Scirocco Exchange

Capacity-building for integrated care

# WP5 Maturity Assessment
# Self-assessment process in the Kosice Region, Slovakia

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# Document information

Department of Social and Behavioural Medicine, Faculty of Medicine, PJ Safarik University in Kosice, Slovakia.

**Authors:** Vladimira Timkova, Zuzana Katreniakova, Iveta Nagyova

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## Statement of originality

This report contains original unpublished work except where clearly indicated otherwise. Acknowledgement of previously published material and of the work of others has been made through appropriate citation, quotation or both.

## Disclaimer

# 1 Introduction

The self-assessment process was conducted by the Department of Social and Behavioural Medicine, PJ Safarik University in Kosice, Slovakia. The mission of the Department of Social and Behavioural Medicine is to deliver cutting edge research, engagement and training that advances social and behavioural medicine, influences health policy and develops professional skills for the delivery of better health and social care in the community.
National coordinator of the SCIROCCO Exchange project, Dr. Iveta Nagyova is actively involved in knowledge translation and serves as an advisor to the WHO Country Office in Slovakia and the Ministry of Health of the Slovak Republic. Since March 2020, she is also President of the European Public Health Association.
The department's interdisciplinary team conducts basic, translational, and clinical research contributing to bio-behavioural and psychosocial innovations in chronic condition management; and promotes development and implementation of patient-centred, integrated models of care.

## 1.1 Characteristics of healthcare system

| Item | Description |
|---|---|
| Region | Slovakia/Kosice (KE) region |
| Geographical scale of the region | Regional (State, province, territory) |
| Geographical size and dispersion of the region (km $^2$) | 49.035/6.753 [1] |
| Population size of the region (thousands) | 5.450 000/799.816 [1] |
| Population density of region (inhabitants/km$^2$) | 111.15/118.42 [1] |
| Life expectancy of the region (years) | 76.70/76.35 [2] |
| Fertility rate of the region (births/woman) | 1.40/1.40 [2] |
| Mortality rate of the region (deaths/1,000 people) | 9.9/9.0 [2] |
| Top three causes of death of the region | cardiovascular diseases, cancer, respiratory diseases [2,4] |
| Organisation and governance of healthcare services | The Slovak health system is based on statutory health insurance, a basic benefit package, universal population coverage, and competitive insurance model with selective contracting, and flexible pricing. About 80% of healthcare spending in the Slovak Republic (SR) is publicly funded. Compulsory health insurance contributions are collected by the health insurance companies. There is one state-owned health insurer and two privately owned health insurance companies. They are obliged to ensure accessible healthcare regulated by |

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| | legislation – this means to contract a sufficient network of providers as determined by the Ministry of Health and Self-governing Regions (regional responsibilities mainly for outpatient care). The Health Care Surveillance Authority is responsible for surveillance over the health insurance and healthcare provision. Pharmacies and diagnostic laboratories, as well as almost 90% of outpatient facilities are private. The state owns the largest healthcare facilities in the country, including university hospitals, large regional hospitals, specialist institutions, psychiatric hospitals, and sanatoria. Institutional healthcare consists of 71 general hospitals, 42 specialized hospitals, 29 spa facilities, 12 hospices, 6 mobile hospices, 9 nursing homes, and 1 biomedical research facility. Healthcare is financed by public resources - via health insurance. The main source of revenue of the health insurance companies is represented by contributions from employees and employers, self-employed, voluntarily unemployed, publicly financed contributions on behalf of economically inactive persons, and dividends. Additional source of financing includes public financial resources represented by budgets of particular municipalities, or the Ministry of Health. Another important component is the category of direct payments of patients, e.g. co-payments for prescribed medication, durable medical equipment, dental care, fees in private hospitals/outpatient healthcare, and direct payments for over-the-counter medication, or spa treatment. The sole investments come only from the EU structural funds. The outpatient care includes primary care and specialized care. Primary care in SR consists of GPs for adults/children, gynaecologists, and dentists. [1-7] |
| Healthcare spending of the region (% of GDP) | 5.2 billion € (5.8%of GDP) [3]/NA |
| Healthcare expenditure of the region (thousands) | 1.538 € per capita [2,3]/NA |
| Distribution of spending in the region | Inpatient care: 28%; 1276.000 000<br>Outpatient care: 23%; 1044.000 000<br>-specialised care 17.7%; 809.000 000<br>-primary acre 5.1%; 235.000 000<br>Prevention: 0.01%; 312.073 |

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| | Social services: 0.23%; 12.000 000<br>Medications: 24%; 1258.000 000[6] |
| Size of the workforce (thousands) and its distribution (%) in the region. | Nurses; SR: 30.732 (5.6/1.000 inhabitants) (8)<br>Midwifes SR: 1.834 (0.3/1.000 inhabitants) (8)<br>Nurses; KE region: 4.745 (5.9/1.000 inhabitants) (8)<br>Midwifes KE region: 260 (0.3/1.000 inhabitants) (8)<br>Nurses; inpatient care; SR: 16.913 (5.9/1.000 inhabitants) (8)<br>Nurses; inpatient care; KE region: 2.876 (3.6/1.000 inhabitants) (8)<br>Nurses and midwifes; outpatient care; SR: 11.286 (2.1/1.000 inhabitants) (8)<br>Nurses; outpatient care; KE region: 1.837 (2.3/1.000 inhabitants) (8)<br>Physicians SR: 18.608 (3.4/1.000 inhabitants) (8)<br>Physicians KE region: 2.958 (3.7/1.000 inhabitants) (8)<br>Physicians; inpatient care; SR: 6.774 (1.2/1.000 inhabitants) (8)<br>Physicians; inpatient care; KE region: 1.038 (1.3/1.000 inhabitants) (9)<br>Physicians and dentists; outpatient care SR: 11.050 (2.0/1.000 inhabitants) (8)<br>Physicians; outpatient care; KE region: 1.837 (2.3/1.000 inhabitants) (8)<br>General practitioners SR: 3.480 (8)<br>General practitioners for adults, SR: 2.430 (0.4/1.000 inhabitants) (3)<br>General practitioners for children, SR: 1.050 (0.2/1.000 inhabitants) (3)<br>General practitioners KE region: 508 (4)<br>General practitioners for adults, KE region: 319 (4) (0.4/1.000 inhabitants)<br>General practitioners for children, KE region: 189 (4) (0.2/ 1.000 inhabitants)<br>Dentists SR: 2.723 (0.5/1.000 inhabitants) (8)<br>Dentists KE region: 483 (0.6/1.000 inhabitants) (8)<br>Social workers; SR: 5.000; (1/250 clients)<br>Number of providers of social services in SR: 1.548<br>Number of providers of social services in KE region: 238 |

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| | Informal caregivers in SR: 55.000<br>Informal caregivers in KE region: 5.547<br>Social services establishments in KE region: 1.242<br>Nursing services at home in KE region: 345 (10) |
| Healthcare policies in the country/region | 1. Integrated care. Since 2014, the Slovak healthcare system is in a process of adopting new strategic planning framework which aims to ensure integrated outpatient care, to contain overutilization, and to restructure inpatient healthcare. Integrated care is aimed to consist of organized, coordinated, and collaborative network linking various healthcare providers to secure the availability of continuous health services. Still, some health indicators such as life expectancy, healthy life years (54 yrs.), and avoidable mortality (44% of all deaths)[15] (amenable (1.7/1.000), preventable (3.6/1.000) mortality) in SR are worrisome [3,12]. Furthermore, number of hospitalizations in SR is higher (184/1.000) than in other OECD countries (156/1.000); number of physician visits is twice as high as in other OECD countries (11 per year). The image and status of the general practitioners (GPs) is poor. GPs often fulfil the role of "referral clerks" to specialists and healthcare becomes more expensive. Moreover, passive capitation provides GPs incentives to see few patients and to work shorter hours. Specialists in SR are paid fee-for-service, their overall reimbursement is capped, which results in long waiting periods for specialized care. This fragmentation of outpatient healthcare and overuse of inpatient healthcare has a negative impact on healthcare quality and costs. Thus, the main goal of integrated care in SR is to: A) improve efficiency by strengthening primary care, and B) reduce reliance on the specialized care and hospital sector. Poor hospital management, high numbers of unused acute care beds, over-prescription of medications, overuse of specialized, tertiary healthcare, limited amount of core competencies in GPs, high average age of nurses and physicians, especially in GPs (56.7 years), and poor gatekeeping lead to inefficiency of healthcare. Eliminating these inefficiencies in healthcare is one of the key factors in improvement of healthcare quality and cost reduction. [3,5,7,14,15] C) The next goal of |

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| | integrated care is to ensure health system to be renewed by GPs and specialists by means of residential program (financially promoted specialization study), with subsequent placement in the regions with shortage or high average age of physicians in outpatient care. D) Finally, integrated care also aims to implement public health programmes focusing on prevention of communicable and noncommunicable diseases. (3,5, 10, 7, 15)<br><br>2. Inpatient healthcare is provided by hospitals or other healthcare facilities. In this area, the key priorities include: A) to redefine and stratify types of hospitals and range of healthcare services they provide, review existing types and organisational structures in inpatient healthcare (e.g. as individual hospitals in SR significantly differ in terms of mortality, re-operation, and rehospitalization of patients, they will be authorised to provide a certain specialization only if they will be able to achieve the required minimal limit of these procedures);* B) as according to OECD, by 2050, 30% of the Slovak population may be over 65, insufficient long-term and institutionalised care will require immediate solutions. There is poor quality, availability, and no financing or lack of financing from insurance companies. Thus, it is necessary to re-evaluate a number and structure of acute care beds and to strengthen after-care, rehabilitation, nursing care beds and beds for long-term patients; C) to implement a programme related to renewal of healthcare infrastructure of hospitals aimed to effectively use the human resources, buildings and medical equipment; D) to effectively receive and transfer information (eHealth) between the hospitals and other healthcare facilities of inpatient/outpatient healthcare; E) to stress the continuity of healthcare while transferring patients from hospital to their own home or wider community environment. (5,14,15)<br>**2020: law was not approved*<br><br>3. Public health indicators such as life expectancy at birth, number of life lost years due to premature deaths and disease consequences and prevalence of chronic non-communicable diseases, place Slovakia at the bottom of the ranking of EU countries. Therefore, priorities of **public health** are: A) to |

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| | create a healthcare system at national, regional and local level; B) to implement the public health programs for prevention of socially significant diseases and health risks; C) to increase the level of public health in communities of socially disadvantaged people; D) to increase the level of readiness for biological, chemical and radiation threats; E) to better improve understanding of social determinants of health (multisectoral collaboration in the field of life, work and social environment); F) to strengthen individual interest and responsibility for own health, to promote health literacy, healthy lifestyle, physical activity, healthy eating, decrease in consumption of alcohol and tobacco, prevention of drug addiction, prevention of mental health disorders. [4,6,9,10] |

### 1.2 Integrated care in the Kosice Region / Slovakia

Integrated care in the Kosice region / Slovakia is minimally implemented. Slovakia lags behind in implementing health information technologies as compared to other countries in Europe. The focus of integrated care is related to integration of mandatory primary outpatient care, gynaecological care, and dental care as the first contact physicians. The Ministry of Health of the Slovak Republic declares that a total of 126 million € will serve for building and reconstruction of 140 integrated centres. In these integrated care centres, the presence of other services such as social care or psychological care is optional. Moreover, there is no system of integration of health and social care services for people with chronic diseases, disabilities, people in older age, homeless or other vulnerable groups. The responsibility for provision of social services is decentralized to the municipalities and the regional self-governments. The overall financing is insufficient, provided by the state, regions and the municipalities. [3,5,7,10,13]

# 2 Self-assessment process in the Kosice Region / Slovakia

## 2.1 Identification process of the local stakeholders

For the self-assessment process the stakeholders from the regional and local level were selected based on the previous collaboration and with regard to the main dimensions of SCIROCCO Exchange Maturity Model. In total 23 representatives of various institutions were included in the assessment process:

Table 1: Stakeholders' profile

| Type of organisation | Stakeholder |
|---|---|
| State administration | Regional Public Health Authority in Kosice (2 people)<br>Healthcare Surveillance Authority – Kosice<br>Social Insurance Agency in Slovakia – Kosice<br>Office of Labour, Social Affairs and Family Kosice |
| Self-government – regional and local level | Kosice Self-governing Region - departments/units on regional development, fundraising, social services, healthcare (7 people)<br>District of Kosice – North (unit on social affairs) |
| University | PJ Safarik University in Kosice – Faculty of Public Affairs<br>PJ Safarik University in Kosice – Faculty of Law |
| Regional representatives of professional healthcare associations | General practitioner<br>Doctor - specialist in Rehabilitation<br>Physiotherapist |
| Primary health care provider | Doctor - specialist in Neurology |
| Health and social care provider | Manager in complex of health and social care facilities |
| Patients' non-governmental organisations | League Against Cancer – Kosice<br>Union of blind and partially visually impaired in Slovakia – Kosice<br>Association for Mental Health - INTEGRA, o.z., Michalovce |

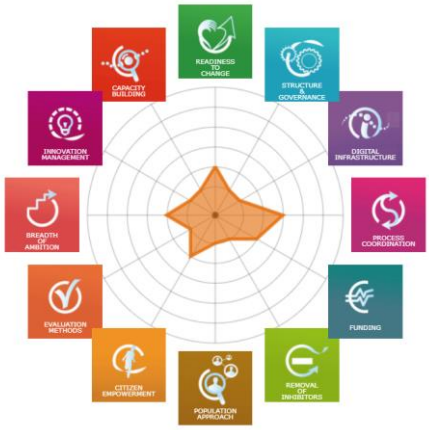
## 2.2 Self-assessment survey

Individual self-assessment surveys were conducted using the translated Slovak version of SCIROCCO Exchange self-assessment tool. Data were collected in February - March 2020. An invitation letter with the printed form of informed consent and tool was sent via regular mail to selected participants at the end of February (Annex 1, Annex 2, Annex 3). They could fulfil the paper version or online version of the Tool (after receiving an e-mail reminder in the middle of March). A short manual in Slovak with detailed instructions for completing the online version was also prepared and sent with the e-mail reminder (Annex 4).

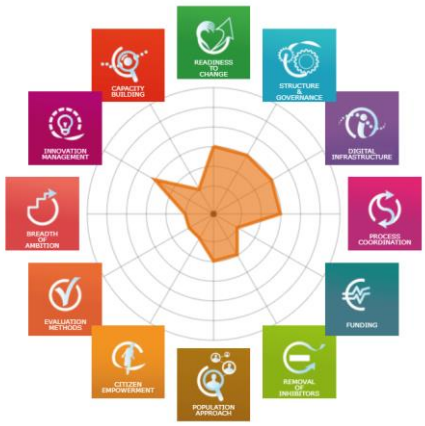
Out of 23 eligible respondents, the Regional Public Health Authority in Kosice and Kosice Self-governing Region nominated only one person per institution (i.e. 2 respondents instead of 9 invited), 7 stakeholders did not respond, and 2 stakeholders sent an apology that they could not attend, yielding a total response rate of 30.0%. One of the presumed reasons for non-participation was time coincidence with measures introduced by the national government in connection with the outbreak of COVID-19. A total of 7 stakeholders participated in the self-assessment process. All stakeholders filled the paper version of the Tool.

## 2.2.1 Outcomes of self-assessment survey

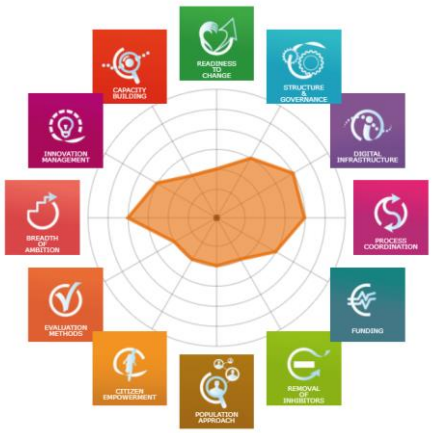
1. General Manager of health and social care facilities



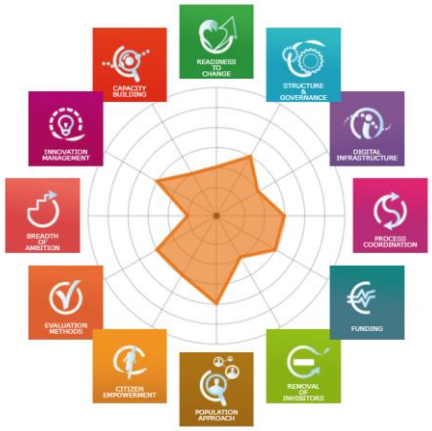

2. Manager of social insurance agency, Kosice



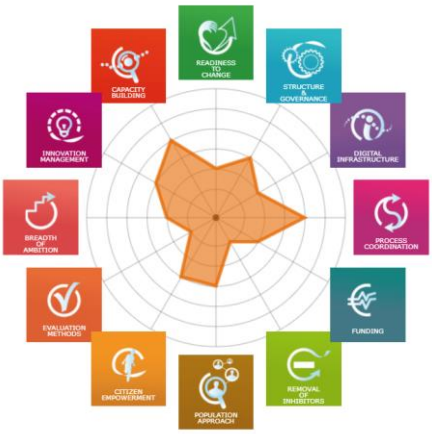

3. Vice-Director of regional Public Health Authority



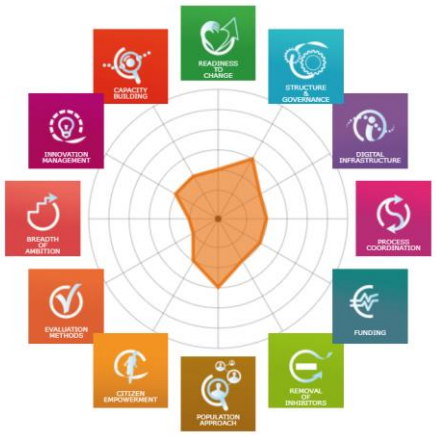

4. Regional Expert for Physiotherapy and Medical Rehabilitation



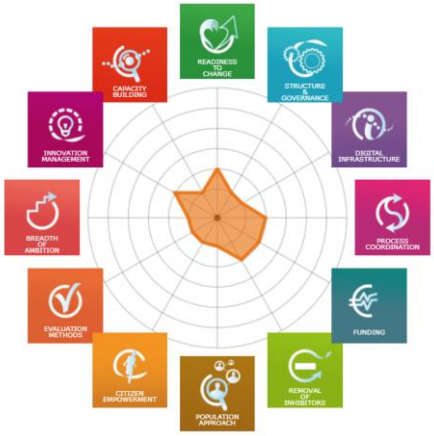

5. Social worker of Kosice district – North (Social affairs unit)




6. Director of Association for Mental Health - INTEGRA, Michalovce



7. Head of Department on Social Care Facilities Administration, Kosice Self-Governing Region



## 2.3 Stakeholder workshop

The negotiation and consensus building workshop was held on the 26th of March 2020. Due to the restrictions related to safety measures to prevent the spread of COVID-19 in Slovakia the meeting was organised virtually, using the GoToMeeting Platform. The stakeholders workshop lasted for 2.5 hours. A total of 3 professionals (out of 7 stakeholders) were available to participate virtually, and 4 stakeholders sent their apology in advance. All attendees were representatives of different settings at regional or local level (self-governing region, health and social services, and clinical health care).

Before the meeting all stakeholders filled their individual integrated care assessments, using the paper version of SCIROCCO Exchange tool. The outcomes of theses assessments were then entered into the online Slovak version of the SCIROCCO Self-Assessment Tool. A short presentation with the outcomes was also sent in advance of the meeting in order to facilitate the discussion during the meeting (Annex 5).

### 2.3.1 Negotiation and consensus building

Consensus-building process was based on moderated discussion. A moderator was the SCIROCCO project national team member and an expert in a field of health and social care. The main principle of consensus building was built on expert discussion via shared facts, experience of the clinical practices, and social care experiences, offered opinions, and responds to questions asked by the moderator. The discussion was triggered and facilitated by using the online shared presentation and also with the assistance of 2 other members of SCIROCCO project national team.

The differences in stakeholders' perceptions on the level of maturity for integrated care in Kosice Self-Governing region is illustrated in the Figure 1 below:

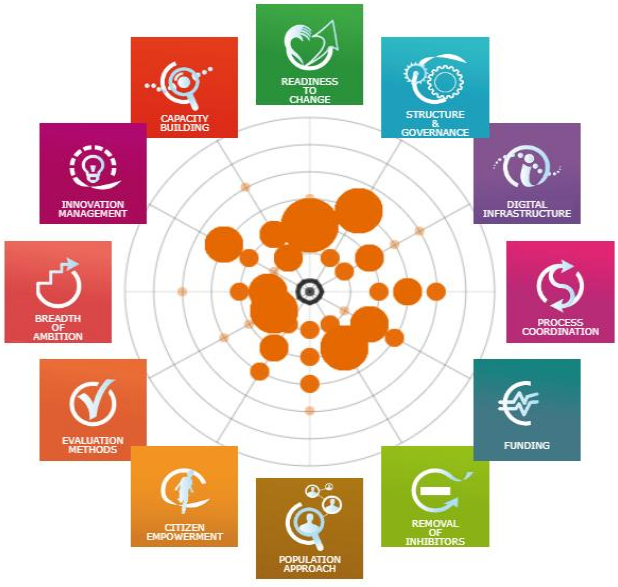



Figure 1: Composite diagram – Kosice Self-Governing Region

There hasn´t been recognised one single dimension that could be identified as having reached appropriate maturity level. The overall dimension score was very poor and the maturity level in the final consensus varied mostly between 0 (in 4 dimensions) and 1 (in 7 dimensions). Final consensus showed that only one dimension (Process Coordination) was able to reach higher, but still not satisfactory, level of maturity (score 2). The main reason for the insufficient maturity level of health and social care in Slovakia at regional as well as at national level is lack of effective communication and co-ordination between the Ministry of Health and the Ministry of Labour, Social Affairs and Family of the SR. Governmental authorities are aware of the lack of integration between health and social system or under-developed long-term care. Nevertheless, no efficient policy, nor systematic actions are taken.

### 2.3.2 Final consensus

The consensus spider diagram shows the maturity of Kosice Self-Governing Region for integrated care. The local stakeholders reached consensus across the twelve dimensions of SCIROCCO Exchange tool.

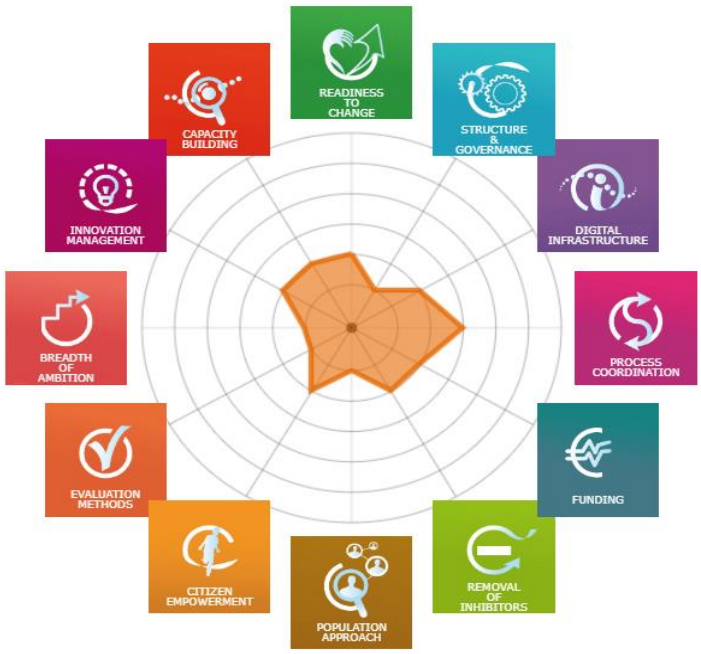



Figure 2: Consensus diagram – Kosice Self-Governing Region

| Dimension | Scoring | Justifications & Reflections |
|---|---|---|
| Readiness to Change | 1 | The need is accepted. However, a feasible vision or any planning is lacking. |
| Structure & Governance | 0 | No systematic guidelines are given by the national or regional government. There are some rare incentives exist - accompanied by non-systematic, individual bottom up approach to change. There is a potential for cooperation between professionals, especially within the social care system, but there is no clear vision, planning, or management exist at regional level. Despite the fact that the national "Long-term Care Strategy" exists since 2019, there is no real progress from perspective of implementation. The communication between the Ministry of Health and the Ministry of Labour, Social Affairs and Family of the SR is formal ad ineffective. |
| Digital Infrastructure | 1 | There is a certain level of data sharing, as well as data availability and data protection (but it is usually limited to the healthcare system by means of e-Health). There is no digital infrastructure with a potential to interlink health and social care systems. Both systems (health and social care) are built on their own separate digital infrastructure and there is no plan to change it. According to official government documents dealing with digital infrastructure, there is no legislative support for the integration of health and social care. |
| Process Coordination | 2 | There are some basic norms adopted and standard procedures developed; however, it is not possible to integrate health and social care, as these standards are not uniform, interdisciplinary and suitable for usage by a wide range of existing diagnoses. |
| Funding | 1 | While there is a certain level of funding within the EU sources, these financial resources are primarily used for the construction and reconstruction of integrated care centres. These centres are planned to provide primarily an integration of primary care medical professionals (GPs, paediatricians and gynaecologists). The availability of other services such as social services and psychological care is only optional. |
| Removal of inhibitors | 1 | There is no initiative or will to remove inhibitors. A more detailed picture could be given by a detailed analysis of the causes of worrying health indicators (such as avoidable deaths or health life years). However, no one wants to take responsibility for this. It is also assumed that adoption of some effective measures would lead to financial loss of some involved subjects. |
| Population Approach | 0 | A population-based approach is needed, but it is still not applied to all diagnoses - just to some of them (e.g. cerebral palsy). In addition, there is no screening tool to identify vulnerable (at high-risk) population groups in Slovakia. There is also a lack of available community services. Therefore, people often have no other efficient solution than call an ambulance and stay in hospital (also in cases when hospitalisation would not be required). |
| Citizen Empowerment | 1 | Citizens are not in the centre of attention. There are no integrated health and social services in case of health problems, especially for older people. The state does not provide adequate assistance and support. Measures or policies aimed at preventing these tragic situations are not adopted. Patient organisations substitute the role of the state and its responsibility. |
| Evaluation Methods | 0 | A Health Technology Assessment strategy is planned; however, it has not been formally adopted by the competent national authorities yet. |
| Breadth of Ambition | 0 | Several pilot projects are ongoing. However, integration exists to some extent only between hospital and outpatient healthcare. |

| Dimension | Scoring | Justifications & Reflections |
|---|---|---|
| Innovation Management | 1 | Innovations are very limited and mostly exist only in one separate and specific area. Innovations are not systematic and are based largely on its own individual initiative. The pressure to change is mostly driven from the bottom up and is very rarely supported. Therefore, it is difficult to create and enforce innovative ideas. Occasionally, innovations are strengthened by management at organizational level. |
| Capacity Building | 1 | The high average age of social care and health care professionals (especially doctors, nurses) may represent one of the significant obstacles in capacity building. Capacity building is preferably driven by bottom-up initiatives and non-governmental organisations. |

# 3 Analysis of the outcomes

1. The self-assessment outcomes reflect the current situation and the most significant problems related to integrated care implementation at regional as well as national level in Slovakia.
2. Self-assessment outcomes were not surprising. Based on previous knowledge and negative experience related to integrated care implementation at national level similar results were expected and confirmed at regional level.
3. Common factors connecting all the dimensions seem to be the absence of clear, uniform and effective state governance, preferably from the level of Ministry of Health and Ministry of Labour, Social Affairs and Family of the Slovak Republic, together with a lack of measures adopted by national and regional governments to facilitate the integration process between health and social care systems. Also, an absence of community-based services, missing person-centered care approach in care provision, and changes usually driven only by bottom-up initiatives and non-governmental organisations can be considered other important weaknesses of integrated care implementation process in Slovakia at both, national and regional level.
4. There hasn´t been recognised one single dimension that could be identified as having reached an appropriate maturity level. Final consensus showed that only one dimension (*4. Process Coordination*) was able to reach higher, but still not satisfactory, level of maturity (score 2). The overall dimension score was very poor and the maturity level in the final consensus varied mostly between 0 (in 4 dimensions) and 1 (in 7 dimensions). Thus, further improvement in all assessed dimensions is necessary.
5. The maturity level was found to have the lowest value (score 0) in the four following dimensions: 2. Structure & Governance, 7. Population Approach, 9. Evaluation Methods, and 10. Breadth of Ambition. Of those, Structure and Governance dimension seems to be the most important starting point that may help to facilitate the process of adoption of all inevitable changes. One of the key problems is lack of communication and coordination between The Ministry of Health and The Ministry of Labour, Social Affairs and Family. Governmental authorities are aware of the lack of integration between health and social system or underdeveloped long-term care. Nevertheless, no efficient policy, nor systematic actions have been taken. An expert working group that would be able to advise/propose measures for integration process at the regional level and/or municipality level is needed. Another important issue identified by stakeholders is funding. Although certain level of funding within the EU sources is available, these financial resources are primarily used for the (re)construction of integrated care centres.
6. Structural characteristics such as high average age of social care professionals and health care professionals may have negative effect on integration of health and social care. The need for integrated care is accepted, but only in terms of individual values. Feasible vision or any planning is still lacking. The problem may be excessive conservatism bias and resistance to change. In general, this is our „national“ phenomenon. Furthermore, involvement of responsible institutions or individuals is poor. Therefore, change is usually driven only by bottom-up initiatives and non-governmental organizations. In general,

there is low level of awareness of the need for integrated care in different populations. Consequently, people do not put pressure on the competent authorities and don´t ask them to find solutions.

# 4 Key messages

When accompanied by the outcomes of consensus meeting, the SCIROCCO Exchange tool may be of great help in the process of adoption of necessary changes as it may facilitate the further development process related to integrated care. In terms of the total quality management (TQM), this tool represents the important part of the PDCA cycle that needs to be completed. Some specific actions related to adoption of new measures need to be taken, however. Finally, SCIROCCO Tool helps to facilitate interdisciplinary discussion.

# 5 Conclusions and next steps

The following next steps were identified by stakeholders as a result of the maturity assessment process:

- Communication of the outcomes of the maturity assessment process at regional level in order to increase the awareness about the need for integrated care and to get this concept of integrated care on the agenda of upcoming economic and social development program of the Kosice region;
- Communication of the outcomes of the maturity assessment process at national level in order to get the concept of integrated care on the agenda of new government of the Slovak Republic (government policy statement).

# References


1. Smatana M, Pažitný P, Kandilaki D, et al. (2016) Slovakia: Health system review. Health Systems in Transition 18(6):1–210
2. OECD/European Observatory on Health Systems and Policies. (2017) Slovak Republic: Country Health Profile 2017, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels. Available at: http://dx.doi.org/10.1787/9789264283541-en
3. Ministerstvo financií SR. (2018) Revízia výdavkov na zdravotníctvo II. 74 pgs.
4. Dringuš P., Jusková Z., Klimovská Z. et al. (2016) Priority zdravotnej politiky pre Košický kraj na obdobie 2016 – 2020. Available at: https://web.vucke.sk/files/zdravotnictvo/priority-zdravotnej-politiky-ksk-2016-2020-final.pdf
5. Ministerstvo zdravotníctva SR. (2018) Implementačná stratégia - systém integrovaného poskytovania zdravotnej starostlivosti: Modernizácia zdravotníckej infraštruktúry a zlepšenie dostupnosti kvalitných služieb v primárnej a akútnej lôžkovej zdravotnej starostlivosti.
6. Gavurová, B., Kováč, V., & Fedačko, J. (2017). Regional disparities in medical equipment distribution in the Slovak Republic–a platform for a health policy regulatory mechanism. *Health economics review 7*(1): 39.
7. Kokia E, Kaye R, Shimshoni J, et al. (2014) Community care in Slovakia: The integrated care center. Haelth systems consulting group. 1-46.
8. NCZI. (2017) Available at: http://www.nczisk.sk/Statisticke_vystupy/Publikacie_statisticke_prehlady/Zdravotnicke_rocenky/Pages/default.aspx
9. NCZI. (2016) Sieť zdravotníckych zariadení a pracovníci v zdravotníctve v SR 2016. Available at: http://www.nczisk.sk/Aktuality/Pages/Siet-zdravotnickych-zariadeni-a-pracovnici-v-zdravotnictve-v-SR-2016.aspx
10. Cangár, M., Machajdíková M. (2017) Dlhodobá starostlivosť v Slovenskej republike - Potreba systémovej zmeny. Available at: https://www.rpsp.eu/wp-content/uploads/2018/04/LTCpolicybrief_final.pdf.