Vedecký príspevok Scientific Article
Recenzované/ Review: 11. 11. 2020
https://doi.org/10.24040/eas.2020.21.2.58-73

Formal and Informal Care for Seniors in the Household in the Southern Gemer Region of Slovakia

Formálne a neformálne opatrovanie seniorov v domácnosti na južnom Gemeri

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Abstract: The aim of this paper is to analyse the formal and informal care for seniors in households in a selected region of the Banská Bystrica self-governing region in Slovakia - the Southern Gemer region which can be said to be „underdeveloped". The data we have used for the analysis consist of 12 municipalities and one city. In our study, we focused on seniors aged 65 and over. The analysis of the availability of formal services in the field of providing social care for the elderly 65+ showed that the focus (main) responsibility in this area is geared towards informal care for the elderly in households, despite the inappropriate age structure of caregivers. Our research revealed the well-being as being an important determinant that requires the availability but also the quality of formal and informal care for seniors in households.

Key words: *Formal care. Informal care. Seniors. Households. Municipality. Well-being.*

JEL Classification: B55. D91.

Introduction

This paper focuses on population aging as a serious challenge to the developed world. International organisations, institutions as well as national governments are looking for ways to solve this problem including the Slovak Republic. Specific attention is paid to the so-called active ageing. More precisely, we analyse the issue of long-term care for the elderly at the present and what scenario could be expected in the future. Hence, this paper is motivated to examine long-term care practices from the perspectives of formal care providers and informal caregivers for the elderly at home. The aim of this paper is to analyse residential outpatient and informal care for seniors in the households in a selected region of the Banská Bystrica self-governing region in Slovakia (BBSGR). For the analysis of formal and informal care for the elderly in the household, we selected the Southern Gemer region with the attribute „underdeveloped region". The data we have used for the analysis consist of 12 municipalities and one city. We focused on seniors aged 65 and

over. Old age in many developing countries could be considered a time when seniors are no longer capable of taking care of themself and require the aid of others (Gorman, 2000).

It is forecasted that by the year 2030, 24% of the population will be over 65 years of age in the European Union, with 30% of them being older than 80 (Eurostat, 2019). Many of them will be living in community-dwelling for older adults who suffer from long-term and complex health problems, for which both informal (e.g. spouses, children, friends) and formal caregivers (e.g. publicly or privately paid homecare professionals) need to be deployed. This will contribute to an increase in the prevalence of mixed care networks of multiple informal and formal caregivers will have to collaborate in providing care in the home environment. Policymakers aim for more contact and cooperation between informal and formal caregivers as it may enhance the quality of care (Huber, Hennessy, 2005). Research shows as well that timely and satisfactory cooperation between these different types of caregivers is a prerequisite for good quality of care. These findings would highlight the importance of enhancing the availability of formal long term care services for both care recipients and caregivers. (Miyawaki, Kobayashi, Noguchi et al., 2020).

1. Formal and informal care for older people

Formal care for older people usually refers to paid care services provided by a residential institution or individual for a person in need. Informal care refers to unpaid care provided by family, close relatives, friends, and neighbors. Both forms of caregiving involve a spectrum of tasks, but informal care givers seldom receive enough training for these tasks. Formal caregivers are trained in the field, but the depth of their training varies. Informal care, also known as unpaid care or family care, constitutes a significant share of the total long-term care (Hoffmann, Rodrigues, 2010).

The definition of "informal care" employed for the purpose of this note is broad. In our study we take informal care to include any care or help provided to older people (family or otherwise), care provided to working age adults, young people and children with disability as well as people living with mental health problems. Different countries have different conceptions of what an informal carer is, and we take care not to exclude any understanding of informal care. There is a lack of standard definition on which to base inclusion criteria for empirical research and hence studies include varying groups, depending on for example co-habitation and amount or type of care provided (Molyneaux, 2011).

The available estimates of the number of informal caregivers ranges from 10% up to 25% of the total population in Europe. The average varies significantly between countries, groups of countries and depending on how informal care is defined and measured. Informal carers are often women, either providing care to a spouse, parents or parents-in-law, and a large share is provided by people who are older than standard retirement age (Colombo et al., 2011). Informal care is likely to become even more important in the future due to demographic change, health care advances, long-term care policy and cost-containment pressures leading to the favouring community care options over institutionalisation where possible (Riedel, 2012).

Informal care forms a cornerstone of all long-term care systems in Europe. It is has also been gaining increasing recognition in international policy circles as a key issue for

future welfare policy. The European Pillar of Social Rights (2017) makes explicit the commitment to people providing care, including their rights to flexible working and access to care services.

On the one hand it is seen as crucial to avoid unnecessary, and expensive hospitalisation or institutionalisation, while on the other hand many countries have stringent needs assessments before a user receives publicly funded long-term care. In this context, the caring function of families remains the key type of care provision. Informal care is often seen as a cost-effective way of preventing institutionalisation and enabling users to remain at home. However, informal care is not cost-free either to individuals or to the state (Rodrigues et al., 2013; Pickard et al., 2017). The needs of carers and the impact of providing informal care on key life outcomes such as employment, health, and wellbeing are further being increasingly recognised in the academic literature and in national policies across Europe (Brimblecombe et al., 2018).

As research show several countries offer formal long-term care services for seniors provided by paid professionals. Nordic countries (Norway, Sweden, Denmark, and Finland), the UK, Ireland, Spain, and Australia have developed a tax-based model of formal long-term care services. Germany, Japan, Korea, Luxembourg and the Netherlands, provides comprehensive formal long term care programs via a social insurance system known as long-term care insurance (Miyawaki et al, 2020). Formal care systems for seniors aim to "socialize" long-term care burdens by taking over part of the responsibility of informal caregivers (unpaid people providing care to family members) for providing care to family members. This is assumed to mitigate the caregiving burden among informal caregivers and improve their well-being (Colombo et al, 2011).

Other research points to an effect between informal and formal care (Bonsang, 2009; Van Houtven, Norton, 2004; Jacobs et al., 2015). Altough, when taking into account individual level factors, such as the level of needs of the care recipient, the substitution effect persists only as long as needs are low and require unskilled care (Bonsang, 2009). This implies some degree of specialization between formal and informal sources of care according to the individual needs of the care recipient. In addition, recent studies support a bridging hypothesis suggesting that receiving informal support may function as a bridge to formal services, e.g. when informal caregivers help facilitate the ongoing contact between the care recipient and the formal care system (Jacobs at al., 2015). Formal and informal care can have its rewards and benefits for family and caregivingers. Furthermore, positive psychological effects due to caregiving may mitigate some of the challenges of caregiving, as positive effects are associated with lower levels of burden and depression and better overall mental health. However, family caregiving can also have invisible costs. Although most children feel responsible and are motivated to care for their parents or in-laws ,there is uncertainty about their ability and willingness to assume full responsibility for such care. Thus, informal caregiving, including the circumstances of carers, the challenges they experience and their need for support from formal care services as well as other informal networks, is often hidden or even invisible (Losada et al., 2010).

An increasing number of older adults with care needs continue to live in their homes because of personal preferences and policies on ageing in place. Depending on the societal context, the needs of community dwelling older adults can be met by care from multiple

sources: publicly provided services, informal caregivers and private services purchased out-of-pocket. However, as a result of the expected increase in public expenditure for long-term care services (Lipszyc et al., 2012), many countries are reforming their care policies, and the boundaries between the provision of public, family and market based services.

We consider it important to note that the World Health Organization, has "10 priorities for a decade of action on healthy ageing" is an initiative that was recently launched by to encourage all countries to develop effective long term care systems and to reduce caregiver burden (e.g. formal and informal care) (World Health Organization, 2017).

2. Social care for the elderly in the Slovak Republic

Since 2012, the Slovak Republic has begun the process of transforming social services in order to create and secure conditions for all citizens who depend on assistance in the natural, social environment of their community. This process also includes the transfer of selected competences to the local and regional level, thereby ensuring the principle of social subsidiarity, which should support the community character of the provision of social services. There is currently a multi-level system of long-term care services in the Slovak Republic that are not interconnected; there is no system of coordination of individual services in favor of addressing the individual situation of a citizen in need of assistance. Health care and social services are also two separate systems. Each of these systems is governed by its own legislation and standards. As there is no unified system of long-term integrated care in the Slovak Republic, those support services are traditionally fragmented in three areas:

1. System of social services – System of social services is regulated by the Social Services Act no. 448/2008. In terms of long-term care, this it is a one of the legislative standards for long-term care. Social services are aimed at preventing, solving or mitigating the unfavorable social situation of a person, their family or community. Currently, social services for seniors are provided mainly in senior living facilities, specialized facilities and social service centres. Outpatient social services are provided for seniors mainly through home care services.
3. Health care system – care for seniors is also provided within the structures of the health system (Act no. 576/2004 Coll.). Here, it is primarily aimed at patients with chronic diseases and seniors in need of geriatric care. In the healthcare system, this is mainly provided through home nursing agencies; ambulatory care and institutional care (long-term care departments, geriatric and palliative departments in hospitals), but also in specialized healthcare facilities, especially in long-term care facilities, psychiatric hospitals, nursing homes and hospices. All these types of healthcare are financed by health insurance companies, mainly on a flat-rate basis.
4. Informal care – through this system, care for seniors is mostly provided by their relatives. It takes place mainly in the home environment and is supported by care allowance (Act no. 448/2008 Coll.).

Although the central government (represented by the Ministry of Labour, Social Affairs and Family and by the Ministry of Health) creates legislation at the national level, provision of services to citizens is competitively split between regional and local municipalities. Self-governing regions in the Slovak Republic, i.e. regions with a population ranging from 560,000 up to 820,000 inhabitants, are mainly in charge of residential social services.

The competence for providing outpatient social services has been shifted to the level of municipalities. The local municipality is mainly responsible for:

- preparation of a community plan for social services and creating conditions to support community development,
- provision of social counseling and selected outpatient and residential social services.

Although the transfer of competences was a logical step in bringing services closer to the citizen, the great fragmentation of competences among small municipalities does not allow for creating comprehensive system of long-term care for the elderly. Moreover, the transfer of competences did not result in an obligation for municipalities to provide these services, so most municipalities, due to insufficient personnel and skills, provide these services at an insufficient level or do not provide them at all. In this case, citizens are forced to apply for services through their self-governing region, which only provides residential services.

Those inadequacies in the system of long-term care are nowadays compensated mostly by informal care. That represents a major risk in the long run. According to Eurostat projections, the age structure of the European population is expected to change significantly over the next decades. Slovakia will be one of the countries most impacted by population aging. While today there are approximately 20 people of retirement age per 100 people of working age, in 2060 there should be three times as many. Thus, the Slovak Republic will rank among the states with the oldest population in the EU (Eurostat, 2019).

By 2080, people aged 65 or over are expected to account for 29.1% of the EU28 population compared to 19.4% in 2017, while at the same time the share of persons aged 65+ in Slovakia will increase from the current 14% to around 30% already in 2060. The proportion of people aged 80 and over will increase to 12% by 2060 (currently only 3%). Such a significant increase in the proportion of the oldest population implies, in addition to healthcare requirements, a significant increase in long-term care requirements - both formal and informal (Eurostat, 2019).

2.1 The Banská Bystrica self-governing region

The Banská Bystrica self-governing region is one of the least developed regions of the Slovak Republic. At the same time, this region is one of the fastest aging regions in the Slovak Republic. In 2018, the aging index in Slovakia was 101.90, while in the Banská Bystrica Region it reached 114.77. The situation in some districts of the region was even more unfavorable. The demographic specificity of the Banská Bystrica Self-Governing Region is that it has the lowest population density in the Slovak Republic, with fewer than 70 inhabitants per square kilometer. The dominance of municipalities with a small population and rural settlements is an important factor, which should be considered when planning long-term care.

There is a need to understand the Banská Bystrica self-governing region thoroughly. The current infrastructure of long-term care services in such a spatially fragmented system is insufficient in all areas for outpatient and residential social services. Municipalities are not required to provide outpatient social services but may do so voluntarily. They provide them mainly as home care services, currently financed mainly through demand driven projects from the European Structural Funds. Out of the total number of municipalities (516 in

the Banská Bystrica Region) only 133 municipalities have registered home care services. Transport services are provided only by 15 municipalities. Only two municipalities provide monitoring and signaling of the assistance needed. Nursing care at home is provided by 39 home nursing agencies. Ambulatory services for seniors through day care centres are provided by 15 municipalities and through registered day centres by 11 municipalities.

In spite of the fact that social services for seniors primarily fall within the competence of local municipalities, up to 40.2% of the capacity of facilities for seniors is provided by the self-governing region beyond its original competences. Within the multi-level division of competencies, the self-governing region is competent to provide specialized services for citizens with specific needs, in the case of seniors, namely citizens diagnosed with Alzheimer, Parkinson or dementia. Those specialized services currently do not have enough capacity.

Improper division of competencies is also reflected in the ever-increasing number of citizens on the waiting lists of residential care facilities. While at the end of 2014 there were 4,521 waiting citizens in Slovakia, by the end of 2017 their number had increased to 9,586. The largest increases were recorded in facilities for seniors, where their number in Slovakia increased from 1,717 in 2014 to 5,525 in 2017. The high number of applications for accommodation in residential facilities is also influenced by the lack of preventive and outpatient services at the local level that could reflect the needs of seniors and saturate in their home environment.

The number of applicants for residential services is also increasing in the Banská Bystrica self-governing region. At the end of 2018, the self-governing region registered 1,724 applicants for residential services. That number exceeds twice the capacity of facilities for seniors in its competence (Internal information from BBSGR).

Unmet needs of seniors are compensated by relatives acting as informal care givers. Almost half of informal care givers are of economically active age. Leaving them out of the labour market is a loss for them and for society as a whole. This, together with the rural settlement and migration of young people to study and work in cities and abroad, increases the risk of the phenomenon of lonely seniors and becomes a serious argument for strengthening preventive and screening activities. The economic situation of households also affects the provision of long-term care services. It must be stated that seniors do not have enough of their own resources to solve the problem of caring for themselves.

The Banská Bystrica self goverment region solves existing problems in various ways. One of them is the presented project which was implemented by the order on regional self-government. In this area we have selected the Southern Gemer region as there is a real need to solve these problems and the Mayors are willing to cooperate and have determination and enough capacity.

2.2 Regional monitoring of current care for the elderly

The analysis was a first pilot survey of regional care for the elderly in a selected region of the Southern Gemer. The survey was designed in consultation with the Banská Bystrica self- governing region and tested with five municipalities. Four selected criteria were tested: capacity, commitment, need, cooperation. In January 2020, we distributed questionnaires to 59 Mayors in this region. 47 Mayors returned the completed questionnaire (80% response rate). The result of the questionnaire survey can be seen in the table below.

Table 1 Survey of five municipalities – selected criteria

	Capacity	Commitment	Need	Collaboration
Brezno	Strong	Strong	High	Strong
Poltar	Weak	Strong	Low	Strong
Revuca north	Strong	Medium	High	Medium
Rimavska Sobota + Revuca south Gemer	Medium	Weak	Medium	Medium
Velký Krtis	Medium	Weak	High	Weak

Source: Own elaboration based on research data, 2020.

The Southern Gemer region has limited finance and staffing elderly services are seen as one of the main items on the agenda. They are providing care of seniors informally. There are several providers across the area, but uncoordinated. Municipalities provide lots of services informally. The need for collaboration is recognized and municipalities are willing to contribute.

This region is located in the south-eastern part of Slovakia and with an average 53 inhabitants per km2 is considered a sparsely populated area (compared to 110 inhabitants per sq km country average). Administratively, the region of Gemer consists of 3 districts, Rimavska Sobota, Revúca and Rožňava, comprising of about 200 municipalities and is divided between 2 units of local government: the self-governing region of Banska Bystrica and the self-governing region of Košice. The region of Gemer suffers from economic underdevelopment, which has been worsened by the out-migration of young educated people from the region. Due to the persistent high level of long-term unemployment, the 3 districts of Gemer qualify as the least developed regions within a government development strategy. Long-term unemployment is seen as the utmost social challenge for the region; this factor also deepens the social and economic marginalisation of Roma communities and other disadvantaged groups in the region (Action Plan of Gemer, 2020).

Our attention was paid to selected 12 municipalities and one town in this region (Figure 1). In terms of data sensitivity, we will not specifically name of municipalities and city in this article.

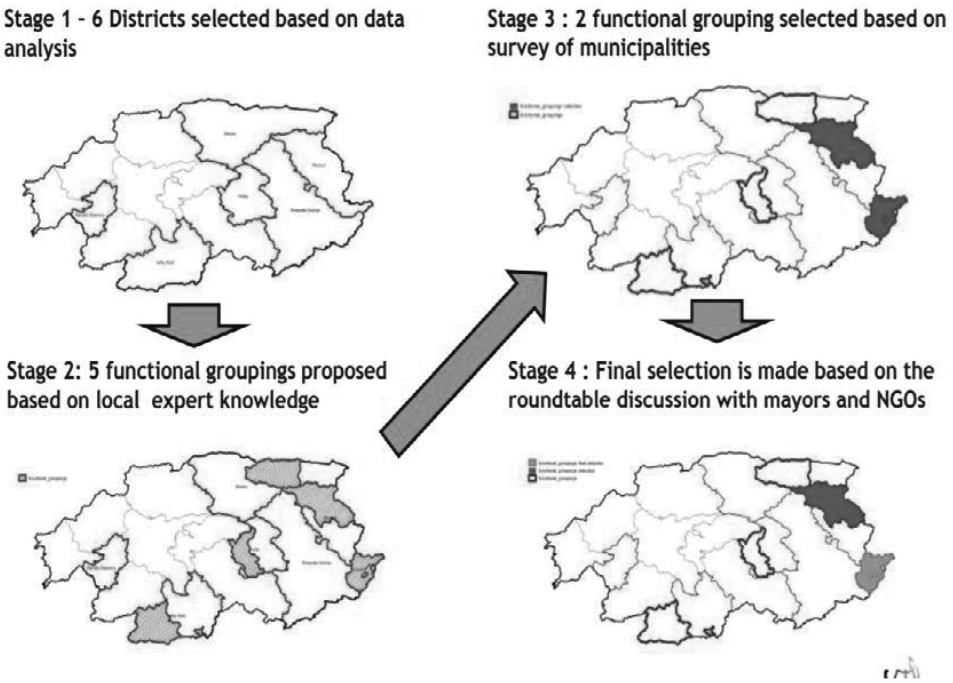


Figure 1 Process of functional grouping selection
Source: Own elaboration, 2020.

3. Data and methods

The first part of the empirical analysis provides an overview of the number of seniors 65 plus in the selected region. This is a unique and piloted survey. The purpose of analysis of the survey data is to provide an overview of the availability or supply of informal and formal care for the elderly in the Southern Gemer region. We use statistical calculation methods, which are recorded in tables and graphs and provide information on the type of indicators that may be used to measure informal care. On the next figure we can see the process of functional grouping selection (12 municipalities and 1 city). We had tested four criteria: capacity, commitment, need, collaboration.

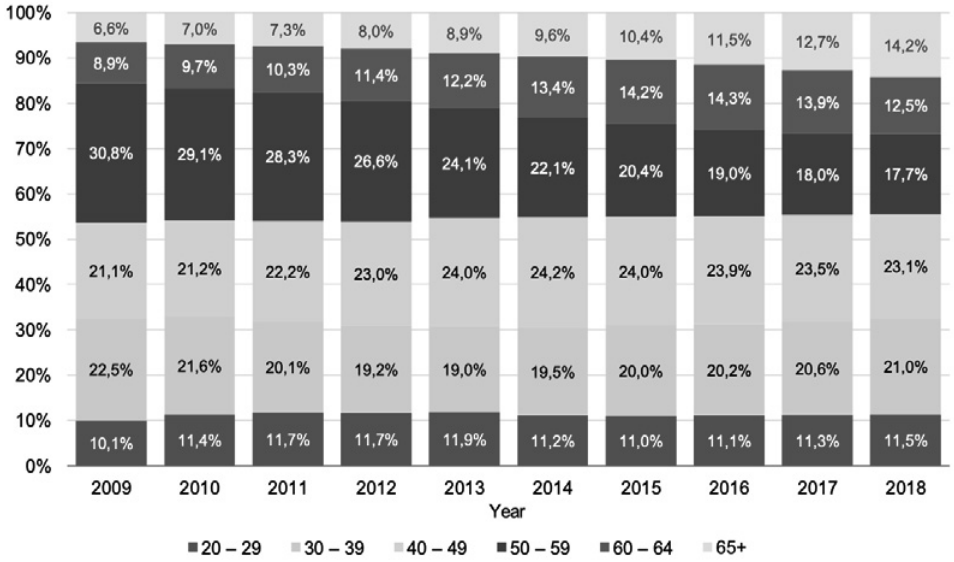
The survey was carried out through data obtained from individual Mayors of the selected municipalities. The Mayors of individual municipalities have the best overview of seniors and the care itself, whether formal or informal care. The survey ran from March 2019 to March 2020. The data were obtained from residential, outpatient, formal and informal care as well as from evidence discussing the future provision of informal care and the data needed to better understand informal home care.

Table 2 Population 65+ in selected municipalities and city

	Population to 01/01/2019	Population 65+ to 1.1.2019	% share 65 + / total population
City	7 177	1 471	**20**
Municipality 1	900	137	15
Municipality 2	848	140	17
Municipality 3	628	103	16
Municipality 4	136	40	**29**
Municipality 5	711	132	19
Municipality 6	956	169	18
Municipality 7	183	47	**26**
Municipality 8	811	201	**25**
Municipality 9	229	42	18
Municipality 10	378	88	**23**
Municipality 11	383	80	**21**
Municipality 12	801	126	16

Source: Own elaboration based on research data, 2020.

As can be seen in table 2, in these 12 municipilities and one city there are 2,059 Seniors (65+), 15,85% of the total population of 12,994 citizens in this selected area. A comparison of the development of the age structure in the monitored communities in the years 2009 - 2018 (Graph 1) shows that the researched issue is extremely topical and urgent.



Graph 1 Development in Age structure in selected municipalities and city
Source: Own elaboration based on research data and Eurostat, 2019.

4. Results and discussion

If we examine the existing capacities of formal care providers (according to individual types and types of social services) in the selected region, we find the tendency to underestimate the need for the senior care. Another negative practice is the long waiting list residential social services and facilities. In the case of clients of this age category, we can even speak of a kind of inhumane approach, where the availability of social care is conditioned by the mortality of already placed clients. For these reasons, such a practice is unsustainable in the long run.

Table 3 Capacity of social services in selected municipalities and city

Social Services	Typy of social service	Capacity
Residential	Retirement Home	145 /capacity is full/ 60 waiters in the list
	Social Services Home	120/ capacity is full
	Supported Housing	16
Outpatient	Day Care Center	15
	Transportation Service	1 provider
Non-formal care		there of 48 seniors over 81 years

Source: Own elaboration based on research data, 2019.

Our research revealed another very important determinant that affects the availability but also the quality of formal care of the examined age group of seniors. This is the age limit of caregivers, i.e. recipients of care allowances. As Table 3 shows, the proportion of those who are already retired is alarming.

The vast majority provide informal care for one person all day in a household. The highest share of seniors who are cared for are in Municipality 7 (12.62%), Municipality 5 (11.11%) and Municipalty 3 (10.65%). The average number for municipalities is 7%, in the city only 4.62. It is highest in Municipality 2 and Municipalty 1 (about 2%). The average age of caregivers - if they are of retirement age is 71-80 (60%) and 5% over the age of 81.

Table 4 Recipients of the care allowance, 2019 – Formal care

Number of carers	161
- of which in retirement age	57
Number of guardians	165
- of which in retirement age	107
- 81 plus	48

Source: Own elaboration based on research data, 2019.

The analysis of the availability of formal services in the field of providing social care for the elderly 65+ showed that the focus (main) responsibility in this direction remains on informal care for the elderly in households, despite the inappropriate age structure of caregivers. The depopulation of regions (the departure of the younger population, especially from smaller municipalities), labor mobility and the spatial migration of the productive part of the population mean that the elderly are gradually taken care of by the elderly.

This trend is influenced by several factors. An important determinant of often voluntary self-help long-term care for elderly household members is, in addition to capacity unavailability, the financial cost of formal social services. The existing gap between the level of pensions and the rising costs of providing formal care services is insurmountable for many families. The issue of economic aspects of population aging is reflected in many foreign studies in terms of economic activity (Lawson, 2016), private consumption (Aigner-Walder, Döring 2012), expenses for health care (Hyun et al., 2016), demand for housing (Coleman, 2014), issues and challenges of local government (Waśniowska, Jedynak, 2020).

Another factor is the persistent conservative attitudes of Slovak households to the way of providing care for older members. Despite significant industrialization, Slovakia is still a predominantly rural country, as evidenced by the region in which we conducted a pilot survey. The value anchoring of Slovak families is still significantly influenced by belonging, mutual family help, intergenerational responsibility and the feeling of obligation to provide for their parents (or disabled household members). These facts affect the large extent of informal care for the elderly in the home environment (Martinkovičová and Kika, 2016). This kind of unpaid work is strenuous. As research shows (Waniger et al., 2019; Stojak et al., 2019; Ślusarska et al., 2019), family caregivers of seniors and disabled adults frequently bear the responsibility of aiding in instrumental activities of daily living and locating resources, often while raising their own families. As the demand for care rises, caregivers may experience declining physical health and increased social and emotional stress compared to their noncaregiving counterparts. Torres and Cao (2019) in their study identify external and internalized ageism and complicated age-based identity as important reasons why older adults preferred "third places" to age-separated spaces such as senior centers and formal settings such as health care settings. They found that neighborhood "third places" offer important physical venues for older adults to process negative or hurried interactions in other formal and age-separated places.

Based on the assessment of the needs in the field of social services and the current situation, we propose some measures to increase their availability and subsequent quality, which are captured in Table 5.

Table 5 Analysis of the situation and suggestions for the improvement of social services

Population Needs	**Current situation**	**Improvement proposed**
Need of social services is based on nationally set standards and local situation. 1. Standards for **minimal anemities for municipalities** based on number of inhabitants (Ministry of Transport and Construction) 2. Proposal of **recommended standards of service facilities** based on analysis of needs of per 1,000 or 10, 000 inhabitans (Nešpor, 2017) 3. **Community planning of social services**	Residential social service are at 69.4% of needed capacity **Outreach social service** (home care services) **are at 2.6% of needed capacity !!!** No support services for non-formal carers. There are also outpatient social service and their capacity is underestimated (according to community plans)	**Significant increase of outreach social services** - home care services, monitoring services, transport services **Support of non-formal family carers via different types of services -** advisory, respite service, day care center or daily center **Increase of specialized residential care** specialized facility for people with dementia, Alzheimer's patients and (in BBSGR region nearest 90 km/ 1:30 hour by car, in Košice region 35 km/ 31 min by car), nursing home for short term stays (nearest 28 km/ 30 min by car)

Source: Own elaboration, 2020.

Regardless of the above, the quality of life of this group of people remains an important issue. The concern is how they feel about living their daily lives, whether in institutional or family care. Therefore, not only the way of ensuring dignified aging but also its quality in terms of well-being (well-being, satisfaction, joy, fulfillment of life, mobility) or ill-being (morbidity, discomfort, exclusion, sadness, loneliness) as components active aging.

The concept of well-being applied to older people's quality of life is not yet sufficiently understood and reflected. A common definition of the term remains lacking. In many investigations older people perceived own quality of life as a life that has value, meaning and purpose when they:

- feel safe and they are listened to, valued and respected,
- are able to get the help they need, when they need it, in the way they want it,
- live in a place which suits them and their lives,
- are able to do the things that matter to them.

The prevalence of positive emotions, which are the result of senior citizens' active social contacts, is also confirmed by the analysis of socio-economic aspects of the seniors' quality of life in Slovakia (Hasa, 2019). The analysis focused on the comparison of socioeconomic aspects of seniors who are living in their homes quality of life and the quality of life of those who are clients of social services. Stay in a social service facility can trigger such negative emotions as anxiety, insignificance or stress from anonymity and uniformity. The society can provide services like food, accommodation or medical care, but fails to give senior citizens a sense of life and to create an emotional background for them. On the other hand, seniors who are clients of social service facilities appreciate the fact that they live in a collective and do not feel alone. They also demonstrate the improvement in maintaining social links with other people and tend to be more interested in their hobbies and leisure activities. As for satisfaction with the quality of life there is no significant difference between seniors-clients of social services facilities and seniors living in the home environment. On the other hand, the feeling of security as part of personal wellbeing is stronger among seniors who are clients of social service facilities than those living at home (Hasa, 2019).

Conclusion

The fact that the population ageing issue in Slovakia is one of the most important topics is also confirmed by the latest information from the Statistical Office of Slovak Republic which was published in May 2019. The basic monitored characteristics include the long-term trend of intensive ageing of the Slovak population. The relationship between the abundance of children and seniors in society is captured by the so-called ageing index. This index exceeded the threshold of 100 for the first time in 2018. In Slovakia, there were more than 102 seniors per 100 children, thus people over 65 years old. The year 2018 is a breakthrough in monitoring of population ageing, the number and proportion of seniors for the first time in Slovakia's history exceeded the number and proportion of children (SO SR, 2019).

Social ageing is characterized by changes in social roles, lifestyle and economic security. It is also connected to a number of negative conditions, such as social exclusion, prejudice and age discrimination, generational intolerance, segregation, as well as higher morbidity, atypical disease progression, lessen ability to communicated own needs, loss of

orientation in social events due to rapid advancement of technology and others. In addition, it may include changes in residence, limitation or loss of social contacts, weakening of interactions, or loneliness (Hasa, 2019).

The value system of today's society is set in a way that highlights the biologically conditioned competencies of youth and attributes such as performance, vitality, energy, or others, while showing negative attitude towards the eldarly. Similarly, the social status of senior citizens is included by the society in the inefficient old-age pensioners category which results in elderly people being at disadvantage and having to confront with a constantly changing social environment. It is necessary to remember that the senior population is an integral part of society and has a huge potential not only for employment but also for active participation in the life of all social structures (Kaščáková and Martinkovičová, 2019). The level of seniors' well-being is a reflection of care and attention of the whole society about this population group.

The term well-being (cognitive, affective and eudaimonic) is a common denominator for finding and acknowledging the broad spectrum of indicators that influence the quality of life of seniors. In general, researching well-being is a relatively new trend, which relates to the shift from GDP to the quality of life. Examining ageing well and the issue of active and healthy ageing is part of this new focus. It brings knowledge of important indicators of quality ageing. It shows the importance of the psychological well-being of older adults and the fact that everyone should have the opportunity to live a long and healthy life. WHO defines Healthy Ageing "as the process of developing and maintaining the functional ability that enables well-being in older age". Functional ability is about having the capabilities that enable all people to be and do what they have reason to value. This includes a person's ability to meet their basic needs; learn, grow and make decisions; to be mobile; to build and maintain relationships; and to contribute to society (WHO, 2017).

A paradox of ageing has been observed in later life: although advancing age is associated with physical and cognitive decline, well-being is consistently found to be higher in later life than among young or middle aged adults (Myers, Diener, 1995). There was a graded association between self-reported health and well-being. Engaging in physical activity is paramount to ageing well. Being physically active is inextricably linked to independent living and other factors such as social support, both of which are crucial aspects for older adults' well-being. Regular physical activity is also linked to immune function improvements and resistance to illness.

To achieve such parameters of aging, we still need to make a lot of effort. This requires coordination of stakeholders from the national to the regional and municipal level. Also the mutual harmonization of both forms of social care for the elderly, both formal and informal, in such a form that one of them is naturally available to every senior.

As we already mentioned, the project was a pilot survey of regional care for the elderly in a selected region of the Southern Gemer, and the methodology used did not yet exist in other research used, which makes it impossible to compile. However, the results as well as cooperation with local governments and mayors have shown that similar projects can bring important information, help solve practical local problems and reveal weaknesses in coping with the problem of population aging.

Grantová support: This research paper originated in partial fulfilment and with the support of the VEGA No.1/0621/17 project "Decision-making Process of Slovak Households about Allocation of Time for Paid and Unpaid Work and Household Strategies' Impact on Selected Areas of the Economic Practice" at the Faculty of Economics, Matej Bel University in Slovakia.

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