in the availability of services.** The legally defined minimum network of mobile hospice, hospice and palliative units does not meet the recommendations of international professional organisations (WHO, EAPC) or the needs of the population. Moreover, these minimum requirements are not met in several regions. Palliative departments are established in only three of the eight counties.

•**The lack of field palliative services significantly limits the choice of survival location in terminally ill patients. Most people prefer to die in a natural environment**. According to the recommendations of professional organizations, Slovakia should have about 55 mobile hospices (10 mobile hospices per 1 million inhabitants)36 , currently there are 22 of them, but only 8 of them provide paliatologist services, which are an essential part of care.

•**Only one in 22 mobile hospices is set up directly in an inpatient health facility.** This reduces the level of efficiency and continuity of care.

•**Many field and inpatient palliative care providers do not have sufficient material and technical equipment to provide care according to modern therapeutic procedures.**

•**Due to the low payment of health insurance companies, the operation of palliative services is not attractive.** Most providers are non-profit and ecclesiastical charities whose main sources of income are donations and direct payments from clients. Therefore, services are often not available to lower income patients.

4) Inefficient way of financing

•**The financing system for long-term social care is fragmented and opaque.** Public sources of financing from the state budget consist mainly of two contributions to compensate for severe disability and a contribution from the state budget to provide social services conditional on reliance on care. Local and

regional government budgets and reimbursements from recipients of social services are also sources of funding for social services.

- **Allowances are not provided directly to a person in need of long-term care, but to a service provider or carer. This type of funding may negatively affect the real possibility of realising the right to independent living under the UN Convention on the Rights of Persons with Disabilities.** Funds for the provision of care are not provided to a person with disabilities (with the exception of the personal assistance allowance), but to a carer or social service provider. Thus, a person with a disability becomes an object of care defined by another entity and loses the possibility of decision-making and personal independence.
- **The funding system severely disadvantages the provision of field services and contributes to the institutionalisation of long-term care.** Due to non-systematic financing, the number of home care recipients is decreasing. Between 2009 and 2019, their number decreased by about 25 %, from around 17 000 to 13 000 in the case of caregivers in the municipality (in the case of non-public care providers, the number of caregivers is slightly increasing from around 1900 to 2150, this positive trend being mainly influenced by funding from the Structural Funds). Municipalities are obliged by law to provide a field care service, it should be financed from tax revenues. In particular, smaller municipalities do not comply with this obligation. Weaknesses in the system since 2013 partially remediate the European Structural Funds, but this solution is time-limited and unsustainable.
- **Reimbursement by health insurance companies for care in hospice and nursing homes is significantly insufficient to cover the costs of care.** In these healthcare facilities, which provide follow-up care to the patient, the provision of social care is not reimbursed. They compensate for the lack of resources by increasing payments from clients or donations. This reduces the availability of services for low-income groups. Long-term care insurance may also be considered in the future.
- **Low pay makes the position of caregiver unattractive, especially in field services.** According to the findings of the Supreme Audit Office, the average monthly salary of a field caregiver for public providers in 2019 was EUR 586, for non-public EUR 441, i.e. significantly lower than the average wage in the economy (EUR 1092) and the average salary of a caregiver in a social services facility (EUR 875 for public providers). In 2019, the average monthly wage of a field caregiver was 54% of the average wage in the economy. For non-public providers, this was only 40%.
- **Informal carers caring for relatives with lower levels of dependency are not entitled to care allowance.**
- **Low flat-rate payments for nursing care from public health insurance for nursing care in social services facilities reduce the possibility of obtaining and adequately evaluating qualified medical staff. At the same time, they increase the total amount of compensation paid by the recipient of the social service, who pays special compensation for providing/ensuring nursing care to many providers.**
- **The provision of palliative services in both institutional and home care is financially disadvantageous for providers .** Insurance premiums are significantly lower than the cost of care. Providers are therefore forced to cover the missing funds by increasing client payments or donations.
- **Low payments by insurance companies discourage public providers from setting up their own mobile palliative services and hospices. For example, in 2020, in the 11 months of the year in which specialised palliative care was provided at home,** the Klen mobile hospice received EUR 17 000 – including human resources, all operating costs, including a passenger car, fuel, specialised medical supplies, many non-prescription medicines (with an 'outpatient code'), continuous dispensers of medicines, and so on.
- **The problem of low reimbursements by insurance companies is also felt by home nursing providers.** For example, reimbursements do not take into account the cost of transport to the patient. Health insurance companies HNCA reduce payments for services performed due to internal regulations that are not in line with the provision of care in accordance with the SPDTP.

•The issue of unequal remuneration of recipients of care allowance, in the case of a recipient of a pension benefit or a carer who does not receive a pension benefit, while having the same obligations in the case of unequal remuneration.

5) A dysfunctional system of supervision of social assistance, including care at home

• **The system of supervision and control over the provision of social assistance is fragmented and inefficient –** competences in its implementation are divided between municipalities, several organisational units at the Ministry of Labour, Social Affairs and Family of the Slovak Republic and public health authorities.

• **Personnel capacity is lacking to ensure systematic supervision**, which corresponds to the number of inspections carried out In 2020, 189 complaints were submitted to the Ministry of Labour, Social Affairs and Family for failure to respect human rights in social service facilities, of which only 18 were supervised by the Ministry of Labour, Social Affairs and Family. In 2019, this was only 37 out of 719 referrals.

•**The current system of supervision does not cover at all almost 75.5 thousand persons cared for by informal carers and personal assistants.** This applies in particular to home care provided by family members in receipt of care allowance. For informal care and personal assistance, quality conditions and competence in supervision are not defined.

•**Absence of a system of control and supervision of nursing care provided in social service facilities.** Due to the fact that several social services facilities are not providers of health care, there is no control over the provision of health care from the Health Care Supervision Authority and HTU nurse.

6) Absence of preparedness of NH, SSF for patient isolation needs

Absence of preparedness of NH, SSF for the needs of isolation of the patient. It is desirable to ensure the elimination of the risk of infection and, at the same time, aggression, behavioral disorders, endangerment of co-patients, personnel. Within the empire there is a need for the creation of isolation rooms (10% - 20% beds) NH, SSF to ensure quarantine-isolation measures.

7) Non-additional level of application and implementation of telemedicine and telenursing

Absence of telemedicine and telenursing in outpatient and inpatient health care, e.g.: hospice, mobile hospice, HNCA, NH, SSF as part of a more comprehensive healthcare provision. The implementation of innovative information technologies compensates but also complements the indirect contact between doctor, nurse and patient by telecontact. Currently, the implementation and development of telemedicine and telenursing in Slovakia is a necessity within the Empire.

8) Absence of regulation of the institution of prior wish, including long-term care

The issue of the institution of prior wish is an unresolved problem in the provision of health care as such, including long-term socio-health care. *"In relation to the need to know the real preferences of a person from whom informed consent cannot be obtained at a given moment, the key institute of prior desire is. A previous wish is defined as a decision to consent or refuse healthcare in the event of a change in health status in the future. It is usually in written form and contains a manifestation of the patient's will concerning medical procedures in the event of a situation foreseen in the manifestation of will. Although the previous wish is usually discussed in relation to treatments at the final stage of life, it may, however, apply to any medical treatment. The basic condition for applying a prior wish is that the patient is not in a position to express his or her 'current' preferences. If the patient is able to make a decision about himself, he expresses his decision in the form of informed consent and the previous wish does not apply. The Institute of Prior Wish was introduced into the legal system of the Slovak Republic by the Convention for the Protection of Human Rights and Biomedicine, according to which "a patient who is not in such a state at the time of the intervention that he or she can express his*

or her wish must take into account the wish he or she expressed earlier with the intervention." However, the fact remains that the legislator has not developed this Institute in almost two decades since the ratification of the Convention. In practice, the absence of legislation means that, although de jure the institution of prior wish is part of the legal order of the Slovak Republic, de facto its acceptance may be risky for health professionals. In many other developed countries, including the Czech Republic, the detailed regulation of previous wishes is part of the legal order. However, the application of this institute in practice is certainly not easy. Even with the most precise legislation, it may happen that the patient's previous wishes are not respected, for example because of doubts about legal capacity at the time of its creation or the occurrence of circumstances that could not have been foreseen by the patient. Ethically, the most problematic seems to be the use of this institute to give consent to perform euthanasia to people with advanced dementia. In that regard, the question arises, in particular, whether, at the time of the euthanasia, the patient actually considers his or her condition to be as unbearable as he or she 'imagined' it to be at the time when he or she made the previous wish.'

1.2. Involvement of stakeholders

The following organisations participated in the preparation of the Strategy for Long-Term Care in the Slovak Republic, which was prepared by the Ministry of Labour, Social Affairs and Family of the Slovak Republic in cooperation with the Ministry of Health of the Slovak Republic: Association of Social Service Providers in the Slovak Republic, SocialForum, Association of Self-governing Regions SK8, Association of Towns and Municipalities of Slovakia, Union of Towns of Slovakia, Union of Pensioners in Slovakia, National Council of Citizens with Disabilities, Slovak Society of Palliative Medicine, Slovak Medical Chamber, Slovak Medical Society, Association for the Protection of Patients' Rights, Slovak Chamber of Nurses with Midwives, Club of Residents and Independent Personalities, Committee of the National Council of the Slovak Republic for Health, Chief Expert for Nursing - PhDr. Helena Gondárová-Vyhničková, dipl. s., COMMON PEOPLE and Independent Personalities.

When the legislation in question was amended, discussions took place between the professional public and representatives of the Ministry of Health of the Slovak Republic, when the necessary adjustments were identified, as well as areas from the Recovery and Resilience Plan, within the individual components.

The SPS and other professional organisations, together with healthcare providers, participate in the reform and implementation of measures under the responsibility of the Ministry of Health of the Slovak Republic.

2. Policy objectives and measures (to be adopted)

In the Government Programme Statement for 2020-2024, the government committed to create a system of long-term socio-health care, to unify assessment activities in assessing the need for assistance of another person, to introduce a targeted form of financing social services by introducing a dependency allowance, to create conditions for the provision of social services on a community-based basis, to reform palliative care, to create a functional system of independent control of complaints and supervision of the provision of social services, and to deepen the digitalisation of public administration and the fulfilment of e-government objectives. The proposed objectives of the strategy are an integral part of the Slovak recovery and resilience plan contained in Component 13: Accessible and high-quality long-term socio-health care. The proposed reforms and investments also respond to several of the Commission's country-specific recommendations for Slovakia for 2019 and 2020.

2.1. Overall policy response

Addressing the shortcomings identified in relation to the objectives of the recommendations through **individual measures and reforms** is :

The reform of long-term socio-health care in Slovakia is currently implemented in the Recovery and Resilience Plan, Component 13 Accessible and high-quality long-term socio-health care (publicly available information: 171196_subor.pdf (rokovanie.sk)).
Policy area: Health.
Objective: The objective of the component is to prepare Slovakia for the rapid ageing of the population by providing quality, accessible and comprehensive support to people with long-term and palliative care needs. The provision of such care will increase the inclusion in society of persons with disabilities in accordance with their rights as enshrined in the United Nations Convention on the Rights of Persons with Disabilities ('the Convention'),1 as well as their level of social protection. Reforms and investments will increase the linkage and efficiency of health and social care and make it more resilient to critical situations. It will also kick-start the process of digitalisation of public administration in the provision of integrated long-term care, including the digitalisation of decision-making processes. The comprehensive reform of long-term and palliative care was committed by the Government of the Slovak Republic in the Programme Declaration of the Government for 2020-2024. The proposed reforms and investments also respond to a number of European Commission recommendations for Slovakia for 2019 and 2020. To achieve this, the following reforms and investments are essential:

Reforms:
1. Reform of the integration and financing of health and social care.
2. Reform of the assessment work.
3. Expanding and restoring after-care, long-term and palliative care capacities, taking into account the needs and preferences of the population concerned.
4. Reform of the supervision of social care.

Investments:
1. Expanding community-based care capacities.
2. Expanding and restoring after-care and nursing capacities.
3. Expanding and restoring palliative care capacities.
4. Construction of infrastructure for the supervision of social assistance.
5. Digitisation and support of the assessment work

1. Reform of the integration and financing of long-term social and health care

Objectives:
- The objective of the reform is to establish a strategic and legislative framework for the functional link between health and social care.
- Under intensive cooperation of the health and labour, social affairs and family departments, legislation will be proposed and adopted to ensure that persons with disabilities and seniors who are clients of social services provide nursing health care covered by health insurance to the same extent, quality and standard as the rest of the population, in a social services facility (right to health, Article 25 of the Convention) or in a home environment.
- As a professional activity, nursing care can be provided in various types of social services and in various forms of services (terrestrial, outpatient and residential). At the same time, it will be essential to ensure transparent decision-making on the extent of nursing care needed and to ensure quality and safety control in the provision of care.

•Funding for nursing care in the context of integrated long-term care will be based on an adjustment of funding through public health insurance. The current level of the so-called lump-sum payment by the health insurance company will be adjusted to take more account of real costs.
•The conditions for the conclusion of contracts with health insurance companies for the performance of nursing care in social services facilities will be modified. The new rules will make it easier for social care institutions to make greater use of the person responsible for providing nursing care, the qualifications of other health professionals involved in nursing care, the need for the doctor's consent to indicate nursing care to the nurse, and the requirements for the material and technical requirements for providing nursing care by the institution.
•Clients of social services will be provided with high-quality and accessible psychiatric or psychological care through psychosocial centres and their mobile units. Psychosocial centres will be established as a new form of community-based service as part of the mental health care reform (Recovery and Resilience Plan - Component 12 Human, Modern and Accessible Mental Health Care).
•In institutional care, support teams of the patient will be established. Their task will be to identify persons requiring specific forms of available long-term care in a timely manner, using a defined evaluation system with red flags. This will ensure the continuity and timeliness of ongoing nursing and social care.
•The new personal budget system will make the long-term care financing system more efficient and transparent. The funds will go directly to the person in need of care and not to the caregiver or service provider. There will be room for targeted and comprehensive support for a person with a need for long-term care. Regional and local government funding for social services will continue to be maintained.
•The new funding scheme will support the emergence and development of services in the community. The personal budget of the beneficiary will consist of a direct financial benefit and a voucher for social services. Demand for and ability to pay for on-site and community services will increase.
•The new system will contribute to addressing the shortage of staff in the social services sector, in particular in the field. Enhanced funding through the voucher will make the position of caregiver on the ground more attractive.
•Support of stable, professional and high-quality personnel security in the field of LTHC.
•In the new system, providers of off-road services will not be disadvantaged in terms of funding compared to providers of residential and ambulance services, nor will people with a lower degree of dependence be disadvantaged.
•The new funding system will contribute to linking social and health care. Persons who will be hospitalised in an inpatient health care facility which also includes the provision of social care (e.g. nursing home, hospice) will be able to use the personal budget within the scope of the provided social care to finance social care also in such an institution.
•Adjusting the payment of insurance companies for palliative and nursing care will make its provision more attractive and at the same time increase the availability of its provision in the home environment for lower income groups, who are currently often unable to afford services (the scope of health care, the scope of social care and the way in which they are financed will be defined by special legislation).

<u>Implementation:</u>

•The reform consists of several legislative steps, which will be initiated and implemented by the Ministry of Health of the Slovak Republic (MH SR) and the Ministry of Labour, Social Affairs and Family of the Slovak Republic in close cooperation.
•The joint working group of the Ministry of Health of the Slovak Republic and the Ministry of Labour, Social Affairs and Family of the Slovak Republic on the development of a new strategy and legislation started its work informally in June 2020.
•The first stage in the preparation of the reform will be the presentation of a strategic document on the integration of socio-health care. The basis for its creation will be the outputs of the working group, as well as preliminary analyses on the revision of expenditure on long-term care, which is being prepared by the Ministry of Finance of the Slovak Republic (MF SR).

•The Ministry of Labour, Social Affairs and Family of the Slovak Republic will prepare the concept of financing of social services, which will be the basis for the creation of new legislation in the field of financing and will submit it for public discussion.
•The launch of the Social Services Information System from 1 January 2022 was a prerequisite for the reform of the financing of social services.
•The Social Policy Section of the MoLSAF SR is primarily responsible for the preparation of the concept and reform of the financing of social care.
•Measures to support the performance and training of workers in the field of LTHC through the European Structural and Investment Funds.
Demographic developments, together with a new form of financing social services, will require a higher need for resources from the state budget compared to the current state. The Ministry of Labour, Social Affairs and Family of the Slovak Republic will consult with the Ministry of Finance of the Slovak Republic on the details of the reform and the related financial entitlements during the preparation process.
•The Health Section of the Ministry of Health of the Slovak Republic, primarily the Department of Long-Term and Palliative Care of the Ministry of Health of the Slovak Republic, is responsible for the draft act in the field of long-term and palliative care and for the preparation of legislation regulating payments by insurance companies for palliative and nursing care, including care in social services and in the home environment.
Addressee:
•MoH SR, MoLSAF SR, MoF SR, health insurance companies, health and social care providers, local and regional territorial self-government.
Timetable of measures:
•Launch of the new Social Services Information System as of 1 January 2022.
•The new law on long-term and palliative care (MH SR) will be approved by Q1 2023.
•The new concept of financing social services (MoLSAF SR) will be submitted for public debate by Q4 2023.
•The new legislation on the financing of social services (MoLSAF SR) will be approved by Q4 2025 at the latest.

2. Reform of the assessment procedure

Objectives:
•The new assessment system will be uniform and efficient. In the new system, assessment will be carried out only by the Offices of Labour, Social Affairs and Family, according to a uniform methodology based on WHODAS53, which is based on the principles of the Convention. The unification of the assessment activity does not include the assessment carried out by the Social Insurance Agency for the purposes of invalidity, since its subject matter is not the assessment of the need for assistance by another person, but the decline in the ability to carry out gainful employment.
•The assessment shall comprehensively assess the needs of a person with long-term care needs. The assessment will not be limited to the areas of mobility and self-care, but will assess a wide range of needs of people with disabilities, e.g. in the areas of education, labour integration and participation in society, health protection and material security.
•The assessment system will be linked to support tools, including occupational rehabilitation services, early intervention, personal assistance and other social services.
•Digitalisation will relieve both doctors and assessed persons of the administrative burden. A person with a disability will not have to prove their state of health or financial situation. All medical assessors will use the e-health system, authorities will draw the information necessary for their activities from public administration registers, meaningless qualifications will be removed, and the system will be open to all doctors.
•Medical assessment activities will also be more attractive thanks to the financial compensation arrangements for medical assessors, which will increase the number of medical assessors working at the OoLSAF SR.

Implementation:

- The Social Policy Section of the Ministry of Labour, Social Affairs and Family of the Slovak Republic is primarily responsible for drafting and submitting new legislation on assessment activities, as well as for implementation.
- The draft legislation will be consulted with representatives of organisations of persons with disabilities, representatives of associations of local and regional self-government and the OoLSAF SR.
- The Ministry of Labour, Social Affairs and Family of the Slovak Republic will cooperate with the National Centre of Health Information to prepare the e-health system for assessment activities.

Addressee:

- MoLSAF SR, MoH SR, Representative Organisations of Persons with Disabilities, Local Self-Government Bodies, OoLSAF SR, NHIC.

Timetable of measures:

- Approval of the new legislation on assessment activities by Q1 2023 at the latest.
- Provision of new equipment for assessment staff by Q1 2024 at the latest.

3. Reform of the supervision of social care

Objectives:

- The supervisory system will be unified and strengthened by the creation of an independent supervisory authority that will ensure:

overseeing the provision of social services;

o Supervision of the quality of the provision of social services;

o Supervision of the quality and scope of assistance provided with a personal budget (linked to reform 1); overseeing the provision of health care in social services, in cooperation with the Health Care Surveillance Authority.

- New conditions for the quality of care in both institutions and households will be defined. The new conditions will be in line with the World Health Organization (WHO) QualityRights Toolkit and will contribute to the fulfilment of the obligations of the Convention to provide persons with disabilities with protection against cruel, inhuman or degrading treatment or punishment (Article 15 of the Convention) and protection against all forms of exploitation, violence and abuse (Article 16 of the Convention). The supervision will also include the provision of methodological support to social service providers and informal carers, leading to an increase in the quality of the assistance provided.
- The new supervisory authority will have approximately 165 inspectors, of which 33 are already active in the system (performing inspection, supervision and quality assessment as employees of the MoLSAF SR and OoLSAF SR).

Implementation:

- The Social Policy Section of the MoLSAF SR is primarily responsible for drawing up and submitting a proposal for new legislation, as well as for its implementation.
- The investment shall provide the infrastructure for the functioning of the supervisory authority – the head office as well as 8 regional branches. At the same time, the material and technical conditions for the new supervisory authority – cars, computer equipment and other necessary preconditions for action – will be prepared.
- The target number of inspectors is expected to be reached in 2023.

Addressee:

- MoLSAF SR, local and regional territorial self-government, providers of social services;

Timetable of measures:

- The remit of the new supervisory authority will be regulated in a separate law on the supervision of social care, which will be approved by Q1 2022.
- The surveillance infrastructure will be built by Q1 2024 at the latest.

4. Expanding and restoring after-care, long-term and palliative care capacities, taking into account the needs and preferences of the population concerned

Investment 1: Expanding community-based care capacities

Objectives:

- In particular, the capacity of community-based residential facilities (e.g. supported housing) will increase significantly. It will be possible to move part of the clients from large-capacity facilities to smaller community-type facilities. At the same time, part of the new capacities will be dedicated to new beneficiaries.
- New outpatient facilities (e.g. daily stationary, rehabilitation centre) will contribute to accelerating deinstitutionalisation while reducing the burden on informal carers. This investment will make it possible to cover the current uncovered demand and prepare the system for the projected growth in demand for a change in the financing system.
- Investments shall also support the construction of new low-capacity socio-health care facilities (e.g. specialised facilities) with complex needs.
- The reform of the long-term care financing system will also support the development and promotion of community-based services and the deinstitutionalisation process, including staff capacity building. (Reform 1).

Implementation:

- The planning of new capacities in community-type facilities generated by the transformation of existing facilities of both public and non-public providers will reflect the readiness of transformation projects. Currently, 49 (+18 in 2021) social service facilities are involved in the National Project Deinstitutionalisation – Supporting Transformation Teams, with 7 323 social service recipients. These facilities are actively preparing for the creation of new community-based services as well as residential long-term care services.54 Planned new capacities will also be open to social service providers not involved in the National Project Deinstitutionalisation – Supporting Transformation Teams if they provide community-based services.
- Outpatient services of both public and non-public providers will be regionally distributed, taking into account current coverage and projected future demand, as well as the readiness of municipalities.
- The capacities of new low-capacity socio-health facilities of both public and non-public providers will be distributed according to needs analysis in the regions.

Addressee:

- MoLSAF SR, local and regional territorial self-government, public and non-public providers of social services.

Timetable:

- Investments in the expansion of the network of outpatient and community residential facilities will be carried out continuously in 2021-Q2 2026.
- The MoLSAF SR will submit an investment plan for the implementation of Investment 1 by Q3 2021.
- Investments will take the form of calls that will be open to social service providers regardless of the type of settlor. Rapid and ongoing information to potential beneficiaries will be important.
- The MoLSAF SR will provide both content and project support. It will inform potential beneficiaries of the specific conditions of the calls after the approval of the Slovak recovery and resilience plan through meetings with representatives of regional and local self-government as well as through information seminars for providers.
- The Ministry of Labour, Social Affairs and Family of the Slovak Republic envisages a period of three months for consultations on the intentions in terms of content and architecture. Subsequently, the collection of project intentions will take place, taking into account the state of preparedness of the projects.

•In Q4/2021, the call will be launched and consultations will be held on the submission of applications by public and non-public providers of the Ministry of Labour, Social Affairs and Family of the Slovak Republic with the aim of simplifying public procurement for project and construction documentation by procuring a framework contract.

Investment 2: Expanding and restoring after-care and nursing capacities

Objectives:

•New inpatient follow-up capacities will contribute to the adequate recovery of the patient. In the short term, the risk of rehospitalisation is reduced, in the long term, quality aftercare prevents the emergence of a need for long-term care, or at least slows down the progress of dependency.

•In the case of fragile patients or people after serious injuries, intensive nursing and social care is the starting point for stabilizing their condition. It is necessary to ensure the bridging of the critical period after the patient is discharged from the hospital, when assessment and interventions are needed for the stabilization of the condition and the comprehensive management of continuing long-term care.

•Investments will contribute to the expansion and renewal of the home nursing network. The increase in the number of network providers is a step towards filling the optimal network, which will be determined in the next steps. Investments in retrofitting existing providers will increase the quality of care provided.

Implementation:

•Legislative changes, in particular the adoption of the optimisation of the hospital network (component 11) and the law on long-term and palliative care (for more details see Reform 1), which will clearly define follow-up care and its link to other types of care, are a precondition for investment in the reconstruction of the units.

•The priority in investments will be the transformation of part of the current chronic and acute beds into aftercare beds. Following the identification of a new optimal hospital network, part of the current acute beds are expected to be freed up for after-care needs. (component 11 Modern and accessible inpatient and acute care).

•Intensive cooperation within the Ministry of Health of the Slovak Republic, as well as cooperation with the Ministry of Labour, Social Affairs and Family of the Slovak Republic, is essential for the successful implementation of the proposed transformation.

•By Q3 2021, the Ministry of Health will submit an investment plan for the implementation of Investment 2.

•All healthcare providers, regardless of the type of founder, will be able to apply for funding of projects under the investment in the form of a call published by the Ministry of Health of the Slovak Republic.

Addressee:

•Ministry of Health of the Slovak Republic, health care providers, health insurance companies, municipalities.

Timetable:

•Reconstruction of after-care beds in hospitals will be carried out continuously in 2022-Q2 2026.

•The equipment of new and existing HNCA will be implemented continuously in Q1 2025. Investments in HNCA will take the form of calls. Rapid and ongoing information to potential beneficiaries will be important.

Investment 3: Expanding and restoring palliative care capacities

Objectives:

•Affordable and high-quality palliative care services will ensure terminally ill patients a dignified survival of the last months of life at home or in another setting according to their personal preference, in order to preserve the autonomy and dignity of the dying person for as long as possible.

•The optimal network of palliative compartments and stone hospices is filled. These facilities/departments will provide palliative care in line with the concept of palliative care and the new Long-Term and Palliative Care Act (Reform 1).
•The establishment of mobile hospices at stone hospices and palliative wards will strengthen the continuity and quality of care. At the same time, regional disparities in the availability of services will be compensated for and the proportion of patients with chronic incurable disease who die at home will increase.
•Investing in the construction of new low-capacity stone hospices will improve their regional accessibility. Investments in the reconstruction of existing hospices and in mobile hospices will improve the material and technical equipment and thus help to increase the quality of the care provided, in line with the new requirements that will result from legislative adjustments.

Implementation:
•New palliative units will be created following the optimisation of the hospital network, which will determine the regional distribution of acute palliative beds. Part of the new palliative beds will be created in new or reconstructed hospitals as part of the investments under component 11.
•By Q3 2021, the Ministry of Health will submit an investment plan for the implementation of Investment 3.
•All healthcare providers, regardless of the type of founder, will be able to apply for funding of projects under the investment in the form of a call published by the Ministry of Health of the Slovak Republic.
Addressee:
•Ministry of Health of the Slovak Republic, healthcare providers, health insurance companies, municipalities, non-profit organisations
Timetable:
•Reconstruction of palliative care beds in hospitals will be carried out continuously in Q3 2025.
•Construction and restoration of stone hospices will be carried out continuously in 2022-2025.
•The equipment of new and existing mobile hospices will be implemented continuously until Q1 2025.

Following legislative adjustments that allowed the definition of individual types of healthcare, the conclusion of contracts with health insurance companies and the setting of reimbursements for these types of healthcare, calls were launched from the Recovery and Resilience Plan, Component 13. Further information is publicly available and can be found at: https://www.mzsr.sk/?Plan-recovery-and-resilience.

In the RRP - Component 13: Accessible and high quality long-term social - health care :

Extension of the home nursing network (challenge code: 13I02-21- V04)
EVALUATION FINISHED
Amount of funding available for the call: 1 401 557,00
Balance of call funds: 86 718,32
(Promulgated on 29 July 2022, Amendment 27 October 2022, Closed on 31 October 2022)

Renewal of the home nursing network (challenge code: 13I02-21- V05)
EVALUATION FINISHED
Amount of funding available for the call: 3 237 912,00
Balance of call funds: 690 060,31
(Promulgated on 29 July 2022, Amendment 27 October 2022, Closed on 30 November 2022)

Extension and renewal of the stone hospice network (challenge code: 13I03-21- V07)
EVALUATION FINISHED
Amount of funding available for the call: 12 556 921,00

Balance of call funds: 3 461 823,37
(Promulgated on 28 November 2022, Amendment 13 May 2024, Closed on 16 March 2023)

Extension and renewal of the mobile hospice network (challenge code: 13I03-21- V01)
EVALUATION FINISHED
Amount of funding available for the call: 2 388 246,00
Balance of call funds: 1 040 456,53
(Promulgated on 6 July 2022, Amendment 30 September 2022, Closed on 30 November 2022)

Under the Recovery and Resilience Plan Component 12 Human, Modern and Accessible Mental Health Care, the following reforms and investments are being implemented:

Reform 2: Development of acutely undersized capacity areas in mental health care. Investment 2.2: Establishment of detention facilities:
•for men, women and adolescents;
•adoption of legislation – provision of healthcare in detention.
I. Detention facility – Hronovce Detention Institute.
•Q4 2022 - start of use.
•75 places – gradually filling capacities. II. detention facility – Kremnica.
•75 places;
•the project documentation is prepared for the building permit, it will be submitted by the end of March, including the project documentation of the public works project, which will be submitted to the Ministry of Transport of the Slovak Republic for the purpose of carrying out state expertise.

Reform 2: Development of acutely undersized capacity areas in mental health care. Investment 2.3: Building Psycho-Social Centers.
Expected status: 12 PSC-9 for adults, 3 for children.
Objectives:
•creating a combination of health and social services under one roof for both adults and children with long-term psychiatric conditions and with limited social adaptation;
•ensuring adequate long-term care in a natural environment by a mobile team;
•prevention of institutionalisation - improvement of quality of life;
•Reducing the duration of hospitalization - preventing hospitalization.
Investment: €7,828,895
Call for applications for the Recovery and Resilience Facility, 'Building psycho-social hubs', Call code: 12I03-21-V16, closed, in the process of evaluation, start of operation Q4 2025.

Reform 2: Development of acutely undersized capacity areas in mental health care. Investment 2.4: Addition of the Psychiatric Stationary Network (PS).
Expected status: 15 PS-7 for adults, 5 for children, 3 for children with PPP (eating disorders).
Objectives:
•building up a network of stationaries with psycho-social rehabilitation for children and adults with the aim of treatment, preventing and reducing hospitalisation, with an emphasis on maintaining quality of life or full return to society and reducing unemployment and disability;
•providing treatment with psycho-social rehabilitation for children and adults;
•shortening the duration of hospitalization - prevention of hospitalization;
•maintaining quality of life or a full return to society, reducing unemployment and disability;
•from 1 September 2022 an increase in the payment from public health insurance, per place per day – EUR 60/adult, EUR 80/children.

Investment: € 6 524 096
Call for applications for the Recovery and Resilience Facility, 'Complementing the psychiatric stationary network', Call code: 12I04-21-V12, closed, in the process of evaluation, start of operation Q4 2025.

Reform 2: Development of acutely undersized capacity areas in mental health care. Investment 2.5: Establishment of specialised centres for autism spectrum disorders (hereinafter ASDs).
Expected status: 3 ASD centres (geographical availability/region).

Objectives:
- the establishment of new diagnostic-intervention centres for persons with autism spectrum disorders ('ASD centres') with qualified staff;
- coverage of the need for three broad regions;
- increasing the availability of specialised ASD care facilities to ensure adequate treatment of the disease;
- comprehensible treatment and multidisciplinary case management of children with ASD;

the establishment of diagnostic-intervention centres for persons with ASD with qualified personnel;
- inclusion of research;
- multi-source funding;
- SPDTP - ASD screening, diagnosis, pharmacotherapy, patient management.

Investment: € 2 348 720
Call for applications for the Recovery and Resilience Facility, 'Building dedicated centres for autism spectrum disorders', Call code: 12I05-21-V15, Construction of 3 ASD centers closed, start of operation Q4 2025, in preparation of a new call announcement.

Reform 3: Modernization of diagnostic methods and treatments.
Investment 3.3: Modernization of departments in institutional care.
Expected status: 244 beds (200 - 2 bed rooms with bathroom, 44 secession rooms).
Objectives:
- humanisation of the conditions for hospitalisation, i.e. reduction of the number of patients in a room with a separate sanitary facility;
- excluding the use of net beds and replacing them with secular rooms - a room for safe stay - 44 insulating (secular) rooms;
- destigmatisation and optimisation of the security regime;
- humanization of conditions for hospitalization by reconstruction of the bed fund;
- reduction of the number of patients in a room with a separate sanitary facility;
- No reduction in the number of beds.

Investment: € 10 643 438 Call for applications – open until the allocated funds are exhausted or Q3 2024.

Reform 3: Modernization of diagnostic methods and treatments.
Investment 3.4: Rehabilitation of material and technical equipment.
Expected status: new instrumentation.
Objectives:
- modernization of diagnosis and treatment of mental disorders conditioned by SPDTP;
- defining technical specifications for the procurement of equipment;
- e.g.: ECT device, rtms, EEG, Vital Function Monitor, ECG, Oxymeter, Anaesthetic device, Defibrillator, Germicide source. Investment: €1 316 767 Call for applications – open until the allocated funds are exhausted or Q3 2023.

Investment 5: National Mental Health Support Line during the pandemic
Expected status: pilot project during COVID-19 (July 2021/1 year)

Objectives:
•the NMHHL was initially set up for a period of 12 months in July 2021 from RRP resources due to the COVID-19 pandemic;
•psychological counselling, crisis intervention for psychological problems (COVID-19, UA war);
•advising and supporting healthcare professionals and the public in coping with excessive stress, stress, acute stress response, or symptoms of developing post-traumatic stress response.
Management:
•24 advisors (2 supervisors, 1 supervision per week), monitoring reports;
•9 advisors UA line and 15 advisors SK line;
•number of contacts per month - Ø 370 calls;
•regular monthly monitoring reports - number of calls, number of advisors, UA/SK line.
Investment: €0.6 million
Closure: 30.09.2023

The reform of psychiatric care in Slovakia ('the reform') is implemented through a change in the system of healthcare provision in the field of psychiatry, as part of two comprehensive reforms: health care and mental health care reforms. **The reform will promote the development of community-based mental health care and look at the specificities of care for different groups.**
The Government of the Slovak Republic will implement the mental health care reform, in the context declared in the Programme Statement of the Government of the Slovak Republic for 2023-2027:'Mental health has long been a neglected and underestimated area. We will therefore propose solutions to increase the availability of mental health services, an integrated and cross-sectoral approach, the prevention of mental disorders and the promotion of mental well-being.' **The Ministry of Health of the Slovak Republic and the Slovak Psychiatric Society of the Slovak Medical Society ('SPS') on 06. 06. In 2022, they signed a 'Memorandum of Cooperation on the Implementation of the Psychiatric Care Reform'.**
The National Programme for Active Ageing 2021-2030 addresses all areas of people's lives as they age and its vision is to support the building of a sustainable society, one where present and future generations have the chance to enjoy quality of life. **The National Programme for Active Ageing 2021-2030**, as a national tool for active ageing policies, aims to achieve this by promoting and valorising the potential of people of all ages. The overall aim of the document is to create the best possible value, source and institutional conditions. The **National Programme for Active Ageing 2021-2030** intends to address **the issue of active ageing as a permanent priority that goes beyond policy cycles and legislatures.** The document was prepared in a participatory manner. **The aim** of the document was **to create a sustainable and feasible material that represents a social commitment** of responsible entities accepted and accepted by a wide range of social and political actors and covered by the Government of the Slovak Republic. The target group **of the National Active Ageing Programme 2021-2030** is not defined by any age or living situation. The document **focuses on all persons actively preparing for ageing , including older persons**, who could be disadvantaged in any way in access to public services or other support due to their age. **The National Programme for Active Ageing 2021-2030 includes more than 80 actions in nine domains - the areas of support for active ageing. Their implementation is mainly financed from the national budget, but also from the Recovery and Resilience Plan and the Partnership Agreement 2021-2027.** It was adopted **by Government Resolution No 657 of 16 November 2021.** Consolidated versions **of the National Programme for Active Ageing 2021-2030** with monitoring of changes following the evaluation cycles can be found at the following links: National Programme for Active Ageing 2021-2030 (consolidated version following the 2021-2022 update; PDF 1.32 MB).
The **Action Plan 2023-2024 of the National Programme for Rare Disease Patient Healthcare until 2030 is currently in force.** Publicly available information: https://rokovanie.gov.sk/RVL/Material/27999/1.

Several strategic documents and legislation have been issued as part of the reforms of their vision and implementation:

1. **The Ministry of Health of the Slovak Republic** has enshrined the new legislative framework in Act No 576/2004, which has made it possible to define **long-term healthcare and palliative care** in the existing concept of regulating the provision of healthcare. This modification has ensured clarity of access in the provision of healthcare and there will be no segmentation of individual parts of healthcare.

2. This also fits into the concept **of provision of health care from birth to quality and full life expectancy,** which is regulated in the existing Act No 576/2004 on health care, services related to the provision of health care and amending certain acts, as amended, and thus the essence of **regulation was also fulfilled by adding the area of long-term health and palliative care.**

3. The modification of the existing Act (No 576/2004 Coll.) has the same legal weight and binding force as the creation of a new Act. **Ultimately, there was room for linking long-term health and long-term social care** through the following:

4. Definition **of a medical support team** including a social worker (Section 86zl(1) of Act No 581/2004, date of entry into force: 01.08. 2022).

5. Enabling care through **a multidisciplinary approach to the patient**, involving the use of knowledge and practices in particular in the field of social work (Section 36 of Act No 576/2004 Coll., date of entry into force: 01.08.2022).

6. Enshrining **the instruction of** a person with palliative health care needs on the possibilities of social service (Section 6ba of Act No 576/2004 Coll., date of entry into force: 01.08.2022).

7. **Taking into account the language specificities of national minorities**, (Section 6(2) of Act No 576/2004 Coll., date of entry into force: 01.08.2022).

8. **Defining the possibility to provide artificial pulmonary ventilation**, in the form of outpatient health care in the patient's home environment as well as in social and legal protection facilities for children and social guardianship. (Act No 576/2004, Section 10a(2)(c), (d), (7) and (9), Date of entry into force: 01.08. 2022 and Annexes A and B, Section 1(1) of Decree No 92/2018. Date of entry into force: 31.03.2023).

9. Establishment of a framework within which **a social assistance institution may provide nursing care,** Section 6(6) of Act No 576/2004, Date of entry into force: 01.08. 2022).

10. Carrying out **data collection for the purpose of monitoring the availability and evaluating the quality and efficiency of nursing care in the framework of long-term healthcare provision (Section** 6c(1) and (3) of Act No 576/2004, date of entry into force: 01.08. 2022).

11. The concept of health care in the field of psychiatry.

12. The concept of health care in the field of child psychiatry.

13. The concept of humanization of inpatient health care in the field of psychiatry.

14. The concept of health care in the field of medicine addictions.

15. The concept of health care in the field of clinical psychology.

16. Professional guidance from the Ministry of Health of the Slovak Republic on the proposal to place a patient undergoing protective treatment in a healthcare facility in an inpatient care facility in a detention facility or in a juvenile detention facility and on the procedure for its submission.

17. Status of the working group on restraint and alternatives to it in the field of psychiatry and child psychiatry.

18. Methodological Instruction of the Ministry of Health of the Slovak Republic on a Visit to the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment

19. Methodological instructions for filling in the form Semi-annual Statement on Restrictive Means P (MH SR) 4-02 year 2023.

20. Draft measure of the Ministry of Health of the Slovak Republic amending Decree No 09812/2008-OL of the Ministry of Health of the Slovak Republic of 10 September 2008 on minimum requirements for staffing and material and technical equipment of individual types of health institutions, as amended.

21. Decree of the Ministry of Health of the Slovak Republic No 417/2022 Coll. on minimum requirements for staffing and material and technical equipment of detention centres and youth detention centres.
22. Decree of the Ministry of Health of the Slovak Republic No 84/2016 laying down the defining characteristics of individual types of health institutions.
23. Act No 495/2022 amending Act No 576/2004 on health care, services related to the provision of health care and amending certain acts, as amended, and amending Act No 578/2004 on healthcare providers, health professionals, professional organisations in the health sector and amending certain acts, as amended.
24. Decree No 143/2023 of the Ministry of Health of the Slovak Republic on the content requirements of internal order in the health care facility of institutional health care in the professional focus of psychiatry and in the professional focus of child psychiatry.
25. Decree No 358/2023 of the Ministry of Health of the Slovak Republic laying down details on the use of means of restraint and the keeping of a register of means of restraint.
26. Decree No 237/2023 of the Ministry of Health of the Slovak Republic supplementing Decree No 10/2014 of the Ministry of Health of the Slovak Republic laying down a list of statistical summaries in the health sector, details of the procedure, methods, the scope of the reporting units and the deadlines for reporting in the context of the statistical survey in the health sector and their characteristics, as amended.
27. Standard procedure for procedural management in connection with the hospitalisation of an adult patient without informed consent in a psychiatric ward (involuntary hospitalisation).
28. Comprehensive management of patients undergoing electroconvulsive therapy.
29. Journal of the Ministry of Health of the Slovak Republic ('MH SR'). Subsequently, the concept was signed by the Minister of Health and published in the Journal of the Ministry of Health of the Slovak Republic, Volume 31-41, dated 25 September 2023, Volume 71.
30. Methodological instruction of the Ministry of Health of the Slovak Republic to visit the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.
31. Standard procedures developed for specific groups: Autism spectrum disorders, eating disorders, etc.

2.2. Detailed description of the measures

The evaluation of the fulfilment of the objectives of the Strategy as at 31 May 2024 describes the current situation in the implementation of individual measures and tasks of the Strategy in the Slovak Republic.
An interdepartmental link is essential in dealing with the issue of long-term care and at the same time aligning legislation in the field of health and social services with clearly defined reimbursements.

As part of the Strategy and also through the reforms and investments of the Recovery and Resilience Plan Component 13, the implementation of individual investments and reforms is essential for long-term care. Creating modern and accessible mental health care as part of the reform and through the reforms and investments of the Recovery and Resilience Plan Component 12 Human, modern and accessible mental health care, focusing on strong coordinated inter-ministerial cooperation and regulation, increasing the availability of health-social care for all patient groups with an emphasis on community-based solutions, modernising diagnostic and therapeutic procedures, innovating the education of mental health staff, strengthening mental health support and preventing the development of disorders by developing community-based care.

1. Reform of the integration and financing of long-term social and health care

ACTION 1.	***Launch of the new Social Services Information System as of 1 January 2022.***
	The introduction of the Social Services Information System will create a database of up-to-date data sources to strengthen the management, control and supervisory competences in the field of social services. Furthermore, reporting in social services will be unified and a new system of data collection in social services under the responsibility of the Ministry will be prepared so that the data collected are up-to-date, but also verifiable and relevant for the purposes of collecting data on social services, evaluating the measures taken, adopting new measures and overall setting of policy parameters in the field of social services. The introduction of the Social Services Information System will also create the prerequisites for streamlining the system of providing financial contributions under the remit of the Ministry of Labour, Social Affairs and Family of the Slovak Republic. The measure – the launch of a new information system – makes important information in the field of social services also available through an information system available on the internet. The information to be contained in the social services information system is laid down in Part Fifteen of Act No 448/2008 on social services and amending Act No 455/1991 on trade entrepreneurship (the Trade Licensing Act), as amended. The social services information system shall keep a register, applications shall be accepted and persons shall be registered in relation to the provision of financial support and the accreditation of the educational programme, as well as accreditation for professional activities. In addition to the above sections, there is further information in the register.

Deadline: 01 January 2022
Responsible for the implementation of: MoLSAF SR
Evaluation of performance: Task fulfilled

IMPLEMENTATION:	The Social Services Information System was approved by Act No 280/2019 (amending the Social Services Act), which entered into force on 1 January 2022. The administrator of the social services information system is the Ministry of Labour, Social Affairs and Family of the Slovak Republic and consists of several modules – a **module of the register**, in which information on providers and the social services they provide is kept by higher territorial units. Another is **a collection module** in which respondents - municipalities, higher territorial units and social service providers - keep relevant records and submit applications for financial contributions from the Ministry's budget. The third module is a **central module**, under the responsibility of the Ministry, designed to process data from the register module and the collection module and to keep records under the responsibility of the Ministry (financial contributions, accreditations). The last module is a **public module**, which is available to the public and contains information on social services, their providers, financial support and entities accredited for educational programmes and professional activities. The individual modules have been deployed gradually since the beginning of 2022 and since April 2022 (launch of the collection module) it is gradually filled with data from municipalities, HTU and providers of social services in the registers

	under the Social Services Act, which are available in the collection module.

Action 2.	***New law on long-term and palliative care.***
	The Ministry of Health of the Slovak Republic will prepare a draft law in the field of long-term and palliative care and will prepare legislation regulating payments by insurance companies for palliative and nursing care, including care in social services and in the home environment.

Deadline: Q1 2023
Responsible for the implementation of: Ministry of Health of the Slovak Republic
Evaluation of performance: Task fulfilled

IMPLEMENTATION:	After a thorough assessment of the existing legislation, the Slovak Ministry of Health, as the drafter of the Act, reconsidered its intention to draw up a separate draft Act on long-term and palliative healthcare for long-term healthcare and, in order to maintain the complexity of the legislation governing healthcare, considered it sufficient to amend the already existing Act No 576/2004. The draft Act was submitted for discussion by the Government on 6 April 2022, when it was also discussed and Resolution No 262 was adopted. By Decision No 1421 of the President of the National Council of the Slovak Republic of 4 May 2022, the Government was assigned to discuss the draft law in the Constitutional Law Committee of the National Council of the Slovak Republic, the Committee on Social Affairs of the National Council of the Slovak Republic until 10 June 2022 and the Committee on Health of the National Council of the Slovak Republic until 13 June 2022. The draft law was approved by the National Council of the Slovak Republic on 29 June 2022 with effect from 1 August 2022. The aim of the proposed legislation of Act No. 576/2004 Coll. is to ensure the availability, quality and efficiency of long-term health care and palliative health care for persons whose health condition requires it, not only in health care facilities, but mainly in the home or other natural environment in which these persons are located. It is the basic regulatory framework for long-term healthcare and palliative healthcare. The draft law defines the concept of long-term health care and its various forms, palliative health care, including the modification of contractual and reimbursement mechanisms of this health care and defines the scope of data necessary for monitoring the availability, quality and efficiency of this care. The basis for defining long-term healthcare is the definition of the eligible person to whom it is provided. This definition draws a line between acute health care and long-term health care. When medical options are exhausted when long-term healthcare is provided, this healthcare is transferred to some form of social care/social services. At the same time, defining the duration of provision for different forms of long-term health care has created

	space for the continuous provision of social care and assistance for this person. In order to improve the quality and better coordination of healthcare and to prevent repeated hospitalisations, healthcare providers and social assistance institutions are obliged to submit to the health insurance company the data determined by law and, at the same time, the health insurance company is obliged to submit to the Ministry of Health in anonymised form these data related to the provision of nursing care as follow-up nursing care and long-term nursing care in electronic form, the form of which will be published on its website by the Ministry of Health of the Slovak Republic. This draft law supplements the activities of social assistance facilities with nursing care as follow-up health care and long-term nursing care. At the same time, for those social assistance institutions which have a contract with a health insurance company, the obligation to communicate to the health insurance companies, within the scope and time limit laid down by law, the data necessary for monitoring long-term health care is defined. The bill also defines the right of a person receiving health care to receive social assistance and spiritual service. It also defines a support team whose creation will ensure the missing link and coordination of healthcare and social services and strengthen their provision at community level. The provision of social assistance (e.g. guidance on home care options and conditions, the provision of medical devices, compensatory allowances or other social assistance by municipalities, relevant institutions or financial support by non-profit organisations) will ensure that a person is released from an inpatient health facility to their natural environment with social support as soon as possible. Health care will also be complemented by the provision of spiritual support to a person, thereby achieving a positive impact on their state of health. In order to ensure the provision of long-term health care and palliative health care by health care providers, reimbursement for such care is defined in a price measure in the form of fixed prices for individual health services covered by public health insurance, and only for the period of two years of data collection strictly necessary to monitor the availability and evaluate the quality and efficiency of such care. The Ministry of Health assumes that sufficient and relevant data on the availability of nursing care as follow-up health care and long-term nursing care will be obtained within this period, on the basis of which the quality of this care will be evaluated and the method of its financing adjusted without the need for regulation by the Ministry. On the basis of the application practice, a new obligation to have a responsible person with professional competence under the applicable legislation is laid down for child protection and social guardianship institutions which do not have contracts with health insurance companies. This is due, among other things, to the impossibility of registering a child protection and social guardianship facility with the Health Care Surveillance Authority.

	Drafts of related and implementing regulations were also submitted for information as annexes to the draft law, with expected effect from 1 September 2022, namely: a draft measure amending Decree No 07045/2003 of the Ministry of Health of the Slovak Republic of 30 December 2003 laying down the scope of price regulation in the field of health, as amended; a draft Government Regulation amending Decree No 776/2004 of the Ministry of Health of the Slovak Republic of 10 September 2008 on minimum requirements for the staffing and material and technical equipment of individual types of health care facilities, as amended; and a draft Government Decree amending Decree No 84/2016 of the Ministry of Health of the Slovak Republic laying down the defining characteristics of individual types of health care facilities; and a draft Decree amending Decree No 92/2018 of the Ministry of Health of the Slovak Republic laying down the indicative criteria for the provision of nursing care in social services and child protection and social welfare facilities for the provision of social care facilities; Laws: Search in draft laws : Details of the bill - National Council of the Slovak Republic (nrsr.sk) Procedures and methodology in the provision of long-term healthcare, e.g. tasks, definition of activities, competences of individual providers, patient pathway, control system, education, etc. will be regulated in concepts, standards, methodological guidelines and guidelines according to the professional focus of individual healthcare providers. The Commission for the Development and Implementation of Standard Diagnostic and Therapeutic Procedures of the Ministry of Health approved the following standard procedures in long-term care as from the date of approval of the document "Strategy for long-term care in the Slovak Republic": 1.Comprehensive satisfaction of the needs of persons in after-care and long-term care – effective from 1 October 2021 2.Management of timely provision of follow-up and long-term socio-health care - effective from 1 October 2021 3.Management of the risk of destabilisation in long-term nursing care - effective from 1 October 2021 4.Patient and family-oriented care – effective from 15.12.2022 5.Multidisciplinary adult health management in residential long-term care facilities – effective from 15.12.2022 The following standard procedures have been approved in the previous period: 2018 Standard Practices in Nursing: 1.Comprehensive Nursing Patient Management (CNMoP) at the Domestic Nursing Service Agency (HNCA) 2.Comprehensive Nursing Patient Management (CNMoP) in NH 3.Comprehensive Nursing Patient Management (CNMoP) in Palliative Care (Child) 4.Comprehensive Nursing Patient Management (CNMoP) in Palliative Care in Adults 5.Comprehensive Nursing Patient Management (CNMoP) in a Social

	Assistance Facility 2018-2021 Standard Practices in Palliative Medicine: 1.Agitation in palliative medicine Gastrointestinal symptoms in palliative medicine 3.Comprehensive management of pediatric patient in home palliative care 4.Palliative treatment of renal failure patient and end-of-life chronic haemodialysis programme patient Respiratory symptoms in palliative medicine 2021 Standard Practices in Intensive Care Nursing: 1.Management of nursing patient care on artificial pulmonary ventilation 2.Management of nursing care of patient on venous extracorporeal membrane oxygenation All the above standard procedures are published on the website of the Ministry of Health of the Slovak Republic. **Implementation update of the measure for 2022:** in 2022 – standard clinical procedures in intensive care : 1. Management of nursing care for a patient with acute pain

Action 3.	***A new approach to financing social services***
	The Ministry of Labour, Social Affairs and Family of the Slovak Republic will prepare a concept for the financing of social services, which will inform the development of new legislation in the field of financing and submit it for public discussion.

Deadline: Q4 2023
Responsible for the implementation of: MoLSAF SR
Evaluation of performance: The task is carried out

IMPLEMENTATION:	The reform of the financing of social services is preceded by the preparation of the 'Concept on the Financing of Social Services' (the 'Concept'). The purpose of the Blueprint is to define a systemic and comprehensive way of addressing the reform of the financing of social services, which aims at creating a strategic and legislative framework for the functional link between health and social care, introducing a new personal budget system, making the financing system for long-term care more efficient and transparent. The Blueprint contains the basic baselines and the definition of short- and long-term objectives, which will be implemented through the reform of the financing of social services. In order to respect the participatory principle in public policy-making, a working group on the preparation of the Concept for Financing Social Services was set up in September 2022, composed of representatives of local and regional authorities, organisations bringing together various groups of social service providers, representing persons with disabilities and the elderly, professional and professional organisations and the professional public. The first meeting of the

	Working Group on the preparation of the concept of financing social services took place in November 2022. So far, the working group has had 6 regular meetings, more than 10 online workshops on sub-topics, questionnaire surveys and comments on the first version of the concept in summer 2023. The following documents were gradually published on the Ministry's website: October 2023: https://www.employment.gov.sk/files/slovensky/esf/plan-obnovy/prezentacie/prezentaciampsvr_sr_financovanie-socialnych-sluzieb_web.pdf in December 2023, a broader version: https://www.employment.gov.sk/files/slovensky/esf/plan-renewals/presentation/presentation-scheduled-version-concepts-reform-financing-social-services.pdf. Following the inter-ministerial consultation and the sending of the material to the working group, the full texts were published on the website: https://www.employment.gov.sk/files/slovensky/esf/plan-obnovy/prezentacie/navrh-koncepcia-reformy-financovania-socialnych-sluzieb.pdf https://www.employment.gov.sk/files/slovensky/esf/plan-renovations/presentations/priloha-c-1_analyza.pdf. The Concept is expected to be approved by the Minister of Labour, Social Affairs and Family at the end of 2024.

Action 4.	***New legislation on the financing of social services.***
	The objective of the reform is to establish a strategic and legislative framework for the functional link between health and social care. This includes the preparation of the introduction of a personal budget – a new cash allowance for care. A personal budget as a tool that gives people in long-term need of social care and support control over how this support is provided and organised. A key principle in the use of care allowance in terms of personal budget is that it is the person reliant on the help of another person who has influence and control over who and how this support is provided and organised. The care allowance will abolish some of the allowances currently provided. The new personal budget system will make the long-term care financing system more efficient and transparent. Persons who will be hospitalised in an inpatient health care facility that includes the provision of social care (e.g. nursing home, hospice) will also be able to use their personal budget to finance social care in such a facility. The new funding scheme will support the emergence and development of services in the community and contribute to addressing the shortage of staff in the social services sector, in particular in the field. Enhanced funding through the voucher will make the position of caregiver on the ground more attractive.

Deadline: Q4 2025
Responsible for the implementation of: MoLSAF SR
Evaluation of performance: The task is carried out

IMPLEMENTATION:	The preparation of the legislative text on the reform of the financing of social services will build on the results of the forthcoming Concept on Financing of Social Services (see Action 3).

Action 4.	***New legislation on the financing of social services.***
	The objective of the reform is to establish a strategic and legislative framework for the functional link between health and social care. The new personal budget system will make the long-term care financing system more efficient and transparent. Persons who will be hospitalised in an inpatient health care facility that includes the provision of social care (e.g. nursing home, hospice) will also be able to use their personal budget to finance social care in such a facility. The new funding scheme will support the emergence and development of services in the community and contribute to addressing the shortage of staff in the social services sector, in particular in the field. Enhanced funding through the voucher will make the position of caregiver on the ground more attractive.

Deadline: Q4 2025
Responsible for the implementation of: MoLSAF SR
Evaluation of performance: The task is carried out

IMPLEMENTATION:	The preparation of the legislative text on the reform of the financing of social services will build on the results of the public debate on the upcoming concept of financing social services (see Action 3), which will be presented for public debate in Q4 2023.

2. Reform of the assessment procedure

Action 5.	***Approval of new legislation on assessment activities***
	The new assessment system will be uniform and efficient. In the new system, the assessment work will be carried out according to a uniform methodology based on WHODAS, which is based on the principles of the UN Convention on the Rights of Persons with Disabilities. The unification of the assessment activity does not include the assessment carried out by the Social Insurance Agency for the purposes of invalidity, since its subject matter is not the assessment of the need for assistance by another person, but the decline in the ability to carry out gainful employment. The assessment shall comprehensively assess the needs of a person with long-term care needs. The assessment will not be limited to the areas of mobility and self-care, but will assess a wide range of needs of people with disabilities, e.g. in the areas of education, labour integration and participation in society, health protection and material security.

Deadline: Q2 2024
Responsible for the implementation of: MoLSAF SR
Evaluation of performance: The task is carried out

IMPLEMENTATION:	In 2022, the Ministry of Labour, Social Affairs and Family of the Slovak Republic prepared Government Regulation No 416/2022 supplementing Slovak Government Regulation No 131/2022 on certain measures in the field of subsidies within the competence of the Ministry of Labour, Social Affairs and Family of the Slovak Republic at the time of an emergency, state of emergency or state of emergency declared in connection with a mass influx of foreigners into the territory of the Slovak Republic caused by an armed conflict on the territory of Ukraine, as amended. The aim of the Government Regulation was to address the needs of persons with serious disabilities who left Ukraine in the context of the armed conflict and are staying on the territory of the Slovak Republic. These are persons who have obtained exit status in the Slovak Republic (temporary refuge is provided to them) or whose status has subsequently ceased to exist because they have applied for asylum or subsidiary protection or because they have obtained temporary residence. The Government Ordinance introduced the assessment of severely disabled displaced persons through a modified WHODAS questionnaire. In this way, the possibility of assessing persons with disabilities was verified in practice through the WHODAS questionnaire, which will serve as a basis for the reform of the assessment work.

Action 6.	***Provision of new equipment for assessment staff***
	The assessment system will be linked to support tools, including occupational rehabilitation services, early intervention, personal assistance and other social services. Digitalisation will relieve both doctors and assessed persons of the administrative burden. A person with a disability will not have to prove their state of health or financial situation. All medical assessors will use the e-health system, authorities will draw the information necessary for their activities from public administration registers, meaningless qualifications will be removed, and the system will be open to all doctors.

Deadline: Q1 2024
Responsible for the implementation of: MoLSAF SR
Evaluation of performance: The task is carried out

IMPLEMENTATION:	The acquisition of the material and technical equipment of the assessment staff will be implemented through the investments of the Recovery and Resilience Plan of the Slovak Republic. The investment shall include expenditure related to the procurement of IT and office equipment and accessories. The procurement documents for the necessary equipment will be prepared in Q4 2023.

3. Reform of the supervision of social care

Action 7.	***The remit of the new supervisory authority will be regulated in a separate law on the supervision of social care***

	The oversight system will be unified and strengthened by the creation of an independent oversight body that will ensure oversight of the provision of social services, oversight of the quality of the provision of social services, oversight of the quality and scope of assistance provided with a personal budget (linked to reform 1); and overseeing the provision of health care in social services, in cooperation with the Health Care Surveillance Authority. New conditions for the quality of care in both institutions and households will be defined. The new conditions will be in line with the World Health Organization (WHO) QualityRights Toolkit and will contribute to the fulfilment of the obligations of the Convention to provide persons with disabilities with protection against cruel, inhuman or degrading treatment or punishment (Article 15 of the Convention) and protection against all forms of exploitation, violence and abuse (Article 16 of the Convention). The supervision will also include the provision of methodological support to social service providers and informal carers, leading to an increase in the quality of the assistance provided.

Deadline: Q1 2022
Responsible for the implementation of: MoLSAF SR
Evaluation of performance: The task is accomplished

IMPLEMENTATION:	The reform shall be implemented through a draft law on inspection in social matters. The draft law has de-renewed the regulation of administrative supervision in the field of social affairs. The purpose of the present legislation was to establish a functioning system of administrative supervision of the fulfilment of obligations in the field of social affairs and thus to contribute to strengthening the efficiency and quality of social assistance provided within the framework of social security law. Administrative supervision as a control activity of the Ministry of Labour, Social Affairs and Family of the Slovak Republic ('the Ministry') is carried out by the Ministry both ex lege and vis-à-vis otherwise non-subordinated (supervised) entities. The activities of the supervised entities are controlled from the point of view of their compliance with the fulfilment of obligations in the application of social security law in defined areas by the supervised entities, and subsequently the responsibility for infringements of these obligations by the supervised entities is established. Thus, the Ministry responds in a legally relevant manner to the deficiencies identified (e.g. it requires the supervised entity to take urgent measures to remedy the deficiencies identified and the causes of their occurrence, verifies the adoption and fulfilment of these measures, imposes a fine on the supervised entity for committing an administrative offence). The inspection in social matters is carried out by the Ministry through a specialised unit, the Social Inspection Unit, which has been established for this purpose by law. At the same time, effective safeguards were included in the draft law to ensure ex lege the requirements of impartiality and objectivity, autonomy, transparency and independence of inspections in social matters, in line with the general objective of streamlining the performance, rationalisation and improvement of the state administration.

The Act lays down the primary tasks and powers of the Social Inspection Unit in the field of administrative supervision in social matters, as well as the powers and obligations of civil servants entrusted with the performance of administrative supervision in social matters and invited persons in the performance of administrative supervision. It specifies the rights and obligations of the supervised entity, the rights and obligations of persons in the performance of inspections in social matters, the course and material requirements of the performance of administrative supervision, as well as the decision of the Ministry on sanctions for breach of obligations laid down by special regulations and this Act.

At the same time, the Act modified Annex 2 to the Social Services Act, which deals with the quality standards of the social service provided. The focus has shifted from monitoring the fulfilment of quality conditions by the social service provider to the result of its activity, which is the quality, in accordance with the Social Services Act, of the social service provided. The newly drafted Annex 2 to the Act takes into account the recommendations of the Voluntary European Quality Framework for Social Services, which emphasises the quality principles applicable to social services, in particular relations between providers and recipients of social services, relations between service providers, public authorities and other stakeholders, and staffing and spatial conditions. The design of the quality standards, especially in the area of respect for fundamental human rights and freedoms, was based on the used and proven tool for evaluating the level of respect for fundamental human rights and freedoms developed and used by the World Health Organization (WHO QualityRights Toolkit) to monitor the implementation of the UN Convention on the Rights of Persons with Disabilities in the practice of health and social care providers. The selected principles and criteria of this instrument have been reflected in the drafting of the quality standards by specifying, on the basis of their formulation, the selected criteria and the relevant standards in the field of fundamental human rights and freedoms and by adding procedural, personnel and operational standards to these criteria. The amendment aims to specify how, in practice, the provision of a social service translates the exercise of a particular right into an obligation on the part of the provider of the social service.

In order to provide methodological support, the Ministry will also draw up and publish an evaluation report on the results of supervisory activities for the previous calendar year, which, in addition to statistical data, will analyse the results of inspection activities in such a way that, in addition to informative, it also performs a methodological and preventive function. Together with the Ministry's obligation to publish inspection results, this is an important element in ensuring transparency in the performance of inspection activities.

State of play of the legislative process: I. reading

- By Government Resolution No 322 of 11 May 2022, the Government approved the proposal and authorised the Prime Minister to submit the Government's draft law to the President of the National Council of the Slovak Republic for further constitutional discussion;
- By Decision No 1073 of the President of the National Council of the Slovak Republic of 30 May 2022, the Government bill was assigned for discussion to

	the Constitutional Law Committee of the National Council of the Slovak Republic and the Committee on Social Affairs of the National Council of the Slovak Republic. The Committee on Social Affairs of the National Council of the Slovak Republic was designated by decision as the committee responsible. The decision also set a deadline of 9 September 2022 for discussion of the draft law at second reading in committee and 12 September 2022 in the committee responsible. - Social Inspection Act No 345/2022 amending certain acts, in force from 26 October 2022 and in force from 1 November 2022

Action 8.	***Developing an infrastructure to ensure oversight***
	The measure will provide the infrastructure for the functioning of the supervisory authority – the head office as well as 8 regional branches. At the same time, the material and technical conditions for the new supervisory authority – cars, computer equipment and other necessary preconditions for action – will be prepared.

Deadline: Q1 2024
Responsible for the implementation of: MoLSAF SR
Evaluation of performance: The task is carried out

IMPLEMENTATION:	As at 31.12.2022. The inspection in social affairs filled 14 jobs in Bratislava, the launch of 5 competitions in the Bratislava region. In December 2022, a commercial tender "Acquisition of real estate for workplaces of the Inspectorate in Social Affairs of the Ministry of Labour, Social Affairs and Family of the Slovak Republic" was launched pursuant to Sections 281 - 288 of Act No 513/1991. Commercial Code, as amended, on the most appropriate proposals for the conclusion of purchase contracts by which the announcer acquires ownership rights to real estate for the purpose of establishing workplaces for its organizational unit - Inspection in social matters, in individual regional cities.

4. Expanding and restoring after-care, long-term and palliative care capacities, taking into account the needs and preferences of the population concerned

Action 9.	***Investments in the expansion of the network of outpatient and community residential facilities***
	The investment shall increase the capacity of community-based residential facilities (e.g. supported housing). It will be possible to move part of the clients from large-capacity facilities to smaller community-type facilities. At the same time, part of the new capacities will be dedicated to new beneficiaries. New outpatient facilities (e.g. daily stationary, rehabilitation centre) will contribute to accelerating deinstitutionalisation while reducing the burden on informal carers. This investment will make it possible to cover the current uncovered demand and prepare the system for the projected growth in demand

	for a change in the financing system. Investments shall also support the construction of new low-capacity socio-health care facilities (e.g. specialised facilities) with complex needs.

Deadline: 2021- Q2 2026
Responsible for the implementation of: MoLSAF SR
Evaluation of performance: The task is carried out

IMPLEMENTATION:	The measure is implemented through the Recovery and Resilience Plan - Component 13 - Accessible and high-quality long-term socio-health care and its Investment 1: Expanding community-based social care capacities. The planned new capacities will be open to both public and non-public providers of social services, including those not involved in the National Project Deinstitutionalisation of Social Services Facilities – Supporting Transformation Teams if they provide community-based services. On 5 October 2022, a call for project ideas was launched for the expansion of community-based care capacities (code 13I01-22-V01), which will be open until June 2024. On 23 May 2023, a call for applications for the Facility (code 13I01-22-V02) was published. Call No 13I01-22-V03 will be launched during June 2024. The indicative amount of funding for the call is EUR 70 million excluding VAT. The investment could/could have supported: • **Outpatient services (estimated number of supported places: 1 024)**: ○ Early Intervention Service ○ facility for seniors ○ nursing home ○ Rehabilitation centre ○ the Social Services Home ○ specialized facility ○ The Daily Stationary • **Low-capacity accommodation services with a capacity of up to 12 places - year-round or weekly form of stay (estimated number of supported places: 613):** ○ Supported housing facility ○ facility for seniors ○ nursing home ○ Rehabilitation centre ○ the Social Services Home ○ specialized facility • **Socio-medical low-capacity facilities with a capacity of up to 30 places (estimated number of supported places: 720)** ○ facility for seniors ○ nursing home ○ specialized facility In April 2024, the Ministry suspended the submission of applications for the Facility under Investment 1, Category C (social-health low-capacity facilities up to 30 places), due to the overrun of the number of new client places in the applications already received.

Action 10.	***Submit an investment plan to expand community-based care capacities***
	The National Project Deinstitutionalisation of Social Services Facilities – Support for Transformation Teams (NP DI STT) supports the transition from institutional to community-based care in the Slovak Republic resulting from the international commitments of the Slovak Republic and the implementation of the National DI Strategy. The aim of the project is the preparation, creation and systematic methodological support of transformation teams in the creation of transformation plans of specific social service institutions (SSF) involved in the process of transition from institutional to community-based care and the initiation of transformation processes in the communities where these SSF will be located. The involved SSF are preparing a comprehensive transformation plan that will contribute to improving the living conditions of recipients of social services and will be part of the process of transition from institutional to community-based care and will kick-start transformation processes in the communities where these facilities will be located. Transformation teams (selected employees and equipment recipients) are regularly involved in training activities, consultations and supervisions that support them in their work, problem solving and subsequently in the preparation and creation of concrete transformation plans. The planning of new capacities in community-type facilities generated by the transformation of existing facilities of both public and non-public providers will reflect the readiness of transformation projects.

Deadline:	Q3 2021
Responsible for the implementation of:	MoLSAF SR
Evaluation of performance:	The task is accomplished

IMPLEMENTATION:	**In the National Project on Deinstitutionalisation of Social Service Facilities – Supporting Transformation Teams** (NP DI STT), the preparation, creation and systematic methodological support of transformation teams in the creation of transformation plans of specific social service facilities (SSF) involved in the process of transition from institutional to community-based care and kick-starting transformation processes in the communities where these SSSF are located took place. The involved SSF have prepared a comprehensive transformation plan that will contribute to improving the living conditions of recipients of social services and is part of the process of transition from institutional to community-based care and will kick-start transformation processes in the communities where these facilities are located. As at 31. 12. In 2022, 94 entities were contracted for the whole project. The number of transformation plans finally submitted as at 31 December 2022 is 52. In 2022, 982 hours of individual and 898 hours of group supervision took place, aimed at solving the problems of staff of the involved facilities (priority members of transformation teams, internal working teams (management, departments) and recipients of social services present in professional practices in the context of preparing for change processes. In view of the ongoing epidemiological situation and the closure of the SSF, the inspections had a

	strong supportive effect for employees and clients of the establishments and also served as a prevention of burnout of employees exposed to severe stress situations. Foreign study trips were also carried out for employees of the 28 SSF involved, employees of 4 self-governing regions and professionals carrying out project activities in 10 social services facilities in the Czech Republic, with the aim of exchanging experiences and getting to know examples of good practice. **DOP Support for deinstitutionalisation of social services facilities** Called on 10th. 9. 2021. K 30. 03. 2022 Call closed. Call aimed at ensuring continuous support to facilities that have entered the deinstitutionalisation process through the NP DI STT and are interested in continuing the deinstitutionalisation process. The aim is to provide continuous support to social service facilities in transition to ensure the transition of clients from existing social service facilities to community-based services by: - supporting and preparing the recipients of residential social services in the process of deinstitutionalisation, in line with the established transformation plan, with the active participation of the staff providing the services; - supporting employees in providing new, innovative social services at community level, with an emphasis on the individual needs of clients during the deinstitutionalisation process, - supporting the implementation of the transformation plan and the practical implementation of the transformation process in the social services facility, - supervision for employees of social services facilities. - 15 applications for non-repayable financial contribution approved, with the total amount of the approved non-refundable grant: 1 134 thousand. Eur - It is now 14. 07. 10 projects contracted in 2022

Action 11.	***Launching a call and providing consultations on the submission of applications by both public and non-public providers.***
	A call for project proposals will be published via the website of the Ministry of Labour, Social Affairs and Family of the Slovak Republic for those interested in providing the means of the Recovery and Resilience Plan of the Slovak Republic. Prior to the launch of the call, consultations will be held to clarify the concepts and other specificities of the project, as well as calls for project proposals.

Deadline: Q4/2021
Responsible for the implementation of: MoLSAF SR
Evaluation of performance: The task is accomplished

IMPLEMENTATION:	On the website of the Ministry of Labour, Social Affairs and Family of the Slovak Republic, updated information is published in the Recovery and Resilience Plan section and the call for project plans for the expansion of community-based care

	capacities is available at: Call for project plans - MoLSAF SR (gov. https://www.employment.gov.sk/sk/uvodna-stranka/plan-recovery-resilience/call-submission-project-aims/sk)). The Call was published on 5 October 2022. At the same time, information seminars were held remotely in the first quarter of 2022, with the aim of providing information to potential applicants for funding, and individual consultations are provided on an ongoing basis to public and non-public providers of social services on the conditions for providing funds to expand the network of social services provided at community level. Public and non-public social service providers are potential applicants for the Facility. For this reason, the information seminars were aimed at providing basic information on the investment in question based on the Recovery and Resilience Plan of the Slovak Republic, as well as at providing information on the call for project plans being prepared at that time, at bringing the approval process closer together and at the same time at answering questions that were continuously ongoing during the next period, while these activities and consultations took place throughout 2022 and the Ministry of Labour, Social Affairs and Family of the Slovak Republic was intensively engaged in these activities even after the Call was announced, even now, by means of email communication using component13@employment.gov.sk for consultations on the issues in question.

Action 12.	***Reconstruction of after-care beds in hospitals***
	New inpatient follow-up capacities will contribute to the adequate recovery of the patient. In the short term, the risk of rehospitalisation is reduced, in the long term, quality aftercare prevents the emergence of a need for long-term care, or at least slows down the progress of dependency.

Deadline: 2022-Q2 2026
Responsible for the implementation of: Ministry of Health of the Slovak Republic
Evaluation of performance: The task is carried out

IMPLEMENTATION:	Legislative changes, in particular the adoption of the optimisation of the hospital network (component 11) and the law on long-term and palliative care (Reform 1), which will clearly define follow-up care and its link to other types of care, are a precondition for investment in the reconstruction of the units. The priority in investments will be the transformation of part of the current chronic and acute beds into aftercare beds. Following the identification of a new optimal hospital network , a **part of the current acute beds for after-care needs (component 11 Modern and accessible institutional and acute care) of at least 650 beds is expected to be released.** The Decree on the categorisation of institutional care is currently in the process of processing comments/contradictory proceedings. It is scheduled to enter into force on 15 September 2022. The decree contains the first categorization of the constitutional CPC in general terms, and regulates what medical services will be provided at which of the five levels of hospitals. As a follow-up to this process, the preparation of a call for follow-up services will

	start in the course of September. The call builds on the forthcoming categorisation of hospitals after the UN and the outputs of the follow-up working group. The final version of the call must take into account the results of the working groups. The call is expected to be launched at the end of December 2022, following NICA's comments. All providers, regardless of the type of founder, will be able to apply for financing of projects under the investment in the form of a call published by the Ministry of Health of the Slovak Republic. The preparation of an investment plan in the sense of the current version of the RRP is therefore irrelevant at this stage. It also follows up on the UN and the monitoring step 'Geographical distribution of different types of hospitals, defined scope of health services provided and number of beds, minimum conditions for each type of care are set', which was moved to 4Q/2022. The document is therefore in the process of being drafted. The law on long-term and palliative care was adopted with effect from 1 August 2022 (Reform 1, Measure 2). The Ministry of Health of the Slovak Republic will prepare the concept of follow-up health care, which will provide basic information on optimal management and treatment of the patient with the need for follow-up health care. **Implementation update of the measure for 2022:** Reconstruction of post-care beds in hospitals will be implemented through a call from Component 13 of the Slovak Recovery and Resilience Plan. Due to its link to the Optimisation of the hospital network in Slovakia, its declaration has been postponed to 2023.

Action 13.	***The equipment of new and existing HNCA will be implemented on an ongoing basis in 2021-2025. Investments in HNCA will take the form of calls. Rapid and ongoing information to potential beneficiaries will be important.***
	Investments will contribute to the expansion and renewal of the home nursing network. The increase in the number of network providers is a step towards filling the optimal network, which will be determined in the next steps. Investments in retrofitting existing providers will increase the quality of care provided.

Deadline:	Q1 2025
Responsible for the implementation of:	Ministry of Health of the Slovak Republic
Evaluation of performance:	The task is carried out

IMPLEMENTATION:	The investment in the material and technical equipment of 91 new and existing home nursing care agencies shall establish at least **11 new home nursing care agencies and ensure the re-equipment of at least 80 existing home nursing care agencies**, through the Recovery and Resilience Plan of the Slovak Republic, component 13. The call for applicants for money mechanism funds from the RRP for the material technical equipment of existing or new mobile hospice will be published in August on the website of the Ministry of Health of the Slovak Republic.

The awareness of potential applicants was ensured continuously through video and teleconferences, in meetings and negotiations with representatives of the professional community in the development of legislative changes (draft law on long-term and palliative care) as well as expert consultations in the creation of a call and application or professional events (informationplatform of RRP in the health sector, which the Ministry of Health of the Slovak Republic organizes for representatives of the HTU on a regular approximately monthly basis).

The health insurance company will reimburse the healthcare provider providing long-term healthcare or palliative healthcare during the period from 1 August 2022 to 30 June 2024 for this healthcare provided by the price regulation in accordance with the adopted legislation (Reform 1, Measure 2).
The stabilisation and development of jobs in home nursing care agencies will be supported through the National Programme Strengthening Long-Term Care from the OP Human Resources React.
The objective of the NP is to pilot the verification of the systemic provision of long-term and palliative healthcare by qualified personnel in outpatient-type healthcare facilities – mobile hospice and home nursing care agencies.
Total duration of implementation of the main and supporting activities of the project: 12/2023. The deadline for launching the call is July 2022.

The main activity of the NP within the meaning of the OP Human Resources will be the support of stability and professionalism of employees of long-term and palliative health care. Its implementation will contribute to the promotion and creation of jobs in home nursing care for:

HNCA - Nurse - specialist (600 persons)
HNCA - Physiotherapist (84 persons)

The stabilisation and creation of HNCA medical staff posts will contribute to a positive impact on broadening the interest in the use and delivery of home nursing care.
Closer and more frequent contact with a person in need of long-term or nursing health care will be ensured, thus preventing acute conditions and ensuring better and better collection of information on related services, which will feed into the next sub-activity carried out under the NP.
The sub-activities of the NP will also include the development of methodologies and standards for stabilization and professionalization of healthcare personnel in mobile hospice. The application of methodologies and standards will be the basis for later accreditation of emerging facilities. The methodologies will be the basis for the implementation of the adopted amendment to Act No 576/2004 on health care.

Implementation update of the measure for 2022:
In July 2022, calls were launched from the Slovak recovery and resilience plan to: Extension of the home nursing network (challenge code:13I02-21-V04) Renewal of the home nursing network (challenge code: 13I02-21-V05) Both calls were launched on 29 July 2022. The calls were amended on 27 October 2022 and closed on 31 October and 30 November 2022 respectively.

Action 14.	***Reconstruction of palliative care beds in hospitals***
	Affordable and high-quality palliative care services will ensure terminally ill patients a dignified survival of the last months of life at home or in another setting according to their personal preference, in order to preserve the autonomy and dignity of the dying person for as long as possible. The optimal network of palliative compartments and stone hospices is filled. These facilities/departments will provide palliative care in line with the concept of palliative care and the new Long-Term and Palliative Care Act (Reform 1).

Deadline: Q3 2025
Responsible for the implementation of: Ministry of Health of the Slovak Republic
Evaluation of performance: The task is carried out

IMPLEMENTATION:	New palliative units will be created following the optimisation of the hospital network, which will determine the regional distribution of acute palliative beds**.** Part of the new palliative beds will be created in new or reconstructed hospitals as part of the investments under component 11. Approximately **90 beds of palliative compartments** are created by reconstruction of existing beds. Some of them will be the result of reprofiling the compartments for long-term ill patients, part of which will be created from acute beds, which will be released by optimizing the network. The Decree on the categorisation of institutional care is currently in the process of processing comments/contradictory proceedings. It is planned to enter into force on 15 September 2022. The decree contains the first categorization of the constitutional healt care in general terms, and regulates what medical services will be provided at which of the five levels of hospitals. As a follow-up to this process, the preparation of a call for palliative care units will start in the course of September. The call builds on the forthcoming categorisation of hospitals after the UN and the outputs of the follow-up working group. The final version of the call must take into account the results of the working groups. The call is expected to be launched at the end of December 2022, following NICA's comments. Following the approval of the Decree, the Ministry of Health will draw up a concept of palliative care. The law on long-term and palliative care was adopted with effect from 1 August 2022 (Reform 1, Measure 2). All providers, regardless of the type of founder, will be able to apply for financing of projects under the investment in the form of a call published by the Ministry of Health of the Slovak Republic. The preparation of an investment plan in the sense of the current version of the RRP is therefore irrelevant at this stage. It also follows up on the UN and the monitoring step 'Geographical distribution of different types of hospitals, defined scope of health services provided and number of beds, minimum conditions for each type of care are

	set', which was moved to 4Q/2022. The document is therefore in the process of being drafted. **Implementation update of the measure for 2022:** The reconstruction of palliative care beds in hospitals will be implemented through a call from Component 13 of the Slovak Recovery and Resilience Plan. Due to its link to the Optimisation of the hospital network in Slovakia, its declaration has been postponed to 2023.

Action 15.	***Construction and restoration of stone hospices***
	Investing in the construction of new low-capacity stone hospices will improve their regional accessibility. Investments in the reconstruction of existing hospices will improve the material and technical equipment and thus help to increase the quality of the care provided, in line with the new requirements that will result from legislative adjustments.

Deadline: 2022-2025
Responsible for the implementation of: Ministry of Health of the Slovak Republic
Evaluation of performance: The task is carried out

IMPLEMENTATION:	Stone hospices currently operating in the territory of the Slovak Republic were almost all founded about 15 years ago. Their planning and preparation began about 20 years ago, which defines their expected condition and individual functionalities of these devices. This applies to the construction from the point of view of both external and internal, and at the same time to the functionality and functionality of the devices, which includes moral wear, since the operation of these devices is highly demanding. The investment in palliative beds in stone hospices involves the creation of approximately **180 beds ,** through the construction of new hospices (80 beds, 20-26 beds per hospice) and the reconstruction of existing hospices (100 beds). Hospices will be used for the long-term palliative care of patients whose health or family situation does not allow for home palliative treatment. As part of the investment, all healthcare providers, regardless of the type of founder, will be able to apply for project funding in the form of a call published by the Ministry of Health of the Slovak Republic. The draft call is currently being prepared, as consultations are ongoing with several sections of the Ministry of Health and the Health Implementation Agency (HHIA). In June, two meetings were held at the HHIA to consult on the specification of the financial allocation for the construction and reconstruction of stone hospices, together with the need to supplement the professional conditions for providing the call mechanism resources necessary for construction. Subsequently, a document was prepared, which serves as a basis for the preparation of the call for stone hospices from the professional point of view, eligible applicants and eligibility conditions were defined. The criteria of

	the call will focus on the geographical availability and number of beds and take into account the scarce areas through the map of the stone hospice network developed. The expected date for its announcement after final approval is September 2022. The investment in palliative beds in stone hospices will contribute to the fulfilment of the public minimum network of stone hospices. These facilities will provide palliative care in accordance with the concept of palliative care, which will be developed following the approval of the Decree on the categorisation of institutional care and the newly adopted Long-Term and Palliative Care Act (Reform 1, Measure 2). Affordable and high-quality palliative care services will ensure terminally ill patients a dignified survival of the last months of life at home or in another setting according to their personal preference, in order to preserve the autonomy and dignity of the dying person for as long as possible. **Implementation update of the measure for 2022:** In November 2022, the call Expanding and renewing the stone hospice network was launched (call code: 13I03-21- V07)

Action 16.	***Equipping new and existing mobile hospices***
	The establishment of mobile hospices at stone hospices and palliative wards will strengthen the continuity and quality of care. At the same time, regional disparities in the availability of services will be compensated for and the proportion of patients with chronic incurable disease who die at home will increase.

Deadline:	Q1 2025
Responsible for the implementation of:	Ministry of Health of the Slovak Republic
Evaluation of performance:	The task is carried out

IMPLEMENTATION:	The investment in the material and technical equipment of new and existing mobile hospices shall support **at least 20 new mobile hospices and at least 6 existing hospices** through the Slovak Recovery and Resilience Plan, component 13. The call for applicants for money mechanism funds from the RRP SR for the material technical equipment of existing or new mobile hospice was published on the website of the Ministry of Health of the Slovak Republic in July and should be active for 3 months. The conditions for applicants will take into account the existing MOHO network and the need to develop it. The evaluation criteria assess the prevalence of mobile hospice in individual self-governing regions. The health insurance company will reimburse the healthcare provider providing long-term healthcare or palliative healthcare during the period from 1 August 2022 to 30 June 2024 for this healthcare provided by the price regulation in accordance with the adopted legislation (Reform 1).

	The stabilisation and development of jobs in mobile hospices will be supported through the National Programme Strengthening Long-Term Care from the OP Human Resources React. Total duration of implementation of the main and supporting activities of the project: 12/2023. The deadline for launching the call is July 2022. The main activity of the NP within the meaning of the OP HR will be the support of stability and professionalism of employees of long-term and palliative health care. Its implementation will contribute to the promotion and creation of palliative care jobs for: - **MOHO - Doctor (29 persons)** - **MOHO - Nurse - specialist (58 persons)** - **MOHO - Assisting profession (psychologists** and psychotherapists, physiotherapists, nutritional therapists, social workers and religious experts) **(44 persons)** Increasing the number of medical staff and assisting professions will ensure closer and more frequent contact with a person in need of long-term or palliative healthcare, thus preventing acute conditions and ensuring better and better collection of information on related services, which will feed into the next sub-activity carried out under the NP. The sub-activities of the NP will also include the development of methodologies and standards for stabilization and professionalization of healthcare personnel in mobile hospice. The application of methodologies and standards will be the basis for later accreditation of emerging facilities. The methodologies will be the basis for the implementation of the adopted amendment to Act No 576/2004 on health care. This will ultimately increase the availability of long-term and palliative healthcare, which should also improve the quality of life of these patients and their family members. **Implementation update of the measure for 2022:** In July 2022, a call was launched to expand and renew the mobile hospice network. The change to the call took place in September 2022 and was closed in November 2022.

To support long-term health care, it was:

National project implemented (Ministry of Health of the Slovak Republic (gov.sk)).
Call under Operational Programme 'Human Resources' – OPLZ-NP-2022/8.1.1./RO-01.
Information on the project 'Strengthening Long-Term Health Care' (REACT) fig-eu-oplz.png. **Managing authority:** Ministry of Labour, Social Affairs and Family of the Slovak Republic (https://www.employment.gov.sk). **Name of the national project:** Strengthening long-term health care.
Amount of non-repayable financial contribution: 40 137 691.79 €
Project implementation period: 1.1.2022 - 31.12.2023.
Beneficiary of the project: Ministry of Health of the Slovak Republic 'The project is co-financed by the European Union from the European Social Fund through the Human Resources Operational Programme'.

Objectives and activities of the project: The main objective of the national project is to reflect on the long-term unresolved issue of long-term health care and palliative health care within the Slovak Republic, mainly in the form of outpatient care, by increasing and subsequent sustainability of capacities in the health system and piloting the systemic provision of long-term and palliative health care. The national project also aims at piloting the systemic provision of long-term and palliative healthcare by qualified staff in outpatient-type healthcare facilities – mobile hospice and home nursing care agencies. The final impact will be on the inhabitants of the Slovak Republic (without regional differences) who are reliant on long-term and/or palliative healthcare. Increasing the number of health professionals and assisting professions will ensure closer and more frequent contact with people in need of long-term or palliative health care and their family members, thus preventing and reducing the number of acute conditions addressed by subsequent hospitalisation in acute beds. In conjunction with the Slovak recovery and resilience plan, this will increase the availability of long-term and palliative healthcare, which should also improve the quality of life of these people.
Sub-activity 1 - Promoting the stability and professionalism of long-term and palliative healthcare staff. The objective of the subactivity will be to increase the professionalism of healthcare professionals and assisting professions in order to provide a higher quality of service to persons in the long-term and palliative healthcare regime. The essence of this subactivity is mainly to stabilize current employees and increase the motivation of both existing and new candidates.
Sub-activity 2 – Supporting professional capacity in the facilities of Domestic Nursing Agencies (HNCA) and Mobile Hospice (MOHO). The implementation of the activity will contribute to the stabilisation and job creation of health personnel in MOHO and HNCA, which is expected to have a positive impact on broadening the interest in the use and delivery of home nursing care.
Sub-activity 3 – Collection and analysis of long-term health and palliative care data. The sub-activity will focus on the system collection and evaluation of information, which will be the basis for the definition of measurable indicators at national level and at the same time input into sub-activity No 1.

For each call, measurable indicators have been clearly defined to track developments in the field. Monitoring of key objectives, fulfilment of the timetable of implementation steps, description of activities and description of planned activities for the monitoring period and identification of problems and risks together with monitoring of funds used for the implementation of the investment/reform is through the monitoring report for the monitored period on a regular monthly basis, usually by the 10th of the month.

3. Remaining challenges and needs for EU support

Due to the delay in the optimisation of the hospital network in Slovakia, there was also a delay in the launch of some calls and the associated lower involvement of potential applicants (constitutional health facilities).

In addition to the absence of a stronger systemic grasp of community-based psychiatric care, which is a key element for mental health care reform, staffing by qualified professionals is another factor for its implementation.

1. Support for further training of medical staff.
Funding: **ESF+ - MRR Programme Slovakia**
Objective: Support for the training of health professionals and support staff involved in mental health care in communication and de-escalation techniques to cope with challenging situations is part of the humanisation of psychiatric care to increase safety for patients and staff in psychiatric departments. Training should also cover the practice of preventing aggressive behaviour, the proper use of restraint and the rights and obligations of both the patient and the healthcare provider, with an emphasis on human rights.

Target group: Healthcare professionals pursuant to Section 27 of Act No 578/2004 on healthcare providers, health professionals, professional organisations in the health sector and amending certain acts. Both support staff and non-medical staff involved in mental health care. Providers of inpatient health care. Educational institutions of the type University and Universities. Regular training of medical staff working in psychiatric hospitals at annual intervals.
Result: Accredited education provided by an educational institution of the type of University and Universities for providers of inpatient health care on the basis of a contract, a total of 300 graduates.
Timetable: 2030

3.1. The remaining challenges

Under the Recovery and Resilience Plan, Components 11; 12 and 13 calls, which will be relaunched, have made it easier to apply, increased the level of hospitals that can participate in each call and reduced bureaucratic burdens.
Further, within the framework of the reform and development of community-based psychiatric care , other measures from the **Programme Slovakia to 2030** are proposed and planned :

1. Support the establishment of crisis intervention centres in the field of secondary prevention of mental disorders.
Funding: **EFRR**
Objective: The network of crisis intervention centres will complement the system of psychological and psychiatric care, providing a new type of specialised services, while facilitating outpatient psychiatric care, inpatient psychiatric emergency services and inpatient psychiatric care. The aim is to promote mental health and control skills, prevent the development of a mental disorder or decompensate it.
Target group: Establishment of a network of crisis intervention centres close to institutional psychiatric departments and hospitals and community psychiatric care facilities through reimbursement of expenses for the establishment and reconstruction of premises for the establishment of the centre and reimbursement of expenses for the material and technical equipment of the centre.
Result: In total, 8 crisis intervention and prevention centres will be established in Slovakia.
Timetable: 2030.

2. Building community psychiatric care centres
Funding: **EFRR**
Objective: The creation of new types of community psychiatric facilities will lighten existing psychiatric practices by providing health care for patients with mental disorders at stages where intensive health-social management is needed. They will benefit from outpatient psychiatric treatment linked to different forms of psychotherapy and psychiatric and psychosocial rehabilitation according to their individual needs. Inpatients will shorten or avoid the need for further hospitalization. Increased availability of psychiatric outpatients will allow previously untreated patients to be diagnosed earlier and to start treatment. It also provides mobile field team services.
Target group: A patient in whom it is impossible to achieve the cure of a chronically ongoing mental disorder, as self-sufficient as possible in the community in its natural social environment with the support of a multidisciplinary team, without the need for long-term hospitalization or lifelong institutionalization. This is particularly the case in patients who, despite undergoing specialist outpatient or inpatient psychiatric care, are present with residual symptoms of psychiatric disorders limiting their functionality.
Result: Material and technical security and new psychodiagnostic methods of 15 devices.
Timetable: 2026.

3. Day Psychiatric Stationaries (DPS), (link to social services).
Funding: **EFRR**

Objective: The DPS is a specialised outpatient psychiatric care facility in which a multidisciplinary team provides intensive complex treatment to patients with mental disorders during the day, with particular emphasis on psychotherapy, psychiatric rehabilitation and psychosocial rehabilitation. The aim is to achieve a degree of recovery that allows the best possible occupational and/or social reintegration of the patient in order to achieve the highest quality of life. The DPH is set up separately or as part of other health institutions). The network of psychiatric stationaries should be built in accordance with the principle of geographical availability according to the regions of standard psychiatric care. As part of community-based psychiatric care, DPS of various types will enable patients with severe mental disorders with residual symptoms to be provided with a form of recovery that is feasible and effective. It will include both low-threshold and high-threshold care with differently defined treatment goals. Low-threshold care (community type of psychiatric stationaries) will mainly be about health-social support of the patient's autonomy and retention in the community (prevention of institutionalization). For high-threshold care of health-social support of its self-sufficiency and return to work (disability prevention). Psychiatric addiction treatment stations will provide health-social care to a specific population of patients with addictions.
Target group: Prioritisation of equipment for the material and technical provision of existing psychiatric stationary providers set up by 31 December 2022.
Result: **Material and technical provision of 27 existing psychiatric stationaries**.
Timetable: 2030.

The remaining challenges/shortcomings identified include **an increase in reimbursements for long-term and palliative care provided** to make its provision more attractive among healthcare providers, given the increasing demand for this type of healthcare, with a further increase in demand for the future, given the demographic development of Slovakia's population for the future.

There **is also a lack of systemic support for and regulation of the provision of community-based psychiatric care**, which is a key element for mental health care reform, and therefore challenges and actions are aimed at its development in order to increase the proportion of patients treated in community-based healthcare, increase the number of health professionals providing specific advanced treatment and diagnosis, and also reduce the waiting time for the provision of professional mental health care.

3.2. EU support

Under Component **13 of the RRP,** we are preparing and planning to re-launch calls due to non-fulfilment of milestones, e.g.:

1. Creation of new 650 after-care beds (call code: 13I02-21-V17).
2. Expansion and renewal of residential palliative care capacities - Expansion and renewal of palliative care units capacities (challenge code: 13I03-21-V18).

Under the **Recovery and Resilience Plan Component 12** Human, Modern and Accessible Mental Health Care, the following challenges are planned to be re-launched due to the non-fulfilment of milestones:

1. Call for applications for the Recovery and Resilience Facility, 'Building dedicated centres for autism spectrum disorders', Call code: 12I05-21-V15, Construction of 3 ASD centres, start of operation Q4 2025, new call launch date: June 2024.
2. Call for applications for the Recovery and Resilience Facility, 'Complementing the psychiatric stationary network', Call code: 12I04-21-V12, build 15 PS, start of operation Q4 2025, new call launch date: June 2024.

Up-to-date information is always publicly available on the website of the Ministry of Health of the Slovak Republic (Ministry of Health of the Slovak Republic (gov.sk); https://health.gov.sk/Titulka) and also on the Recovery and Resilience Plan, Components 11; 12 and 13 (https://health.gov.sk/?Plan-recovery-and-resilience).

List of abbreviations used

ASD – autism spectrum disorders
CNMoP – Complex Nursing Management of the patient
CSS – center of social services
CCHAF – center for children and families
DAIM- Department of Anaesthesiology and Intensive Medicine
DPH – daily psychiatric hospitals
EC - European Commission
FTE – full time equivalent
HNCA - Home Nursing Care Agency
HTU – higher territorial unit
IHNC - intensive home nursing care
Long-term APV – artificial pulmonary ventilation
LSAAF - Labour, Social Affairs and Family
LTHC – long-term socio-health care
LTHC Strategy – Long-term care strategy in the Slovak Republic
MF SR – Ministry of Finance of the Slovak Republic
MH SK – Ministry of Health of the Slovak Republic
MoLSAF SR – Ministry of Labour, Social Affairs and Family of the Slovak Republic
National strategy DI – National strategy for the deinstitutionalisation of the social services and alternative care system
NH – nursing home
NHIC - National Health Information Centre
NIO – National Institute of Oncology
NMHHL -National Mental Health Helpline
NP – national project
NP DI STT – National project for the deinstitutionalisation of social service facilities – Support for transformation teams
OoLSAF SR – Office of Labour, Social Affairs and Family of the Slovak Republic
PM – Palliative medicine
PS – psychiatric stationary
PSC – psychosocial center
RRP – recovery and resilience plan
SOC - specialised outpatient care
SPC - Specialised Palliative Care
SPDTP – standard preventive, diagnostic and therapeutic procedures
SPCHSG – social protection of children and social guardianship
SPS - Slovak Psychiatric Society of the Slovak Medical Society
SSF - Social Services Facility